UNICEF Turkmenistan

Social Services Assessment – Final Report

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Contents

Executive summary

This report presents the findings, conclusions and recommendations from an assessment of social services in Turkmenistan undertaken in June-November 2014.

The assessment was based on interviews and focus group discussions with 120 social services system stakeholders including national local and regional authorities, specialists and professionals; parents and grandparents of vulnerable children; managers and specialists from state and NGO service providing organizations.

Main findings

The main two pillars of the system of social assistance in Turkmenistan are extended family and cash benefits including disability and loss of breadwinner allowances. The assessment has shown, however, that there are also other informal community based systems of support in place in the form of Village councils and formal social services of various kinds being provided by state, non-government and public organizations.

State social protection centers offer home-care and center based services to older adults and to adults with disabilities. NGOs and public organizations offer mainly material aid, support with disability equipment and medical treatment, consultation and information. The main demand for services in the current system is from children with disabilities and their families, especially if extended family support is not available; children living in guardianship; children without family care. To a lesser extent there is demand for services for families with children who are struggling to provide care for a range of reasons.

There is some capacity within the existing network of service providers to provide more services to new target groups, for example the State social protection centers could feasibly provide home care services for some older children and young people with multiple disabilities in most regions without significantly increasing their staffing capacity. Some NGOs have national reach and could provide services to more clients as part of state commissioned service delivery.

On the whole, however, there is a need to develop new community-based social services targeting support to children with disabilities and their families, to children without family care and to families with children who are struggling to provide care. This will require detailed needs assessments at the local level aggregated up to regional and national service development plans. There are some social work specialists active in NGOs and public organizations, but there is a need to considerably strengthen human resources in the social sector.

Recommendations

Five options for the development of social services are discussed, based on the findings of the assessment with a focus on building on existing strengths including extended family and informal community support systems:

Option 1 Continue to attach social work functions and provision of social services to existing Etrap-based services focused on habilitation and child development

Option 2 Strengthened Velayat child protection and family support services attached to Khyakimlik statutory bodies

Option 3 Further strengthen school and kindergarten based social pedagogy

Option 4 Contracting NGOs to develop and deliver services – generic or specialized

Option 5 Expand service delivery from existing social protection centers, Infant homes and newly developing Rehabilitation centers

Some or all of these options can be explored for further development prior to piloting. Any service development has to be based community needs assessments. An integrated information management system should be developed to ensure that data is available to support informed decision-making.

1. Introduction and overview of this assessment

The main objective of this study commissioned by UNICEF Turkmenistan was to 'analyze the current system of social services provision to families and children and elaborate possible ways for further development[1]'. A desk review of previous studies and reports in the social protection sphere in Turkmenistan helped to inform the methodology for this assessment. Attempts were made to collect both quantitative and qualitative data as described in the methodological framework for the assessment[2] but in the end only a limited sample of quantitative data was made available in order to help triangulate data from key informant interviews (KII) and focus group discussions (FGD). Some key informant interviews were held with several respondents at a time and some focus group discussions took the form or group consultations or workshops rather than pure focus group discussions[3]. Data was gathered in Ashgabat, Ahal Velayat and Turkmenabat/Lebap Velayat by the consultant, and plans to gather basic data in Mary, Dashoguz and Balkan Velayats were not realized.

The perspectives of a range of actors in the social protection system were captured including parents, specialists and decision-makers at national, regional and local levels and data was gathered that could help to reveal the patterns of demand and supply for social services and inform the possible development of child and family oriented social services. The final list of respondents and data collected is summarized in Table 1.

Table 1 Summary of data gathered and respondents for the social services assessment

Type of respondent	Number consulted	Type of interview or data collection instrument
National Decision-makers	11	Ministry of Labor and Social Protection; Ministry of Education, Ministry of Health - KI interviews
National specialists	7	MLSP; MoE; MoE – early childhood specialists group discussion
NGO Managers	4	Red Crescent, Women and Youth organizations; Blind and Deaf Society - key informant interviews and 4 service provider questionnaires
Specialists from Regional NGOs	4	
Managers from Regional NGOs	6	
Parents and relatives	25	Focus group discussions
Etrap Guardianship Body Specialists	18	3 focus group discussions and 15 demand side questionnaires

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[1] UNICEF Terms of Reference for the Social Services Assessment
[2] Available from UNICEF Turkmenistan
[3] One group for example was planned as a discussion with 10-12 Velayat decision-makers, but when the researcher arrived there were over 60 specialists and decision-makers in the room with around 12 active participants in the discussion. Only the active participants have been counted as respondents in this list.

Velayat Decision-makers	9	Group consultations
State Service Managers	5	Group consultations
State Service Specialists	22	Parent's Centers, Social Protection Centers, Family Doctors/Nurses, PMK members, ECD Centers – 3 state service providers questionnaires
Etrap decision-makers	7	
Academics	2	
TOTAL RESPONDENTS	**120**	**15 Key informant interviews** **3 Velayat group consultations** **8 focus groups with parents and specialists**

Source: P4EC CEE/CIS consultancy group

In addition, the report has been informed by a child disability survey that was carried out in parallel with this assessment, also commissioned by UNICEF Turkmenistan and led by the same researcher. An action-planning workshop was held 18-19 December in Ashgabat with key government stakeholders and the discussions at that workshop have also informed the analysis in this report and the final recommendations.

This report is structured in keeping with a whole system assessment looking at supply and demand and the factors affecting it and in accordance with the logic of the main research questions for the assessment according to the terms of reference:

1. What are the main needs of families with children in urban/rural areas?
2. Who (what agency) is the main point of contact for vulnerable families with children at local level?
3. How is the system of social services currently organized, managed, and arranged for families with children in local/regional/national level? And what type of services do the agencies on different levels provide and to what groups of families and children?
4. How do social protection structures interact with other sectors such as education, health, NGOs – for the purpose of supporting families with children?
5. How should the system of social services for families with children develop?

Main findings are recorded for each section of the report leading to a discussion, conclusion and recommendations for options to develop social services in the final section.

Data Limitations

Only a very limited sample of quantitative data was collected from service providers and from the Etrap specialists who refer children and families to services. There are important gaps among the service providers, for example a Red Crescent representative was interviewed in a KII, but the organization did not return a questionnaire with service provision information and it is one of the largest non-government service providers in the country with representative offices in 5 Velayats and 8 cities so the data available on the scope and type of service provision is limited compared to other service providers. The data

gathered can nevertheless be assumed to some extent to reflect the situation for the whole country, but the absence of data from Mary, Dashoguz and Balkan Velayats makes it difficult to be sure of the exact extent.

Definitions of social services

The concept of social services is not defined in the legislation of Turkmenistan so there is no defined agency responsible for development and delivery of social services. Social protection is defined in the Code on Social Security of 2007 amended in 2012 as: '*social protection represents the state system of material provision and social service of non-able-bodied people, disabled and families with children and other through payments in the form of pensions, state benefits and social allowances'* (cited in UNICEF, 2013). At the same time the code mentions social services as part of a definition of social assistance:

> *Social assistance includes a series of social services provided to persons with disabilities at home or in social assistance institutions: 1) social assistance at home, including social-medical assistance; 2) half-residential social assistance in day-care social assistance facilities; 3) residential social assistance in full-time social assistance facilities. (cited in UNICEF, 2014b*)

This assessment included the first two types of social assistance provision in its scope, but specific data on residential institutions was not gathered as part of this study. Previous studies indicate an extensive network of 14 residential boarding schools for children with special educational needs; 2 children's homes and 4 infant homes for children without parental care; 1 social care institution for children with intellectual disabilities (UNICEF, 2013, 2014a, 2014b). There are also residential care services provided in two different types of education facilities for younger children – boarding pre-schools where children with disabilities receive kindergarten education in a residential setting and 24-hour kindergartens where children of pre-school age are cared for during the working week.

This study is focused on exploring the provision of social services in the community and outside of these residential facilities, while recognizing that they represent a major investment in social services provision for children by the Government of Turkmenistan. No specific definition of social work or social services was used during this assessment, rather an open enquiry using the terms 'social services', 'social workers'.

2. Main findings - demand

This section identifies the main needs of children and families and explores the available data to determine as far as possible the potential scope and volume of services that may be required in any future social services system.

2.1 Target groups and needs – existing and potential further target groups and their needs

As a rule, respondents found it more difficult to articulate the needs of families with children than to describe the current system of support provision and the existing target groups with

an emphasis on the primary role played by the extended family in meeting the needs of children:

> *It is very rare when people would live alone. All people have relatives and they help with children and in all other issues. There are probably very few families who need assistance* (consultation with Velayat decision-makers, region B)

> *Mainly all families do not need any assistance with caring for children. If needed, relatives can help*. (KII with NGO service provider)

Need for specialized support for children with disabilities

Most respondents recognize children with disabilities and their families as having special needs that require special support and many non-specialists see this support largely in terms of the existing forms of service provision:

> *Families who have children with mental disabilities are registered and we work with them so that their children are placed in specialized internats. There they can get education* (FGD with Guardianship organ specialists, region B)

> *Frankly speaking, I cannot imagine how children with disabilities can go to normal school. They have special needs; it is better to organize teaching for them at home. (Consultation with decision-makers in region B)*

Professionals working with children with disabilities are more likely to mention their need for specialized assistive devices, therapies or particular medicines and supplies:

> *Some of our children need physical assistance instruments depending on the type of disability...special massage...* (KII, ECD center specialists)

> *For children with disability the most critical need is for medicine and pampers. A lot of families also need wheelchairs, hearing aids, walkers, crutches. Very often doctors prescribe medicines that are very expensive and we cannot get them in the framework of the government supply program*. (KII with NGO leader)

Parents of children with disabilities articulate their needs more in terms of support to help their child develop fully:

> *My son is 10 and he has cerebral palsy. Many parents of children with disabilities need information on how to care, how to develop, how to educate their children.* (KII, parent of child with disabilities)

Also in terms of their own needs for psychological or moral support to help them come to terms with their child's disability and find the strength and courage to continue:

> *I would like at least once or twice a year to visit joint trainings for such mothers as me. Because many mothers are ashamed of their children, they are afraid to take children to the park, to the shop. They need such trainings desperately – at least to feel support and not be afraid* (KII, parent of child with disabilities)

Professionals also talk about parents' needs especially for support in accessing child care so that they can work, presumably when extended family members are unable or unwilling to provide child care:

> *...we have one mother. Her 8 year old child visits our center, but she is working and needs to leave him for longer periods – up to 3 hours in general. Of course, we do allow her to do this – it is what she needs besides the usual services we provide.* (KII with ECD specialists)

Need for parenting information, knowledge and skills

Some professionals and decision-makers describe the range of government service provision for children and families as being comprehensive so that all needs of children and families are met. They do, however, recognize the need to ensure that parents know about these services and there is a need to share information more widely to parents:

> *The government has developed many programs for children - kindergartens are being built, preparation for school programs, family doctors and nurses. The only need is probably information, especially in rural areas.* (KII, academic)

Related to the need for information, some respondents highlight the need for parents to learn more about their child's development and ways of interacting with their child in order to maximize their development:

> *Parents who visit 'Parent centers' are very interested in all issues of early child development, they ask what is 'preparation for school? What are motor skills and how can they be developed?'* (FGD with specialists from Parent centers)

> *Parents whose children have been educated at home and then they start to visit the Parents' centers need a lot of support in how to educate their child, how to develop a child. They ask many questions at the beginning.* (Consultation with Velayat B decision-makers)

Parent center specialists also highlight the importance of services being integrated into existing community-based services, for example in kindergartens:

> *Most parents and grandparents see the difference between their children and children from kindergarten. Children from kindergarten are more open, more communicative, more independent and can do more things themselves. So it is very good that Parent centers operation on the basis of*

kindergartens – parents compare and see the difference and next their children go to kindergarten. (FGD with specialists from Parent centers)

Parents and carers who might otherwise not send their children to kindergarten, come to the Parent center at the kindergarten for advice and consultations, see the benefits for child development of pre-school education and are more likely to then may be more willing to enroll their child into kindergarten. The specialists are highlighting that if the Parent centers were to be located separately, this added benefit would be lost of 'seeing the difference' between children who go to kindergarten and those who do not.

