

PROMISING PRACTICES IN COMMUNITY-BASED SOCIAL SERVICES IN CEE/CIS/BALTICS

A Framework for Analysis

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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EXECUTIVE SUMMARY

This report, prepared for the Social Transition Office of the USAID Bureau of Europe and Eurasia, is the result of a desk top study—a secondary analysis of regional and country-specific reports on the evolution of family-focused, community-based social services for vulnerable groups in the region. Paralleling the region’s transition from a command economy to a market-oriented society is a shift in the social contract from a state to a shared state-community responsibility for care of vulnerable groups. This study provides a framework for analyzing common elements in the transition of the social service delivery system that cut across different vulnerable groups. The report identifies internationally recognized standards of practice and describes examples of promising practices in community-based social services emerging in the region.

This study is both informational and analytical. It reviews various reports, assessments, and evaluations of policies, programs, and services in the region and draws conclusions based on reported findings and recommendations. As governments and donors experience shrinking resources, managing investments for long-term gain becomes increasingly important. This information and analysis can be used to inform advocates and political and professional leaders about progress and strategic interventions that incorporate multiple levels of system reform, thereby increasing the potential for sustainable change.

This report on promising practices focuses specifically on the four groups of special interest to the Social Transition Office at USAID: children and youth, disabled people,¹ elderly persons, and Roma as a minority group. Special attention is given to elements in the transformation of systems of care including de-institutionalization, decentralization, targeting of benefits and services, economic and vocational development, human resource development, development of standards, and social inclusion. A primary goal of this paper is to communicate a sense of hopefulness that positive change is occurring in the midst of economic and political turmoil.

Framework for Analysis

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 in the following table.

¹UN definition of “disability” refers to any “number of functional limitations occurring in any population” in the world. Disabled people includes functional limitations due to “physical, intellectual or sensory impairment, medical conditions or mental illness.” (*Standard Rules on the Equalization of Opportunities for Persons with Disability*, G. A. Res. 96, UN GAOR, 48th Session. (1993).

A Framework for Analysis	
<p>Policy and Legal Framework: The overarching values and principles; the targeted vulnerable populations; centralized and decentralized functions; relationships with NGOs; financing and accountability; strategies and implementation plans.</p>	<p>Human Capacity: The capacity of the workforce to perform specific job functions and meet international standards; the availability of education and training for workforce development; and licensing and certification of professionals.</p>
<p>Structure of Services: Identified priority risk groups; categories and types of services available to clients; how potential clients are informed, targeted and assessed; the degree to which services are aimed at supporting family and community living.</p>	<p>Performance Measures: The outcome indicators used to measure change in target groups based on designed interventions; information and monitoring systems to track changes in programs and client groups.</p>

This four-pillar framework can serve as a strategic model in determining potential entry points for system change efforts. Strategies for making sustainable change in a system of social services ideally include, simultaneously, a bottom-up approach (aimed at the practice level including designing new services and building the human resource capacity) and a top-down approach (aimed at the national policy/legislative framework inclusive of standard-setting, monitoring, and accountability).

The bottom-up approach increases local capacity by piloting best practices, enlarging and replicating services in additional localities, and building a “critical mass” that can lead to sustainable changes. The top-down approach provides the basic philosophical framework, emphasizes rights of client-groups, has the potential to provide political incentives, standardizes social services, and may provide for sanctioning non-compliance. Interventions that are strategic and incorporate multiple approaches have the potential for longer-term gains and increased sustainability. Integrated into the model are various dimensions of reform: civil society development, community and economic development, decentralization, targeting, inclusion (such as inclusive education), vocational education and employment, and advocacy.

Summary of Findings

There is a wealth of available information on vulnerable groups and the programs and services aimed at meeting their needs. The information, in fact, can be somewhat overwhelming, because of its volume and its easy access via the Internet. Many governments and NGOs in the region have Web sites and provide information translated into English. Numerous databases, including training curricula and policy and program manuals, provide information on emerging practices and can serve as a form of technical support to program designers and implementers. The challenge is to absorb and collate the various documents, which utilize different technical terms and frameworks to describe the field of social services. Despite this, it is possible to discern elements in the region’s social service policies that can be analyzed using the four-pillar framework.

Policy and Legal Framework

Central and Eastern Europe clearly has made tremendous progress in changing the policy and legal framework needed to transform the system of care in the region *from residential to community-based*,² with slower progress being reported in the countries of Central Asia and the Caucasus, in part due to increased factors of vulnerability such as poverty, unemployment, and internal conflict.³ This has led to an alarming rise in the number of street children, child institutionalization, HIV/AIDS, drug abuse, and the rate of juvenile crime.⁴ Most social sector reforms have been centered on child protection issues. In some countries, Romania for example, the reforms in child protection have also led to reforms promoting decentralization and de-institutionalization for the elderly and disabled.

International treaties are the basis of much of the policy and legal changes: the UN Convention on the Rights of the Child, Declaration on the Rights of Disabled Persons, Universal Declaration of Human Rights, Standard Minimum Rules for the Administration of Juvenile Justice, (Beijing Rules) and The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).⁵ Increasingly, country laws and policies are being changed to reflect the basic principles in these treaties and professional practice standards. The champions of change are representatives of both public and private entities, with significant involvement of civil society organizations. Through these advocacy groups and the increasing numbers of government partnerships with NGOs made possible by NGO/government contracting mechanisms, positive policy changes are taking place. But the problem remains: the gap between policy and practice is huge and growing. Although lack of financial resources is the most frequently cited barrier to the provision of services and reform, the lack of political will and the absence of clear strategic planning for implementation are key factors. UNICEF⁶ identifies three types of family support policies that need to be addressed in order to reduce the gap between policy and the reality of what is available for families at risk of separation.

1. **Type A:** *Universal family and child benefits and services* which were very much a part of the socialist system have eroded and left families to cope on their own with a shrinking safety net.
2. **Type B:** *Specialized family support services* (crisis oriented child protection and family reunification) have been absent and underdeveloped.
3. **Type C:** *Substitute care services* (adoption, foster care, residential care) require more reforms in order to adequately meet the needs of children separated from their families.

² The term “*from residential to community-based*” refers to a process of transforming care models for vulnerable groups from residential, out-of-home care to family-based care. These new models reflect international standards of best practices and the principles of the Convention on the Rights of the Child, which is the guiding policy framework for child welfare programs in the transition countries.

³ Falkingham, Jane (2000). *From Security to Uncertainty: The Impact of Economic Change on Child Welfare in Central Asia*. Innocenti Working Paper No. 76. Florence: UNICEF Innocenti Research Centre.

⁴ Source: www.unicef.org/uzbekistan/protection.html

⁵ The International Human Rights Lexicon Website provides all the treaties categorized by vulnerable groups. See <http://www.internationalhumanrightsexicon.org/>.

⁶ UNICEF. (1997). *Children at risk in central and eastern Europe: Perils and Promises. A Summary*. The MONEE Project Regional Monitoring Report. No 4.

Without adequate systems of accountability and sanctioning, there is little hope that the policy-practice gap will close. Some of this lack of strategic planning is being addressed as an increasing number of countries develop a plan of action that aims to strengthen the family, provide for support for family-type foster homes, and build the capacity of service providers. Setting standards and monitoring the implementation of standards are necessary in order to manage large-scale programs and services, including those delivered by NGOs. (See Table on page 25-26 for a detailed description of the Continuum of Care Model.)

Structures of the Service Delivery System

Across the region, many pockets of best practices emerge for each vulnerable group. De-institutionalization is occurring due to the growing awareness of the human and financial costs of institutional care. Although there is a huge gap between the need for and availability of services, progress can be seen in the growing numbers of demonstration projects that pilot community care and demonstrate to governments and citizens the potential human and financial benefits of community care models. Particularly evident is foster care and family reunification for children and youth, inclusive education for disabled children, activist training and attention to architectural and employment barriers for disabled adults and children, inclusive education and housing for Roma and pensioners, and home-based models of social care for elderly. NGOs provide the bulk of social services and may be the *only* providers to some populations. NGOs continue to define their roles in relation to the public social services sector, which creates a degree of tension between the two sectors. A clearly demonstrated role of the NGO community is in the area of advocacy and public awareness, which impacts policy as well as service delivery.

The service delivery system across the region is fragmented, and the ability to target the most vulnerable is limited. There is little understanding of what a continuum of care means or the benefits of providing family and community supports across the life cycle. While segments of the range of services are being developed, there tends to be an overemphasis on the development of the *protection system* over the *prevention mode*. Unfortunately, institutionalization continues to be the primary response to the vulnerability and needs of at-risk children, youth in difficulty with the law, the elderly, and the mentally and physically disabled.

Human Capacity

Human capacity is developing across the region and this provides the most hope that change will take place. Among primary professionals in the community-based system, there is an active movement to increase the professional training of social workers and psychologists. An increasing number of professional associations are advocating for change in services and for regulation of their professions. With a growing emphasis on community rehabilitation, rehabilitation professionals such as physical and occupational therapists and special educators are in great demand, with an increasing number of professional schools opening. Again, the ability to meet the demand for a qualified workforce is very limited. Salaries are low and education at both public and private universities is expensive. NGOs that provide technical training as part of the demonstration of services are among the greatest resources in workforce development. There is an expanding field of human service workers who demonstrate tremendous enthusiasm and hope.

Performance Outcomes and Indicators

The need for national monitoring systems and standardized indicators is being recognized and developed, most specifically for children. The need to integrate measures of well-being into performance indicators is just now gaining some recognition. A major initiative called the *Multi-National Project for Monitoring and Measuring Children's Well-Being* is an ongoing multi-phase effort to improve the ability to measure and monitor the status of children around the globe. In an effort to shift service outcomes for public and private providers of social services beyond measures of child survival to child well-being, five domains⁷ of children's well-being and approximately 60 indicators were identified in this initiative. Quantitative measures of household income, numbers of children, elderly people, and disabled who reside in institutional care or have been deinstitutionalized do little to inform stakeholders and governments about the well-being of children and families and overall quality of life. Qualitative measures of well-being that reflect the human side of people and contribute to quality of life need to be applied. The above-mentioned project, which was launched in 2001 and continues through 2005, has four primary objectives:

1. To identify indicator measures and build a reliable and valid scientific protocol for new data on children's well-being;
2. To build a collaborative multi-national network of partners and local researchers who will use this protocol to study children's well-being;
3. To develop an archive of the data collected in national and local studies; and
4. To build a strategic plan for disseminating the knowledge gained from the studies and build partnerships with potential users of the data – professionals, policy-makers, advocates, communities, children, and youth.

As the shift from quantitative measures to more qualitative measures takes place for children, there is the potential that such measures can be applied to other vulnerable groups, such as the elderly, disabled people, and minorities.

The Way Forward: Implications for USAID

As funding streams are reduced and capacity in the region grows, most particularly in the NGO sector, integrated models of reform that address a range of issues could potentially expand the results of USAID investment. Leveraging the development of community care models within the public and private sectors requires linking with other donors and integrating efforts for different vulnerable groups. Based on information gathered in this desktop study, implications for USAID are outlined below using the four-pillar framework.

Policy and Legal Framework and Performance Outcomes

- *Donor Coordination in Policy Formation and Monitoring Systems.* National level changes require systematic and coordinated efforts between the donor community and the

⁷ A description of the five domains can be found on page 48.

public sector. USAID can leverage other donors that work directly with national and local governmental entities on policy and legal framework reform and setting up systems for monitoring and accountability by providing technical assistance and training mechanisms. Issues that need to be addressed are modernizing tax laws, outsourcing services to NGOs, public education and professional advocacy, decentralization of public services, inclusion of pilot programs, and tracking services that target vulnerable groups.

- *Regional Network on Policy Formation and Financing.* Facilitate inter-country dialogue on the desired social service outcomes and relevant policy and financing issues that promote achieving those outcomes. Possible topics for a regional agenda include: objectives of the social services system, innovative models for delivering services and their costs, legal and policy framework and institutional agreements, social contracting with NGOs, human resource needs and costs, monitoring and tracking, research and evaluation, and financing of system change.
- *Strengthening Civil Society Organizations and Public/Private Partnerships.* Leverage partnerships between NGOs and public services, a best practice for community-based programs. Capacity-building of NGOs and development of the technical expertise in the public sector through social contracting mechanisms can help build confidence and a resource base that will provide for increased sustainability.

Human Capacity

- *Social Work Case Management.* Facilitate a wider application of the best practices in social work case management methods that have been successfully implemented in Armenia and Romania. These countries utilize a system of professional services that includes client-identification, outreach, and assessment that results in improved targeting⁸ of social assistance⁹ and social services.¹⁰

⁸ Targeting aims to ensure that programs provide for intended clients, but often targeting results in selection of beneficiaries who are more motivated, not necessarily those who are in greatest need. Targeting households with the greatest potential to benefit from assistance can help ensure that the project gets established and will benefit the community in the long run. Over time, the project may expand to those in greatest need.

⁹ Social Assistance is assistance of a monetary value provided by governments to individuals and families, for example a monthly amount of money or subsidized necessities: food, transportation, housing and utilities, medicines, and telephones. In Soviet times, benefits were received from the state regardless of personal or family income. Governments now are reforming *social assistance* so the financial and subsidized goods and services are targeted to those who are in the greatest need. This means that benefits are provided (monetary and in-kind subsidies) only when people can document their level of need based on prescribed eligibility criteria, through what is most often called a “means-test.” The level of support ideally depends on the level of need. This is more in line with how the U.S. determines public assistance for vulnerable groups. The overall goal is to bring the functional income level up to a level that is usually established by policy and/or law.

¹⁰ Social Services (sometimes called human services) refers to a comprehensive range of programs and services that are intended to improve the well-being of individual, family, and community life in a wide range of dimensions (psychological, social, emotional, physical, political, and spiritual). Services are generally part of a continuum of programs including *social protection* (protecting children and adults who are dependant due to psychological, physical, social and/or emotional problems), *rehabilitation* (returning individuals to productive and independent living), and *prevention* (providing information such as parent

- *Regional Network on Peer Mentoring and Technical Assistance.* USAID and other donors have supported the development of technical expertise in the practice of social work, child welfare, disability services, and case management in the region over the last 15 years. A regional network could link technical experts in countries that have had USAID support in system reform (Romania, Armenia, and Bosnia, for example) with individuals in organizations from other countries in the region that are just beginning to initiate reforms, such as in Central Asia. The focus could be on areas such as standards of care, curriculum design for human capacity development, public awareness and community involvement campaigns, and advocacy. The network might include support from regional Participant Training Programs that can bring together mentors for training and model development.

Structure and Types of Services

- *Expand Demonstration of Continuum of Community-Based Social Services to Other Vulnerable Groups.* Expand successful pilot programs in child welfare to disabled persons and the elderly by adapting model programs and leverage other donors to scale up. Romania, in particular, is an example of how this application to different vulnerability groups has been made.
- *Coalition-Building, Advocacy, and Public Awareness.* USAID’s democracy-building and civic participation efforts can be applied to social services by providing technical assistance and training to NGOs and governments on ways to influence public policy and improve access to and quality of community care services.

The information available shows that pockets of positive change do exist, although there are patterns of inconsistency in access and quality of social services in the region. Replication of promising practices, sustaining those systems of care, and addressing inconsistencies in access to and quality of services are challenges that must be addressed. Capacity in the region, developed over the 15 years since the breakup of the Soviet Union, can be built upon. Developing public/private partnerships and building incentives for the political will to change are important contingencies in implementing many legal and policy mandates that are already in place. People seem to know what needs to be done, but having the political will, human resources, and ability to monitor and sustain changes remain important issues.

education, drug awareness, and youth peer counseling). The bulk of social services are provided by NGOs, inclusive of religious organizations, although governments also provide some social services. Increasingly, governments partner with NGOs to contract for services required by law, a process called “social contracting.” Social assistance, which focuses on concrete necessities, is sometimes considered a component of social services, but it is usually integrated into other forms of services such as crisis counseling, family counseling, employment counseling, mental health and substance abuse treatment, foster care, youth prevention programs, and elderly community services that aim to build social support at the family and community level. The overall goal is to increase community and family social support systems to reduce the overall dependence of families. Reforms in the region are aimed at increasing social service programs provided within the community where families and individuals live, and at reducing reliance on institutional care.

