SOCIAL SERVICES IN THE REPUBLIC OF TAJIKISTAN

Study Report
Social Services in the Republic of Tajikistan

Study report

Dushanbe – 2012
Authors and Contributors

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The views expressed in this report belong to the authors and do not necessarily represent the views of the EU or GIZ.

Mapping of social welfare services in Tajikistan as a part of this research was conducted on the request of the Ministry of Labour and Social Protection of Population of the Republic of Tajikistan and is available at http://www.mehnat.tj/mapping

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Preface

This report provides a description and analysis of the system of social services in Tajikistan as a resource to inform and guide the on-going modernisation process. The report integrates the findings of several interrelated components of a study carried out within the framework of the EU-funded project ‘Technical Assistance to Sector Policy Support Programme in the Social Protection Sector – Service Delivery Component, Tajikistan’.

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<td>Analysis of secondary data on living conditions and access to basic social services in Tajikistan and synthesis of findings from all other outputs</td>
<td>Describes the situation in social service provision in Tajikistan in general and identifies the main problems of actual and potential beneficiaries of social welfare services in particular.</td>
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<td>Assessment of beneficiary needs for social welfare services and assessment of current service provision</td>
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Acknowledgments

The project team would like to convey its thanks to the Ministry of Labour and Social Protection of the Republic of Tajikistan for providing support at all stages, including providing access to available statistical information at national and local levels. We warmly appreciate the time spent by the respondents in responding to enquiries and taking part in discussions during the fieldwork component and for sharing their experiences of social assistance with honesty and insight.

Overall design and implementation of the research was overseen and guided by Volodymyr Kuzminskyi, EU project Team Leader. Components 1 and 3 respectively were led by Natalia Catrinescu and Clare O’Brien of Oxford Policy Management, with technical assistance from Veronica Sandu in both areas. Qualitative fieldwork (actual/potential beneficiary consultation) was carried out by the Tajik Centre for Sociological Research ‘Zerkalo’ with the guidance of Clare O’Brien and Veronica Sandu. Conceptual and consultative work, exploring and developing proposals on the definition of social services and other related key terms in the Tajikistan context, was led by Erik van Dissel, project key expert on social work. Primary data collection for the mapping of social welfare services was carried out by local project experts Zarrina Alimshoeva and Zamira Komilova, guided by Volodymyr Kuzminskyi. Additional technical support in relation to the analysis of data collected during the mapping exercise was provided by Joanna Rogers on behalf of Oxford Policy Management. Chris Rayment, EU Project Director (Oxford Policy Management), made significant contributions throughout the process including design/methodology, review of draft outputs under each component, and formulation and editing of this integrated report.

GIZ provided significant support to the implementation of component 3 for which we are very grateful.

We would like to acknowledge Andrii Grachov and Oksana Laushnyk for their significant technical work in developing the web-based mapping resource which is available in Russian and English at http://www.mehnat.tj/mapping.

Special thanks also goes to the wider team implementing the EU project ‘Technical Assistance to Sector Policy Support Programme in the Social Protection Sector – Service Delivery Component, Tajikistan’ for their invaluable assistance at various stages, including support to data collection and field work.

Finally we express our gratitude to Mr Robert Brudzynski, Task Manager (Social Protection) at the EU Delegation to the Republic of Tajikistan for his support.
Executive summary

This report presents the findings from a literature review, an extensive mapping of social service provision by 235 service providers across 62 districts of Tajikistan undertaken by the project team in 2011 and a series of consultations with stakeholders at all levels of the system of social services provision including 16 focus groups and 98 household interviews with service users or potential service users and 48 key informant interviews with representatives of social services providers, local authorities and non-government organisations.

The findings of the research suggest that the existing system of social services provision in Tajikistan relies heavily on the legacy of the Soviet system with some new forms of services having been developed, mainly by non-governmental organisations, in the last twenty years. Services inherited from the Soviet system are mainly targeting ‘traditional’ social service user groups including older people, children and adults with disabilities and children without parental care. Newer services are typically targeting less traditional user groups including injecting drug-users, children and adults living with HIV/AIDS, and women and children who are the victims of violence, abuse or sex trafficking.