Most of these needs for parenting skills, knowledge and information are seen through a pedagogical or health lens and focused on achieving particular outcomes in terms of preparation for school or nutrition with little mention of the emotional or psychological needs of children or the need for parenting skills to manage behavior: '…*mothers also need to know what type of food is healthy and how to feed their children properly'* (KII with MoH decision-maker). Professionals and decision-makers often mention parents of children with disabilities as needing more information and knowledge or strengthening of their parenting abilities and skills. One parent of a typically developing child, however, highlighted the need for additional support in parenting skills such as managing difficult behaviors, discipline and establishing boundaries:

> *As parents we need more advice on how to make children behave and keep discipline. I do not know who can help me with this.* (KII with parents)

Children in guardianship

The guardians of children in guardianship care are also mentioned as a distinct target group with particular needs that are similar to those of parents in terms of information and improving the care environment they provide:

> *One grandmother[4] loved her grandson so much that she cannot hear about kindergarten. Then she started to come with him to the Parent centers and the she decided that it was good and sent the younger grandchild to the kindergarten*. (FGD with specialists from Parent centers)

One NGO reports that children in guardianship and their guardians are a distinct beneficiary group that has need for material support, support with housing issues or other care needs:

> *We do provide services for such groups as child orphans who live with guardians…. Guardians can apply for material assistance, we study their needs and provide what we can – some food packages, clothes. In cases where the referral is made about house repairs, we refer them to the local authorities – we can help to write statements. For some people we also provide care at home and hygiene packages.* (KII with NGO service provider)

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[4] This grandmother in this example may not have been a formal guardian, but was clearly a primary caregiver and 'in loco parentis' if she was the main decision-maker about attendance at kindergarten and school preparation

The Guardianship specialists who carry the main responsibility for making guardianship placements further confirm the primary role played by relatives in providing alternative care for children without parental care:

> *For example, last week we reviewed the following referral – a mother died and the father was already deceased, the mother's sister submitted a request to establish guardianship for the child.* (FGD with guardianship specialists, region B)

> *Usually we review cases of guardianship by an uncle/aunt or grandparents. Very rarely there are cases when we send a child to a boarding school or children's home.* (FGD with guardianship specialists, region A)

These specialists also confirm that additional material support is provided to Guardians and then to children without parental care themselves when they are older:

> *Guardians receive benefits for loss of breadwinner until 16 and then the child himself receives it until 21 years old.* (FGD with guardianship specialists region A)

Children without parental or family care

Most children without parental care are in informal kinship care or formal guardianship care and are largely seen as being in family care by respondents. Death of parents was the main reason for loss of parental care mentioned by most respondents and children are reported as not being removed from their families even though they may have been placed in guardianship:

> *During my 13 years in guardianship body I did not have any case when we would remove (separate) child from the family* (FGD with guardianship specialists region A)

Some respondents mention that guardians may have some additional need for support, but most respondents see the provision of care within the extended family or even community as a naturally occurring situation that does not require additional support:

> *…there is no problem to organize care of children – parents, extended families, friends and even neighbors.* (FGD with parents)

> *In case of a very difficult situation in the family, if there are relatives they will take care of children. In all such cases people will refer to the Guardianship body.* (KII with national decision-makers)

Guardianship specialists note some cases of children being placed into the care of non-relatives:

> *Once I had a case - one girl was in 7th grade at school, her mother died and there were no other relatives. We studied this case in detail and her class teacher was appointed guardian and her parent's flat was assigned to the*

> *girl. She lived there herself and the teacher came to help and provide oversight. Another case was a girl with Down's syndrome and her mother's friend was assigned as guardian*. (FGD with guardianship specialists region A)

Families who have lost the main breadwinner are entitled to a special social assistance payment and some respondents, particularly parents and NGOs, mention these families as being vulnerable and having some need for support:

> *We do provide services for such groups as …children who lost their father or mother.* (KII with NGO service provider)

Babies being placed into adoption and adoptive parents are reported by one group of Guardianship authorities as the main group of children with whom they work:

> *The largest number of cases is connected with adoption. All families who would like to adopt a child should submit applications, we review and provide permission for them to adopt (or not) and then put them on the list. We have approximately 20-30 cases of adoption of newborn babies every year. We also monitor all cases of adoption regularly and we check these families for quality of care.* (FGD with Guardianship specialists region B)

This group was reluctant to discuss in any detail why babies might need to be adopted as the topic of unplanned pregnancy or unwed mothers appears to carry some social taboos. A study into children under three years of age in residential care (UNICEF, 2014a) indicates that unwanted pregnancies are the main factor leading to babies being adopted at birth, although a certain number of cases could be adoptions within extended families initiated by the birth and adoptive parents simultaneously.

Orphans and young people without parental care leaving the care of children's homes are not mentioned by any respondents as having particular needs, perhaps because they are perceived as having all their needs met by the state social protection provisions:

> *In the case where a child is a full orphan the state provides housing and ensures enrolment in a higher education establishment.* (FGD with Guardianship specialists region A)

It could also be that there are only 417 children without parental care in the two children's homes in the country (KII with the State Statistics Committee), so only around 40 children each year would be leaving these facilities and therefore the respondents may simply not encounter them or be aware of their needs. There are also some orphans or children without parental care in a special institution at Yolotan in Mary region and in 14 residential special schools, but it is not clear from the available data how many. Ten residential school directors took part in the UNICEF Disability survey and indicated that *all* children return to their birth parents or to their extended family when they leave the schools, but it is not clear how reliable this information is.

Parents needing additional support to provide care

The reasons or factors causing or compounding risk can vary – **disability or illness of parents** was a notable factor emerging from the Under-3 study (UNICEF, 2014a) contributing to the risk of a child ending up in infant home care. It is important to note that parental disability or illness cannot be equated with poor parenting or children at risk. Parents with disabilities or with health conditions may be providing good care to their children, but some may require additional support:

> *My husband and I have some visual difficulties. My child is healthy and it is very difficult for me to help her with homework, to take her somewhere outside to play. It would be great if someone like a social assistant or volunteer could help such families. The other example is when both parents are deaf and cannot talk, their child is ok but with time he/she starts to slow down in development.* (FGD with parents and specialists of NGO)

Factors affecting risk and extent of needs for some groups

Single parenthood (mainly mothers, but also fathers) emerged as factor in both the Under-3 study and the disability survey (UNICEF, 2014a; UNICEF, 2014b). Single parenthood could be a result of marriage breakdown resulting in separation or divorce; unwed mothers; widows or widowers – in all cases a parent is coping with the care of a child on his or her own.

Other factors, which come out of these studies and the desk review, include **social issues** such as housing problems, unemployment, low income and parents serving prison sentences.

All of these factors are compounded and can become critical if there is an **absence of extended family support**. The reasons for a lack of extended family support can also vary – stigma relating to disability or the birth of a child outside of marriage; illness or inability of grandparents to take care; migration to cities for work are all factors that have been noted in various studies (ibid).

One mother interviewed for this study reported that mental health issues contributed to the breakdown of her marriage which ended in divorce and that she is struggling with child care without the full support of her extended family:

> *I divorced my husband, he was addicted to gambling. I lived with my mother-in-law for a while and now I live with my parents, with my two children. My baby is only six months old. I work full time and it is difficult to get support from my family. They are ashamed of the divorce.* (KII with mother of two children)

Most other respondents in this study mention very few factors other than disability and death of parents that could be assessed as contributing to the need of a child or family for some kind of additional support. It could be that respondents were overcompensating because of anxiety that any discussion of social problems might incur criticism or have negative consequences. In a few cases, however, some indication was given of the kinds of

needs that respondents have encountered or consider relevant including parental mental health problems such as problem drinking that can affect care of children:

> *…very rare cases when parents would abuse alcohol or have any other problems.* (FGD with parents)

Or child illness such as tuberculosis:

> *One of the cases from the Commission for Minors Affairs - a schoolteacher informed us that a girl was not attending school. It turned out that she had tuberculosis and thought she would die. Our organization took this case, helped her to get necessary treatment and then cared for her after the hospital.* (KII with NGO service provider)

Tuberculosis also featured in a case that was documented as part of a study into the reasons for use of institutional care for children less than 3 years of age (UNICEF, 2014a). In that case, the parents of four children had tuberculosis. The grandparents were struggling to cope with caring for them and had placed the younger two children into the infant home temporarily and were seeking advice about placing the older two into a residential school. Illness of parents or extended family members – tuberculosis, mental health problems including alcohol or other addictions, while apparently not widespread according to respondents, do seem to be needs that require additional support in some cases.

Social protection legislation specifies that large families with 8 or more children are entitled to additional social protection measures and this could be in recognition of their additional needs for support in raising their children. Respondents in this study did not, however, mention children from this type of family as necessarily being at risk of losing family care.

Young people with challenging behavior

The needs of adolescents and young people (defined by one respondent as aged 14-37 years) are described by respondents mainly in terms of their need for education and being engaged in useful activities:

> *Families in general could not feel any materials needs - most have a land to grow food and domestic animals. The only issue (need) is probably housing issue - how to ensure young families could live on their own. Young people are interested a lot in sport, martial arts, scientific and research activities, girls in carpet making, sewing, beauty industry.* (Consultation with Decision-makers in region C)

One group of Guardianship specialists claimed that there are no children in conflict with the law in Turkmenistan because of this high level of engagement in school and extracurricular activities:

> *In Turkmenistan there are no colonies for children. We almost do not have any delinquent behavior among children and young people. It is because they are busy all the time. There is a scope of different activities for children -*

sport, arts schools, dances, handicrafts and needlework for girls. (FGD with Guardianship specialists in region A)

One specialist in the same group goes further and states that young people in Turkmenistan behave in strict conformity with the standards of behavior expected of them by their parents, teachers and society:

> *I work for 14 years and I only remember 2 cases when we would review difficulties in child's behavior. We do have very good system of propaganda and children are taught how to behave and what they need to do.* (FGD with Guardianship specialists in region A)

In fact, according to the Government of Turkmenistan's report to the UNCRC Committee, there is a colony for 45 boys in Turkmenistan and 2 girls are kept separately in the Dashoguz women's colony. So the views of these Guardianship specialists and some other respondents indicate a general lack of awareness of issues to do with children in conflict with the law.

Another group of Guardianship specialists from a different region had more experience of 'deviant behavior' and referred to the role of the Inspector for Minors and the community police in talking to parents about such behavior. Some respondents also refer indirectly to concerns about the needs of young people in terms of healthy lifestyles:

> *Young people are very smart these days - they can find any necessary information for themselves. We need to watch so that they understand the importance of healthy style of life. ... For young people and young family regular meetings with Council of Elderly would be good.* (FGD with professionals in region C)

Or even more obliquely in terms of anxiety about computer and internet use:

> *More information is needed for young people and children on how to use computers in a proper way, not to waste their time* (FGD with Guardianship specialists in region B)

Key decision-makers, professionals and parents interviewed for this assessment seem largely not to identify young people as having particular needs beyond being kept constructively busy, healthy and educated. At the same time respondents report a considerable network of youth-focused services across the country that are addressing some kinds of needs and these are discussed further in this report.

Children and families in rural areas

Many respondents mention the needs of children and families in rural areas as being greater as access to education and to information is more problematic than in urban areas.

> *The main need is to cover and access the most remote areas, not all families understand that [blind/deaf] children need to study*. (FGD with NGO parents and specialists)

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2.2 Number of children currently and potentially in need of services

Some types of administrative data can provide an indication of the potential level of demand for services among children and families identified above who may have needs for additional support.

The numbers of children receiving disability allowances, attending specialized residential or day schools or pre-schools, certified by the medical expertise commission as having a disability can all help to give an indication of how many potential service users there may be in any given territory - gengesh, Etrap, Velayat – for services for children with disabilities and their families.

The numbers of families receiving loss of breadwinners' allowances or where Guardians have been formally appointed by the Guardianship organs can help to determine roughly how many potential clients there may be for services related to children in guardianship or children without parental care. This type of data can only give a very rough over estimate as in all cases only some of the families, children and households in these groups may require services and additional support, especially given the considerable role of extended family in providing care and support to children without parental care.

Rough estimates relating to families where parents need help in providing care to children because of disability or illness can probably be found at least partially through the service data from adult disability services in each Velayat.

Other groups of potential service users - single parents without extended family support; children whose parents who are struggling to care properly because of mental health issues, psychological or social reasons and young people at risk - are more difficult to define in terms of existing administrative data. The Disability survey (UNICEF, 2014b) indicated that children with disabilities with single mothers are over-represented in some types of residential schools or preschools, suggesting they have a higher need for supportive services. Continuing with this tracing backwards from residential services administrative data to cause of placement, the data from the Guardianship organs is probably the most accurate way of trying to determine the extent to which children who are vulnerable to placement away from their family can be found in each Etrap.

The number of children losing parental care each year is a proxy indicator of the number of children who are in extreme need of support and care either to prevent the separation from parents from happening or to support the child in alternative care. An attempt was made to gather data from Guardianship specialists in all 6 regions of Turkmenistan about the number of children losing parental care and being placed into adoption, guardianship or residential care, but relatively few questionnaires were returned, 14 out of potentially more than 60 Etraps. The data from this small survey nevertheless provides a useful basis to explore the rate of loss of parental care and therefore the potential demand for services at the level of the Etraps, which could be useful in terms of developing systems and structures going forward.