PART ONE

RATIONALE AND OBJECTIVES OF THE STUDY

Rationale

This study addresses the Europe and Eurasia Bureau's Social Transition Team request for a discussion of the development of social safety nets in the region at a time when internal and external funding is being reduced. With almost 15 years of experience with an evolving democracy and market economy, what evidence exists that the region is making the transition from residential care (the legacy of communism) to more humane systems of care? What best practices are emerging in the region to address the needs of vulnerable groups? What policies and systems have been put into place to promote investment in building a community-based system of social services that utilizes international standards of care? What human capacity exists to sustain social investments and replicate best practice models?

The early assumption that E&E societies would be able to sustain social safety nets for vulnerable groups has given way to the realization that, in fact, social systems have deteriorated with corresponding declines in health, economic, and education indicators.¹¹ However, even in the face of continuing decline, there are examples of tremendous gains in social and human capital that can serve as building blocks to reform. This study describes these promising practices. It serves as a statement of the solutions and supports that are evolving from the national (macro-level) to local (grassroots) level initiatives. It also serves as a voice for those who ascribe to the values of family and community and who are committed to helping sustain a system of care for vulnerable groups that corresponds to democratic principles of self-determination and community responsibility.

Objectives of the Study

The overall objectives of this study are to:

- Describe factors that influence vulnerability for children and youth, elderly, disabled people, and minorities, with an emphasis on Roma;
- Provide a framework for analyzing a system of community-based social services that utilizes internationally recognized best practices for selected vulnerable groups;
- Describe regional and country-specific examples of the shift from residential to community care, highlighting the current thinking and experiences about the transformation process; and
- Identify and describe emerging best practices within the region that are country-specific and represent public and private sector initiatives.

¹¹Strategic Framework for Programs in E & E (2004-2008), USAID/Washington/E & E Bureau.

Organization of the Report

The body of this study is divided into an Executive Summary, five Parts, and two Appendices. Part One provides a background for the study and lists its objectives. Part Two provides a definition of vulnerability, describes a range of individual, family, and environmental factors that are linked to vulnerability, and identifies and describes target groups for this study. Part Three focuses on the transformation of systems of care from the institutional model to community care. Attention is given to the principles and models that support a more preventative approach and build independence and self reliance (the active approach) as opposed to program features that are protective and paternalistic and perpetuate dependency on helping systems (the passive approach). Part Four lays out the framework for analyzing internationally recognized standards of best practices in community-based care across all vulnerability groups. Part Five provides some general conclusions of the reviewer with a compilation of recommendations culled from the various reports.

Appendix A provides brief descriptions of promising programs for each of the identified groups and describes several cross-border initiatives aimed at improving access and quality of services. Appendix B provides a list of references and useful websites.

PART TWO

FACTORS OF VULNERABILITY FOR SELECTED GROUPS

Vulnerability in the E & E Region¹²

The fact that there are increasing numbers of vulnerable individuals and groups with accompanying social and psychological problems in the Europe and Eurasia region has been well-documented (UNICEF, 1997, 2001, 2002, 2003; WHO, 1998, 2001, 2002). Children and youth, the elderly, disabled people and minority groups, most particularly Roma, are considered to be among the most vulnerable groups.

Indicators used to identify vulnerability include a broad range of health, environmental, social, and economic factors that reflect individual and family well-being. A combination of factors contributes to increased vulnerability, including individual characteristics of the region's deteriorating economic situation, discrimination against vulnerable groups, and the lack of a system of social safety nets. This study focuses on four categories of vulnerable groups: children (0-14 years of age) and youth (15-24 years of age), the elderly (65+ years of age), disabled persons (inclusive of mental and physical limitations), and the Roma as a minority group.

Vulnerability Defined

In general, the term *vulnerability* refers to the reduced capacity for meeting individual and family social, psychological, health and/or economic needs at different stages of the life cycle. Vulnerability is a multidimensional phenomenon that results from the interaction of social, economic, environmental, and political factors. Although it is common to link vulnerability with single risk factors such as age (i.e., being elderly) or physical characteristics (i.e., being disabled), single risk factors do not necessarily result in vulnerability. Vulnerability is a result of a combination of risk factors (individual, family, and community/societal) plus the various coping mechanisms and strategies available at each of these levels. More simply, vulnerability is a function of exposure to hazard or risk plus the ability to cope (Hossain, 2001).

The term *vulnerable groups* refers to individuals who share common characteristics within a community or society (such as age, physical and mental characteristics, or ethnicity), who are at greater risk of experiencing harmful social, environmental, health, economic, and political conditions than the population as a whole, and who, in general, have access to fewer resources for coping (Barker, 1995, p. 404). A determination of vulnerability for any group needs to reflect the context of policies, programs, and services within a country and region.

¹²For a more detailed report see Pitts, M. (December 30, 2004). *Social Issues Critical for Sustainability of Reform: Vulnerable and Strategic Groups*. Aguirre International. Prepared for USAID/Social Sector/E&E Bureau.

Vulnerability may be considered on three systemic levels: (1) individual; (2) family and community; and (3) broad political and environmental circumstances. The table below demonstrates the linkages between the different levels and potential interactions that increase risk to individuals and groups.

Multidimensional Approach to Vulnerability	
System Level	Vulnerability Factors
Individual: Characteristics of the individual that contribute to dependency resulting in increased vulnerability, such as age, mental/physical ability, ethnicity, and gender.	<ul style="list-style-type: none"> ✓ Children and youth ✓ Elderly ✓ Physically and/or mentally disabled persons (inclusive of depression/suicide risk; addictive disorders) ✓ Ethnic minority
Family and Community: Characteristics of work, school, community, and family life that contribute to vulnerability, such as income, education level, and social behavior.	<ul style="list-style-type: none"> ✓ Family poverty ✓ Unemployment/underemployment ✓ School dropout/poor school performance ✓ Family violence ✓ Delinquency and crime ✓ Internally displaced persons/refugee status ✓ High risk behaviors such as alcohol and drug use/abuse, early sexual activity
Broad Political and Environmental Conditions: Characteristics of the economy and the environment that contribute to vulnerability, such as political and social conditions, crime, and natural disasters.	<ul style="list-style-type: none"> ✓ Political and economic transition ✓ Poverty ✓ Discrimination/social exclusion ✓ Natural disaster such as flood and earthquake ✓ War, political and social upheaval ✓ Political violence and repression ✓ Drug and human trafficking

It is the premise of this paper that community-based provision of social, psychological, and economic supports has the potential to reduce the risk of vulnerability for all groups and lessen the need for residential care, the prevailing “system of care” in the region.

Individual Factors of Vulnerability

The following discussion describes the targeted vulnerable groups, risk factors, and the general state of social services in terms of community-based provision.

Children and Youth

Children and youth are a high priority in the region and are considered to be one of the highest risk groups. Of primary concern is the use of institutionalization as the prevailing response to both family problems and juvenile crime. Related concerns are poverty, outdated child protection systems, poor control of inter-country adoptions, child trafficking, discrimination

against minorities (primarily Roma), and family violence and displacement (UNICEF, 2005, pp. 7-8).

Child Poverty. Most of the poorest countries in the region have relatively young populations and their children are likely to live in conditions of poverty. For example, in three of the poorest countries (Uzbekistan, Tajikistan, and Kyrgyzstan), more than 50 percent of the population is under 25 years of age. Albania also has a high share of its population under the age of 15, and 56 percent of its poor are reported to be under the age of 15. In Russia, 37 percent of the poor are under the age of 15.

*Child Institutionalization.*¹³ Increasing numbers of children throughout the region are being deprived of parental care.¹⁴ An estimated 1.5 million children in the region are in public care. Although most children in institutional care have at least one living parent, they are often referred to as “social orphans” because the reasons for placement are related to social and psychological problems, combined with the legacy of state care for children and the lack of any alternatives (UNICEF, 2003a). Regionally, Bulgaria has the highest rate of placement in both categories (children 0-17 and infants 0-3) with Russia being second, but with a lower rate of infant placement. Moldova has the next highest placement rates for 0-17, although their rate of infant placement is one of the lowest in this group of countries.¹⁵ The Central European countries and Baltics, which have demonstrated economic and social gains, also have high institutionalization rates.¹⁶

Increase in Children Deprived of Parental Care

Illustrative of the gap between policy and reality is the continuing increase in children deprived of parental care. Although all countries have ratified the Convention on the Rights of the Child, which theoretically ensures children the right to a family, the use of institutionalization as a response to child and family risk continues to grow throughout the region. In the Caucasus, Georgia has the highest rate of child institutionalization both in the 0-17 and 0-3 age categories. Although strong family networks in Central Asia have been cited as preventions for the massive institutionalization seen in other countries of CIS, there are still approximately 200,000 children in institutions. Kazakhstan’s rate of infant institutionalization, which is 2.5 times the overall placement rate for children 0-17, doubled between 1994 and 1999. In Tajikistan, the number of children in residential care increased by one-third between 1997 and 2002, with 11,000 children under 16 years of age living in institutions. In Uzbekistan, almost 20,000 children with disabilities are living in institutional care, in addition to 3,500 children without disabilities, nearly 800 infants under one year of age, and 570 children in detention.

¹³ The NGO/UNICEF Regional Network for Children (RCN) summarizes this information in the newsletter on “Leave No Child Out” (LNCO) Campaign, 2004.

¹⁴ The term that is commonly used to refer to children placed in institutional care is “children deprived of parental care.” This term also refers to juveniles in detention centers and other forms of out-of-home placement.

¹⁵ UNICEF (2003). *Innocenti Social Monitor*. UNICEF-Innocenti Research Center: Florence.

¹⁶ Countries of Central Europe include Czech Republic, Hungary, Poland, Slovakia, and Slovenia. The NGO/UNICEF Regional Network for Children (RCN) summarizes this information in the newsletter on “Leave No Child Out” (LNCO) Campaign, 2004.

Current state of social services related to child institutionalization. The use of foster care and guardianship care (usually a form of informal family placement) is growing as an alternative for children in vulnerable situations in the region. Coupled with the development of family support services (most often provided by NGOs), there are some promising trends. Romania, the Balkans, and the Caucasus (as an aggregate) record falling numbers and rates of institutionalization. For Romania, the decrease is attributed to major reforms initiated in late 1997 (UNICEF, 2003a, 2004) that emphasized family reunification and family support services. Romania has the most developed system of foster care in the region, with 47,083 foster and guardian placements compared to 31,611 children in institutions in 2004. Russia, with the largest number of children in need of protection, has 347,500 in guardian care (UNICEF, 2003a). It is important to note that foster care and guardianship care require a full range of services including parent recruitment, training, selection, and monitoring in order to ensure child and family well-being, safety, and permanence, regardless of the type or model of substitute care.

Youth in Difficulty with the Law. UNICEF reports have highlighted the over-reliance on institutional placement as a response to young offenders. Youth are institutionalized in detention centers and prisons, given long sentences, sometimes for petty crimes, with no access to community alternatives of rehabilitative care such as community probation, remedial education, employment training, and family reunification. UNICEF has documented long sentences for children 14-17 years old in some countries, ranging from 2-5 years for what would be considered petty crimes by Western standards.

Reliance on Institutional Placement of Young Offenders

The high rate of youth institutionalization is often the result of the over-reliance on institutional placement as a response to young offenders. In Ukraine, three-fourths of 14-17 year olds were incarcerated for more than two years, and 14 percent were imprisoned for five years or more. In Kyrgyzstan, boys charged with serious offenses are detained for an average of six months, with one hour of daily exercise, no access to education, and no right to family visits. Pre-trial custody for juveniles in Albania can last more than eight months, with juveniles detained alongside accused adults. Although crime rates for youth in the region are low compared to other industrialized countries, the rates of reported crime by those aged 14-17 almost doubled between 1989 and 1998 in 16 of the 25 countries where data were available. Although two-thirds of juvenile crimes are property offenses, violent crime is on the increase. Rates have quadrupled in Poland, and tripled in Bulgaria and Lithuania. Drug-related crimes are emerging at an alarming rate.

Children who live and work on the street, commonly referred to as *street children*, are particularly vulnerable to human rights violations in both the child welfare and juvenile justice systems. The term *street children* itself is perceived as labeling and potentially stigmatizing to a very diverse population of children who live in various transient situations and, more often than not, come in contact with the law (Wernham, 2004).

Current state of social services related to youth in difficulty with the law. The current practice of depriving youth of their liberties is inconsistent with international standards of best practices in

juvenile justice.¹⁷ Although international treaties that guide policy and practice are in place, many countries have been slow to develop alternatives due to limited human and financial capital (UNICEF, 1998a). Specific changes that need to be initiated in the juvenile justice system are consistent with principles of community-based services and include the development of a range of social and legal services and sentencing options, systematic prevention approaches that address socio-economic and psychological issues, separation of criminal justice from child welfare (UNICEF, 1998a), training, monitoring and evaluation, training of media, research and documentation, and complaint procedures (Wernham, 2004).

The Elderly

The *elderly* is a heterogeneous group, with great variations in health status, participation levels and independence (WHO, 2002). The United Nations uses the standard age of 60 to describe *older* people, a young age for those living in Western countries. However, chronological age is not a precise measure for the changes that accompany aging. The likelihood of disability increases with age—with the later years more likely to be lived with disabling conditions (WHO, 2000). The transition to community-based care has been very hard on the aged population in the former Soviet Bloc because many of the elderly are socially isolated, many are women, and deprivation of basic health and physical needs is on the increase.

Concentrations of the Elderly

In Russia, Ukraine, and the Eastern European countries the numbers of the elderly are the greatest, particularly those over 75 years of age. This over-75 group is disproportionately female, many of them single and living alone. Bulgaria, Croatia, Ukraine, and Belarus have large urban populations of elderly, whose location puts them at greater risk of having to manage alone, often separated from families who are the primary source of support in the absence of formal social safety nets and reduced pensions and benefits. (WHO 2000).

In many countries in the region, the population is aging and the youth population is shrinking. The demographic implication of this is that an extraordinary number of people nearing the end stage of life will be a part of the population. The impact of having millions more people with disabilities in society due to the aging process is immeasurable. As with disabilities, the new paradigm in long term care for the elderly is a reliable and accessible community-based system of care that provides increased independent living options (Frieden, 2004).

Current state of social services related to the elderly. Since state-supported institutional mechanisms have almost collapsed, the family remains the most important resource to cope with transitional hardship. Family support has remained strong until now in the Caucasus and Central Asia for cultural reasons, while in Eastern Europe, the incentives for family support that were generated by the Soviet regime are no longer present (Kudat, 1999). Kudat shows that in

¹⁷ *Juvenile justice* broadly means special protection for vulnerable groups (refugees, minorities, exploited children, etc.) especially when deprivation of liberty or separation from the parents is at stake (Committee on the Rights of the Child).

Bulgaria and Hungary, older people living alone rely primarily on pensions. In some countries, pensions are in arrears, which leave the elderly with no source of income. In Romania and Albania, a rising number of older people are being institutionalized because they can no longer take care of themselves and their families have few resources. Elderly women are at greater risk than men, and in Romania the rate of institutionalization is three times higher for older women than men. Kudat also found that living with family members is one of the most important safety nets for the older population in Russia.

In general, the research by Kudat and information from various other assessment reports revealed very large gaps in information about many aspects of the lives of older people. Little is known, for example, about the relative importance of family-based private transfers (younger family members who leave the country for work and send money back home to parents/relatives). Safety nets for older people living alone consist primarily of food distributed by public and private food programs and some energy support for electricity and gas needed for heating and cooking.