As far as it has been possible to determine using available and newly obtained data, the estimated demand for services for older people, people with disabilities and children is spread more or less evenly across all regions of Tajikistan with slightly higher levels of services needed for older people and lower levels of services for children in GBAO. Based on estimates drawn from available data, the demand for services for both adults and children with disabilities may be slightly higher in Sugd.

The estimated demand for services for people registered as living with HIV/AIDS is relatively low (around 40 per 100,000 population) however this rate is understood to be rapidly rising as one third of all new registered cases were recorded in 2010 alone.

As the study shows, only around 1.3% of people aged over 60 years are actually using social services therefore it is likely that most older people are supported informally by relatives, neighbours and friends. Children in the care of the state represent approximately 500 per 100,000 child population and around 160 children per 100,000 child population lose parental care each year.
The beneficiary consultation shows that whilst households may be eligible to access social services, many are not doing so due to a very low level of awareness of what social services are. Service-users themselves are better able to articulate their needs and the demand for services based on their experience of services they have received. This is particularly true for carers of children with disabilities, adults with disabilities and older people.

The provision of services to meet these estimates of demand is at a very low level in the more populated regions of Tajikistan in Sugd, RRP and Khatlon and at a higher, although uneven, level in both GBAO and Dushanbe. Overall, the provision of services is uneven both geographically and across the different social services target groups. There are some districts where no social services are being provided for any of the target beneficiary groups.

Key findings of the study in relation to how demand is currently being met include:

1. The main client groups being reached consistently across all regions of Tajikistan are:
   - older people without family support and adults with disabilities;
   - children with disabilities;
   - children without parental care or at risk of losing parental care;
   - people living with HIV/AIDS and/or injecting drug users.

2. In some regions provision of services is limited to only a few districts and in some districts no services at all are available for these core client groups.

3. Care leavers and homeless people stand out as being among the most under-served groups when looked at as a proportion of the child or adult populations.

4. Children with disabilities, child-orphans, children without parental care and children in vulnerable families are among the highest represented among service users, however most services for these groups of children are provided in residential settings. Only children with disabilities have access to day-care and home-based forms of services reasonably consistently across all regions – although some districts within nearly all regions offer no access to services at all.

5. Older people (those over 60 years of age) who lack family support use social welfare services at a higher rate than other adults across all regions. Nearly all provision for these adults is in the form of home-based care with very little day-care forms of provision that could help to facilitate social participation.
It is reported that home care does not always correspond to or address individual needs.

6. Services for children and adults with HIV/AIDS and intravenous drug users are being delivered in every region. Adults and children living with HIV/AIDS and injecting drug users are receiving services at a high rate compared to other vulnerable groups. This may represent an adequate level of provision but it may need to be increased if infection rates continue to rise.

7. RRP is serving the whole country with a large concentration of long-term residential forms of care. Nearly all long-term residential care for adults is located in RRP whilst there is a chronic shortage of home-based services for adults with disabilities and older people.

8. Most services, apart from temporary residential services appear to be ‘clogged’ up with a static client base, which is receiving on-going, long-term services whether in home-based, day-care or residential form.

9. There is a marked absence of criteria and assessment for enrolling people into services or ensuring that clients cease to receive services or are referred to other services when their needs are met or change.

10. There is a very marked lack of awareness about social services among service-user and potential service-user groups. Other factors that hamper the self-referral of vulnerable people include lack of support to fulfil application requirements.

11. A notable proportion of service providers offer a range of services under one roof. This may indicate the potential to develop a range of service forms, across all regions, building on the foundation of existing monoservice forms. For example home-based service providers could start to develop day-care or drop-in services for isolated older people or for adults with disabilities to support social interaction and participation.

12. Stakeholder respondents indicate a healthy opportunity for engaging volunteers in the provision of outreach, home-based or centre-based services for children and adults.

There are major inconsistencies in the provision of services of different forms to different target beneficiary groups across the country; for example some districts have no services at all for any target beneficiary groups and other districts provide only residential services for children with disabilities and older people.
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This report, along with the extensive online mapping resource which informs it, documents geographic gaps in service provision, gaps in the provision of specific forms of services for particular groups and identifies regional and district variations.