It is not clear how representative the Etraps which returned data are of all Etraps of a similar type, but for the purpose of analysis they were divided into rural and urban Etraps. The analysis looked at some of the differences between these two groups while also trying to determine average rates that could be of use as a rough rule of thumb when trying to forecast need for social services generally.

Overall, as can be seen from the summarized data presented in Table 2, the number of children losing parental care or being placed into institutions or guardianship appears to be generally low. The number increases or reduces from year to year, but the overall trend seems to be towards a decrease when 2014 data is compared to 2012.

Table 2 Average number of children recorded each year by the Guardianship specialists as losing parental care, 'registered', adopted or placed into kinship Guardianship, residential care (temporary or long-term) – data for 2012-2014

Average each year for etraps which provided data	2012	2013	2014
Average number of children losing parental care each year			
7 etraps total	16	16	11
4 City etraps	19	21	12
3 Rural etraps	12	10	9
Children registered by the Organ Opeki each year on average			
9 etraps total	26	33	20
3 City etraps	31	40	17
6 Rural etraps	24	30	21
Kinship guardianship average number of placements in the year			
10 etraps total	8	8	5
3 City etraps	18	21	12
7 Rural etraps	4	2	2
Infant or Children's home or Internat average placements in the year			
10 etraps total	6	6	3
4 City etraps	12	12	6
6 Rural etraps	2	2	2
Average temporary placements into residential care at the request of parents			
5 etraps total	2	2	1
1 City etrap	5	1	2
4 Rural etraps	1	2	1
Average number of children placed into adoption during each year			
11 etraps total	19	20	14

4 City etraps	27	34	19
7 Rural etraps	15	13	11

Source: P4EC CEE/CIS Consultancy group based on data from 14 questionnaires completed by Etrap Guardianship specialists

The data suggests major differences between urban and rural Etraps relating to placement of children into residential care settings with City Etraps placing 3-6 times more children into this type of care than rural Etraps. This could be distortion from the small data sample, but it could also be because the residential care facilities are mainly located in the City and therefore more accessible for use by the City Guardianship authorities and the rural etraps 'make do' with services they are able to access in their communities such as informal kinship care. This could also be related to stronger traditions in the rural areas around keeping the child in the family and support from the extended family being more easily available. Families who have moved from a rural area to the City, for example, may have left their extended family network behind and therefore not have immediately available support.

 A similar difference can be seen for the average number of placements into formal Guardianship care with many more children on average being placed by the City Guardianship specialists than in the rural Etraps. The explanation for this is not clear as the other types of placement, adoption and temporary placement at parents' request into residential care, do not show such a difference between rural and urban. It could be problems with the data or it could be that in rural Etraps there is more informal kinship care and stronger family traditions that do not become formalized. Fewer children overall, of those identified or registered by the Guardianship organ, therefore are being placed into any kind of formal care whether residential or Guardianship.

The data in Table 2 also illustrates how heavily the system relies on adoption and guardianship with the majority of the placements being made in both cases into the families of relatives. Of 153 adoptions recorded for 2014 in 11 questionnaires, 8 or around 5% were by non-relatives. Of an average 20 children in 2014 in 9 Etraps who were registered by the Guardianship authorities 14 or around 75% went into adoption, 5 (20%) entered Guardianship and the rest went into residential care or informal kinship care.

If it is assumed that children registered by the Guardianship specialists are those most in need – babies abandoned at birth, children of all ages who are orphaned or have lost parental care and need formal guardianship – then each Etrap can expect at least 20 children each year to require supportive services.

Children with disabilities are also among those included in the Guardianship data on children without parental care, but were not disaggregated for this assessment. The Disability survey, based on international experience, suggests that 1-4% of the child population may have moderate to severe disabilities and that up to 20% may be at risk of disability (UNICEF, 2014b). Of these, most have the support of extended family in providing day-to-day care, but around 12% of parents said they have nobody to help them and around 20% said they need support with everyday care. This gives a rule of thumb to calculate the number of children with disabilities who may require services in any given Etrap and Table 3 uses some

of the child population data provided by the Etrap Guardianship specialists to illustrate how this could be done.

Table 3 Rough, conservative needs-led forecast of minimum numbers of children with disabilities and their families who may require services and support at home in each etrap

A	B	C	D	E	F
Etrap child population given for 2014 – 3 rural Etraps	**Number of children who may have moderate to severe disabilities (minimum 1%)**	**Of B, number who may not have extended family support (around 12%)**	**Of B, number whose parents may require support with everyday care tasks (20%)**	**Tentative number of potential service users**	**Per 1000 child population**
15,000	150	18	30	18-30	12-20
20,000	200	24	40	24-40	12-20
40,000	400	48	80	48-80	12-20

Source: P4EC CEE/CIS Consultancy group based on data from UNICEF, 2014b and guardianship specialists

Given that the Disability survey data cannot be considered to be representative, especially of rural families, as the sample was too small and given that extended family support may be more common among rural families - columns C and D in this table should be treated with caution. Ideally, all plans for developing social services should be based on detailed needs assessments at community or Gengesh level that are then aggregated up to the Etrap and Velayat levels. Nevertheless, Table 3 does offer a needs-led approach for at least moving towards a ballpark understanding of the scope and scale of outreach services that may be required in each Etrap. Clearly it also would be fairly straightforward to correlate these estimates against administrative data on child disability allowances, health and education records if it were available.

Summary of demand for social services among children and families in each Etrap based on 2014 data

This analysis of the available data identifies several distinct target groups and types of need and suggests some rough estimates of the level of demand there could be in each Etrap:
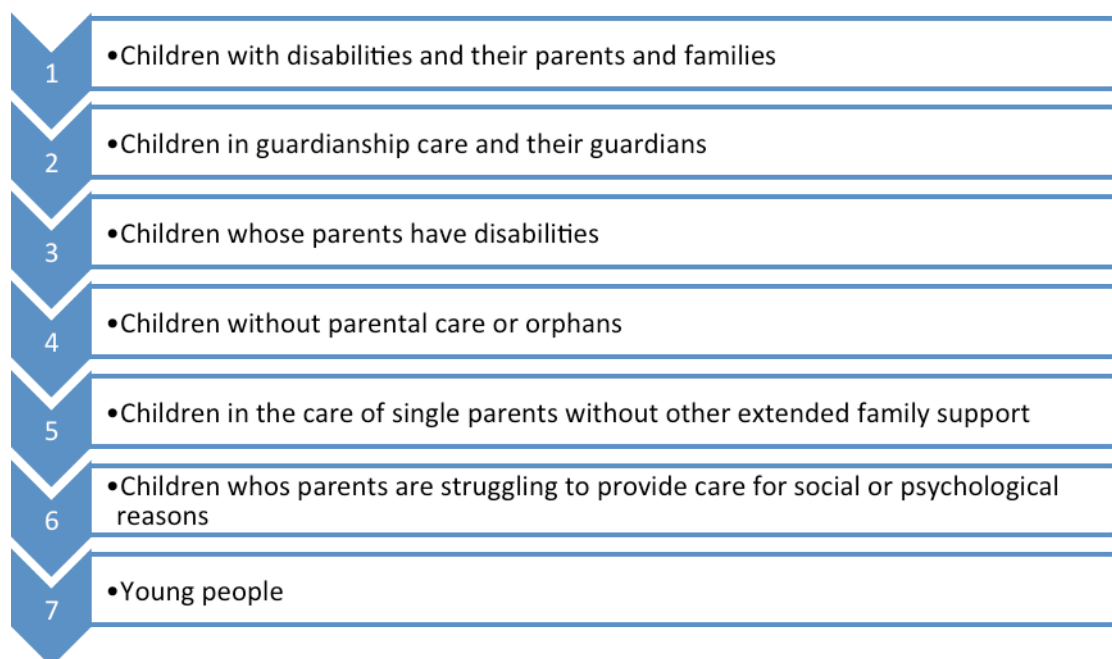
1. The main group identified is children with disabilities and their families and a range of needs from equipment and supplies to specialized support with communication, mobility, education and health. This could be around 1-4% of the child population in any Etrap so a minimum of around 150-400 children in rural Etraps for example. Parents of children with disabilities also need psychological support, more information, knowledge and skills. A majority of families may have extended families supporting them to care for their child, but in around 12-20% of cases parents and families may need additional practical support to provide day-to-day care.

2. The second main clearly identified group to emerge from the assessment is children in guardianship care and their guardians who are usually, but not always, relatives. There are around 2 children entering this type of care each year in rural Etraps and 5 in City Etraps.

The needs of this group are less clearly identified, but generally resemble those of parents in some of the other groups – more information and knowledge about caring, material support or support with social issues such as housing. On the whole, the children living with guardians are not perceived by respondents as being without parental or family care even if they are orphans. It is not always clear whether the children in this group are in formal or informal guardianship care.[5] If those in informal kinship care are considered as having support needs, then an estimate has to be made of how many there are and added to those in formal Guardianship. Children in formal Guardianship can receive a 'loss of breadwinners' allowance – paid to the Guardian until the child is 16 years of age and then to the child until the age of 21 years.

3. A group that is defined more or less clearly by the assessment is parents who need support to care for their children. This includes parents with disabilities and also long term health problems such as tuberculosis. In this group, as with all groups, the child and family are only considered to have needs if there is no extended family supporting them, or if the support provided by extended family is not sufficient.

4. A fourth group to emerge, but to a much lesser extent that the first three groups in terms of the extent to which respondents mention it, is children without parental care or orphans. This group overlaps with the second group, but the distinction is that these children are perceived to be outside family care and are probably in the care of residential institutions. The assessment suggests there may be around 2 such cases per year on average for rural Etraps and 6 for City Etraps.

5. Single parenthood combined with an absence of extended family, appears to be a risk factor for placement into residential care as these parents have needs for additional support in caring for their children, especially if they have a child with disabilities. This does not mean that all single parents fall into a distinct group with particular needs, but that single parenthood is a factor to consider when assessing needs.

6. Children in the care of parents who are struggling to care properly because of mental health issues, psychological or social reasons and are in need of extra support is the most ill-defined and least mentioned group emerging from the assessment, nevertheless is does emerge. It is possible that there are 1-2 such children and parents in each Etrap who end up each year temporarily placing their child into residential care because they have no other options for support.

7. Young people are not seen as having particular needs, but a very few respondents refer indirectly to concerns about healthy lifestyles and deviant behavior. Children and families in rural areas are generally reported by many respondents as having greater needs, although the Guardianship data available to this study does not confirm this perception as there are higher levels of loss of family care among city children.

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[5] According to the Guidelines on Alternative Care of Children (UN, 2009), a child in the guardianship of a grandparent organized through the Guardianship organ is in formal care, and a child in the care of a grandparent not organized through the Guardianship organ is in informal care – in both cases the child is considered to be in kinship care.

Figure 1 Typology of target groups for social services identified by respondents

1. • Children with disabilities and their parents and families

2. • Children in guardianship care and their guardians

3. • Children whose parents have disabilities

4. • Children without parental care or orphans

5. • Children in the care of single parents without other extended family support

6. • Children whos parents are struggling to provide care for social or psychological reasons

7. • Young people

Infants and newborn babies are not presented here as a separate group as they or their parents could be present in any of the groups. The main difference between very young children under 3 years of age and older children is that they are perceived as being mainly the responsibility of the health system. This means that as social services policies and strategies are development, consideration has to be given to this separate group to ensure that relevant services are also being made available to them and their parents either through the health system or through the social services system.

3. Main findings -Supply

This section explores the data from the assessment to describe the existing system of social services provision and the views of respondents on the types of services that need to be developed.

3.1 Existing community-based social services for children and families – formal and informal

This assessment and the accompanying UNICEF studies on young children under three years of age in residential care and children with disabilities (UNICEF 2014a and b) clearly illustrate the extent to which care for children in Turkmenistan is rooted in deep-seated family traditions and values with family defined broadly as extended family where three generations vertically and several sibling branches horizontally may share a household. Even if an extended family member does not live in the household with a child and parents, they may play a role in providing care and supporting parents. Social assistance policies lean on the extended family for provision of informal support in child-rearing and current policy can be described as having two pillars – cash assistance and extended family providing informal support services.

It should be noted that the Disability survey showed that the siblings of children with disabilities are also reported by over 20% of the parents who responded as having caring responsibilities. If these care responsibilities are not shared by other adults in the family, consideration must be given to whether the social assistance policy actually intends to rely on children for the provision of care or whether the policy would be to seek to provide additional support so that siblings of children with disabilities are able to also have full access to their rights to education, play and leisure and well as meeting their filial responsibilities in the family.