Disabled People¹⁸

Across the region, the communist legacy of treatment of disabled people (those who are afflicted with physical, intellectual or sensory impairment, medical conditions or mental illness) has resulted in a large institutional population of both children and adults with disability. Estimates are that 1.3 million disabled people live in 7,400 institutions in Eastern Europe and the former Soviet Union.

The impairments, conditions, or illnesses may be permanent or transitory in nature.¹⁹ Although there is a movement to improve the availability of statistics on disability, accurate data are difficult to gather. Hungary reports as many as 1 million disabled citizens. Poland expects to have a disabled population of 6 million in 2010. People living with disabilities the longest reside in some of the poorest countries, often becoming functionally disabled by their mid to late-50s, an age considered to be the prime of life in the Western World (WHO, 2001).²⁰ People with mental disabilities are one of the groups most neglected by governments in the region, according to a report by the Open Society Institute.²¹

¹⁸ The terms “disabled people” and “people with disabilities” are used interchangeably. This terminology “respects the plurality of identities of people with disabilities and associated social change movements around the globe.” See <http://www.disabilityworld.org/aboutus.html#term> for additional information on terminology and definitions. Current terminology recognizes the necessity of addressing both the individual needs (such as rehabilitation and technical aids) and the shortcomings of the society (various obstacles for participation). (<http://www.un.org/esa/socdev/enable/dissre01.htm#Purpose>)

¹⁹ *United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities*. Adopted by the UN General Assembly, forty-eighth session resolution 48/96, annex, of 20 December, 1993. (<http://www.un.org/esa/socdev/enable/dissre01.htm#Purpose>)

²⁰ Another measure that could be used to measure vulnerability due to disability is the comparative data from Disability-Adjusted Life Expectancy and Life Expectancy. When taken together, these two indicators give a picture of: 1) how early individuals, on average, in these countries can expect to develop and live with a disability; and 2) the number of years, on average, that someone will live with a disability and may require social/medical services (i.e., the difference between Life Expectancy and the Disability-Adjusted Life Expectancy).

²¹ *Integrating the Disabled: Reports from Central and Eastern Europe and the Former Soviet Union*, December 9, 2003, Open Society Institute. Published by Transitions Online (TOL) at the following

The economic cost of institutionalization is huge due to the revenue and tax base lost by disabled people not working. The social cost is the creation of dependency on the system. Although there are differences in the way various governments treat people with disabilities in the region, in general the treatment model is dominated by the “medical model” in which persons with disabilities are treated as “sick” and in need of being “cured” by professional intervention. Other issues related to the treatment of disabled people include detention without court review, deplorable physical conditions in institutions and social care homes where many disabled live, unqualified and untrained professional staff in institutions, lack of treatment or treatment options, and restraint and seclusion. Soviet-style policies that give families control of disabled persons and their property without due process continue to be used (Lewis, 2002).

In general, children with disabilities continue to be perceived as “diseased,” inhuman, and lacking any capacity to grow and develop. Their rights as children and as humans are for the most part ignored (Sammon, 2001). Institutionalization of children with disabilities has increased in most countries since the mid-1990s.

Institutional Placement of the Disabled

Lack of services and limited financial support often result in institutional placement of disabled children and adults by family members unable to provide adequate care in the community. In Albania, disability is one of the most frequently cited reasons for the institutional placement of children (Rowland, 2000), although it is probably more related to poverty and lack of family supports. Although there are differences in diagnosis and classification of disabilities and the methodology for collecting statistics from country to country, figures would indicate that at least a half million children with disabilities are living in institutional care. As in most countries in the region, financial assistance is available for parents of children with disabilities, but payments are small, and money alone is not sufficient to assist families in the care of a child at home (Rowland, 2000). In Bulgaria, UNDP (2000) estimates that approximately 15 percent of all children in institutional care have a recognizable disability. In Georgia, the estimated 1,900 disabled children living in institutional settings, as well as those living in their own communities, are isolated, with virtually no access to education. In Kosovo, proposed reforms for children with disabilities have been placed further down on the reform agenda due to lack of resources.

Current state of social services related to disabled people. The emergence of the “social model” of treatment, which recognizes persons with disabilities as equals who are fighting societal barriers that limit development, is, at best, inconsistent. This model, which emphasizes social responsibility and changing the attitudes of others (Sammon, 2001), has produced results that lie along a continuum of reform. On the one end of the spectrum, Slovenia has made progress in the removal of architectural barriers to the disabled, and Hungary and the Czech Republic have made advances in legislation and development of disability organizations.

Website: http://www.soros.org/initiatives/mhi/articles_publications/publications/integrating_20031209.

This is an initiative of The Open Society Institute to address the situation in selected countries in the region, focusing on emerging trends in alternative services and ongoing challenges for the social inclusion of people with mental disabilities.

Social Services for the Disabled

The Center for Independent Living—Sofia, Bulgaria, engages in programs to help people with disabilities independently solve the problems they encounter in their daily lives, eliminating architectural barriers, promoting inclusive education, and assisting them in finding integrated work. The World Institute on Disability (WID) is engaged in training disabled youth in Russia to become activists as a way to empower them as advocates for improved policies and access. In Poland, where firms are required to hire 1 disabled person for every 15 employees or pay a fine, there are about 3,000 “protected-employment enterprises”²² that employ some 300,000 disabled people. In Central Asia, because of the stigma and shame related to mental-health problems, traditional healers, known as *Taeyip*, are seen as an alternative to psychiatric clinics or doctors. A *Taeyip* is usually a middle-aged or elderly Muslim woman who practices traditional and religious healing with the aid of the Koran and a sympathetic ear. Although there are criticisms of this approach, it does place an emphasis on community and family care, empowerment, and healing.

On the other end of the spectrum, Yugoslavia and Ukraine are described as having basically “ignored” their population of people with disabilities (Disability Rights Advocates, 2001). This regional pattern of inconsistency in service provision and responsibility for vulnerable groups is a result of fragmentation of public responsibility, limited human resources, and poverty (Sammon, 2001).

The Roma

Roma, or “gypsies,” are referred to as “a unique minority in Europe” (World Bank, 2005, p. 12). Although the roots of Roma continue to be debated, they are considered to have no distinct historical homeland, yet they live in nearly all countries of Europe and Central Asia. It is difficult to make generalizations about Roma as they constitute an extremely diverse minority, with multiple subgroups based on linguistic, historical, and occupational distinctions.

The Roma Diaspora

While some Roma are nomadic, the vast majority have settled into communities. Estimates of the size of the Roma population in Europe range from 7-9 million. Approximately 70 percent of Roma in Europe live in the countries of Central and Eastern Europe and the Former Soviet Union. Roma are estimated to comprise between 6 and 11 percent of the populations of Bulgaria, FYR Macedonia, Romania, and the Slovak Republic. Romania has the highest absolute number of Roma, estimated to be more than 11 percent of the population (World Bank, 2005, p. 12). Because of higher birthrates, the relative size of the Roma population is increasing across the region, and the size of the youth population is proportionally higher than in the majority population.

²² “Protected-employment enterprises” employ at least 40 percent of persons with disabilities.

The issues in Roma communities are similar to those in non-Roma communities, but the Roma also confront unique problems related to segregation and geographic isolation. Roma minorities are among the poorest in society and are more vulnerable to social exclusion and gaps in service provision (World Bank, 2002a). Roma communities have high rates of malnutrition, non-school attendance, and drug and alcohol abuse (World Bank, 2005, p. 41). Although the law in most countries guarantees equal treatment and protection against discrimination for all people, Roma, in fact, often lack such protection. They are often excluded from public services because they lack the required identity papers, sometimes due to a lack of residency. In urban areas, Roma are highly segregated. They face legal issues related to housing, as they often are the first to be evicted from state-owned property. Many live illegally as squatters in overcrowded housing. Unemployment is a major issue, as Roma are often first to be laid off. Gaps in health status result in a life expectancy that is 10 years less than the majority population, high rates of infant mortality, and unhealthy diets. In general, service professionals (inclusive of health, education, and social services) are not prepared to work with Roma individuals and communities, further marginalizing and disenfranchising large communities of Roma (World Bank, 2002a).

Current state of social services related to Roma: Attention to Roma has increased, in part, because of increased public awareness of the human rights violations they experience (Ringold, et. al., 2003). As part of World Bank's initiative to reduce exclusion of Roma in the next decade, the Decade of Roma Inclusion 2005-2015 has been adopted by eight countries²³ in Southeast Europe. The initiative aims to accelerate social inclusion and improve the economic and social status of Roma in the region; to reduce segregation in housing; to integrate Roma into mainstream educational systems; to increase outreach to Roma communities by social service providers, including health and social workers; and to involve Roma as liaisons between communities and public services (World Bank, 2005, p. 7). To date, there has been more attention to Roma policies and programs in Hungary than in other countries. Hungary's post-transition development process has been both faster and more successful than most and has been leading the EU accession process. Hungary has had greater involvement in minority issues historically, and the growth of civil society has been more rapid in Hungary than in other countries (World Bank, 2005, Chapter Five: Project Experience in Hungary).

Family and Community Factors of Vulnerability

Poverty²⁴

The effects of poverty on vulnerability have received a great deal of attention in the region. The cyclical and cumulative consequences of poverty greatly affect outcomes for children, elderly, disabled people, and minorities. Children who grow up in poverty are more likely to suffer unemployment, low pay, and poor health in adulthood, and to transfer this poverty of opportunity to their children. Child poverty negatively impacts children's educational attainment and adult

²³ Decade of Roma Inclusion's official Website is <http://www.romadecade.org/en/index.php>. The eight countries include Bulgaria, Croatia, the Czech Republic, Hungary, Macedonia, Romania, Serbia and Montenegro and Slovakia.

²⁴ The World Health Organization's definition of poverty is inclusive of a range of deficits of economic, educational, psychological, and social resources (WHO, 2001). It reflects the cyclical, systemic, and dynamic nature of poverty.

labor market performance. Poverty puts children at higher risk for abuse and neglect and women and girls at higher risk for rape. Poverty forces women and girls into occupations that carry a relatively high risk of sexual violence, particularly sex work (Krug, et. al., 2001, p 158). Common mental disorders are twice as frequent among the poor; children from the poorest families have increased risk of mental and behavioral disorders. Persons with chronic disorders often drift into poverty as a result of social exclusion, the high cost of addiction, or loss of a job. The progression of chronic disorders is also related to socioeconomic status due to access barriers to services for the poor. Poor countries have fewer resources for social services and these resources are often unavailable to the poorer segments of society. A large gap exists between the demand for and access to treatment for the poor population (WHO, 2001).

To date, investment in social protection services has primarily provided income supports through social insurance or assistance programs, which are critical for those with limited resources. Social assistance in the form of targeted, means-tested benefits has tended to be the first line of relief for those in poverty. There is a need to integrate at the policy and practice levels financial assistance with other community care models that address mental and physical disability, substance abuse, children in need of protection, family violence, depression and suicide.

Family and Interpersonal Violence

Violence is considered a major public health concern worldwide with significant cost in annual health care expenditures, lost work and investment, and law enforcement (Krug, et. al, 2001). Human costs include stress and trauma, physical and mental illness, disability, and sometimes death. The causes of violence are rooted in the social, cultural, and economic fabric of human life making it difficult to ascertain the prevalence of family and interpersonal violence. Correlations have been found between suicidal behavior and child maltreatment, intimate partner violence, sexual assault, and abuse of the elderly. In countries that have suffered war and other types of violent conflict, the rates of interpersonal conflict remain high even after the cessation of hostilities (WHO, 2001; Krug, et. al., 2001). The World Health Organization (2001) has elaborated a typology of violence that includes four types of violent acts: physical, sexual, psychological, and deprivation or neglect. The typology is an attempt to develop a framework for understanding the complexity of violence and how it affects people, families, and communities everyday (WHO, 2001, 7). WHO (2001) makes a strong case that violence can be prevented. When it does occur, trauma and long-term disability can be ameliorated by long-term care, such as rehabilitation and reintegration (WHO, 2001, p. 15).

Alcohol, Drug Abuse and Addiction

Alcohol abuse, one of the leading causes of death and disability worldwide, is responsible for 4 percent of global deaths and disability, nearly as much as tobacco and five times the burden of illicit drugs (WHO). Alcohol abuse contributes to a wide range of social and health problems, including depression, injuries, cancer, cirrhosis, dependence, family disruption and violence, and loss of work productivity.

The increase in drug trafficking due to the opening of borders has resulted in an increase in drug demand and drug addiction. The demand for heroin in Central Asia and Russia has rapidly increased. The worsening social and economic situation in the region has fed the increase of the

drug trade. Drug prevention and treatment centers are in short supply with very limited community rehabilitation available. The increase in intravenous drug use has resulted in increases in HIV infection and AIDS. Related to this is an increase in drug abuse by women of child-bearing age resulting in increased infant-risk (Osmonaliev, 2005). Children who live among family members who abuse drugs are at a high risk for substance abuse problems (Kumpfer, 2005). Although specific data are not available, the anecdotal evidence indicates that addiction is a critical vulnerability factor for all age groups and contributes to reduced well-being and increased health and social risk factors.

Refugees and Internally Displaced Persons (IDPs)

Although conflicts in the region have diminished, there were approximately three million refugees, asylum seekers, and displaced persons as of 2001. This number has decreased since 1998 by one-half million, but recent and ongoing strife in Afghanistan, Chechnya, and Yugoslavia has resulted in new displacements. The social and economic situation of refugees and IDPs puts them in the vulnerable category. For example, in 2001 in Azerbaijan, seven years after the conflict with Armenia had ended, only 20 percent of the refugees and IDPs were living in housing suitable for long-term habitation. Another 20 percent were still living in temporary asylum facilities, 20 percent were living with relatives, and 8 percent were living in tent camps. The need for resettlement far exceeds the resources available to accomplish it. The importance of refugee status in determining mental health after conflict consistently emerges in studies world wide. In Kosovo and Bosnia, for example, social isolation, including isolation from family, is a predictor of post traumatic stress disorder and depression (Nelson, B., et. al., 2004).

Broad Political and Environmental Factors

Social Exclusion

Social exclusion is defined as a dynamic process in which individuals, households, or communities are excluded from access to resources such as employment, health, and education, and from social and political life (Eurostat, 1998). Social exclusion can lead to a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health, and family breakdown.²⁵ As with poverty, social exclusion results from a combination of individual, family, and environmental factors. It results in part from negative attitudes and discrimination towards the poor, disabled persons, minorities, and others identified as “at risk.” These negative attitudes and the isolation of vulnerable groups through institutionalization increasingly marginalize them.

War and Political Conflict and Displacement

Violence and trauma due to war continue to be great concerns within some countries in the region and increase vulnerability for those most dependent: children, the elderly, and disabled persons. In countries that have suffered war and other types of violent conflict, the rates of interpersonal conflict remain high even after the cessation of hostilities (WHO, 2001; Krug, et. al., 2001). The trauma of war correlates strongly with psychosocial symptoms of anxiety disorder, post traumatic stress disorder (PTSD), depression, and alcoholism. A persistently high

²⁵ Source: www.cabinet-office.gov.uk/seu/index.htm

prevalence of PTSD following conflict situations, torture, or forced migration has been frequently described (Nelson, B., 2004). Screening and assessment is limited, and treatment is often provided in an acute care health facility.

PART THREE TRANSFORMING THE SYSTEM OF CARE FOR VULNERABLE GROUPS

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.

While deeply ingrained attitudes and practices have slowed the establishment of systems of family-focused, community care models, a shift *is* taking place.

Various types of aid to the poor and social protection of the needy are among the most important traditions of the community.
–Manual for Community-based Organizations in Uzbekistan, 2004

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 following summary table outlines the characteristics of programs and services as they shift from a communist ideology to a democratic one.