Conclusions from the report include:

1. The current system of social services does not appear to be systematically identifying and meeting the needs of those who are most vulnerable or aiming to fulfil their rights. Rather, the coverage of social services is patchy and serves a largely static segment of the population in each region. Social services are organised in a rather ad hoc network with few discernible nodes of authority or co-ordination. Data and findings from the study serve to highlight the extent to which district and regional planning for social welfare services is needed.

2. A partial transformation of the system of service provision can be observed where service providers that were designed to deliver mono-typical forms of services have started to add different forms of service delivery to the main form of service delivery specified in their statutes. Some providers of home-based services for older people and adults with disabilities, for example, are developing facilities for temporary or long-term residential services or for day-care services and extending their reach to children with disabilities or children without parental care.

Similarly, some long-term residential care providers are developing day-care or home-based forms of service delivery.

1. The current system of social services is currently over-subscribed for some forms of service delivery and under-subscribed for others. A general observation is that the service forms which have waiting lists are those about which potential beneficiaries are more aware, including home-based services for older people and adults with disabilities, residential services for socially vulnerable children and all forms of services for children with disabilities. Some services do not operate at full capacity; these tend to be newer forms of services, often run by NGOs, which may not be widely known about or which may be perceived as being shameful to approach by potential beneficiaries.

2. The absence of services in RRP is of particular note and seems to point to a chronic lack of planning for service provision.

3. While home-based services for older people and adults with disabilities may be keeping some older people out of residential services, they do not appear to be addressing issues of social isolation.
4. There is an over-reliance on residential forms of service delivery for children. The system of social services currently makes almost no provision for services to children and their families while they are living at home. Children have to become resident in an institution of some kind, whether a sanatorium, boarding school or children’s home, in order to access a range of services, which would better serve their interests if delivered in the family home with the child attending local education services. A priority in planning must be to balance out the provision of day-care and home-based services for socially vulnerable children and reduce reliance on harmful forms of institutional care.

Based on key findings and conclusions, the report discusses some key indicators that could be drawn upon for monitoring social services delivery and reform in Tajikistan. Specific indicator sets, drawn from international experience, are presented with particular relevance to the key target groups, including older people, children in need of protection and adults and children with disabilities. The report also proposes a minimum suite of services that are likely to be needed in most districts and regions in order to meet the needs of children and adults identified in this study.

Recommendations include:

1. Explicit strategic decisions are required from the government to drive forward towards key outcomes for specific target groups.

2. District and regional service plans for the development of services for adults and children need to be developed. It is likely that the scale and reach of service provision needs to increase to the higher rates recorded in the study and to be spread more or less consistently across all districts, at least for core target groups.

3. Particular attention is drawn to the unavailability of community-based services that can support people with disabilities to live at home but receive appropriate care – respite care services are particularly noted.

4. To aid planning at regional, district and service-specific levels, a pro-active and co-ordinated programme to support sharing of technical know-how, other resources, experience and lesson learning is needed.

5. Performance monitoring frameworks need to consider the rates of service usage proportionate to the relevant target population. Services for children with disabilities, for example, should be monitored in relation to the number of children with disabilities in the given district or region.
6. In addition to collection of data that corresponds to and measures progress in relation to chosen goals, objectives and results/outcomes, administrative data - including management information - needs to be systematically recorded and routinely available to support planning, management and performance monitoring.
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<th>Description</th>
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<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EPC/AWG</td>
<td>Economic Policy Committee/Ageing Population Working Group</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>EU-LFS</td>
<td>EU Labour Force Survey (Eurostat)</td>
</tr>
<tr>
<td>EU-SILC</td>
<td>Community Statistics on Income and Living Conditions (Eurostat)</td>
</tr>
<tr>
<td>GBAO</td>
<td>Gorno-Badakhshanskaya Autonomous Oblast</td>
</tr>
<tr>
<td>GIS</td>
<td>Geographic Information System</td>
</tr>
<tr>
<td>GoT</td>
<td>Government of Tajikistan</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>MLSPP</td>
<td>Ministry of Labour and Social Protection of Population</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>PMPC</td>
<td>Psycho-Medico-Pedagogical Consultation</td>
</tr>
<tr>
<td>RRP</td>
<td>Rayony Respublikanskogo Podchineniya (the region of Tajikistan that includes Dushanbe)</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OPM</td>
<td>Oxford Policy Management</td>
</tr>
<tr>
<td>TJS</td>
<td>Tajik Somoni</td>
</tr>
<tr>
<td>SASPEM</td>
<td>State Agency of Social Protection, Employment and Migration</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nation Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nation Children’s Fund</td>
</tr>
</tbody>
</table>
INTRODUCTION