According to respondents, there are a range of other community services and forms of support that can also be described as informal in that they are not constituted, mandated or funded in any way. Respondents mention for example, the 'council of elders' at the village level as well as friends, neighbors and family who mobilize resources, give advice and help in difficult situations:

> *In Turkmenistan there are very strong and old traditions and very strong family education...In fact Council of Elders plays a very important role - these people are highly respected. Even in cases of planning to marry someone, people will seek advice of Elders.* (KII with national decision-maker)

> *Every family has its own the most respected elder person. In case the family issues cannot be solved internally they can refer to the Council of Elders in their village. These people are the most respected and everyone follows their advice*. (Consultation with regional decision-makers in Region A)

> *...families always help; it is traditional for us* (FGD with parents)

These strong informal family and community systems can be perceived as cutting across all aspects of child and family life and any new development of social services must build on the strengths of such close-knit grassroots structures.

In some cases these informal socio-cultural structures seem to overlap and reinforce formal services. The Gengesh is the local village council - an elected body that presumably overlaps with the Council of Elders to at least some extent in most communities. One group of decision makers from region A mentioned that ...*'when a child is born the head of the village council [Gengesh] and family doctors should take the family from the maternity hospital. They also help to prepare all documents for social benefits'*. The civic responsibilities of the village council representative, who may also be in the Council of Elders, cross over here into the formal health and social assistance systems.

Target groups of the existing system

When asked to choose from a pre-defined list of service users, the responses from seven service providers that completed questionnaires closely mirror the findings from the assessment illustrated above in Figure 1. There are services currently available to some extent for the first four groups of children and families identified by respondents and to a much lesser extent for groups 5, 6 and 7 as illustrated in Figure 2. Four of the seven organizations (two ECD centers, two disability NGOs) that completed the questionnaire are

however disability specialist organisations focused on children with disabilities, which could mean that these results are affected by a sample bias.

Figure 2 Number of organizations reporting each type of vulnerable group among their service users
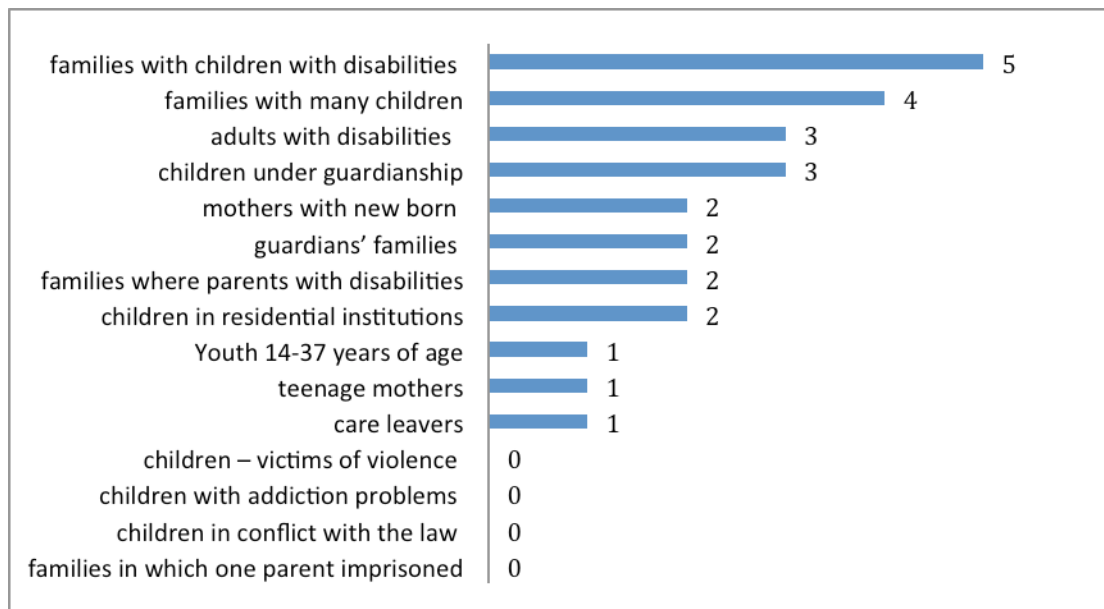
Source: questionnaires completed by 7 service providers

This does not mean that services for the other groups are not available in Turkmenistan as the survey had only a limited response from 7 organizations and the Red Crescent, a major provider of some types of social services did not return a questionnaire, but it is interesting that the description of service users or target groups for services given by respondents above is confirmed to some extent by this small survey of service providers.

Overview of the system of formal service provision

Formal social service provision mentioned by respondents can be broken into four bands according to the extent to which they are available and reaching their target groups:

BAND 1 Widely available State or NGO services which may not be social services, but carry social service and social work functions and described by many respondents of all kinds – parents, specialists, NGOs and decision-makers - as the first point of referral or contact for families in need

BAND 2 Social services provided to a limited extent by bodies with statutory mandates, but that are not service providing entities as such – described mainly by decision-makers and statutory specialists as a first point of referral

BAND 3 Newly emerging State or NGO services which are not yet widely available – described by some respondents who are close to these services as meeting needs effectively including parents, professionals and decision-makers

BAND 4 Humanitarian or material support and group activities which are classified as social services by many respondents, but which may actually be fulfilling different functions and

achieving different goals - direct aid or relief in emergencies, leisure or rehabilitation, health and well-being improvement, pedagogical or employment services.

The services provided by the organizations in the four bands can also be classified according to the two non-residential types of social services specified in the Code on Social Security mentioned above:

TYPE 1 delivered in the home

TYPE 2 provided in a day-care setting

This typology and classification of the existing services is set out in Table 3. Without a set definition of what can be defined as a 'social service' or as 'social work', these classifications are annotated with descriptions of what the author considers social services to be as distinct from health or education services for example, and drawing wherever possible on the descriptions of services provided by respondents themselves.

Several respondents mentioned new rehabilitation centers for children with disabilities during the assessment. Each Velayat is establishing a rehabilitation center for 400 children with disabilities that will be run under the Ministry of Education. Some respondents have concerns that these will become large residential care providers, others welcome this initiative as they see these centers as making specialized education and health services more accessible for children with disabilities and their families, especially in more rural areas. It was not possible to talk to staff or managers of these centers during the assessment and it is not yet clear what types and mix of services these centers will offer so they have not been included in the overview of Table 3, but it should be noted that these centers also represent a potential resource for the development of social services, especially for children with disabilities if they focus on developing service types 1 and 2 – home-based outreach services and center-based day care services.

Table 3 Typology and classification of formal social services currently being provided as defined and described by respondents

Name of service	Social service elements or functions	Band and type of service (according to classification on pages 21-22)	Comments or description
Family doctor and visiting nurse	Home visiting, provision of parenting and child development information, knowledge and skills, counseling and support provided through trusting relationships developed through daily visits in the first month of an infant's life	A well-established healthcare service mentioned by a vast majority of respondents as being of crucial importance as a frontline, community based outreach service - BAND 1, TYPE 1	Family doctors and visiting nurses appear to have a high level of trust among most respondents including parents: *All issues related to health and child development we address to family doctors and nurses, they are like members of our families – they know all and they can advise on different issues, not only medical.* (Region A parents) *Family doctors are main contact for all of us – they visit regularly and provide all necessary assistance for families with children* (Region C parents) *The service of Family doctors was introduced in 1995. One family doctors serves 900-1100 persons.* (Region A decision-makers)
Young Mothers' School	Training in all aspects of care and child development for pregnant women	Mentioned by only one group of respondents – BAND 3, TYPE 2	*In Health House there is also Young Mothers school - pregnant women from 28 weeks can visit 1 per week. They are trained in all aspects of care and child development.* (Region A decision-makers)
Parent centers	Providing advice and training to parents to improve knowledge of child development and strengthen parenting skills in early childhood	Mentioned by many respondents as being an important community based services – BAND 1, TYPE 2	The main goal is pedagogical – preparation for school. The service is based in kindergartens, well-rooted at community level and has a strong information outreach element with teachers going door to door to inform families about the Centers. It is not clear whether children with disabilities and their parents are accessing these services. *On Saturdays, when Parents' Centers operates representatives of healthcare and social protection agencies visit these centers and provide lectures or consultations to parent, i.e. on social benefits.* (Region C decision-makers)
Early Childhood Development Centers	Providing psychological support to parents and some day care provision for children with disabilities	Mentioned by many as an important innovation, but only two pilot centers currently operating in two regions – BAND 3, TYPE 2	The main purpose is pedagogical school preparation and improved child development. From parent responses it is clear that there are other services being provided including psychological support, counseling and parenting advice: *I also had a lot of behavioral questions – why my child cry when he see other adults, why he becomes shy when other people are around. And this center helped me a lot, they helped to understand and to learn how to react and support my child. (*Region C parent). There was a different view of these services also provided during the assessment: *Our parents visited ECD Centers, but they did not like the approach. Parents are not involved in the activities with children,*

			parents are not explained or taught how to work with children. (KII with NGO)
Social Protection Centers	Social care services for elderly people and persons with disabilities	Mentioned by many, but only in relation to adults – BAND 1, TYPES 1 AND 2 (and also residential services)	Each Velayat has a center which services the whole target population in the region. It is not clear whether the current caseload of clients is meeting all of the need: *In practice when all people in the household is with disability social protection department assign social worker who helps with household duties. But when there is at least one person listed (registered) with no disability they consider that this person can help and social workers does not visit this household.* (parent with disabilities, NGO) *Currently there are 480 clients, 63 staff (incl. 26 social workers). 1 social worker service 16 persons. We also have 1 staff member who organizes cultural and sport activities. We have 3 departments: - day care department - clients come from Mon to Fri from morning till lunch - 50 clients; Night care department - stay from Monday till Friday all day and night round, go home for weekends - 30 clients; At home assistance department - when social workers go to visit clients at home and help.* (Region C professionals)
Khyakimlik	Assessment and referral to other services, administration of social benefits, mobilizing community resources on housing or transport issues relevant to children and families – oversight of statutory services and government NGOs	Mentioned by many – BAND 1, TYPE 2 – while the Khyakimlik office might engage in outreach work for information purpose, parents would normally have to visit the Etrap or Velayat center in order to ask for and receive support from the Khyakimlik	*Some questions, especially about housing could be referred to the Khyakimlik.* (Region A specialists) *All social issues are the responsibility of Khyakimliks.* (national NGO)
Guardianship and Trusteeship Organ	Statutory service – assesses potential adopters, refers children for adoption and guardianship or into institutional care, monitors children in adoption and guardianship placements, supports guardians to resolve housing, social benefits or other legal issues.	One specialist in every Etrap and a standing inter-sectoral decision-making body. Mentioned as a first point of contact only by Guardianship specialists or Velayat decision-makers – BAND 2, TYPE 1	*Guardianship Commission consist of 7 persons - deputy head of Khyakimlik, specialist of guardianship body, representatives of education, social protection, police, health, civil acts register office. Meetings are called as soon as we have 1-2 referrals.* (Region A Guardianship specialists)

Commission for Minor's Affairs	Statutory service – intervenes when children or parents are not behaving as they should. Makes an assessment and refers children to other services.	One inspector in every Etrap and a standing inter-sectoral decision-making body. Mentioned as a first point of contact only by Guardianship specialists or Velayat decision-makers – BAND 2, TYPE 1	*Inspection on minors at the police and community police officer are the main contact in case of any difficulties. They go around yards, visit schools, talk to parents in case of any deviant behavior. If this does not help they can present the case at the Commission.* (Region B Guardianship specialists)
Public organizations	Needs assessments, family strengthening, legal advice, information, casework, referral to other services and group work with specific target groups. *NGOs are also important in providing assistance to families with children – Union of Young People with Disabilities, Youth Organization, Women Organization, Deaf and Blind Society.* (KII with national decision-makers)	Most Velayats have at least one Women's or Youth Organization or a branch of the Deaf/Blind and Disability Societies. BAND 4 with elements of BAND 1 TYPES 1 and 2	Tend to mainly provide material aid, equipment for people with disabilities. Organize outings, festivities. *The Youth Organization organizes a lot of activities for children and youth - competitions, sport activities, festivals.*(Region A decision-makers) The Disability survey results tend to suggest that young people with disabilities do not access these services on the whole. *Women Organization serve for all women, including single, women with many children, young women who started to work, elderly. The Women's Organization organizes competition of families, competitions for young employees, other artistic competitions and festivals.* (Region B specialists) The Children's Fund of the Youth Organization - provides support to children from families with many children, for families with rural areas, for families with children with disabilities, for children in institutions. We organize mainly different events - New Year, 1 September, 1 June - sweet table and different presents. (KII with NGO)
Independent NGOs	Needs assessments, family strengthening, legal advice, information, referral to other services, day care provision, case work and group work with specific target groups.	Very few active independent NGOs, although some have extensive reach with over 1000 clients. BAND 3 with elements of BAND 4, TYPES 1 and 2	Mainly provide material aid, equipment for people with disabilities, but also some elements of individual case work, mobilizing community resources, day care, parent training, counseling and psychological services. One NGO provides volunteer peer-to-peer mentoring services for children with intellectual disabilities (see description below in section on gaps in services)

Source: P4EC CEE/CIS consultancy group based on data from respondents

As Table 3 illustrates, the assessment has shown that there are many social services being delivered as a side-product of other types of health and education services, by NGOs or informally at the community level. This finding runs counter to the impression from the desk review that community-based social services are at an early stage of development.