Services for Vulnerable Individuals and Families under Communism	Services for Vulnerable Individuals and Families in a Democracy
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

<ul style="list-style-type: none"> • are centralized and hierarchical • Workers' job functions are administrative and procedural • The purpose of monitoring is for political and social control 	<ul style="list-style-type: none"> • Management and financing structures are decentralized and participatory • Human service workers are professionalized • The purpose of monitoring is for protection and quality
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Continuum of Care Model

A useful system for designing social services under the region’s new social contract is the continuum of care model. The continuum of care model represents a range of programs and services common for all vulnerable groups, is inclusive of prevention and treatment interventions, and promotes family and community care over institutional care (see following table). Support systems that address both the psychological features of risk, such as stress, stigma, motivation, substance abuse, and family dysfunction, need to be integrated with services addressing material needs such as poverty, housing, and nutrition. Systems of services that invest in people support personal choice and responsibility, emphasize coping and adaptation to a changing and stressful environment, and utilize community-building as an approach for increased sustainability. The capacity of a service delivery system to adequately assess vulnerability, plan an intervention, define outcomes, and monitor changes is a key element in targeting scarce public and private resources to those most in need.

The following table is a generalized model of continuum of care across the life cycle, which has been adapted from various sources (WHO, UNICEF, World Bank). It includes a range of programs and services that are *universal and preventative* (such as child health screenings), *ameliorative* (services that provide support within the family and community), and *restorative* (services that often supplant family systems because those systems have broken down). A community-based continuum of care model first prevents, then provides early interventions, and as the last resort, protects.

COMMUNITY-BASED CONTINUUM OF CARE ACROSS THE LIFE CYCLE			
	Range of Services During the Life Cycle Based on Degree of Risk or Harm		
Stages of the Life Cycle	Universal/ Preventative: Private for-profit and non-profit sector are the primary provider of services which are aimed at all persons regardless of need	Ameliorative: Services aimed at removing the risk and supporting return to self-reliance; it is assumed family and community systems are intact but fragile	Restorative: Services aimed at finding family alternatives since the family care systems no longer function
Birth	Early detection screening programs; parenting classes and parent support groups; day care; parent classes to promote safety in the home; infant/toddler toy-lending programs; maternity leave	High risk infant screening; infant stimulation; specialized day care and rehabilitation; protective day care; child abuse prevention programs; financial supports	Early detection for drug-exposed infants; foster care and family reunification ²⁶ ; adoption; stimulation and rehabilitation services; infant/mother and family shelters; financial supports
Early Childhood	Preschool programs; day care; play groups; child development classes; safety education programs	Protective day care and preschool programs; short-term foster care with family preservation services; volunteer programs such as Toys for Tots; child abuse prevention programs; financial supports and in-kind financial assistance	Foster care; family reunification services; adoption; therapeutic and protective day care and foster care; parent visitation; court-appointed advocates; financial supports and in-kind material assistance
Childhood	Daycare, recreation programs, scouting programs, peer mentoring; drug prevention programs; public awareness campaigns and laws prohibiting alcohol and cigarette use	Protective day care and preschool programs; short-term foster care with family preservation services; peer mentoring and big brother/big sister programs; school mediation programs; financial assistance and in-kind material assistance	Specialized foster care and family reunification; therapeutic and protective day care; adoption; parent visitation; court advocates; family shelters; food canteens, financial supports and in-kind material assistance
Adolescence	After-school care; recreation programs; prohibition of alcohol and drug use	Group homes and independent living skills programs; suicide prevention hotlines	Group homes and independent living programs and job training; shelters; drug/alcohol rehabilitation
Reproductive years	Pre-natal and parenting classes; family support and family life education; labeling of dangers of alcohol and drug use during pregnancy	Parent support groups; parent advocacy groups; self-help groups such as Alcoholics Anonymous, Narcotic Anonymous; Parents Anonymous	Early detection of high risk pregnancy and counseling; infant/mother and family shelters; domestic abuse shelters; homeless shelters; drug/alcohol detox and rehabilitation; employment training and retraining and job-finding; entitlement programs including unemployment benefits

²⁶ Family reunification services are considered as an alternative service for institutional placement. The service provider works with the family to reduce the crisis/stress and to identify other family members (including extended family members) who might be able to take the child or children. This is called “kinship care.” The overall goal is to keep the child in the family of origin, if possible, as opposed to foster care placement or adoption.

Middle age	Specialized support groups such as singles, divorced, adult children of alcoholics; education and support programs for adult children; information and referral services	Counseling; crisis telephone; employee assistance programs; day hospital programs; access to entitlement programs; targeted benefits	Fostering of mentally retarded adults; small group home facilities; supported employment programs
Senior Citizens and Old Age	Association of Retired Persons (AARP); other advocacy groups; meals on wheels; senior community centers	Crisis telephone; health and social day care programs; access to entitlement programs and targeted benefits	Assisted living and nursing care facilities; rehabilitation facilities; small group home facilities

Elements of an Effective Community-Based System of Services

There is a general consensus among donors and stakeholders in the region that basic services for all are a fundamental right (Convention on the Rights of the Child, Mehrotra, et. al., 2000), that institutionalization can be damaging to human development needs, and that all societies need to provide equal access to a range of social safety nets. The transformation of systems of care is multi-faceted and complex and involves simultaneously dismantling the old system and designing and developing the new system utilizing both policy and practice mechanisms. Elements to be considered in the transformation process that can both leverage reform as well as increase impact are included in the discussion below. This discussion relates to a system of community-based care that cuts across all of the vulnerability groups.

De-institutionalization

The term de-institutionalization refers to the trend of moving the care of individuals in dependant situations from residential facilities into the community, with the support of family and a range of community social services. De-institutionalization is a complex process leading to the implementation of a solid network of community alternatives (WHO, 2001). Critical to system reform is the inclusion of families, consumers, and NGOs in advocacy, legal reform, and service delivery.

De-institutionalization of the mentally ill and access to a continuum of community care services have recently received added attention through The World Bank, which has established reform guidelines that propose the establishment and strengthening of mental health delivery systems within the framework of primary health care. Using a life cycle framework, these services should include supervisory and community-based rehabilitation and school health. Information, education, and communication strategies with workforce development and monitoring mechanisms are important to the development of a system of mental health care.

A Framework of Community Care

- Services are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- Interventions are related to disabilities as well as symptoms (focuses on functional behavior);
- Treatment and care are specific to the diagnosis and needs of each individual;
- A wide range of services address the needs of people with mental and behavioral disorders;
- Services are coordinated between mental health professionals and community agencies;
- Services are ambulatory rather than static and include home treatment;
- Partnerships are developed with caregivers; and
- Legislation supports the above aspects of care.

–WHO (2001, p. 50)

Although de-institutionalization of children has received some attention in the region, performance measures have focused primarily on numbers of children de-institutionalized and numbers of children prevented from institutionalization. Ceric, et. al., (undated) suggests in a paper on de-institutionalization (of the mentally ill), that nothing will change if the process of de-institutionalization means “forcing discharges” and “prohibiting admissions.” A simultaneous process must take place to set up community care programs and services while children, the elderly, and disabled people are moved out of institutional settings. Establishing a range of alternative services that includes human resource and monitoring systems is an important element of de-institutionalization. Closing residential beds must be accompanied by a strong focus on the development of family support mechanisms.

Effective Targeting of Benefits and Services

Targeting is a strategy for ensuring that services are provided to those the program is intended to serve and who meet specified criteria of eligibility. It is a key feature of internationally recognized best practices. Targeting includes a process of outreach and case-finding, information and education, and assessment and access. Targeting is sometimes referred to as “the point of contact between the provider and the clients” and “where the services are actually delivered.” The social services provider, often a social worker, is the link between the service and the individual making the application for a service. The social worker determines the eligibility and is sometimes referred to as the “gatekeeper.” This is a crucial issue in the design of the institutional aspects and incentives of social programs. Unfortunately, many systems depend on self-targeting (sometimes called self-selection), which occurs when the individual initiates the process of application for eligibility without any external influence or intervention. Sometimes called the *passive approach*, this method of self-targeting often results in reduced accessibility because individuals may not have the correct information about services; they may not have transportation for making an application or accessing a service; or they may be discriminated against because of personal characteristics such as ethnicity, age, sex, or other characteristics. Often, people who have the greatest need for services are the least likely to apply and have access to them.

Advocacy

Advocacy is an action that empowers individuals and/or communities and is critical in the transformation process. Champions of change include individuals who represent vulnerable groups or associations and coalitions of associations that provide information resulting in attitude and behavioral transformations at the community level. Beneficiaries of services and their family members are sometimes taught to be self-advocates in order to access programs and services to which they are entitled and to seek more responsive policies and practices. The media, partnering with the public and private sectors, can serve an important function by providing positive images of “the face” of helping programs and services as well as by providing a “watchdog” function when individuals and groups are disenfranchised or marginalized. Volunteer participation and citizen involvement in service delivery can serve an advocacy function through media and public engagement campaigns. Various community development efforts can serve to mobilize communities to influence public policy and advocate for improved targeting and access.

Non-Governmental Organizations (NGOs) and Social Services

NGOs are emerging as the primary provider of targeted relief to those in need in the E&E region, although there is limited information about the activities and effectiveness of their work. The political and social transition in the region has left communities, and especially the public services, unprepared and stretched to provide the safety nets for individuals and families in difficulty. The NGO community is sometimes their only support system. Public policy and financing mechanisms in some countries now allow outsourcing (or contracting) of some social protection programs such as shelters, day care, and foster care programs. There are a variety of funding streams that support local grassroots efforts, but they are generally short-term and difficult to sustain. Through funding streams such as umbrella grants, a rich array of grassroots, community-based organizations (CBOs) have emerged that are linked to technical assistance providers aimed at addressing special vulnerable groups. Often, however, these services have not been adequately linked to the policy development initiatives with the public sector.

Economic and Vocational Development

Service delivery systems must provide vulnerable populations with assistance in becoming self-reliant. Loss of employment due to layoffs, illness, or personal problems also results in loss of motivation, personal self-esteem, and money. To meet these challenges, assistance programs need to incorporate services such as vocational training and retraining, small business training, and microenterprise development programs, including technical assistance and individual and group credit. This requires a shift in program values to include a strength-based approach to case-assessment and planning and a move away from the relief model that is consistent with many social services initiatives.

Human Resource Development

System reform is dependent on the availability of human resources to implement the shift of job functions from administrative and procedural interventions to direct psychosocial and community intervention models that utilize professional standards of practice. Trained personnel are needed to perform job functions that reflect family-centered values and skills and to provide

case management, education, support, and clinical counseling. Systems of education and training, as well as financing and management of programs, need to be considered an integral part of transforming policies and services.

Decentralized and Participatory Management Systems

Decentralized financing, administrative, and management structures are basic to a community-based system of services. Policies and programs must promote democratic decision-making at the administrative, management, and direct-service level. Participatory structures include mechanisms for all levels of staff and client groups to influence policy and programs. Programs and services should be accountable to an oversight body such as the governance boards typical of non-governmental organizations, national policy boards, and licensing and accreditation bodies.

Development of Standards of Care and Standards of Practice

Standards are agreed-upon statements of a measure of quality of services and professional practice. They require a quality assurance mechanism for implementation, and they are important tools for promoting individual rights and improving services (UNICEF, 2003b, p. 5). Public service 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. Systems of accountability that monitor performance are integral to standards of care and practice.

Social Inclusion

Local governments, communities, and social service organizations play a significant role in ensuring that local services are inclusive and responsive to the needs of vulnerable groups. An inclusive approach provides mechanisms that promote involvement and participation of vulnerable groups in mainstream society while trying to maintain cultural identity and social autonomy. Income transfers, accessible through a system of programs and services, have been cited as one method for reducing social exclusion by reducing poverty (Kamerman, et. al., 2003, UNICEF, 2000). The impact of income transfers (or social assistance benefits) is determined by how well the system for targeting and access functions. Some argue that income transfers to the poor, and safety net policies more generally, have been shown to be at best a short-term answer and at worst a waste of money (Ravallion, 2003, p. 1). Others feel that administrative targeting procedures are not adequate to reduce social exclusion; that to be successful, additional outreach and case-finding initiatives consistent with best practices need to be conducted. Engaging those who are targeted for assistance as part of the program planning and implementation process is a first step in social inclusion and requires a different human resource capacity, i.e., staff who know how to engage clients and families.

PART FOUR

INTERNATIONALLY RECOGNIZED BEST PRACTICES

“In the end, what matters is people. In the end, a country’s transition will be judged by whether its citizens live better than they did before. Equity—how people share the benefits and pains of transition—is important.”

–World Bank, 1996, p. 66

Best Practices Defined

Best practices in social services delivery systems are identified practices or interventions that are linked to specific outcomes and contribute to improved individual, family, and/or community well-being. Best practices are multidimensional and incorporate economic, psychological, social, and political factors. Interventions grounded in research findings that demonstrate the quality of practices linked to specific outcomes are known as evidence-based practices. Best practices are based on evidence-based practices. For example, evidence (both from research and practice) demonstrates that assertive community treatment helps people with mental, physical, and behavioral disorders stay out of residential, hospital settings and live in the community. Some of the best practices (WHO, 2001) in assertive community treatment that have been demonstrated to contribute to improved outcomes for vulnerable groups and their families include the following:

- Case management and psychosocial care;
- Self-help and peer support: education, encouragement and motivation, building social networks and mutual trust, participation in meaningful activities;
- Assistance with housing;
- Financial assistance;
- Day care/partial hospitalization;
- Employment assistance;
- Medical care and medication management;
- Transportation; and
- Family education and support services to facilitate and reinforce family attachments and care giving through support groups, in-home visits, individual and family advocacy, respite, telephone hotlines, transportation, and family recreation.

Basic Pillars for Analysis of Best Practices in Social Services

Systems of services have common elements that provide a basic framework for analysis and that can serve as entry points for reform. This framework for analyzing best practice elements is based on four pillars of a functioning service system.

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, strategies for implementing policies, and centralized and decentralized functions for public entities.

Pillar 2 – Structure and Types of Programs and Services. Pillar 2 includes types and ranges of programs and services, financial supports, and accessibility. This pillar 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.

Pillar 3 – Human Capacity. 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 of care. This pillar includes professional education and training; curriculum development activities; professional regulation such as licensure, certification, and registration; practice standards; and monitoring of performance.

Pillar 4 – Outcomes and Performance Indicators. Pillar 4 describes how outcomes are defined, measured, and monitored by government policies and donor interventions. Outcomes may include reduced dependency on institutionalization and increased utilization rates of community-based care. Performance measures that promote family and community reintegration and are supported by systems that monitor individual outcomes and the quality of programs and services are consistent with best practices

The matrix on the following page provides a framework for analyzing the promising practices found in Appendix A. This framework identifies international standards of practice that can serve as a guide for addressing needed reforms and capacity issues within each of the four-pillars: policy and legal framework, structure of services, human capacity, and monitoring and evaluation functions of the service delivery system. The selection of the specific countries and programs presented in Appendix A was made in an attempt to present a wide-range of programs and services within the public and private sectors and highlight promising practices within each of the four pillars.

Since this is a desktop study, selection was also influenced by personal knowledge of the author relative to certain programs and the availability of information on the Internet. For example, q2aCroatia was selected because the author has known the director of social work at the University of Zagreb and has personal knowledge of the programs and services since an initial visit in 1993. Other programs were selected through information that was obtained through various listservs and e-mail contacts. The NGO, *Ponimanie*, in Belarus was selected for discussion after information about the program was presented on the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) listserv and follow-up communication was conducted via e-mail with the Executive Director. The matrix is meant to be illustrative rather than an exhaustive study of all programs that meet the identified criteria.