1.1 Purpose of the research

1.2 Structure of the report
Introduction

1.1 Purpose of the research

This study was designed and carried out with the purpose of better understanding the scope and scale of existing social services provision in Tajikistan and to examine the nature and scale of demand. It aims to analyse the situation, including the experiences of current and potential beneficiaries of social services, and to identify the problems facing priority groups. Finally it makes some suggestions, drawing on international good practice, in relation to what any emerging social services performance measuring system in Tajikistan may need to focus on, depending on the strategic priorities and choices that are made. In the absence of an overarching state strategy for social services in Tajikistan, the intention was that findings from this research could increasing understanding of the existing system among local and international actors and stakeholders and also offer some practical ideas to support developments and reforms going forward.

The research findings draw on a mixture of primary and secondary qualitative and quantitative data obtained through desk-based literature review, extensive field work across the country and consultative work with stakeholders involved in the development of social services in Tajikistan:

1. A review of literature on living conditions and basic public services in Tajikistan;

2. Project-facilitated discussion aiming to define key terms, including ‘vulnerability’, ‘social exclusion’, and ‘social services’;

3. A detailed mapping of social services currently operating in Tajikistan (available in the form of a detailed online database (http://www.mehnat.tj/mapping) ; and

4. A qualitative field work survey to assess current social care service provision and understand unmet needs through engagement with existing and potential social care beneficiaries, as well as representatives of providers.
Drawing on an analysis of the data obtained, this report also makes proposals and suggestions to support the further strategic and operational development of social services in Tajikistan, including recommendations on indicators that could guide strategic and service-level planning, and contribute to monitoring frameworks and systems.

1.2 Structure of the report

This report is presented in five sections:

1. An introduction providing an overview of the purpose of the research.

2. A presentation of the conceptual framework used to guide design, implementation and analysis stages of the research process.

3. An overview and discussion of the methodology used in each component of the overall research.

4. Presentation of qualitative and quantitative data in relation to the nature and scale of demand for and supply of social services in Tajikistan, including the views and experiences of social care services beneficiaries and those who may at some stage become beneficiaries.

5. Analysis of the data and proposals for further development of social services, including potential indicators that could guide planning and monitoring.
2 CONCEPTUAL FRAMEWORK

2.1 Conceptualisation of social services

2.2 Conceptual framework for the analysis
   2.2.1 ‘Forms’ of social service
   2.2.2 ‘Types’ of social service
   2.2.3 Target groups
This section presents the conceptual framework which informed the research design and which also provides a framework for analysis.

2.1 Conceptualisation of social services

The conceptualisation and definition of ‘social services’ is challenging, not only because various models of social provision are applied throughout the world, but also because the term is often used interchangeably with concepts such as ‘basic social services’, ‘essential social services’ (both referring to the provision of services in education, health, including nutrition, reproductive health, and clean water supply and sanitation – at the primary or basic level), as well as ‘welfare’, ‘welfare work’, ‘social care services’, and ‘social work’ (all referring to programmes concerned with overcoming adverse situations that affect individuals, excluding basic health and education).

A graphic presentation of an indicative taxonomy of the social protection system developed by the project (including a framework of major elements of the concept ‘social services’ in broad understanding of this term) is shown in Annex C. Using this framework as a basis social services can be conceptualised in a broad sense, comprising a number of distinctive activities, which complement each other and can sometimes be attributed to several types of services. Social services include the following elements:

- Essential services (civil defence, public utilities, water and sanitation);
- Primary health care (water and sanitation, basic healthcare, mother and child health, health promotion, immunisation, reproductive health, and therapies);
- Social welfare (therapies, social work, social pedagogy, social care, social housing, and justice);
- Justice and policing;
- Education (preschool and school preparation, compulsory schooling, basic vocational training, and career information, guidance, and advice);
- Employment services (career information, guidance, and advice, unemployment support, labour regulation, and public works); and
- Social Assistance (public works, subsidies, concessions, and cash assistance).
Another way of conceptualisation of social services is that social services can be defined by levels of need as follows:

- **For all**: safe water and sanitation, basic primary health-care, social security, shelter, subsidised basic foods, social assistance, basic education, basic vocational training, employment, justice and security, transport, civil defence, and recreation.