Table 4 provides a more detailed breakdown of the types of services provided by four NGOs and public organizations which completed service provision questionnaires where they were asked to provide detailed information on their capacity for service provision, number of clients, number of staff and types of services provided.

Table 4 Types of services provided by NGOs and public organizations

Type of service provision	Number of NGO providers offering this service frequently	Number of NGOs providers offering this service more rarely
provision of information	3	
consulting services	3	
intervention in crisis situations	2	1
social assistance	1	2
social integration and adaptation	1	2
habilitation / rehabilitation	2	1
services at home (household)	1	2
day care for children		1
legal assistance	3	1
psychological assistance	1	1
trainings and group meetings	2	2
in-kind goods	4	
financial support	3	
transportation services	2	1
others (please indicate)	referrals to other service providers	

Source: P4EC CEE/CIS Consultancy group based on questionnaires returned by NGO and public organizations

As discussed earlier, residential social care provision also represents an extensive element of social services provision in Turkmenistan, but in some cases it appears to be accompanied by other types of community based services that are providing necessary support. This is true for some residential specialized boarding schools, which some children attend as day schools and Infant homes, which provide some kinds of social care services. The 'two pillar' model of social protection in Turkmenistan described earlier in this report can be amended to add other pillars and blocks representing different types of social services all contributing to child well-being and development.

Figure 3 Model of current child and family social services provision in Turkmenistan
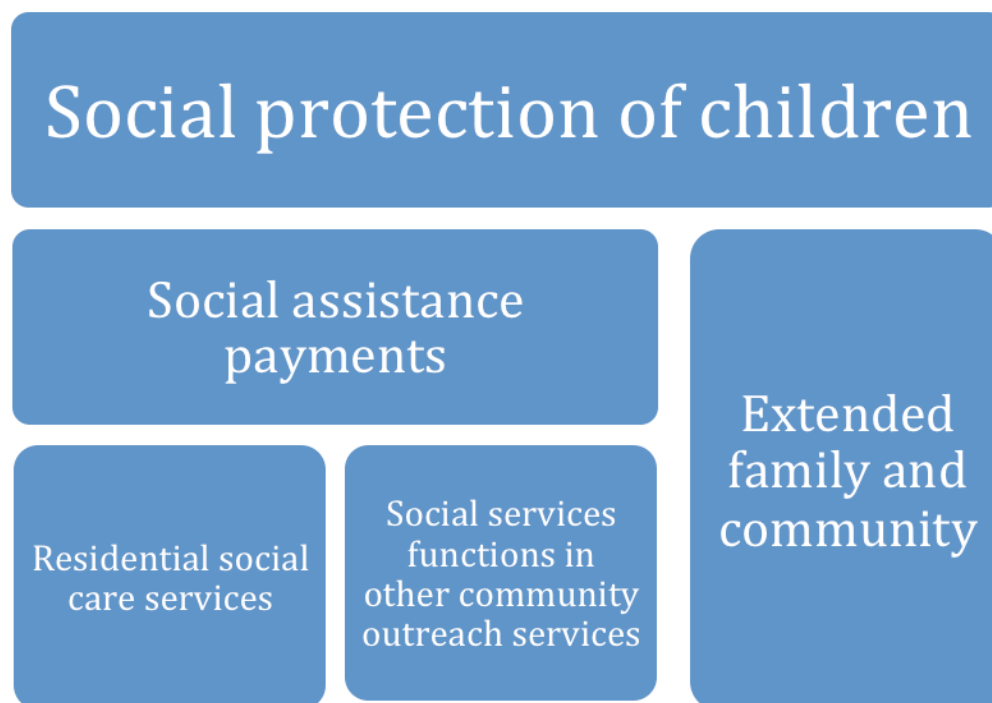
Source: P4EC CEE/CIS consultancy group

The potential to further develop social services that are rooted in existing community outreach services in the health and education sectors, as well as in connection to the Khyakimlik statutory organs, is clearly established in this assessment. An assessment of the existing capacity of the formal sector for service delivery – number of staff deployed, infrastructure and coverage – and the way services interlink is mapped in the next section of the report. The ways in which these existing formal and informal structures could play a role in further developing community based social services are explored in the final section of this report.

3.3 Capacity of the existing system of formal services – staff, caseloads, infrastructure

The questionnaire which service providers were asked to complete for this assessment was not an exhaustive audit of service delivery capacity, but was intended to provide a top line overview of the number of staff deployed in service delivery across the country, their caseloads, qualifications and functions and to make some assessment of whether there is any capacity to deliver additional services to children and families within existing structures.

Data gathered was incomplete with not all organizations completing all questions and a bias towards organizations working with children with disabilities among the sample. There are one or two useful insights, however, that can be taken from the questionnaires that were returned as illustrated through three case studies set out in Box 1.

BOX 1 - CASE STUDIES – organizational capacity of three types of service providers

One state service provider (a Center for Social Protection delivering services to the elderly and adults with disabilities) reports 33 specialists providing services to 485 long-term clients with a caseload of 16-18 clients per specialist. This service provider has another 31 staff members including 23 support staff (for example day-care center cleaners and nursing staff, cooks and canteen staff), 2 senior managers and 6 administration staff. This service provider is serving a whole Velayat and its service users are only long-term services users so they receive services on a regular basis over long periods of time.

One public organization (a disability focused NGO currently working only with adults) reports 120 staff and 2943 beneficiaries or clients – it does not report a caseload, but among 120 staff 27 are defined as specialists providing services which would give a caseload of 109 clients per specialist. A further 27 are defined as technical support staff. This organization is a national organization with one head office and five regional branches and reports 23 senior managers and 43 administrative staff. Information was not provided as to the types of service users, whether long-term or short-term, but the nature of some services provided – legal advice, group meetings and events, material support, suggest some one-off or short term service users; while other services such as home care and social integration services suggest long-term service users.

One independent NGO (a disability focused NGO working with both children and adults) reports 7 staff serving 2485 clients – 2005 one-off, 358 short-term and 122 long-term service users – in two regions. This organization does not report a caseload, but reports that all 7 staff members including management and administration staff also provide direct specialist services to clients. So, if the 122 long-term service users are taken as the main client group, gives a caseload of around 30 service users for each staff member. This service provider does not have a building or space for delivering services, but has applied to the local authority for a space to be provided as a contribution to its work.

Source: P4EC CEE/CIS Consultancy group based on questionnaires from service providers

These case studies illustrate that some types of organization may be top-heavy in management and administration, but this is related to national reach through branch offices in every Velayat. Investment in service delivery at the branch office level could help to increase reach to children with disabilities and their families by building on the existing investment in infrastructure, management and administration – there is the potential for more short and long-term services to be delivered by more specialists under a similar management and administration structure.

Other types of organizations such as the independent NGO in the case study may be under-resourced and over-stretched, running mainly on enthusiasm and volunteer inputs, but with more stable core funding, has the potential to systematize and consolidate service delivery while maintaining the flexibility and individual approach which this type of non-state service provider can typically offer.

The state run center appears to be running efficiently with minimal management and administration compared to service provision, but with a comfortable caseload that might

have the potential to increase slightly. These centers could have the potential to expand their home care service, for example to target adults with disabilities who also have children in the household or to young people aged 16-23 with multiple disabilities or motor disorders – a further 2-3 cases per worker could be possible depending on the how the current caseloads are organized in terms of distance from the centre to the households where homecare services are being provided. Clearly more information is required, but there appears to be some potential for reaching at least one or two of the target groups that are currently underserved without significant increase in staff numbers or infrastructure – at least on the basis of the limited examples given here. Other similar centers may be over-stretched and with different caseloads and patterns of service use by clients. It is less clear from the data provided, whether there is enough capacity in the existing management and infrastructure to add a whole new service focused on children and families to these Centers.

There seems to be greater potential in exploring the new Rehabilitation Centers, ECD Centers and existing residential social care providers such as the Infant homes as options for expanding the reach of community based social services to children and families.

3.2 Gaps in existing community-based social services for children and families identified by respondents

The Disability survey identified gaps in services for children with disabilities and their families which are attached in two tables in Annex 1 for ease of reference and which cut across all disciplines and policy portfolios (health, education and social sectors). Inclusive education, for example, is not currently available for children with disabilities and nor are medical services and assistive devices based on a contemporary understanding of disability and latest technology. Some of these gaps in the health and education sectors may also require accompanying social services if they are to be filled effectively.

Achievement of inclusive education, for example, as well as requiring changes to education policy, teaching processes and goals, also requires that parents and families are able to provide day-to-day care for their child, to take him or her to and from school and are able to function as normally as possible as a whole family unit without the well-being or quality of life of siblings, parents or other family members being constrained because of care duties for the child with disabilities. At the moment, residential services are replacing day-to-day family care for many children. In some families, achieving this balance – a supportive and constructive home environment and inclusive education environment – requires active partnership between schools and family members and the provision of additional supportive services that are often best led by social workers rather than teaching personnel. This report will focus on the social work or social services elements that could be developed on the basis of the existing system and will define where these elements overlap with other portfolios especially in education and health.

Consideration is also given, when analyzing gaps in services, to the role of the extended family as co-carers of children, especially of children with disabilities, but also children without parental care. Where 'building parent skills' is mentioned as a needed service, consideration should be given to building the parenting and care provision skills of other caregivers in the family.

Perceptions of gaps and needed services

All respondents mentioned, to one extent or another, the need **for one point of referral and more information** about who can help and how, as a key need for all families, but especially in rural areas.

For children with disabilities, this information needs to be provided at birth or at the point when diagnosis of impairments is taking place as this is the point when parents and families need to understand what to expect of their child's development, what their child needs in order to maximize her or his abilities and development, and what they can expect in terms of services and support not only in the immediate young childhood period but in the medium to long term in terms of education and the transition into adulthood. If parents could be provided with all the available information and immediate referrals to a range of relevant organizations that can provide necessary support and knowledge, this could help to reduce the stress that families experience when a child with disabilities is born or a diagnosis confirmed and increase the quality of care for the child in the family.

For other children and families in the 7 target groups for services described above, this information needs to be provided through trusted channels which are universally accessible.

One respondent suggests that '*more centers for children and families are needed so they know where to get all information*', but the assessment suggests that both Family Doctor services and Parent Centers have the wide reach which could make them key actors in any system of formal social services, both as bearers of information and as professionals who can identify signs of risk or crisis and refer children and families early in the child's life and early in an emerging crisis to specialized social services. Developing new services doesn't have to mean developing new infrastructure. Careful consideration will have to be given to a) additional training that would be required for the doctors and nurses in these already stretched services to be able to take on additional functions b) possibilities of adding social work professionals to the teams of these services given the complexities of inter-sectoral working c) links with statutory child protection services and local community informal services. The assessment also suggests that the Khyakimlik, Gengesh and/or Council of Elders are all trusted sources of information, but it is not clear how appropriate or feasible it would be to create an outreach information and referral system through these structures.

Parents' perceptions of gaps in services

Self-help and mutual support groups are needed for parents and carers of children with disabilities where they can share experience and learning. These types of groups are, by their nature an informal, community-based form of support, but can be facilitated by formal service providers if they are not emerging of their own accord. In other countries, these types of mutual support groups often evolve into formal entities engaged in information dissemination, research, advocacy and policy development activities. Some also become service providers.

Personal assistants for parents with disabilities, for household issues, homework and other child development needs are mentioned by one group of parents with disabilities, but could

equally apply to the parents without disabilities but with children who have disabilities and who require constant care or need support to be mobile outside the home, at school or during leisure activities. There are various models for developing this type of support service.   In some countries in the region, parents or carers can apply for a carer's allowance and take on formal responsibilities for providing this type of personal assistance to a child with disabilities. In other countries around the world, a personal assistant for a child or adult with disabilities has special training and is a para-professional within the system of social services provision.

Training for parents to improve parenting skills, knowledge and capacity was mentioned by several parents, but also by many professionals and decision-makers as an important gap in services which needs to be developed *'psychological support and different trainings for parents would be ... very useful'*. This applies to parents of children with disabilities, but also to parents of typically developing children '*developing parental capacities would be helpful for a lot of families'*. As mentioned above, any programs or services which start to develop parent training should be sure to consider the other family members also involved in providing care, especially for children in households with large extended families where many adults may be providing care.