BEST PRACTICES IN COMMUNITY-BASED SERVICES
Policy and Legal Framework: <i>This refers to the overarching values and principles, the targeted vulnerable populations, centralized and decentralized functions, relationships with NGOs, financing and accountability, and strategic and implementation plans.</i>
1. Identifies and defines priority groups at-risk
2. Promotes family and community care over residential and institutional-based care
3. Identifies internationally recognized standards of care and professional practice
4. Provides a mechanism for contracting with NGOs in providing social services
5. Provides accountability and sanctioning mechanisms
6. Engages consumers and advocacy groups in designing and evaluating public policy
Structure and Types of Programs and Services: <i>Categories and types of services available to clients; how potential clients are informed, targeted and assessed; and the degree to which services are aimed at supporting family and community living.</i>
7. Provides a range of programs from prevention to protection that reflects international standards
8. Provides mechanisms to shift from residential care to community care
9. Promotes principles and values of practice that reflect capacity-building over “relief and rescue”
10. Puts in place assessment processes for targeting those the program is designed to serve
11. Puts in place client accessibility mechanisms such as client outreach and citizen awareness/public education
12. Ensures that at-risk groups have influence over decisions of service providers
13. Integrates approach to assessment, planning and intervention
14. Provides mechanisms for community participation and volunteerism
15. Institutes public awareness and public education campaigns aimed to influence public attitudes and citizen involvement
Human Capacity Development: <i>This refers to the human resources available to provide services that meet care standards, the specific job functions, the availability of education and training resources for developing a qualified workforce, and regulatory mechanisms.</i>
16. Integrates job functions with assessment, planning, intervention and follow-up (social work case management and multidisciplinary planning)
17. Professionalizes treatment and rehabilitation workforce
18. Regulates practitioners through licensing or certification procedures
19. Educates and trains human service professionals
20. Trains workforce using curricula that reflect principles and values of human capacity building, prevention, and community care
21. Promotes professional standards of practice through curricula and programs
22. Focuses partnerships between universities, advocacy groups and public and private service delivery organizations on performance improvement through workforce development
23. Promotes quality of service and quality workforce through professional associations with advocacy functions
Performance Measures: <i>Outcome indicators used to measure client change based on identified need; information and monitoring systems in place to measure change and track clients.</i>
24. Measures reduced risk and/or improved well-being
25. Employs information systems to monitor programs and services
26. Employs information systems to monitor clients

PART FIVE

OBSERVATIONS, FINDINGS, AND RECOMMENDATIONS

In spite of the growing gap between policy and reality as the region's governments try to respond to the ever-increasing needs of their most vulnerable citizens, promising practices are emerging and provide evidence that the political will exists to transform models of care to support families and communities. To ascertain the progress being made in the transition from institutional to community care for some of the most vulnerable citizens – children and youth, elderly, disabled and Roma as a minority group – some general observations are presented here, followed by findings and recommendations gleaned from various reports.

General Observations

There is a wealth of information describing the situation of vulnerable groups, especially children and youth. However, actual statistical information useful in policy formation and program planning is not easily obtained, as sometimes the data are manipulated for political reasons. In some cases, statistics are not available because definitions and criteria are not yet developed, as is the case for “disabled people.” Similarly, data related to Roma are just beginning to be collected, as the World Bank has initiated the “Decade of Inclusion: 2005-2015” as a way to bring attention to the plight of the Roma and to stimulate system reform.

A large number of documents are available on the Web that elaborate theoretical models of community-based care and best practices. (It remains an open question as to how accessible this valuable information is to those “on the ground” who are responsible for design and implementation at the policy and practice levels within countries in the region.) It is more difficult to find how programs and services are monitored and evaluated and what outcomes result from their interventions. Although the awareness and knowledge of the basic values of community care are reflected in various documents, statistics indicate that countries are increasingly using institutions for the care of vulnerable children, the elderly, and disabled persons. Institutionalization has at least doubled during the transition period to date. Economic strength, institutional capacity, and the political will to provide community-based care varies from country to country and, within each country, from region to region. In general, the states of the former Soviet Union are moving more slowly to community care models than the Eastern European countries, a condition that can be related, in part, to the incentive of EU accession.

General Findings

Policy and Legal Framework

- Most countries have developed policies that identify priority risk groups in their respective countries, but not all have policies related to the development of community-care and family-based models.

- The gap between policy and reality is growing and is affected by the limited human and financial capacity of governments, corruption, the lack of political will, and an ever-increasing number of vulnerable individuals and families due to increased poverty, unemployment, and reduced welfare benefits.
- Exemplary models for contracting social services to NGOs are in the development stages.
- As advocacy groups that represent the most vulnerable citizens continue to increase in number and capacity, their potential to influence public policy is growing. This has been demonstrated more recently in the training of young disabled activists and their increased potential to influence public policy.²⁷
- Economic growth and revenue-raising initiatives can provide needed resources for poverty-reduction schemes.
- A joint UNICEF/World Bank assessment of child-care systems identified key elements in need of reform that are critical in addressing the capacity of social welfare systems. The assessment pointed out the need to develop and apply international standards through policy formation and legislative reform in governance, financial flows, case management, decision-making patterns, and criteria for child placement.²⁸
- There has been progress in the countries of CEE and CIS on the development of legal standards to protect children from violence.²⁹

Structure of Services

- The primary social safety net for children, the elderly, and disabled people in risk situations is the family, including the extended family. Investment in social protection services has primarily provided income supports through social insurance programs, which sometimes become the primary source of family income.
- There is limited capacity for protecting vulnerable groups from neglect, abuse, and maltreatment at the service delivery level, although new legal protections are in place.
- Awareness-raising and behavior change initiatives are needed to prevent and treat physical and psychological violence in the home, schools, and other institutions where there is general public acceptance of violence as a form of punishment.
- The structure of services continues to be fragmented, with little understanding of a continuum of community-based care across the life cycle. While certain segments of the continuum have developed, governments still emphasize the protection system over prevention.
- Social assistance in the form of targeted, means-tested benefits is the first line of relief for those in poverty, but benefits do not always go to those most in need.

²⁷ World Institute on Disability (WID). International network of disabled youth activist teams promoting equal access to education. 1st quarterly program report 11-1-2003 through 1-31-2004. Submitted to USAID April 9, 2004 by Bruce Curtis, Russia Project Manager.

²⁸ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division, p. 6.

²⁹ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division, p. 9.

- Many champions of change in the public and private sectors are making a difference at the grassroots level. They are primarily working within the advocacy and service delivery initiatives of non-governmental organizations.
- NGOs provide the bulk of social services and sometimes are the *only* provider for some populations. The NGOs continue to define their role in relation to the public social services sector, creating tension between the two sectors. The NGO community has acquired a clearly defined role, impacting policy as well as service delivery, in the area of advocacy and public awareness.

Human Capacity

- Human capacity in social services is developing across the region, and this provides the most hope for change.
- An active movement is growing to increase professional training of social workers and psychologists—the primary professionals in a community-based system. In spite of inconsistent growth, progress is being made and increased opportunities for training and education exist at the academic and practice levels.
- An increasing number of professional associations advocate for change in services and for the regulation of their professions.
- With a growing emphasis on community rehabilitation, professionals such as physical and occupational therapists and special educators are in great demand. While salaries are low, those in the social service field demonstrate tremendous enthusiasm and hope.
- The professional approach to social work increasingly reflects an emphasis on outreach and case-finding mechanisms.

Performance Measures

- Performance measures continue to be focused on de-institutionalization rather than on improved well-being and quality of life variables. Strengthening family and community support structures and human capacity are often overlooked as primary goals of community-based interventions.
- Indicators that are concrete and related to material needs are a basic measure, since poverty continues to be the primary indicator of vulnerability in the transition countries. Psychological and social issues related to personal and family functioning continue to escape sustained attention.
- In measuring disability, diagnostic categories rather than functional capacity continue to predominate as indicators.
- UNICEF has identified lack of time and money as major constraints in the effort to systematically define indicators and measures.³⁰
- There is a lack of capacity on the part of UNICEF and public and private partners for applying results-based management and a human rights-based approach to child protection.³¹

³⁰ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division, p. 6.

³¹ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division, p. 6.

**Summary of Findings:
Best Practices in Community-Based Services**

Policy and Legal Framework: *This refers to the overarching values and principles, the targeted vulnerable populations, centralized and decentralized functions, relationships with NGOs, financing and accountability, and implementation strategies.*

Governments are increasingly utilizing a policy framework to officially recognize priority vulnerable groups and promote, in principle, a transition from institutional to community care models. Overall, children deprived of parental care (most often referred to as institutionalized children) have received the most attention. Disabled persons and Roma are increasingly being focused on through international initiatives including the development of international human rights treaties and national policy frameworks. Emphasis on the elderly has primarily been on pension reform except for countries such as Armenia, where service provision to elderly has received considerable attention. Countries that have experienced internal and cross-border conflicts, such as the Caucasus and the former Yugoslavia, emphasize Internally Displaced Persons (IDPs) and Refugees. Reducing poverty and unemployment are very high priorities in most countries, with special emphasis on youth. Little attention has been paid to children and families in difficult circumstances, and this focus is not found in the child protection system.

Social and psychological risk factors such as alcoholism, mental illness, and domestic violence have been strategically identified as priority areas of concern only in selected countries, most often in response to the work of advocacy groups. Advocates, usually working through NGOs, are very active in trying to bring social and psychological risk factors to the attention of policy makers and political leaders. The increasing rate of drug use throughout the region has raised concerns about HIV/AIDS and an increase in drug-addicted infants, a risk factor for child abandonment and institutionalization.

Probably the most remarkable change is the growth of the NGO community and the recognition by most governments of the critical role of NGOs in providing community-care for the ever-increasing numbers of vulnerable citizens. International and national consumer and advocacy groups are increasingly involved in public policy debates and initiatives to influence social policy reforms. Governments increasingly have mechanisms for partnering with NGOs that range from sharing resources, such as staff and space, to funding public-mandated social services through a contractual arrangement.

Yet there are two major barriers to reform at the policy and legal framework level: governments' inability to strategically plan and implement incremental steps within specific time frames, and lack of mechanisms to hold public and private providers accountable for stated outcomes. Although major donors and implementers, and to a lesser extent public services, increasingly emphasize the utilization of international standards for service delivery at the local level, decentralization of service provision has been slow and there are few mechanisms to hold service providers accountable. The challenge is to integrate international standards into the policy and legal framework that provides governments and private entities with their mandate for more humane models of care.

Structure and Types of Programs and Services: *Categories and types of services available to clients; how potential clients are informed, targeted and assessed; and the degree to which services are aimed at supporting family and community living.*

There are many exemplary models of community care for vulnerable groups emerging across the region that demonstrate a range of services from prevention to protection. Areas that have received most attention are de-institutionalization of children and youth, integration of disabled persons into community life, access to health and social services for elderly persons, and inclusive education for Roma. There are examples of programs and services in all countries, primarily through NGOs with international linkages, which utilize international standards as a practice framework. Most exemplary models have been developed with international financial and technical support.

The question is how to bring these models that are scattered across the region up to scale by replicating programs and services to serve a larger target population. Although financial and human constraints are major barriers, there is also a knowledge gap among the public in general. International, national, and local public education and public awareness campaigns that utilize media and other public information methodologies are needed to change attitudes, target services, and reduce stigmatization and discrimination. Citizen engagement and community participation are major outcomes of the work of NGOs, as evidenced both in increased volunteerism and in service delivery. Through public awareness and public education campaigns, citizens and communities are volunteering and engaging in the provision of services, such as foster parenting and community support for children and youth. Although the models are there, they are scattered and fragmented and cannot meet the growing gap between those in need and the availability of services. Services tend to emphasize a specific category of vulnerability (elderly, disabled, institutionalized children) rather than emphasizing services to children and families in all categories who face a temporary crisis situation. There are few linkages between unemployment, health, education, and social services providers.

Evidence shows that those persons most in need have less accessibility to services due to a range of personal, social, and cultural barriers such as lack of adequate transportation, inaccurate and/or lack of information, discrimination, complicated bureaucratic procedures, lack of identity papers, etc. To improve programs and services policymakers, professionals, and the public must be educated about community care models and ways to integrate a fragmented system that will improve access in the face of increasing poverty and discrimination. Effective targeting of those most in need and least likely to access services presents a significant challenge, particularly in the more rural and remote areas of the region. Public education, outreach (including communication and transportation services), assessment, and planning must be used to address this challenge. Financial incentives for local governments to provide community care over residential care are also critical mechanisms to ensure the transition is more than a philosophy.

Human Capacity: *This refers to the human resources available to provide services that meet care standards, the specific job functions, the availability of education and training resources for developing a qualified workforce, and regulatory mechanisms.*

The recognition that people working in public and private social service jobs need to have specific competencies to perform professional job functions has been the entry point for many reform efforts. Education is highly valued in the former Soviet Bloc culture, and this has provided an important conduit for change. Educational programs have proved to be a critical starting point for reform efforts. USAID's Participant Training Program has played a critical role in providing information and skills necessary for initiating and implementing

changes. Curriculum development, training of teachers and professors, and an emphasis on knowledge and skill-development of those on the front-line have received a great deal of attention and support. Across the region, there has been an increasing professionalization of social services providers, with primary emphasis on social work education and training.

With an increased emphasis on disabled persons and other disability-related conditions such as addictions, mental illness, and juvenile crime, rehabilitative models are being implemented across the region. Workforce development initiatives that reflect principles and values of capacity-building, prevention, and community care are strong. An outgrowth of this is the development of professional associations that serve as advocates for policy reforms, improved access and quality of care. There are a number of partnerships between educational institutions, professional associations, and service provider organizations that provide models for quality improvement and consumer advocacy, although they are scattered across the region. There is an increasing recognition among public and private providers of the need to regulate professional practice as a mechanism to ensure quality; however, without a link to policies and laws on standards and mechanisms for accountability, the application of regulatory and licensing mechanisms will be limited.

With the rise of private universities and training programs and the increasing cost of public universities, access to professional training remains limited to those who have financial resources. Faculties of social work and psychology within the public universities have been slower to implement real reforms initiated through technical assistance and faculty development programs. "Brain drain" is a major issue for human services professionals as competent and skilled professionals that receive their education abroad often do not return to their country of origin. Another growing phenomenon is the recruitment of professional human services workers from Western countries as a way to meet the shortages of professional social workers and other direct care workers.

Performance Outcomes and Measures: *Outcome indicators used to measure client change based on identified need; information and monitoring systems in place to measure change and track clients.*

This area has received the least attention throughout the region, yet, it is very critical in determining the degree to which policies and laws, programs and services, and human resources have the intended impact. Performance outcomes and measures in the area of social services primarily utilize quantitative measures such as numbers of children deinstitutionalized, numbers of children served in programs, and numbers of services provided. In order to measure qualitative outcomes such as reduced risk and or improved wellbeing, indicators and systems must be employed that monitor a wider range of quality of life variables. UNICEF and World Bank have developed some regional and global initiatives that will better determine how children are doing and how to monitor changes. The design and implementation of computer-based information systems that monitor children and families in the public system, (such as in Romania and Bosnia) and those that monitor programs and services, (such as in Armenia) are just beginning to emerge as models.

General Recommendations³²

Reports reviewed in this study presented many recommendations that could strengthen efforts in the shift to community-based care for the many populations in need of social safety net support. The following serve as exemplary recommendations chosen to highlight issues within the four pillars that frame this study:

Policy and Legal Framework

- Reduce exclusion of vulnerable populations by establishing the central government's role in defining priority risk groups, in setting policy, in providing incentives for local governments, and in addressing the needs of disadvantaged groups.
- Employ a policy framework that includes an integrated family and life cycle approach, requires multi-sector interventions (social welfare, education, health, and labor markets) and ensures better targeting of benefits. Reinforce the centrality of family, which historically has been integral to the culture of all countries in the region, and integrate it into community development efforts.
- To reduce the gap between policy and reality, put in place mechanisms that make local and national bodies (NGOs and the public sector) accountable—including methods for sanctioning those not in compliance.
- Expand at the local level policy development and legislative changes that promote the development of alternative services such as foster care and domestic adoption and a range of family support services.
- Abuse, neglect, and exploitation are identified as primary concerns for UNICEF in the Medium-Term Strategic Plan for 2002-2005.³³ Legislative changes are needed in conjunction with public awareness-raising about the damaging effects of family violence. Develop a national policy dealing with domestic violence that ensures basic spousal and child rights, protects against abuse, and provides treatment. Criminalize domestic violence and abuse in intimate partner relationships.