- **For vulnerable groups**: support in accessing universal services, inclusion.

- **For those with complex needs**: protection from abuse for children, older people and those with disabilities; social-care, habilitation and rehabilitation, integration and re-integration, support in accessing universal services.

- **For those in emergency situations or in crisis**: care and protection; re-integration, habilitation and rehabilitation.

In Tajikistan, the conceptualisation of social services has been undergoing significant transformation from the Soviet system to a Tajikistan-specific system of social service provision, which is congruent with its historical, political, cultural, social, economic context and sustainably affordable from within its national resource base.
Social Services in the Republic of Tajikistan

The legislative definition of social services is provided by Law № 359 of 2008 ‘On Social Services’. It defines social services as a set of activities related to social support, provision of social-household, socio-medical, psychological-pedagogical, social-legal, other services and material assistance, social adaptation and rehabilitation of persons in difficult life situations. ‘Difficult life situations’ are regarded as ‘those situations objectively preventing normal activities of a person or the situation that the person cannot overcome independently’, such as:

- disability, old age or illness;
- effects of work related injury or professional disease;
- loss of breadwinner, loneliness, orphanage, absence of care;
- lack of permanent residence;
- permanent psychiatric dependence, outcome of violence or situations related to high-risk; and
- other difficult situations.

There are three key terms defined in the Law on Social Services which all translate into English as ‘social services’. Here we offer slightly differentiated translations to support a better understanding and analysis of the legislative framework within which social services are organised in Tajikistan:

1. **Sotsialnoe obsluzhivanie** - this is the term used in the title of this piece of legislation and can be taken to mean the system of planning, delivering and managing social services as a whole. ‘Social service provision’ could be a more accurate translation.

2. **Sotsialnaya sluzhba** - this term is used to describe the organisation that delivers the social services regardless of whether it is a state, private or non-profit organisation or an individual entrepreneur. This is probably closest to the term ‘social services’ used, for example, in the UK. For the purposes of clarity, it is proposed to use the translation ‘social service provider(s)’ in relation to this term.

3. **Sotsialnie uslugi** – the types of activities or work undertaken to support the individual service users. The definition in the legislation goes on to clarify that these activities aim to ‘meet the needs of citizens, are undertaken in their interests, to provide help in difficult life situations or as prevention of difficult life situations’. This term also translates as ‘social services’ but is more a denotation of a classification of specific types of activities or work undertaken by the social service organisations with clients. It is probably most useful to use the term ‘type of social welfare services’ in English as described in section 2.2.2.
As already noted the law provides for social services (sotsialnyie uslugi) to be delivered by social service providers in the following forms:

- Social services in the home
- Social services in residential care institutions
- Social services in day care facilities

A definition of ‘social services’ based on the current legislative and policy framework of the Republic of Tajikistan is proposed for use in this analysis and as a foundation for the conclusions and recommendations of this report:

"Social services are services that support citizens of Tajikistan who are living in difficult life circumstances to overcome the barriers that prevent them living a normal life."

The meaning of ‘support’ and ‘normal’ in this definition require further elaboration but, broadly speaking, this definition distinguishes between the types of social services examined, for example, in the indicative taxonomy (Annex C) and ‘social services’ as they are commonly understood in international social work practice. Social services in this definition include social care services and some forms of social support and protection – those that are addressing special needs rather than universal needs. The definition of ‘social services’ used in this report fits into the ‘social welfare’ band of the taxonomy and specifically to the interventions: therapies, social work, social pedagogy and social care. This helps to distinguish ‘social services’ from ‘social assistance’, ‘social security’ and other social protection measures. This analysis focuses on services, which are aimed at citizens with varying degrees of special needs for support and protection and are not universal services such as education, health and water and sanitation.