Decision makers and specialists

Professional social workers are mentioned by several respondents as being needed, mainly at the national decision-making level, but also among regional decision makers. They are mentioned without necessarily referring to the types of services they could be delivering. Respondents also mention services that need social workers such as 'diverse services for children without parental care', without necessarily mentioning social workers:

> *It could be a good idea to introduce social workers, who can visit families and provide support.* (KII national decision-makers)

> *We need to develop the work of social workers as profession, to involve more volunteers. At Parents' Centers we try to promote a professional approach for providing services.* (Region C Velayat decision-makers)

> *New profession of social work (or pedagogue) should be established in universities* (KII academic)

> *Developing diverse services for children orphans and deprived of parental care who are in the full care of state* (KII national specialist) [author note: such services would require professional social workers]

Expanding provision of ECD services is mentioned by several respondents from a range of structures and at national and regional level. '*Early Childhood Development Center – very important initiative', 'need to develop these centers across the country'*. The main issue is that these services work best for those who live near them and accessibility in the local community is important if they are to be effective.

> *It is very important to provide psychological services for mothers, and they will come to these services if they will be close. It is important to have it accessible, close to home.* (KII with mother of boy with autism, visits the center every day)

The use of Parent centers as outposts of ECD services and of Family doctor services for developmental screening to some extent represents a strategy for expanding the reach of these types of services, but the feedback of some parents indicates a need for easy access to the psychological and practical day-care support these services can provide as well as to the developmental services they provide to children. Consideration should also be given to ensuring that as ECD services develop and expand, they should meet the global standards of early intervention services which are focused on multi-disciplinary teams (not just a speech therapist and a psychologist) and on including parents and carers as equal partners in the professional team as they are seen as an expert on their own child and actively involved in the habilitation and development process.

Training for children and youth were also mentioned. One suggestion was that young people and young families should have regular meetings with the Council of Elders.

Other needs identified by respondents

Training for professionals and specialists is mentioned by many respondents as important for developing new specialists and professionals, but also for existing specialists.

> *In 2009 there was a series of trainings and seminars for Guardianship organ specialists - they were very useful. It would be good to have such seminars at least once per year and with an international trainer.* (Region B Guardianship specialists)

> *All agencies need methodological and training support for further development and provision of quality services*. (Region C specialists)

> *Seminars and trainings on social work are very needed for the whole system. We need to develop new approaches and implement best practices in our country.* (KII NGO)

Strengthened coordination and regulatory framework for social services is mentioned by one respondent, although several others also mentioned that services could be better coordinated '*Social services needs to be better coordinated and of better quality. Thus, it is needed to establish some type of register, one-stop shop and develop standards so that these services are accessible'* (KII academic)*.*

3.3 Other types of social services which could be relevant for some target groups

The gaps identified by respondents correspond to their views of the main target groups and apply mainly to improving services for target groups 1-4 from the typology set out in Figure 1 above although the mention by one respondent of the need to develop diverse services for orphans and children without parental care needs to be highlighted as so many other

respondents do not mention this group, assuming that all orphans are cared for in guardianship placements or informal kinship care. The Guidelines on Alternative Care for Children provide an important set of principles for planning the development of a range of services for children without parental care. The main priority is to ensure that the 'necessity principle' is upheld and that only children who absolutely need to be in the full-time care of the state enter formal care. The types of services that can help to fulfill this principle include:

Individual casework by social workers which tries to support families to find solutions at the community level to the problems that are affecting their ability to care for their children so that children can remain in the care of the family and receive adequate care. The role of the social worker is to assess the needs and strengths of the family and develop a plan to address the problem or crisis that is affecting the ability of the family to care for their child or children. The family then implements the plan with coordination by the social worker, who also coordinates with other services.   Social workers can draw on a range of services to support families including parent and carer training; social assistance; practical support from community sources in the case of crises; health and education services; respite services; personal assistants or support with home care tasks or getting children to and from school. This type of intervention can be organized through community-based social workers or mobile teams (see below).

Family group conferences where trained facilitators support the extended family, friends and other adults in the child's immediate circle to find care solutions if the child is at risk of being separated from the family. This type of group decision-making could also be used for deciding on how best to care for a child with disabilities especially in a situation where there are very few extended family members willing or able to provide support and help to provide care.

Crisis intervention services which are based on individual casework by social workers, but which last for short periods to support families in overcoming a crisis. Often, crisis intervention can also help to break destructive patterns of behavior and lead to long-term family stability. Crisis intervention differs from casework in that it may require more intensive and higher cost inputs at the time of the crisis and its immediate aftermath.

Mobile teams are multi-disciplinary teams of specialists who travel to remote areas on a regular basis and provide social services in situ. Mobile teams can target children with disabilities and their families in remote rural areas, in which case they would be comprised of a team of specialists who can address communication, mobility, care, environment and social issues together at the same time. Mobile teams can also target children at risk in families where parents or family members with mental health problems or long-term illness such as tuberculosis are struggling to provide care. In this case, they might comprise a psychologist and social worker, who can coordinate services with other health and education services such as the

Family doctor or kindergarten. Mobile teams can also be used in urban settings where access to other types of services may be constrained.

Respite care is short, planned stays in another family-based setting which helps a family experiencing high stress in providing care to a child with complex needs to find relief or respite. The care could be overnight or it could be for a few hours each day, it could be provided by extended family members or by volunteers or professionally trained carers. The person providing the care is trained to be able to ensure that the child is not only adequately cared for during their stay, but also is learning and developing. This service can also be called, for example: 'social nanny', 'freeing up of parents' or 'guest families'.

If all these services cannot help to ensure that the child is receiving adequate care in the family and a referral is made into alternative care then the Guidelines on Alternative Care for Children set out the 'suitability principle' – that any care provision should be suitable to each child's individual needs taking into account age, ability and all other individual characteristics. In order to ensure that this principle is upheld a number of services can be developed so that there is a range of diverse services from which the most suitable care provision for each individual child can be chosen.

Guardianship already exists and is widely used in Turkmenistan to provide care for children without parental care. When it is not possible for extended family members to take care of a child without parental care, it could be possible to do more to find other guardians for each child. Individual casework and family group conferences (see above), for example, could help to identify another community member who could provide guardianship to the child rather than a child being sent away from their community. Several examples of such care being provided by a friend or teacher were mentioned in the assessment and social services can help to ensure that this option is explored more carefully and extensively for each child before the decision is taken to refer to care that is not based in a family. Children in guardianship care, whether of relatives or non-relatives, also require monitoring and support from professionals who understand children's needs and can ensure that they are being met. Guardians also require support, especially if they are providing care to a child who has extensive or complex care needs. It could be that guardianship care can be expanded especially for children with disabilities without parental care, who are otherwise likely to be referred into residential care. Consideration should also be given to using guardianship for providing temporary care in a crisis – sudden death of parents or abandonment of a baby – while permanent care arrangements are being decided.

Family type group homes are a form of small-scale residential care that is designed to be as much as possible like a family. The building in which this type of care is provided is usually a normal apartment or house in the community and a small number of children live in this group home with a small number of staff. There are many different models of how to structure the staffing and the way this care is

organized. This type of care can be used for short-term placements in a crisis as well as for long-term care provision for children who require residential care.

There are a range of other types of alternative care which could be developed based on international best practice and the guidance given in the Guidelines on Alternative Care of Children, but these two are the main types which seem relevant to Turkmenistan at this stage of developing social services.

Other community-based services which can enhance and strengthen both prevention and alternative care include:

> **Mentoring** for young people without parental care or for disadvantaged young people in the community provides an alternative to the advice or guidance that a young person might normally get from their family or the traditional community members. This type of service is usually run by a professional social worker but mentors are volunteers. This service can help to steer young people through some of the more difficult periods of adolescence, ensure they have a trusted person to help them with important decisions and support a healthy lifestyle. This type of volunteer scheme could also be used for children with disabilities who are being educated at home where the mentor could be close in age to the child with disabilities, so more a 'buddy' than a mentor, with the aim of supporting socialization and reducing isolation and strengthening inclusion.

The Red Crescent described this kind of volunteer scheme for children with disabilities in special schools during the assessment:

> *We implement Youth project - young people visit schools for children with mental disabilities once per week and deliver training for children. Usually 2 volunteers are linked to 1 class of children and work for a year. Volunteers are very creative and children like to spend time with them very much. We also train them; we prepare them for specifics of work with children with mental disabilities. They should serve at least 4 hours per week to be called Red Crescent volunteer.*

It should be possible to extend such a mentoring or 'buddy' scheme to residential schools and to children who are not attending school as they are being educated at home. This type of program has the added advantage of supporting the process of changing attitudes to disability and developing an inclusive social environment. Mentoring schemes can also be developed to link elderly people with no extended family to children or families without any extended family for the mutual benefit of both parties.

> **Contact families** are volunteer families who have been through a crisis and are able to share their experiences and mentor a family that may be entering a crisis. Contact families could also be developed as a service for families of children with disabilities who have limited extended family support.

> **Supported independent living services** for young people with disabilities and for children without parental care leaving residential care. These services provide

housing with some specialized support tailored to the needs of the individual. They often include an element of support in accessing employment services, vocational training or higher education.

There are many other types of community based social services, both formal and informal which have been developed throughout the CEE/CIS region and globally and one of the recommendations from this assessment is that the Government of Turkmenistan should consider the experience of other countries in order to build a social services system that has learned from the mistakes and successes of others, while maintaining the integrity of the strong community and family traditions of Turkmenistan. Countries which offer a number of possibly interesting models of social services development that could be of interest to the Government of Turkmenistan include the United Kingdom, Germany, France, Serbia, Lithuania, Russia, Ukraine, Moldova and Kazakhstan.

4. Conclusions, recommendations and options for developing social services

Many conclusions and recommendations have been discussed earlier in this report, but are summarized again here and are followed by proposals for a number of options for developing social services in Turkmenistan with some discussion of the strengths and weaknesses of each option.

4.1 Conclusions and recommendations

This assessment, together with the Disability survey and the study of children under 3 years of age, have shown that there is an extensive provision of community based health and education services in Turkmenistan which also carry some social services or social care functions. These services reach most families and children, although access may still be problematic in some rural areas. Education services tend not to be inclusive for children with disabilities who are mainly educated at specialized schools, often in residential or semi-residential settings (full or weekly boarding) or at home. Some of this residential education appears to be provided as day school in some cases, but further data is required to be sure of the whole picture.

Informal support mechanisms at the community level are heavily reliant on extended family and in most cases children do have access to extended family. In an important minority of cases, estimated at 12%-20% of children with disabilities by the Disability survey, this resource is absent and additional support is needed beyond that which the extended family traditionally provides. Children with disabilities and their families can experience discrimination and stigmatization in their communities that means informal community support may not always be provided, so formal responses may need to be developed.

Main points of contact for children and families in need of information, support and help are the Family doctors and visiting nurses; Parent centers, kindergartens and schools; the Khyakimlik, Gengesh or Council of Elders; the Red Crescent and other NGOs or public

organizations. To a lesser extent, families also go to the Guardianship and Trusteeship organs or the Commission of Minors' Affairs.

Key features of the existing provision of social services include:

Target groups of existing community-based services are mainly children with disabilities and their families and children in guardianship. It is not clear to what extent existing service provision covers these groups and meets their needs.

Children without parental care or extended family care are likely to be cared for in residential children's homes or infant homes.

Newborn babies without parental care are likely to be adopted by relatives or other adopters and support to prevent their relinquishment in maternity houses or to prevent unwanted pregnancy is limited. Statutory organs carry out assessments, approval, monitoring and support of guardians and adopters.

Strong informal support from extended family - mainly family members or extended family members care about the children in their own family, but also 'neighbors, friends and other community members'. Most, but not all, children and families are supported by extended family. An average of 2 children per year in rural Etraps and 6 in urban Etraps lose family care as extended family cannot or does not want to provide care.

Community support – Etrap and Velayat Khyakimliks and the Council of Elders offer informal community support as well as playing a role in formal social assistance provision.

Visiting doctors and nurses make regular visits to the family and the child especially during the first year of life. Families refer first to Family doctors on any issues with the health of the child. They also consult with the family nurse on issues of care and child development. Family doctors make referrals to Health Houses. Families with children with disabilities can also receive free treatment, massage, and other physiotherapeutic procedures.

Parent centers operate as pre-school preparation services and they also organize trainings and information sessions for parents.

For the elderly and adults with disabilities – Centers of Social Protection provide day care and longer-term care services for elderly and people with disabilities as well as home visiting and household assistance. There could be potential to extend these services to adults with disabilities who have children and to older children and young people with disabilities.

ECD Centers – provide a form of day care, psychological support, a local community service as well as early childhood development and school preparation, but currently only exist in two Etraps. The service model needs strengthening to conform more closely with international early intervention services before it becomes more widely disseminated.

NGOs and public organizations – provide mainly in-kind and financial support, legal assistance, information and consultations, but also crisis intervention, social assistance, training and group meetings, rehabilitation. Some psychological support and mentoring, day care or help with transport are also provided by these organizations. The reach and scope of

service delivery varies, but several NGOs and public organizations surveyed for this assessment seem to have capacity to extend their reach and the number of beneficiaries if funding were to be available.