Structure of Services

- Target and link social services at the community level with social assistance and social insurance, education, and health to provide a systemic, needs-based approach for the best utilization of resources.
- Improve service delivery systems to integrate a human development framework with economic and material needs.
- Address issues of targeting (reaching the beneficiaries that the programs and services are meant to serve) and access (benefiting from the service).

³² These recommendations are from various sources listed in the References Section. They are not attributed to any one source, as they tended to be general recommendations repeated by different authors/sources.

³³ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division, pp 9-10.

- Utilize outreach combined with public information activities to disseminate information on the availability of social assistance benefits to reduce social exclusion, especially among such groups as the Roma.
- Improve targeting and access using multi-level approaches through community development activities for community, government, civil society, and religious groups. Develop partnerships geared to specific cultural traditions of the target group.
- Increase civil society involvement in service delivery through partnerships between government and NGOs.
- Plan reform initiatives to provide a long-term approach to social service delivery, as short-term responses perpetuate inconsistency and reduce the effectiveness of social investments in social sector reform.
- Build work incentives into social assistance programs through time limits, work requirements, and other means, to reduce dependence on social benefits and increase independence and self-reliance.
- Develop community development activities including micro-credit arrangements and social funds to upgrade housing.
- Use public initiatives to develop partnerships and networks by linking civil society and community development programs that already support vulnerable groups.
- Organize regional technical assistance networks or regional institutes around the structure of a comprehensive system of services, to include assessment and case planning, monitoring and development of human capital, public involvement campaigns, and management and finance training.

Human Capacity

- Strengthen professional associations engaged in advocacy and institutional capacity building that have a potential for developing regulation and licensing programs for practitioners.
- Identify workforce development initiatives that include the strengthening of university education programs through curriculum and faculty development. Implement technical and professional training programs developed through public and private partnerships, shifts in job functions, and changes in job classifications.
- Expand social workers' job functions to include job finding and re-employment/retraining initiatives.

Performance Measures

- UNICEF³⁴ identifies the need to develop indicators for child protection and to improve documentation and analysis of child protection issues in order to provide needed information relative to service delivery, human capacity development needs, and policy formation.
- Build a capacity for analysis at governmental and institutional levels through research and policy aimed at demonstrating evidence-based practices (practices that are linked to specific outcomes and demonstrated through research).

³⁴ UNICEF. (2003). Child Protection: Progress Analysis and Achievements in 2003. Medium Term Strategic Plan 2002-2005 developed by the Programme Division.

- Design program outcomes through methods that increase participation and information flows to ensure that services are responsive to local needs. Access to quality services is of key importance and can be accomplished through well-targeted interventions that involve the potential client-population, stakeholders, and service providers.
- Define outcomes by using developmental, psychosocial, and well-being indicators in addition to the more easily measured indicators such as school attendance, institutionalization rates, family reintegration, and income.
- Link data collection and monitoring systems to service delivery as a way to develop and enforce standards of care and service.

Looking Ahead

The spirit of reform is alive and well within the hearts and souls of many reform minded advocates, governments, and donors within the region. Much of the reform is being initiated by civil society organizations or NGOs. Reports provide information on types of clients, their needs and types of interventions, with less information on how specific interventions are linked to outcomes. Where new service structures are put into place, gaps are apparent in policy, access, and in the human capacity to increase and replicate services for the large and growing numbers of vulnerable groups. But incremental steps have been taken. Promising practices, both in the public and private sectors, are emerging. Adaptation and replication could be facilitated through formalized networks and databases that provide information and technical assistance. The examples of “Promising Practices” in Appendix A could serve as models for adaptation and replication in other regions and countries that share the common aim of improving care of their most vulnerable groups.

APPENDIX A

SELECTED EXAMPLES OF PROMISING PRACTICES IN COMMUNITY-BASED SERVICES

Promising Practices in Croatia

Public Social Services
NGO MODUS

Promising Practices in Belarus

NGO *Ponimanie* (Understanding)

Promising Practices in the Region: Services for Children and Youth

Standards
Accountability
NGO Partnering and Advocacy
Advocacy by Professional Associations
Emphasis on Indicators of Child Well-Being

Promising Practices for the Region: Disability

International Network of Disabled Youth Activities
Vocational Rehabilitation of the Disabled in Ukraine
NGOs in Czech Republic
NGO in Latvia
Reform of Policy and Legal Framework for People with
Mental Disabilities

Promising Practices in Services to Roma

Hungary
Bulgaria

Promising Practices in Prevention and Early Intervention Services

The Elderly
At-risk Children and Adults
Youth

Promising Practices in Social Contracting with NGOs to Provide Social Services

Promising Practices in Croatia³⁵
Public Social Services

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Social protection was recently moved to Health and Social Welfare with renewed emphasis on implementing community care for vulnerable groups. Although legislation has existed since 1984 promoting family-focused, community care for disabled and the rights of disabled persons, only now have efforts begun to de-institutionalize adults and children. Finance and administration are centralized but programs and services are decentralized. New protections give courts decision-making authority over child placement in child custody and abuse cases rather than leaving those decisions up to individual social workers. • The state has the capacity to contract with NGOs for social services. • Advocacy groups (associations of parents of children with special needs, single parents, and large families) are involved in policy reform initiatives. • Consumer and client groups are organizing to promote policy reforms that favor family and community care models.
<p>Structure of Programs and Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making • Public awareness and public education aimed to influence public attitudes and citizen involvement 	<p>The Department for Children and Families has 100 Centers for Social Work, which have existed for more than 50 years providing family protection, guardianship, family counseling, and divorce mediation. Social services available through the local Centers for Social Work include:</p> <ul style="list-style-type: none"> • Divorce mediation: Emphasizing prevention, divorcing couples with children are required to participate in mediation. • In-home care for children with disabilities: Social assistance provides allowances for families with children and for persons with disabilities; the right to have in-home assistance; and the right of the parent to stay home with a disabled child until the child's 7th birthday. • Institutional facilities for children: There are 14 state and 3 private (NGO) institutional facilities for children in need of protection, with an average of 50 children in each facility. Social workers at each facility provide family reunification, family placement, and foster care services. • Foster care: The system, which has existed for many years, was professionalized in the mid-1990s. It now includes a system of recruitment, evaluation, training, certification, supervision, and support for foster parents caring for approximately 2,500 children in care. Therapeutic foster care for children with disabilities is planned. • Adoptions: There are approximately 120-130 national adoptions per year. International adoption is limited (5 or 6 per year) although there is external pressure to increase this number. A new initiative is planned to increase adoptions of special needs children. • Disability care: There are 25 homes for persons with disabilities (for 6,000-7,000 adults and children) and the goal is to replicate the

³⁵ Information obtained by personal interviews and review of official documents.

	<p>system of group home care. Currently, there are seven towns that have group homes for 5-6 individuals, with about 100 placed to date. These homes provide occupational therapy and employment services including job coaching; promote family visits; and integrate children with special needs in therapeutic day care programs.</p> <ul style="list-style-type: none"> • Domestic violence prevention: UNICEF’s public education campaigns have raised awareness about domestic violence in the public and private sectors. This increased awareness has made social services and police better prepared to intervene in the increased family violence cases being reported.
<p>Human Capacity</p> <ul style="list-style-type: none"> • 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 • Licensure and certification of professional staff promotes quality care • Workforce development and performance improvement initiatives improve staff capacity 	<ul style="list-style-type: none"> • Each Center for Social Work consists of a team that includes an integrated approach to professional social work, psychology, social educator (pedagogue), and legal services. There is an integrated team planning approach that emphasizes community-based, rehabilitative approaches and family support. • Psychology, social work, social pedagogue, and law faculties have well-developed curricula for developing necessary knowledge and skills for direct care services providers, with a strong emphasis on supervisory and management skills. • Psychologists must be licensed, and it is anticipated that other professionals (social workers, social pedagogues, and lawyers) will develop licensing procedures. • Various training programs for professional staff are in place.
<p>Performance Measures and Outcomes</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being. • Information systems monitor clients 	<p>Each welfare office has a system for monitoring client interventions and reduced risks and improved well-being. There are plans to develop a national system for monitoring clients that will be connected to each local Center to monitor changes in risk factors and improved well-being.</p>

Promising Practices in Croatia
NGO - Modus: Youth, Family and Children Center³⁶

<p style="text-align: center;">Structure of Programs and Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making • Public awareness and public education aimed to influence public attitudes and citizen involvement 	<p>Center established in 2003 to address the need for non-institutional, community-based services. Services target:</p> <ul style="list-style-type: none"> • Children and adolescents who need psychosocial support and assistance; • Parents experiencing difficulties with their children; • Couples who want to improve their relationships; • Families experiencing dysfunctional and destructive relationships; and • Individuals who want to improve their relationships and quality of life. <p>Services include:</p> <ul style="list-style-type: none"> • Counseling and psychotherapy for children, youth, couples, parents, families; • Group education and coping programs (grief and loss, parenting skills, divorced parents and children, and personal development); • Psycho-educational workshops for children and adolescents; • Structured leisure-time activities (social support programs for parents with children ages 5-8 years, creative workshops for children and adolescents); and • Public lectures.
<p style="text-align: center;">Human Capacity</p> <ul style="list-style-type: none"> • Job functions integrate assessment, planning, intervention and monitoring/follow-up • Professional rehabilitative and psychosocial practices promote capacity-building • Curricula provides skills in rehabilitation, prevention, capacity-building and community care • Licensure and certification of professional staff promotes quality care 	<ul style="list-style-type: none"> • Interdisciplinary team including family therapists, psychologists, social workers, psychotherapists, lawyers, and special educators integrates rehabilitative and capacity-building social, health, economic, and psychological interventions. • Integrated social work and psychology faculties at the University of Zagreb emphasize teaching skills in clinical interventions with a unique focus on skill-building for social work supervisors to reduce worker “burnout.” • Center integrates international standards for social work and psychology into its practices and in the licensing of psychologists.
<p style="text-align: center;">Performance Measures</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being • Information systems monitor 	<p>Outcomes include:</p> <ul style="list-style-type: none"> • Promotion of mental health among young people; • Enhancement of protective factors in the family; • Focus on gender-specific issues; and

³⁶ Source: www.dpp.hr/eng/modus.php and personal communications.

<p>programs and services</p> <ul style="list-style-type: none"> Information systems monitor clients 	<ul style="list-style-type: none"> Facilitation of successful psychosocial adjustment to difficult circumstances in a post-war transitional society. <p>Monitoring systems:</p> <ul style="list-style-type: none"> Monitoring systems are being put into place at the local, decentralized level that provide ongoing evaluation of client outcomes and program effectiveness.
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<p align="center">Promising Practices in Belarus NGO <i>Ponimanie</i> (Understanding)³⁷</p>	
<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> Priority groups identified Principles of family and community care developed Internationally recognized standards of care applied Public/private partnerships and contracting implemented Consumer and citizen involvement increased 	<p>The stated values of the NGO are “the family, respect for children’s rights, trust, responsibility, and the relationship between environment and child development.”</p> <ul style="list-style-type: none"> Standards based on Erickson’s theories of human development and human relationships guide practice: self-assertion, adaptation, and developmental psychology. The Web site contains several professional papers that outline their practice principles. Partnering of public services with NGOs is an emerging practice although no formalized mechanism is in place: <i>Ponimanie</i> partners with the Ministry of Education to provide parenting skills classes and with the Ministry of Interior to provide recreational camps. <i>Ponimanie</i> assisted in the creation of a network of NGOs working with children to bring together advocates, consumers, and organizations to influence public policy and increase potential for funding from various sources, including the public sector. <i>Ponimanie</i> also worked with UNICEF and the government of the Republic of Belarus to create the Joint Plan of Action of 2003-2005 for Children.
<p>Structure of Programs and Services</p> <ul style="list-style-type: none"> A range of services from prevention to protection offered Mechanisms for community reintegration, self-reliance and capacity-building established Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making Public awareness and public education aimed to influence public 	<ul style="list-style-type: none"> 146 Social Pedagogical Centers in the country provide services and disseminate information on methodology for a range of community care programs that focus on prevention, early intervention activities, and linkages with family education and counseling as a way to keep youth in their families and communities. Targets teenagers with identified risk factors including institutionalization, family poverty, developmental delays and disability, alcoholism, psychological and relationship problems, and criminal behavior through a program of peer-counseling. Currently they have trained 409 youth in five residential facilities, one technical school, and one social shelter as peer-counselors to provide support and information to other youth. Interventions primarily utilize peer group models, training in social skills and coping skills, parent education, cultural and recreation activities, youth clubs, competitive activities, and counseling for parents and teenagers. De-institutionalization services include foster care, group homes, and reintegration/ prevention services for graduates of institutional boarding schools. Under a USAID grant they have served 139 institutionalized children, and through Swiss funding they have served 19 children, reunited six children with follow-up monitoring, and initiated a small

³⁷ Sources: www.ponimanie.org/ and Final Narrative Report (August 31, 2005) of Ponimanie for CAP B04 SG-12 of the Counterpart Alliance for Partnership Program funded by USAID.

<p>attitudes and citizen involvement</p>	<p>foster care program.</p> <ul style="list-style-type: none"> Utilizes an activist model by training clients and parents in coping and adaptation skills with emphasis on group decision-making, self-determination, and self-advocacy. Volunteer recruitment and placement are mechanisms for engaging the public and providing public education about the risks for the target groups. Partnerships exist with other service NGOs such as the Republican Association of Disabled.
<p>Human Capacity</p> <ul style="list-style-type: none"> Job functions integrate assessment, planning, intervention and monitoring/follow-up Professional rehabilitative and psychosocial practices promote capacity-building Curricula provides skills in rehabilitation, prevention, capacity-building and community care Workforce development and performance improvement initiatives improve staff capacity Professional associations with advocacy function to promote quality of service through quality workforce 	<ul style="list-style-type: none"> Staff and volunteers have acquired skills primarily through the Faculty of Psychology, Postgraduate School. They strongly value psychosocial interventions and demonstrate this by practicing individual, group and family interventions that focus on developing and improving coping and relationship skills. Their practice is based on the belief that a shift in a youth's reference group has a stabilizing and healing effect and can improve outcomes for children. Provided training and support for ten orphanage staff and seven community leaders in psychosocial and capacity-building practices. The Dean of the Faculty of Psychology of the Academy of Postgraduate Education provides professional consultation, monitoring, and supervision of the staff as a way to build capacity and improve intervention skills. 100 professionals trained to work with 2,000 children separated from their parents in two Oblasts through a UNICEF Project, "Local Community: Elements of Regional Models of De-institutionalization." Institute of Community-Based Services for children separated from their parents is in the developmental phase in 50 rural communities to support continued training and dissemination and replication of models. Through a pilot project,³⁸ established interdisciplinary teams on prevention of child abuse and neglect and an interdepartmental council on child protection under the direction of the Vice Mayor of Kalinkovichi District. Specialized training has been provided for 11 staff of the residential facility "Lisa-Kalinkovichi" and 24 professionals at the Social Pedagogical Center. Close partnership between <i>Ponimanie</i> and the Faculty of Psychology, and membership in the network of NGOs working with children provide a basis for future activities to replicate best practices and build capacity.
<p>Performance Outcomes and Measures</p> <ul style="list-style-type: none"> Indicators measure reduced risk and/or improved well-being Information systems monitor programs and services Information systems monitor clients 	<p>Stated outcomes include:</p> <ul style="list-style-type: none"> Mutual understanding, increased hopefulness, and citizen responsibility for children. Reduced impact of institutional life through improved parent-child relationships; increasing civic involvement and responsibility among youth; reduced impact of risk factors through environmental/social changes, increasing social adaptation, and coping skills; and prevention of risk through recreation and cultural activities. Social adaptation measures are outlined as a way to guide the work on a case by case basis. <p>Monitoring and evaluation systems:</p> <ul style="list-style-type: none"> Although there are no systems in place, there is a recognition that evaluation research can be used to measure outcomes. One study on subjective evaluation of positive behavioral changes of teenagers revealed that at least 54 percent felt they had improved.