### 2.2 Conceptual framework for the analysis

Reforming social services provision and developing a new system of social welfare services is a challenging undertaking in any country. This is particularly true for Tajikistan, which in the last two decades has witnessed not only changing political and administrative structures, but also shifting societal norms and beliefs, including the understanding of vulnerable groups and the role of the state in supporting such groups. A common understanding of various terms and concepts relevant to social services is therefore key to developing a clear understanding of the needs and expectations within the society and a strong vision of the desired system going forward.
This study examines services using three dimensions that are based on the language and terms used in the Law on Social Services of 2008:

1. **Where are services offered?** This uses the concept of the ‘forms’ of service (in Russian ‘formy’) outlined in the Law on Social Services, 2008\(^2\).

2. **What services do they offer?** This uses the concept of the ‘types’ of service (‘vidy’) identified in the draft byelaw on the further development of the system of social services for the population (currently under discussion)\(^3\).

3. **To whom are the services offered?** This uses the concept of priority groups developed in the discussion papers on vulnerability and social exclusion.

### 2.2.1. ‘Forms’ of social service

The Law on Social Services defines three forms of social services:

- Social services in the home
- Social services in residential care institutions
- Social services in day care facilities

This categorisation was used as the basis for preliminary collection and systematisation of data for the mapping component. However, in designing the beneficiary assessment component, a modified approach to classifying services was developed for the purposes of analysis. Based around the length of time a services user spends away from their home, a continuum comprising five forms of social services was identified and used in the study:

- home care services
- community services
- day care services
- temporary residential services
- residential services

Applying this approach serves two purposes. First of all, it helps to better conceptualise the term “community-based social services” which is commonly used in Tajikistan but which has not been clearly defined. Secondly, it provides a more helpful basis for studying peoples’ experiences, views and perceptions in relation to the different service forms.
2.2.2. ‘Types’ of social service

A type of social welfare service categorises the activities delivered by service providers, regardless of what form of service they offer. Drawing on existing legislation (Law on Social Services) the following five types of services were proposed for exploration:

- **Support for day-to-day living**: examples might include support a person to carry out basic activities such as getting up and going to bed, dressing, washing, using the toilet, buying food, eating, moving around inside and outside the home, writing letters and paying bills.

- **Socio-medical care**: aimed at supporting the health of social welfare service users. This could include offering help to access health services to which people are entitled; prostheses, glasses, hearing aids and orthopaedic devices; rehabilitation following chronic illness or disability; support to undertake physical exercise; and advice to relatives on how to take care of family members who are ill.

- **Psychosocial support**: including counselling, therapies, and the promotion of social activities to reduce isolation.

- **Socio-pedagogical services**: for example the provision of appropriate education for children with disabilities; activities to help people acquire professional skills; vocational training for teenagers; teaching of sign language; organising cultural events.
Social Services in the Republic of Tajikistan

- **Socio-legal services:** relating to the protection of a person’s rights and interests, for example helping people to understand what services they are entitled to, to obtain relevant documentation, to gain access to financial support including social assistance, pensions and alimony, representation in court or assistance with arranging guardianship of children.

2.2.3. **Target groups**

In order to understand the current situation in social service provision in Tajikistan, the research considered the situation of a number of target groups which display a high level of vulnerability and complex need. The vulnerable groups that are the focus of the research were selected from those identified in the Law on Social Services and from the list of current service users identified during the mapping exercise; these were clustered into a smaller number of groups, each sharing some common features.

The groups were clustered by the following criteria:

1. **Age.** Children and young people have different needs to adults. Among adults, older people may have a different set of needs to those of younger adults. For the purposes of this analysis, a child has been defined as 0-14 years of age given the constraints of available data (under 15 years of age). Where other data sets have been used (e.g. for young people aged 15-19) this has been indicated. Older people have been defined as aged over 60 years.

2. **Functional disorders.** People with a physical or mental disability can have special needs which require a highly individualised and differentiated response. Not all people with disabilities require the same responses from social services. Some people have disabilities from birth; others acquire disabilities through the process of aging or through accidents or emergencies.