Capacity of the existing system includes:

A range of 'specialists' providing direct services including home care services and in a few instances social work services based on individual assessments and casework; a tertiary education system that recognizes the need to develop new professions such as social work specialists.

State services for the elderly and adults with disabilities that could have capacity to add some children and young people to their caseloads. Public organizations with extensive reach and infrastructure, including management structures, which could add more social workers and direct services within existing infrastructure to reach more target groups. NGOs

Four infant homes providing a mix of medical and social care services that have the potential to develop into centers providing non-residential community-based social and rehabilitation services for infants and babies either with or without disabilities. They could maintain their current capacity in terms of staff, buildings, transport and equipment and work towards changing their functions towards supporting the care of babies and young infants in their own families or extended families wherever possible. For children without parental care, options for developing alternative family-based care services managed by these facilities can be explored.

An extensive network of residential boarding schools and pre-schools which could become re-focused on providing day education and enable families to care for their children with disabilities at home with the right kind of social services support.

Principles to consider

Building on the strengths of existing community and extended family responses and not weakening or replacing them unnecessarily.   At the same time making sure that vulnerable children and families who are excluded from receiving informal support as a result of prejudice or discrimination can access alternative community based options.

Focus on supporting families to provide good care in the home that can ensure child's full development and support inclusion in mainstream education and extracurricular activities for children with disabilities rather than setting up segregated 'rehabilitation' services outside the family and away from other children.

Reorienting residential services to best meet needs of children and families – provide transport options to support attendance at school, pre-school or day care on a daily basis instead of on a residential basis; develop social services or provide access to existing home care services for children with disabilities and their families to support daily attendance at school, pre-school or day care rather than residential attendance.

Adopting the model of disability outlined in the International Classification of Functioning as discussed in the Disability survey. The services and systems designed to support children and adults with functional disorders can be better informed and more consistently and effectively implemented by including ICF measures and approaches in their systems. The ICF framework can help to build a common language and approach across sectors and facilitate multi-disciplinary coordination of services that are based on the needs of individuals with disabilities.

Development of new generic specialists – psychology, social pedagogy, social work, community social work; as well as specialized versions of these professions: disability/inclusion, supported independent living, child protection, guardianship and adoption, leaving care, crisis intervention, infant abandonment prevention

A regulatory framework that clarifies the policy of the Government of Turkmenistan in relation to formal and informal social services – legislation, mandates, inter-sectoral protocols, service standards. Decision-makers need to clarify, for example, the extent to which the system should rely on the extended family to provide care for a child with disabilities – including siblings under the age of 18 years given that this can constrain their access to education and other rights.

All policy development and service planning should be based on an understanding of the situation for children and families that is based on the latest monitoring data. An information management system that can track key indicators relating to demand for and supply of social services needs to be developed and used as an integral part of the planning cycle and decision-making process. Information generated through individual casework and needs assessments should be aggregated at service, Etrap and Regional levels to ensure decision-makers have a clear overview of the system as a whole and are able to make informed decisions.

Targeted services need to be developed which are responding to clearly identified needs. Not all families need social services and social services are not able to help all families. They need to be universally accessible, but without artificially drawing in clients who don't really need services. Social services can operate at all levels of need illustrated in Figure 4, but the caseloads and intensity of provision will vary. Social services in Turkmenistan are developing to meet the needs of vulnerable groups, groups with complex needs or with emergency needs or in crisis. Social services should provide information at the level universal services available to all and not necessarily more complex services.

Figure 4 Levels of need for social services
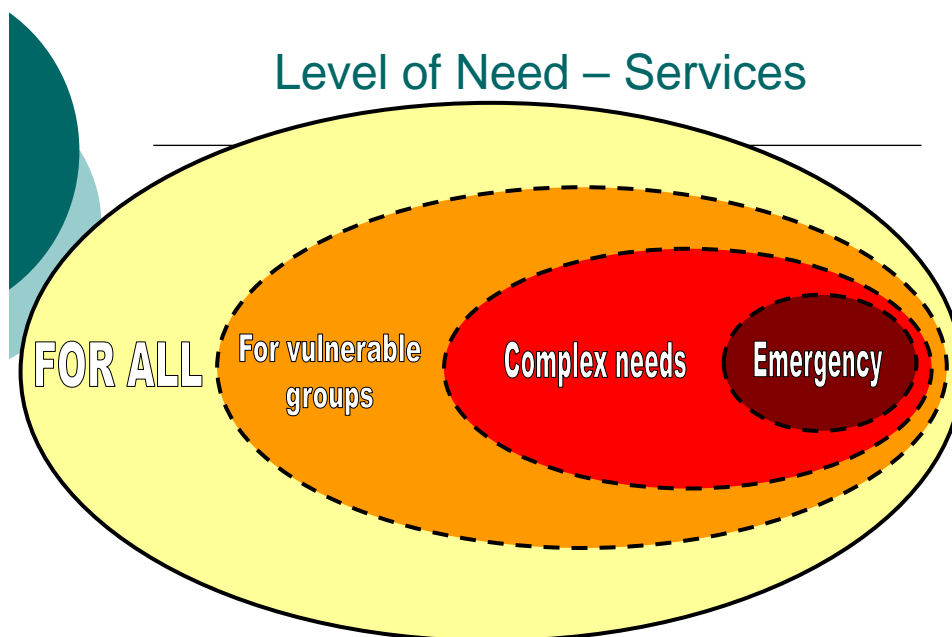
Source: UNICEF, 2009

4.2 Options for developing social services

As mentioned earlier in this report, there is a great deal of experience in Turkmenistan already of developing social services and it is recommended strongly that a full review is made of the lessons that can be learned from this experience as well as from the experience of other countries in the CEE/CIS region of developing social services on the basis of former Soviet social protection systems. Global experience of social services development should also be thoroughly considered, before finalizing any decisions to develop services. With this caveat in mind, a number of options are presented where with some consideration given to their possible weaknesses and strengths based on the available evidence and the authors' understanding and experience of how similar services have developed in other countries.

Conceptual framework

When considering options for developing social services, the goals and purpose of the services have to be at the cornerstone of any service design. For the purposes of the theoretical exercise of exploring options in Turkmenistan, the goal and purpose of social services development policies, based on the UNCRC, UNCPD, ICF, Guidelines on Alternative Care for Children and other international frameworks to which Turkmenistan has subscribed, can be defined as:

Goal: All children are healthy, happy, safe, educated and actively participating in and contributing to society

Objectives:

1. Ensure community-based support is available for families of children whose parents and relatives are struggling to provide care so that they can continue to be cared for in their families with relevant support

2. Ensure safe and supported community-based care is available for children who don't have parental or family care and they are not segregated into specialized institutions outside of the community

Key elements of social services systems

Referral, assessment, planning and review are the key elements of any social work service:

Information provision – if families don't know about social services that are available, they won't seek them out; if professionals in other agencies don't know about social services and what they can do for families and children, then they won't refer children or families to these services

Referral by another agency or self-referral by a parent, carer or child – those who are mandated to refer a child or family to a service have to know that they are referring the child for the right reasons to the right services. The moment when a client first contacts a service is critical for engendering trust and ensuring that a constructive partnership can follow between social worker and client.

Initial assessment - the social service needs to make an initial assessment of needs and to be sure that this is a child and family who can benefit from the services it offers.

Full assessment – a full assessment can take several weeks and involves an in-depth joint evaluation of the child and family situation led by the social workers and involving all family members and related agencies – health services, education services, and community members.

Planning – the full assessment results in a plan which sets out short, medium and longer-term goals for working with the family. It sets out the resources that will be invested in realizing the plan and the responsibilities for implementation.

If the service is focused on providing ongoing support to a family with children with disabilities, for example, then the plan is likely to be for one year after which it will be reviewed and adjusted to take into account the child's changing needs as he or she grows and develops. Disability plans are likely to be cross sectoral and reference the child's health and education needs as well as social, emotional and psychological needs. Separate plans for primary caregivers can also be developed.

For a child at social risk the plan may be for a specific period of time and be aiming to achieve specific changes in the situation of the child and family. It may specify care arrangements if the child is separated from his or her family.

Implementation, monitoring and review – the implementation of the plan requires resources of various kinds and monitoring of its realization takes place with regular meetings between case worker and client and with periodic review to adjust the plan either until the goals have been reached and the case can be closed or the plan needs renewal with a restating of goals as a child grows and develops or the situation changes in the family. Information from individual casework can feed into an information management system to help identify gaps in services and inform decision-making about system development.

The options presented and discussed here should be considered within this hypothetical conceptual framework for social services development and should take into account the principles set out above.

Option 1 Continue to attach social work functions and provision of social services to existing Etrap-based services focused on habilitation and child development

This option builds on the relationship of trust between Family doctors and visiting nurses attaching some information provision and referral functions to these health workers. The Family doctor and visiting nurses would provide households with children with information about social services available in their Etrap and, if they identify the need for an assessment by a social worker because of a) potential disability or impaired functioning in the child b) potential inadequate care by parents, then they bring the social worker with them during a subsequent visit. The social worker carries out an initial assessment and if the child and family are eligible for support, continue to visit the child and family to carry out a full assessment, develop a plan and the implement the plan together with the family. The link to the Family doctor and visiting nurse could be physical, by co-locating the social worker in the same premises based in the community or it could be governed by a protocol where the social worker is physical based in the Gengesh, the school or kindergarten, a rehabilitation center or some other structure, but forms a mobile team with the Family doctor and visiting nurse services.

The strengths of this option are that the Family doctor and visiting nurses are well rooted in their communities and appear to have relatively high levels of trust among community members. This would help to ensure that a new social worker with new functions would be welcomed by community members and families and not rejected from the outset. The caseloads would need to be carefully calculated as it is unlikely that this needs to be a universal service so one social worker could be attached to several Etrap Family doctor and visiting nurse services. This option could risk overloading an already busy service, which has a clear health focus. Introducing specific goals related to childcare and social work could dilute its mandate and the effectiveness of its work.

Option 2 Strengthened Velayat child protection and family support services attached to Khyakimlik statutory bodies

This option builds on the statutory mandates of the Khyakimlik Guardianship and Trusteeship organs and the Commission for Minors' Affairs. Both of these organs are made up of inter-sectoral community decision-makers who have a clear mandate to take decisions about childcare, welfare and protection. These organs have a specialist in every Etrap who

could be joined by either a generic community-based social worker with functions to focus on supporting children with disabilities in their families as well as child protection functions monitoring and supporting the few children who fall into target groups 2-7 in each Etrap. The social worker would be able to complement the work of the Guardianship specialist and the Commission for Minors' inspector with individual casework to support specific children and families. One worker may not be enough in some Etraps and caseloads would have to be monitored to ensure quality of service delivery is maintained. This service could link closely to the Khyakimlik social welfare department responsible for processing social and disability payments and allowances.

The strengths of this option are that the new service would be rooted in an inter-sectoral decision-making body and carry the authority of the Khyakimlik as well as close access to the Khyakimlik resources across health, education, housing, transport and social welfare. The weaknesses are that the functions and ways of working of these two organs are so well established that the change management processes required to refocus their work towards prevention and family support may make this option unworkable. It might, however, be worth piloting alongside another option to test for viability.

Option 3 Further strengthen school and kindergarten based social pedagogy

Attaching social workers or social pedagogues to schools, kindergartens, ECD and Parent centers offers a way of reaching vulnerable groups or groups with complex needs through a trusted and widely accessible universal service. This option could include individual casework services delivered through home visiting alongside group work involving parent training, peer-to-peer mentoring, youth work and strengthened outreach to children not in school or kindergarten. This approach would sit nicely alongside the plans for developing social inclusion and ECD services. Again, given the forecast of need for social services roughly estimated above, school-based or kindergarten based services may not need a worker in every school, but have a mobile team working with a cluster of schools and kindergartens.

The strengths of this option, like the option of building on existing health services, are that the new social workers would carry the trust and authority conferred by the education system. The disadvantages are also similar – the disadvantages of clashing professional cultures and complex change management process. On balance, however, the pedagogical approach lends itself to interacting with parents who are largely receptive to the idea of being told what to do and how to behave, by those in authority. Placing these workers in specialized education settings both residential and day schools and preschools could also help to accelerate the process of targeted assessment of needs, the planning and development of services that are needed to support inclusive education.

Option 4 Contracting NGOs to develop and deliver services – generic or specialized

There are both independent NGOs and public organizations active in delivering services that have complementary reach and flexibility in delivering needs-based services. It is quite feasible that, with the right regulatory framework, NGOs could deliver many of the specialized services needed for groups with vulnerabilities, complex or emergency needs.

State grants or contracts could be assigned to enable these organizations to hire social workers, train and manage them and to deliver services based on referrals from the Khyakimlik statutory bodies, police, Family doctors or teachers.