³⁸ Project funded by the Swiss Office of Development & Cooperation-Belarus at in Kalinkovichi District.

Selected Promising Practices for Children and Youth Across the Region

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Internationally recognized standards of care applied • Accountability and sanctioning enforced • Public/private partnerships and contracting implemented 	<p>EveryChild’s policy framework, “Child protection policy, procedures, and guidance” aims to safeguard children from abuse and exploitation and is reflective of Article 19 of the UNCRC. Approved by the Board of Trustees, it clarifies EveryChild’s position on child protection and applies to staff, trustees, and volunteers globally, including London. It will be translated into local languages in every country as the guiding policy on practice standards (www.everychild.org).</p> <p>UNICEF and the World Bank have developed a toolkit³⁹ based on the concept paper “Improving Standards of Child Protection Services in ECA.” It provides methodological support for the implementation of standards and quality control. Outcome indicators include reduced use of institutions for children and increased use of family and community-based services. The toolkit also introduces effective gate keeping⁴⁰ mechanisms.</p> <p>The Macedonian government has partnered with a local NGO, Republic Centre for Helping Persons with a Mental Handicap- MESSAGE, and an International NGO, EveryChild, to establish units within state kindergartens for children with disabilities. This represents Macedonia’s first step on the path to an inclusive educational policy. Advocacy efforts focus on legislative changes to improve services to children with disabilities.</p> <p>In Moldova, EveryChild is developing programs for family reunification, short-term foster care, and socialization for profoundly disabled girls that include support by trained child protection social work teams.</p> <p>In Kyrgyzstan, the Children’s Rehabilitation Center and NGO UMUT-Nadjeshda have partnered to develop a kindergarten that integrates disabled children and street children with “normal” children in educational and socialization activities. A Center for Social Therapy provides rehabilitative care for 15 teenagers with severe and multiple disabilities with the assistance of normal teens.</p> <p>In Bulgaria, a model for day care centers for children with disabilities has been established in 17 municipalities, in part, through joint efforts of local</p>
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³⁹ Bilson, A. & Gotestam, R. Improving Standards of Child Protection Services in CCA Countries: A Toolkit. (2002) Based on *Changing Minds, Policies and Lives*, World Bank and UNICEF at www.worldbank.org.

⁴⁰ Gate keeping is the structured process that controls entry into social services programs. For example, the assessment and planning process for entry into institutional care or foster care serves a gate keeping function, as that is where the determination of eligibility for service is made.

	governments, parent action groups, and international NGOs.
<p>Human Capacity Development</p> <ul style="list-style-type: none"> • Advocacy by professional associations promotes inclusion 	<p>European Social Work Action Day 2003: Disability, Human Rights and Social Work⁴¹ - Social workers promote inclusion of people with disabilities.</p> <ul style="list-style-type: none"> • Social Work Action Day celebrated the role of social work and its contribution to social inclusion in Europe for the approximately 37 million disabled people, and highlighted profiles of social workers with disabilities. • Social Work Associations participating included those from Bulgaria, Romania, Ukraine, Hungary, Latvia, Russia, Poland, and Belarus.
<p>Performance Outcomes and Measures</p> <ul style="list-style-type: none"> • Indicators measure child well-being • Information systems monitor programs and services 	<p>A global project on Monitoring and Measuring Children’s Well-Being⁴² sought to identify internationally comparable indicators of child well-being beyond the useful but narrow mortality and morbidity data that is used in the UN’s annual report. Standards for monitoring and measuring children’s well-being include the following domains: safety and physical status, personal life, civic life, children’s economic resources and contribution, and children’s activities.</p> <p>Russian Federation:⁴³ An EU-funded project in partnership with the Ministry of Health and Social Development is developing a comprehensive 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 to determine their effectiveness and efficiency in improving the delivery of social services. The four target groups for this project approved by the Ministry are</p> <ul style="list-style-type: none"> • Children without parents and leaving residential care; • Unsupervised children and those registered with the “Commissions for children and teenagers rights protection for infringements of the law;” • Juvenile delinquents leaving prisons; and • Victims of domestic violence (children, women). <p>To this end a draft evaluation matrix and guidelines have been prepared which are being tested out on several existing internationally, federally, and locally funded projects. The 11 areas of evaluation include: Justification/Relevance, Acceptability, Effectiveness, Efficiency, Quality, Accessibility, Equity, Sustainability, Information/Dissemination, External Factors, and Evaluation.</p> <p>Planned outcomes include:</p> <ul style="list-style-type: none"> • Increase capacity for design, implementation, and dissemination of strategies within the Russian Federation. • Develop standards for monitoring and evaluation of social services programs and facilitate “bottom up” improvements at the local levels. • Build a comprehensive continuum of care. • Contribute to policy formation.

⁴¹ Sources: <http://www.ifsw.org/Info/SWAD-Activities.pdf> and <http://www.ifsw.org/Info/SWADInform2.pdf>.

⁴² UNICEF. (1998). *Indicators for global monitoring of child rights*: Division of Evaluation, Policy, Planning. New York: UNICEF. www.multinational-indicators.chapinhall.org/domainlist.lasso.

⁴³Henrik, H. & Widmer, T.(2005). *Mini-Guide to Evaluation of Social Projects: An Evaluation Matrix for Social Projects*. EU AID Project on Developing Social Services for Vulnerable Groups II.; Additional project documents include *Project Synopsis: Developing Social Services for Vulnerable Groups II for Russian Federation* and *Project Developing Social Services For Vulnerable Groups II- Evaluation Matrix For Social Project*.

	<ul style="list-style-type: none"> • Integrate systems of social/health/education and employment services. • Improve capacity of local administrators and social workers through identification of gaps in knowledge and skills. • Prevent delinquency and domestic violence through the development of models and procedures for the joint intervention of local stakeholders.
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**International Network of Disabled Youth Activists:
Teams Promoting Equal Access to Education**

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Internationally recognized standards of care applied • Public/private partnerships and contracting implemented • Consumer and citizen involvement increased 	<ul style="list-style-type: none"> • Cross-disability model: Emphasis on functional capacity, difficulties in access of services, stigma and discrimination common across disability groups. • Partnership of five disability NGOs (Hayot, Uzbekistan; Creation of Barrier-Free Environment, Republic of Buryatia; Vozrozhdenia, Gorny Altay; Bridge of Hope, Armenia; and Lotos, Azerbaijan) with disability organization Perspektiva and World Institute on Disability (WID)⁴⁴ promotes changes in policies and laws affecting access and discriminatory practices.
<p>Structure of Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making • Public awareness and public education aimed to influence public attitudes and citizen involvement 	<ul style="list-style-type: none"> • Five disability NGOs have partnered with Perspektiva to develop the International Network of Disabled Youth Activist Teams (two from Siberia and three from NIS countries). Five disabled youth activist teams were established in four countries: two in Russia and three in Armenia, Azerbaijan and Uzbekistan. Thirty disabled youth activists received training on access to education, advocacy, and outreach activities, and created public service announcements. Training materials on disability awareness and access to education have been developed. The Disability Film Festival and International Network Resource Library at Perspektiva were established to serve as a holder of media and film related to disability awareness. Cross-disability is the model; there is no distinction among different disability groups such as visually impaired, deaf, and physically disabled. • Extensive training for young activists on access to education, advocacy, and outreach activities. Disability awareness presentations for school children. Model outreach program. • Quarterly newsletter published by Russian NGO. Education of the public about disability and the right to education through mass media is the model. Staff trained to work with media and journalists. Printed material and video developed. Film festival to highlight visual presentation of inclusion models.
<p>Human Capacity</p> <ul style="list-style-type: none"> • Curricula provides skills in rehabilitation, prevention, capacity- 	<ul style="list-style-type: none"> • Builds capacity of youth to promote the social integration of disabled persons in their countries through learned skills and practical experiences to become more effective disability

⁴⁴ World Institute on Disability (WID). International network of disabled youth activist teams promoting equal access to education. 1st quarterly program report 11-1-2003 through 1-31-2004. Submitted to USAID April 9, 2004 by Bruce Curtis, Russia Project Manager.

building and community care.	advocates and leaders in their communities.
<p style="text-align: center;">Performance Measures</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being • Information systems monitor programs and services • Information systems monitor clients 	<ul style="list-style-type: none"> • Empower disabled youths to take control of their lives and foster positive community attitudes through social advocacy and public education. • Empower disabled youths, parents, and community coalitions to challenge discrimination in society. • Eliminate social and physical barriers to equal education. • Exchange information and experience among disability NGOs

Ukraine
Lutizh: All Ukrainian Centre for the
Vocational Rehabilitation of the Disabled

(Source): http://www.disabilityworld.org/04-05_03/violence/ukraine.shtml

<p style="text-align: center;">Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Internationally recognized standards of care applied • Public/private partnerships and contracting implemented • Consumer and citizen involvement increased 	<ul style="list-style-type: none"> • International Labor Organization (ILO) identifies Ukraine as having the highest disability rates in Europe: 14% of the Ukrainian population, or about 8 million people, are disabled (2.6 million according to official estimates). This number is almost twice the average for the industrialized countries and includes veterans of the Afghanistan war, victims of the Chernobyl nuclear disaster, and victims of the frequent accidents in the mines of the Donbass. • ILO Core Standards guide the practices of the Centre. ILO’s Declaration on Fundamental Principles and Rights at Work is an “expression of commitment by governments and employers’ and workers’ organizations to uphold basic human values--values that are vital to our social and economic lives.” (www.ilo.org) • The Centre’s building meets international standards of accessibility including special toilets, ramps, covered pathways, and a specially equipped swimming pool for rehabilitation and leisure. • The Centre is a partnership that includes the Ukrainian government (which finances the operating costs), the ILO, the United Nations Development Programme (which provides the funds for facilities, equipment, and training), and NGOs and regional governments that are operating the Centres. The idea is to organize a regional network to promote replication and sustainability of the model.
<p style="text-align: center;">Structure of Programs and Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making 	<ul style="list-style-type: none"> • The Program of Vocational Rehabilitation focuses on community living and capacity-building for the physically disabled through a range of education and skill-building programs such as typing, social work, bee-keeping, and information technology. Sports, cultural and social activities are also provided. • Selection of clients is done through an integrated approach that focuses on factors indicating the potential for successful employment, for example, age, motivation, and access to jobs. • Self-employment opportunities are promoted through small business training. Job placement is a combined effort with regional employment centers. Plans for the program include analysis of labor market trends in order to provide better targeted training and placement. • Courses are free, including lodging and medical expenses. • Transportation services for employees from the nearby city are provided by ILO and ensure recruitment of qualified workers.
<p style="text-align: center;">Performance Measures</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being • Information systems monitor clients 	<ul style="list-style-type: none"> • Outcomes stated as employment and independent living with community support for disabled. • Regional employment offices are responsible for placement and monitoring of clients.

Promising Practices in the Czech Republic for Mental Disabilities: Pilot Programs FOKUS, BAOBAB, and the Center for Mental Healthcare Development

“NGOs bring care to the community with hope that the Czech health system will change and reintegrate people with mental health problems.”⁴⁵

Projects of Open Society Mental Health Initiative

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Consumer and citizen involvement increased 	<ul style="list-style-type: none"> • Although mental health remains a peripheral concern for ministers and senior figures in the health system, and people with psychiatric disorders remain marginalized even among the broader category of people with disabilities, in the last few years mental health problems have been identified as important human rights issues in the Czech Republic. Existing programs reach about 25 percent of the client-need. • NGOs are planning to advocate that the state devote more attention to a patient’s life “out of the hospital,” to day-care centers, crisis-intervention centers, and other community-based services. Advocacy efforts are planned to increase state financial support and programming in community care.
<p>Structure of Programs and Services</p> <ul style="list-style-type: none"> • Offers a range of services from prevention to protection • Mechanisms for community reintegration, self-reliance and capacity-building established • Public awareness and public education aimed to influence public attitudes and citizen involvement 	<ul style="list-style-type: none"> • FOKUS, (NGO) provides individual and group therapy, medication management, community employment and sheltered workshop, independent living apartments, and subsidized housing. • Center for Mental Healthcare Development offers day care centers with access to medication and medication-monitoring, which are provided as an alternative to hospitalization. • BAOBAB offers a drop-in center, leisure activities such as painting, trips and excursions, and computer and language courses. • Pilot programs are being implemented to increase community-based options, with an emphasis on medication and symptom management, to reduce the dependence on institutional care. • Ease of access is seen as important for early intervention. Drop-in centers provide the opportunity for clients to visit when they feel the need and are motivated to do so. • Viewed as “self-help organizations” with clients taking initiative in organizing events. • Group provides public education about mental illness. Regularly conducted surveys among townspeople seek reactions from those in close proximity to a person with a mental disability; positive changes in attitudes have been observed. Prague, Brno, and Pízen hold concerts on the grounds of psychiatric institutions as a way of changing attitudes.

⁴⁵ Open Society Mental Health Initiative, Transitions Online (TOL). www.soros.org/initiatives/mhi/news/integrating_20031209

**Promising Practices in Latvia for Mental Disabilities: Pilot Programs
OPEN-MINDED STAFF in Akniste, Latvia**

**“NGOs, health professionals, and village authorities establish Latvia’s
first group home for the mentally disabled.”⁴⁶**

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Advocacy, consumer and citizen involvement increased 	<ul style="list-style-type: none"> • 62,000 Latvians officially registered as mentally disabled (schizophrenia, neurological problems, and intellectual disabilities). State services include nine psychiatric hospitals and 30 social care homes. • There is recent legislation that would bring legal protections for persons with mental health problems in line with the Council of Europe’s European Convention on Human Rights. • As an overall mechanism for change, these pilot programs provide a way to develop and test developing partnerships between public, private, and non-profit agencies. • No specific contracting mechanisms are in place, but partnerships are being developed. For example, the municipality made a house available in the center of the village containing apartments for 10 single people and two couples. • Project employs a “user-centered” approach: projects are designed for and with the consumer groups, local authorities, and local people.
<p>Structure of Programs and Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • 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 	<ul style="list-style-type: none"> • Programs include: family visitation; community based mental health treatment; legal aid; life skills training (leisure activities, budget planning, medication management, recognizing symptoms, crisis and anger management, personal care, sex education, and health); transitional living apartments; group homes; occupational training; support, guidance, and counsel of other independent people and care professionals. • The “user-centered” approach to the project engages the patients in design and implementation of the community model. • Family-ties program was initiated by sending a questionnaire to patients’ relatives resulting in a high number of positive responses. This feedback influenced the implementation of a project to purchase a van to transport patients to visit their families, rather than depending on relatives to visit patients in the hospital. • Staff worked to organize a hospital patient council and win support for the council to function. The hospital patient council writes a monthly newsletter and has served as a way to gain support for the efforts of the community reintegration and de-institutionalization project.
<p>Human Capacity</p> <ul style="list-style-type: none"> • Curricula provides skills in rehabilitation, prevention, capacity-building and community care 	<ul style="list-style-type: none"> • Recently efforts have been made to increase the competency requirements for staff in psychiatric institutions and social care homes, as reforms to initiate rehabilitative practices are being implemented.
<p>Performance Measures</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being 	<ul style="list-style-type: none"> • Outcomes emphasize improved well-being through independent living and rehabilitation.