3. **Social and economic situation.** Amongst vulnerabilities other than disability there is a wide variety of social and economic issues including: drug addiction, homelessness, family difficulties such as violence, abandonment and the status of second wives, health issues such as HIV/AIDs, and legal issues including those affecting people who have been in conflict with the law.

Where data permits, the situation of these groups have been analysed in more detail. The beneficiary consultation covered individuals from all of these groups (or their caregivers, in the case of children). It also covered professionals who work with these groups.
3 METHODOLOGY

3.1 Methodological approach
   3.1.1. Desk based situation analysis
   3.1.2. Social welfare services mapping
   3.1.3. Beneficiary needs assessment

3.2 Data limitations
3 Methodology

3.1 Methodological approach

The methodology for this study was driven by the need to understand the scope and scale of social service provision in Tajikistan and to examine the nature of the demand for, and supply of, social welfare services. Consequently, this study used a range of tools for data collection and analysis.

This study comprised four key components:

1. **Situation analysis** reviewing and analysing secondary data, from a range of sources, on living conditions and access to basic services in Tajikistan.

2. **Project-facilitated consultation and discussion** aiming to define key terms, including ‘vulnerability’, ‘social exclusion’, and ‘social services’.

3. **Comprehensive mapping of social welfare services across Tajikistan.** A census-type survey of all social welfare services provided by government and non-governmental organisations. Data on both inputs and outputs (e.g. number of staff trained, number and type of services provided, number of beneficiaries of services, etc.) was collected.

4. **Consultative beneficiary assessment.** A qualitative assessment based on household interviews, focus groups and interviews with key informants, selected using a purposive sampling method. The assessment collected information on the overall experience of social services users, looked at the needs of individuals and the communities in which they live and explored the extent to which respondents believe existing social care services address those needs.
3.1.1. Desk based situation analysis

This initial stage of the study focused on analysis of the socio-economic situation in Tajikistan including a broad poverty analysis and an overview assessment of the delivery of essential and basic public services as described in the Indicative Taxonomy of Social Protection (Annex C), including health, education, public transport, water and sanitation, and public utilities including electricity and gas. This involved reviewing a wide range of literature (including unpublished ‘grey’ literature) as well as statistical data and other materials available from government and other sources including international organisations and both international and local non-governmental organisations. Although some of the analysis from this stage of the study has been incorporated into the main body of the report, some of the material is provided in annexes and on the accompanying CD.

3.1.2. Social welfare services mapping

A comprehensive mapping of social welfare services currently being delivered across Tajikistan was carried out through a census-type survey between April and September 2011 with final amendments and updates completed in June 2012. The aim of the exercise was to identify currently available social services providers, vulnerable groups receiving services, the geographical distribution of
service provision and determine the capacity\(^4\) of the overall system of service provision in relation to the potential demand for services. This extensive exercise essentially represents an audit of social services currently operating and available in Tajikistan and acts as a benchmark in order to make a gap analysis possible.

The output of this component of the research – a comprehensive database of existing services - is a useful and practical resource in itself that can support social services planning, delivery and monitoring. Notably, it can be a useful tool to aid decision-makers in the MLSPP. The database and report provides new and useful data for general use by service providers, donors and any other actors with an interest in the process of social services development in Tajikistan.

A baseline service-mapping questionnaire was distributed by post to all district administrations in Tajikistan. The questionnaire asked for baseline data concerning social welfare services for all vulnerable groups operating at district level. In addition to the questionnaire sent to local authorities, service providers were subsequently visited by the project team. In addition to the questionnaires and field visits to service providers, consultations were held with SASPEM and local authorities.

In total, interviews were held with 235 service providers in 62 districts, being delivered by local government and NGOs. Information about services under the management of the Ministry of Education and Ministry of Health were kindly submitted by the staff of the relevant Ministries and UNICEF. Additional data for the database was collected from a variety of sources including service directories, planning documents and previous mapping exercises of other organizations.