This option relies on the referring bodies having strong skills to assess initially which organizations can best provide effective services to meet which needs. The advantages are that this could mean quick and flexible development of the staff resources needed for new types of services. The disadvantages are that this type of approach requires a transparent and viable system of commissioning; contracting, financing and monitoring services and this could take some time to develop in a heavily state dominated service delivery culture.

Option 5 Expand service delivery from existing social protection centers, Infant homes and newly developing Rehabilitation centers

This option builds on existing infrastructure, resources and systems of the State social care service providers. Introducing social workers with new functions and mandates to work with children and families would require those who manage these services to adjust to considerable new challenges, but this option could represent a good opportunity to develop services that are rooted in the State service provision budget and therefore immediately sustainable institutionally and financially. This is especially true for the new Rehabilitation centers where it is entirely possible to attach social services and social workers to these centers, who have an outreach remit for working with families across the Velayat. The danger is that links with Etrap statutory bodies or with traditional community structures are not strong enough. For the Infant homes, the constraints for developing these services relate more to the shift in focus away from perceived medical needs of children to their social, psychological, emotional and other needs. This shift will have implications for the organizational culture of these institutions, the way they will be managed and funded. Nevertheless, there are relatively few children currently in the care of the Infant homes or entering their care each year so this set of services represents an opportunity to make a transformational change towards creating community-based services.

Community based needs assessments

At this stage, these options represent the beginning of a discussion of policy options for the development of social services and it is likely that the best option of all is to combine some or all of the elements suggested here as the new system is developed. Ideally any new system will be based on needs assessments and the option chosen for service development should be based on responding to the needs identified. As one group of national decision-makers said in a key informant interview during this assessment:

> *To introduce new services we need to study and research the needs of the families. Which families need what type of assistance? It could be a good idea to introduce social workers who can visit families and provide support. At the same time we need to train these social workers very well, we need to understand what qualification they should have. The main issue for us is how to define the needs of the families to make the assistance targeted. Probably*

we can do this research via schools and health houses. (KII with national decision-makers)

Perhaps this informant would now add that this research could also be done via the Guardianship organs and NGOs as well as through the universal education and health services. The results from this assessment provide a framework for further, detailed needs assessments in each Etrap and Velayat that can be aggregated into full assessment to inform the development of a social services concept or strategy.

Next steps

To conclude, recommendations for the next steps for moving forward with social services development can be summarized as follows:

- Consider experience of other countries – UK, Germany, France, Serbia, Lithuania, Russia, Ukraine, Moldova and Kazakhstan – to assess what has worked and not worked and which parts of this experience are relevant to Turkmenistan.

- Develop a conceptual framework on social services and social work defining goals and objectives and how they relate to other policies such as inclusive education, early childhood development and social protection. The key elements of social work such as referral, case management, assessment and review should also be set out.

- Training and education of an initial cadre of social work specialists and social services managers.

- Needs assessment and regional service development planning in pilot Etraps/Velayats involving the newly trained specialists and managers as well as capacity building of local authorities to manage these processes going forward

- Information management system created and tested based on regional assessments

- Pilot services and system options based on the regional service development plans

- Document and evaluate

- National roll-out

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Annex 1 Gaps in services for children with disabilities

Table A summarizing gaps in services for children with disabilities and Table B an analysis of the current situation in service provision for children with disabilities (from Disability survey, UNICEF, 2014b)

TABLE A Needs of children with disabilities	How they are being met now
Care provision – support with providing day to day care in the home	Extended family members who appears to be available in the majority of instances; NGO
Support with providing day to day care outside the home	ECD centers; residential schools and kindergartens; rehabilitation centers
Improved and strengthened parenting and care skills including: alternative communication where needed, lifting and carrying, child development – what to expect, understanding of disability	Largely not being met although the Family Doctor provides some inputs, developmental pediatrics is being piloted.
Information about services – play, leisure and after school activities; health, education, community services; social services; assistive technology and devices	Not being met
Appropriate diagnostics and medical treatments for early detection and interventions for developmental difficulties and delays in children	Family doctor and visiting nurse – needs strengthening with specialized knowledge and skills, early intervention/developmental pediatrics services need to be established in line with international standards House of Health neurologist and pediatrician – needs modernizing and specialization Treatment abroad by specialists not available in Turkmenistan – physiotherapy, ergotherapy, cognitive behavioral psychology, speech therapy and alternative communication, child neurology and psychiatry
Inclusive community and education services, play and leisure	Not being met
Preparing for independent living	Not being met
Information about disability legislation and support in claiming benefits and accessing services	Largely not being met, although some information is provided by Khyakimliks

TABLE B Summary of the current situation and analysis of strengths, weaknesses and opportunities – services for children with disabilities

Strengths	Weaknesses/Opportunities
Strong family traditions and culture Extended families available to many children and parents on a day to day basis (Grandparent/s in half the families interviewed for the survey)	First line of informal support for children with disabilities and their parents – day care, help with day-to-day care tasks and child rearing Additional/alternative support needed for single parents or those without extended family support readily available
Special schools and institutions for children with disabilities	The majority of children with disabilities are in some form of education. Most of the provision of specialized education is organized in boarding school settings and all provision is segregated in special helping schools, boarding schools or preschools. There is evidence from the disability survey that significant proportion of this type of education is actually provided on a daily or weekly boarding basis. It seems likely that family contact is maintained in many if not most cases, that most children are in this form of education primarily for education purposes and that this type of facility cannot be classified as providing 'institutional care'. There is evidence from the disability survey that a significant proportion of children with motor disabilities may not be accessing any primary or secondary education. Very few children with disabilities attend mainstream schools and those who do have high levels of functioning. It is not clear the extent to which specialized schools are teaching children based on a contemporary understanding of special needs education, alternative communication approaches or individualized approaches to learning. There is no data on children with disabilities attending higher education institutions or technical colleges. Anecdotal evidence is that barriers to entering higher education are high. Parents are not always informed about the choices available to them or about the rights of their children to quality specialized education.
Family doctors and	Services are highly rated by nearly all parents and represent a strong

visiting nurses offer mainly medical services, but also provide advice, information and counseling to parents on behavior, child development and other child focused issues. Developmental pediatrics are being developed for early screening.	potential entry point for offering social services and community based rehabilitation services to children with disabilities and their families in the community.
Public and non-governmental organizations are providing some types of social services and support to some children and families in some parts of most Velayats and Ashgabat.	There are very few NGOs and their coverage across the country is uneven. The main focus of NGO services for children with disabilities is on material support, advice and information, events and parties. Some NGOs provide crisis intervention services, legal consultations and support with claiming benefits, addressing housing issues or accessing assistive devices, sanatorium treatment or medical treatment abroad. Only one NGO provides day care services and even so only rarely.
Informal social services and support is well-rooted at community level with neighbors, friends, local community members providing support and help to families in many cases.	Parents also report negative and even hostile attitudes towards children with disabilities from community members and sometimes even from friends and extended family members. Not all children with disabilities and their families can always rely on receiving informal social services and support of the right kind when it is needed.
Formal social services for children without parental care are provided by statutory officials such as the specialists of the Commissions of Guardianship and Trusteeship. State social services are also provided at Centers for Social Protection in each Velayat and ECD Centers in two Velayats	Centers for Social Protection provide center and home-based services only to the elderly and to adults with disabilities. They could represent a resource for developing home care or day care services for children and young people with disabilities. ECD Centers are being piloted in two Velayats and early monitoring has shown that they provide a valuable *social* service to local community residents – children with disabilities and their parents as well as providing pedagogical and early development services specifically to children. These Centers also act as resource centers for training staff from Parent centers in early childhood development programs. Formal state social services for children with disabilities and their families are currently available only to relatively few children and

Parent centers in etrap kindergartens provide parent training and consultations for children not in preschool.	families. Parents are not always informed about available services. Parent centers are focused mainly on objectives related to preparation for school.
Prosthetics factory producing wheelchairs for adults and other equipment operates under the Ministry of Health. Children who need orthopedic footwear are entitled to receive them free of charge every year.	The factory only produces wheelchairs and equipment for adults. There is no specialized equipment apart from orthopedic footwear produced in Turkmenistan or provided to children. Parents have to resolve these issues themselves and those who can afford it go abroad, to China, Turkey, Russia or even to Europe to access specialists, equipment and up to date therapies and rehabilitation. There is a general lack of equipment, communicative assistive technology and devices available for children with motor disabilities, cerebral palsy and autism which are based on latest developments globally. Parents lack information about assistive technology and latest developments in disability services, treatments, rehabilitation and habilitation approaches.
Social assistance is available to children with disabilities and families: cash benefits include birth allowance, child benefits up to 2 years of age inclusive, child disability benefit at a flat rate up to 15 years of age inclusive, disability pension for 16-17 year olds differentiated according to three groups of severity of disability and a further 20% paid to the main carer if a child requires continuous care (group 1 disability) In-kind benefits include: reduced charges for utilities; preference in	Provision of social assistance to children with disabilities is triggered through a disability assessment carried out by a medical expertise commission 'MSEC' which is possibly based on the Soviet classification of disability system (possibly modified according to ICD-5 – International Classification of Diseases and Related Health Problems – 5th edition). Some parents of children with disabilities report negative and even hostile attitudes from social assistance department staff at Khyakimlik offices when applying for utility bill discounts or housing privileges. Ministry of Social Protection and NGO specialists report that some parents do not want their child to be labeled as 'disabled' as they perceive this status to carry a stigma and therefore don't apply for this status. Parents of children with Down's Syndrome report that in order to apply for disability status their child undergoes extensive medical assessments. If a medical condition such as heart disorders, bowel abnormalities or other health conditions are identified then they may be given disability status. Some parents report that their child is not confirmed as having a disability if they have Down's Syndrome, but no associated health condition. The MTEK disability classification system appears not to recognize that some level of learning disability is

receiving public housing as it becomes available	common to all people with Down's Syndrome regardless of their levels of functioning in other areas. Parents generally lack information about all the benefits and support to which they are entitled and the process for applying for these benefits.
Free medical services and health care for children Annual referral to a health sanatorium for all children and adults with disabilities	Some parents report that they are asked to pay for some of the treatments and medical services to which their children with disabilities are entitled for free. Parents question the quality of some types of medical services for children with disabilities provided by the primary health care system. Parents also report specialists such as speech therapists and massage specialists in the mainstream primary health care system refusing to work with their children because of their disability. For these reasons, some parents end up paying for services in the private sector that should be free of charge in the primary health system. Some types of health care specialisms which are important for some children with disabilities don't exist in the primary health care system – child neurology, child psychiatry, ergo therapy (occupational therapy), physiotherapy – and other types of specialisms may need to be modernized and strengthened – audiology, ophthalmology, pediatrics, neurology and orthopedics. Parents travel to seek access to specialists and treatments abroad that don't exist in Turkmenistan, but have limited access to information about the quality and effectiveness of treatments and services. Parents generally lack information about treatments, habilitation/rehabilitation services, contemporary approaches to orthopedics and assistive technology, mobility devices and other important aspects of health care services for their children.
Legislation provides for employment quotas for people with disabilities	In practice this law is not always enforced or implemented and there is a general lack of support for young people with disabilities wanting to train for professions and enter employment. Reliable data about young people with disabilities in further education or entering employment is not available.
Data is gathered by each Ministry which is relevant to children and young people with disabilities.	Full data is not available on children and young people with disabilities and data that is gathered is not sufficiently disaggregated by type of disability, age, gender, region and other key parameters to enable effective planning of programs and policies. Existing administrative data is not collated into a full data set which can present a whole picture. The State Statistics Committee is able to request data sets from each

	Ministry, but there is a need to determine which key pieces of data should be collected on a systematic basis and collated by the SSC.
There is support for the Paraolympic movement in Turkmenistan and for promoting the rights of people with disabilities. Turkmenistan was the first country in Central Asia region to ratify the Convention on the Rights of People with Disabilities	Public attitudes and behavior towards children with disabilities continues to be largely negative. Some people believe that 'if you look at a child with disabilities you may have a child with disabilities.' Others believe that a child's disability – cerebral palsy or Down's Syndrome – is catching and their child can be 'infected' by a child with disabilities. Public information and national communications campaigns can address these attitudes and behaviors and help reduce social barriers to inclusion in schools, employment and other settings where children with disabilities are currently excluded. Support for such campaigns from the highest levels can help to ensure their effectiveness in reducing discrimination and stigma. Training in understanding of disability for personnel in state services – health, education and social assistance services – and among public officials can also contribute to changing social attitudes and reducing barriers to inclusion.
Some public buildings have been adapted to increase physical accessibility	Public transport is not accessible for many children with disabilities and their families and the prohibitive expense of taking taxis or owning and running a car can compromise the accessibility of education, health and leisure services for many children with disabilities and their families.