⁴⁶ Open Society Mental Health Initiative, Transitions Online (TOL).
www.soros.org/initiatives/mhi/news/integrating_20031209

Promising Practices in Reform of Policy and Legal Framework for People with Mental Health Disabilities

<p>Albania⁴⁷</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Advocacy, consumer and citizen involvement increased 	<p>A Department of Mental Health Development was created within the Ministry of Health. The policy statement outlines a strategy for delivering better services that are closer to the community need, thus fighting segregation and social exclusion. Features include: innovative use of resources; integration of mental health into primary health care; and a legal framework giving authorities, professionals, NGOs, mentally ill people, their families, and the community tools to access rights to treatment, housing, education, and employment. The policy does not allow for long-term hospitalization and launches a demonstration of community-based systems.</p>
<p>Armenia⁴⁸</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Advocacy, consumer and citizen involvement increased 	<p>Mental health regulated by the Ministry of Health. A new law has been proposed on psychiatric care that reforms the mental health system by providing community care. Mental Health Foundation is a lobby group, assisted by US-based Mental Disability Rights International (MDRI) that engages mental health professionals, lawyers, family and mental health consumers, governmental and non-governmental organizations in advocating for new legislation. Training for public health workers to identify and provide support to prevent long-term effects from war trauma has been developed.</p>
<p>Bosnia⁴⁹</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Internationally recognized standards of care applied • Advocacy, consumer and citizen involvement increased 	<p>Mental health services are organized as a component of primary health care and are decentralized to community-based mental health centers. The policy calls for multidisciplinary care, a comprehensive continuum of care, equality in access, and utilization of psychiatric service resources. The transition of psychiatric treatment from hospitals to communities transfers the focus from an illness model to one emphasizing patient characteristics and functional behavior within the environment. Standards have been developed for how services are organized, accessibility, human capacity in terms of numbers of staff/patient ratio, financial resources, and ensurance of human rights. Performance measures include reduction of prevalence of functional disability.</p>
<p>Kyrgyzstan⁵⁰</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and 	<p>Mental health system reform was initiated in 1999 with enactment of a new "Psychiatric Care Law." The national program, "Mental health of the population of the Kyrgyz Republic in 2001-2010," was launched in</p>

⁴⁷ Source: www.mdac.info.

⁴⁸ This is proposed, but it is unclear if it has actually been passed and implemented.

⁴⁹ Decentralization occurred, in part, due to the destruction during the war of hospitals that housed psychiatric patients, leaving many patients without services. (Some outpatient services existed in community health centers.) Psychiatric morbidity increased due to trauma and psychological suffering of the civilian population. As mental health services are being reorganized, there is general agreement that facilities will not be reopened nor will new facilities be built. Note that policy has defined these as best practices, but there has not been sufficient funding to implement this plan.

<p>community care developed</p> <ul style="list-style-type: none"> • Public/private partnerships and contracting implemented • Accountability and sanctioning enforced • Advocacy, consumer and citizen involvement increased 	<p>2000 and corresponds to international standards for mental health services. The key principle of the program is a shift from institutionally-based mental health care to more localized community-based care, with an emphasis on bringing mental health care to individuals in their local communities.</p>
<p>Croatia⁵¹</p> <ul style="list-style-type: none"> • Principles of family and community care developed • Internationally recognized standards of care applied 	<p>Legal framework protects persons with mental disorders and is based on international professional standards, mandating community treatment, and rehabilitation.</p>

⁵⁰ This is an example of policy and philosophy being initiated; however, implementation was suspended due to lack of funding. Although the policy exists, there has been re-centralization, merger of child and adult psychiatric facilities, lack of psychiatric medications, and use of psychiatric facilities for family interventions.

⁵¹ Source: www.mdac.info.

Promising Practices in Services to Roma⁵² Hungary

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Consumer and citizen involvement increased 	<p>The 1993 Hungarian Minorities Act granted considerable cultural, educational and linguistic rights to Hungary's thirteen recognized minorities through a system of national and local minority self-governments, a system unique to Hungary. There is an Office for National and Ethnic Minorities and an independent Minorities Ombudsman to oversee minority rights and protections. The government has established a Roma Office under the office of the Prime Minister to coordinate Roma policy. Minority self-governments (MSGs) are elected bodies that work in partnership with local and national governments. The first one established was the Lungo Drom Gypsy Association. The government is required to provide funding for NMSG headquarters, infrastructure, and operating costs. By June 30, 2000, there were 1,339 MSGs. 78.8 % are involved in social welfare programs.</p>
<p>Structure of Services</p> <ul style="list-style-type: none"> • Offers a range of services from prevention to protection • Mechanisms for community reintegration, self-reliance and capacity-building established 	<p>Nyiregyhaza is located in Szabolcs County and has two large Roma settlements, Oros and Gusev (one of the largest in Hungary). Examples of changes being made and services offered include:</p> <ul style="list-style-type: none"> • Orosi Roma Community Hall was refurbished with special programs for children, job clubs, and art clubs. • Various competitions were introduced to reduce the exclusion in the settlement and reinforce local trust in municipal institutions, programs, and resources. • Emphasis is on capacity-building of Roma through employment programs, education, and housing.
<p>Performance Measures</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being 	<p>Measures used include:</p> <ul style="list-style-type: none"> • Increased social integration; • Improved access to public services; and • Increased participation. <p>Improving conditions of schools and housing, and providing employment within the settlement served to reduce social exclusion.</p>

⁵² *Project Experience in Hungary*. (2005). In World Bank. Roma in an Expanding Europe: Breaking the Poverty Cycle. Washington, DC: World Bank.

Promising Practices in Services to Roma Roma Folklore in the Bulgarian School⁵³

<p>Policy and Legal Framework</p> <ul style="list-style-type: none"> • Priority groups identified • Principles of family and community care developed • Public/private partnerships and contracting implemented • Consumer and citizen involvement increased 	<ul style="list-style-type: none"> • This project was carried out in villages and towns with marginalized and disempowered Gypsy communities. • It is a partnership between Amalipe, the Bulgarian Ministry of Education and Science, and the Open Society Foundation. • It crystallized processes of Romani emancipation and community development that will certainly continue after the end of the project activities.
<p>Structure of Programs and Services</p> <ul style="list-style-type: none"> • A range of services from prevention to protection offered • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning and intervention promotes targeting, improved accessibility, and client involvement in decision-making • Public awareness and public education aimed to influence public attitudes and citizen involvement 	<ul style="list-style-type: none"> • Romani folklore was introduced as an optional class in 14 primary schools in Veliko Turnovo County in central Bulgaria. The idea of the class was to present Romani culture and folklore as well as the relationship between Romani culture and folklore and the folklore of the other ethnic groups living in Bulgaria. This was the first time Romani cultural issues were taught in the public schools as a separate subject. The new course was taught to 30 classes, involving more than 550 students of Romani and non-Romani backgrounds. Two textbooks of Romani folklore were published: <i>Stories by the Fireplace</i> and <i>Roads Retold</i> by Deyan Kolev, Teodora Krumova and Antonia Krasteva. They presented the most important parts of Romani history. The textbooks contained folklore from most of the gypsy communities, groups, and subgroups in Bulgaria (Yerlii, Kaldarashi, Rudari, Millet, and others). • Prevention programs that promote social inclusion, parent involvement, peer and family support programs, and self-advocacy skills. • Desegregation of education. • Building capacity of Romani, non-Romani, local authorities, and educators.
<p>Human Capacity</p> <ul style="list-style-type: none"> • Curricula provides skills in rehabilitation, prevention, capacity-building and community care. • Workforce development and performance improvement initiatives 	<ul style="list-style-type: none"> • Trained teachers to work in a multicultural environment. Teacher's capacity impacts student attitudes, participation, and engagement as well as performance. • Organized two workshops to introduce the teachers to Romani folklore, culture, and history as well as to train them to work with Romani children. Pioneered a methodology that applies a multicultural and interactive approach in the education process. Had wide range of activities including celebrations, concerts, broadcasting, and exhibitions that had a public awareness/public education component.

⁵³ Kolev, Deyan. *Preparing the Ground for the Desegregation of Romani Education*. www.errrc.org.

<p>Performance Indicators</p> <ul style="list-style-type: none"> • Indicators measure reduced risk and/or improved well-being • Information systems monitor programs and services • Information systems monitor clients 	<p>Outcomes include:</p> <ul style="list-style-type: none"> • Broader impact than the education process itself; impact on local authorities and improved community relations. • Committed involvement of local authorities in finding solutions to the educational problems facing Roma; initiated a process of change in the education institutions at a deeper level; created pre-conditions for general improvement of the education situation of Roma; stimulated Romani emancipation; and has played a role in Romani community-building. • Improved achievement potential for students due to increased self-confidence and self awareness. • Introduced the rich world of Romani folklore and taught children ethnic and religious tolerance. • Systematic methods for engaging parents (rather than relying on ad hoc engagement). Impacts community well-being and student/parent/teacher relationships. • Monitored relationships between stakeholders (local authorities, implementers, schools) and community-at-large. • Impacted Romani community by increasing self-confidence and consequently self-advocacy. Ministry and Open Society Foundation continued support after the initial project was completed; Amalipe gained financial support from local authorities of nine municipalities; program was replicated from 14 to 32 primary schools including 1,000 students.
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Promising Practices in Prevention Initiatives for Vulnerable Groups Across the Life Cycle

<p>Structure of Services for Elderly</p> <ul style="list-style-type: none"> • Offers a range of services from prevention to protection • Mechanisms for community reintegration, self-reliance and capacity-building established • Public awareness and public education aimed to influence public attitudes and citizen involvement expanded 	<p>Life 90 is a self-help activist movement in Eastern Europe to support community-living of elderly. Czech Republic's Life 90, a self supporting organization, promotes the concept of active old age and provides assistance to older persons to protect them against crimes.</p> <p>Bulgaria's Life 90 are pensioners who are associating as an advocacy group to set up emergency services, cooperative discount stores, and small scale repair and service delivery centers that respond to the special needs of older people.</p>
<p>Structure of Services for At-Risk Children and Adults, IDPs, and Refugees</p> <ul style="list-style-type: none"> • Offers a range of services from prevention to protection • Mechanisms for community reintegration, self-reliance and capacity-building established • Integrated approach to assessment, planning, and intervention promotes targeting, improved accessibility, and client involvement in decision-making • Public awareness and public education aimed to influence public attitudes and citizen involvement expanded 	<p>CRINGO⁵⁴ Network (Caucasian Refugee and IDP NGO Network) is a voluntary, independent, non-commercial, non-political network of social services and advocacy organizations organized to serve at-risk groups, including refugees and IDPs. It was started in September 2001 and unites more than 60 NGOs from the North and South Caucasus (www.cringo.net).</p> <p>Beliefs include:</p> <ul style="list-style-type: none"> • Networking across borders and equal opportunity; • Practical and concrete approaches to provision of basic services; • Participation of beneficiaries; • Early warning and early response to emergency situations; • Assistance for legal and social issues to refugees, IDPs, and all disenfranchised peoples; • Improved cooperation between NGOs in the Caucasus; and • Transparency in information exchange between Caucasian NGOs and beneficiaries. <p>Outcomes are:</p> <ul style="list-style-type: none"> • Increased access to services through advocacy and public awareness. • Reduced conflict, peace-building and participatory decision-making. • Capacity-building among youth in peace-building. • Monitoring and influencing public decision-making bodies.
<p>Structure of Services for Youth</p> <ul style="list-style-type: none"> • Offers a range of services from prevention to protection • Mechanisms for community reintegration, self-reliance and capacity-building established 	<p>Youth In Action⁵⁵ is a youth Web initiative that serves as a resource to educate students and teachers about USAID's work, and a tool to build dialogue on the issues surrounding young people in the region. Programs focus on prevention and early intervention for youth-at-risk, and examples include:</p> <ul style="list-style-type: none"> • Summer Basketball Camp in Kragujevic, Serbia; • Albanian Students Build Businesses at their School; • USAID Macedonia-Community Self-Help Initiative, in which youth

⁵⁴ Source: www.cringo.net.

⁵⁵ Source: www.usaid.gov/locations/europe_eurasia/youth/.

<ul style="list-style-type: none"> • Integrates client involvement in decision-making. • Public awareness and public education aimed to influence public attitudes and citizen involvement expanded 	<p>work to help improve harmony and well-being of their community;</p> <ul style="list-style-type: none"> • Roma Rights Forum “ARKA” education and Internet Club for youth; • With a focus on environmental education, computers were provided to 145 orphanage youth giving them access to modern educational software; and • Activities such as sheep farming helped families with young children living in rural communities increase their income.
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Promising Practices in Social Contracting with NGOs in Delivery of Social Services

Modernizing social services includes improving the ability of governments to outsource the delivery of social services to other providers. The decentralization of services transfers responsibility and control to local authorities, who then have the potential to contract with independent providers.⁵⁶ Due to the specific nature of their activities, NGOs seem to be the best partner for state and municipalities in delivery of community-based social services. There is hope, with guidance from the West, that despite the lack of supporting legislation, NGOs will be accepted as social service providers throughout the region. Tax preferences are considered important in creating a strong enabling environment for NGOs, as they allow NGOs to have a reduced tax burden through tax exemptions. Most countries in Central and Eastern Europe have made progress toward modernizing their tax laws by granting tax exemptions to certain NGOs for at least some sources of income. Other incentives include tax benefits to individual donors in the form of either a deduction or tax credit (such as in Hungary).⁵⁷ Further examples include:

- In **Poland**, long-term partnerships between local authorities and NGOs are permissible through the Public Benefit Activity and Volunteerism Law. The law allows various public service providers to access public funds for delivery of public services and to participate in relevant policy making processes (half of the members of the Council for Public Benefit are NGO representatives). New legislation implements a process of contracting on a transparent and competitive basis.
- **Hungary** funds social services centrally but local governments, obligated to provide social services, can decide whether to provide them independently or privatize them by contracting with external providers such as NGOs licensed as social service providers. NGOs can apply as a public benefit organization, which provides them the greatest tax benefit. Individuals can donate 1% of their income tax to any NGO. Decentralization and social contracting are well-developed in Hungary. Barriers to best practices in contracting include the bureaucracy of state funding procedures and lack of transparency in distribution and accountability in state funds granted to NGOs.
- In the **Czech Republic** the legal framework does not regulate the status of social service providers, thereby allowing anyone to be considered a social service provider. However, only those listed with the Czech Ministry of Labor and Social Activities (MOLSA) can receive state subsidies for social service delivery. In 2003, social services funding was decentralized through allocation of funds from the state budget to regions, which then organize and supervise the spending of social service funds. The rules for social contracting between the state and local authorities and NGOs is set forth in a MOLSA rulebook regulating the overall tender procedure, method for applying documents required by NGOs, project evaluation, conclusion of the contracts, and provision of funding. Annual competitions for delivery of social services, to which only NGOs can apply, are announced by MOLSA.
- **Bulgaria** has legislation that permits NGOs providing social services to receive funding from the municipal and/or state budgets. Provision of funds is implemented through a specific procedure for conducting tenders and assigning social services delivery. Although there is question about how they function in practice, technically, the municipal councils provide assistance and help in social services delivery and public control over implementation.

⁵⁶ Bulgarian Center for Not-for-Profit Law. (2004). Social Service Contracting between States and NGO's: England, Germany, Poland, Hungary, Czech Republic, and Bulgarian Practice-A Comparative Analysis. Sofia, Bulgaria.

⁵⁷ International Center for Not-for-Profit Law. (2002). Survey of tax laws affecting NGOs in Central and Eastern Europe. Publication funded through the Office of Democracy and Governance Bureau for Europe and Eurasia, USAID, Washington, DC.

APPENDIX B

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