The data collected included:

- Name and address of the service provider
- Location under the administrative divisions of Tajikistan (Dushanbe, GBAO, Khatlon and Sugd oblasts and RRP)
- Forms and types of services being provided\(^5\)
- Types of beneficiaries receiving services in 2010
- Beneficiaries’ region of origin
- Number of staff
- Service capacity (maximum number of beneficiaries that could be enrolled in each service at the same time)
- Sources of financing

Initial analysis revealed significant inaccuracy in the data supplied. To improve accuracy, follow-up visits were made to each of the service providers which focused on a review of beneficiary lists.
The services listed for each rayon were categorised into the following forms in-line with domestic legislation (see also section 2.2 conceptual framework):

- Social welfare services in the home (Home care)
- Social welfare services in residential facilities
  - Long-term social welfare services in residential-care institutions (more than 3 months)
  - Temporary social welfare services in residential-care institutions (less than 3 months)
- Social welfare services in day-care centres (day care services)

Services which did not meet the definitions of this categorisation were removed and gaps in the data provided were highlighted. This approach to categorisation allowed meaningful comparison to be made between the districts in terms of coverage and capacity of existing social services provision.

Based on the statistics and information collected, a comprehensive database of available services was created. This database, including the details of 235 social welfare service providers, offers the most comprehensive single source of information about social services provision in Tajikistan at the time of writing.

A special module of the MLSPP website was developed as a platform to disseminate the information collected and an electronic directory was designed. Visualization of the service maps was carried out using a geographic information system (GIS) and put online (http://www.mehnat.tj/mapping).

3.1.3. Beneficiary needs assessment

The beneficiary assessment was carried out using interviews and focus group discussions in order to obtain specific information on the types of services that exist, the activities they offer, the quality of services delivered and ease of access to the services. It compares this with the views of service providers as well as households on what they need, with the aim of judging the extent to which the current supply of services matches demand.

Qualitative research is a useful method to gain an insight into local views on vulnerability and to explore in depth the specific experiences different people in relation to accessing and using social services. It offers an opportunity to hear in detail the opinions of people who may not usually speak in formal arenas. This is particularly important given that people using or in need of social care services do not always manage to get their voices heard. The qualitative data was complemented by the collection of a small amount of quantitative data, mainly in the form of scorecards on respondents’ perception of their own well-being, to provide better insight into how people view their own needs in relation to others.
The methodology for the fieldwork entailed identifying beneficiaries of social services and professionals working in the social sector who interact with these people, either as social service providers or in another capacity such as family doctors and teachers. Nine research sites were then selected to maximise the range of vulnerable groups and social service providers for interview. A set of instruments was designed to ensure consistency of research across all locations and the local fieldwork research team was trained and supervised both beforehand and in the field.

As discussed in some detail during the design of the research methodology, although this type of qualitative research generates valuable diagnostic material it does not make claims of statistical representativeness as it was conducted in nine locations in Tajikistan. However, through careful selection of the districts (in Tajik ‘nohiya’; in Russian ‘rayon’) to cover all four regions (in Tajik ‘viloyat’; in Russian ‘oblast’), and also large cities, smaller towns and rural areas, it has generated credible indicative findings on vulnerability and the demand for, and supply of, social services.

Following extensive consultation with the EU it was agreed that the beneficiary assessment would be carried out in all four regions of Tajikistan, covering two locations in each region, plus the capital, Dushanbe. The locations were selected to maximise the range of experiences that could be captured. This meant selecting locations of different sizes and levels of urbanisation, but also some locations where social services were not yet strongly developed and others where there were already many different services. All districts had at least one service provider, the home care department for older people and people with disabilities, which is present throughout the country. Most districts also had day care or residential facilities targeted at some of the vulnerable groups.

<table>
<thead>
<tr>
<th>Region</th>
<th>District</th>
<th>Characteristics</th>
<th>Extent of social services</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRP</td>
<td>Dushanbe</td>
<td>Urban, large (capital)</td>
<td>Very high</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Hisor</td>
<td>Urban, medium</td>
<td>Low</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Rudaki</td>
<td>Rural</td>
<td>Low</td>
<td>3</td>
</tr>
<tr>
<td>Soghd</td>
<td>Khujand</td>
<td>Urban (centre of region)</td>
<td>High</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Konibodom</td>
<td>Rural</td>
<td>Low</td>
<td>1</td>
</tr>
<tr>
<td>Khatlon</td>
<td>Kurgan-Tyube</td>
<td>Urban (centre of region)</td>
<td>Medium</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Danghara</td>
<td>Rural</td>
<td>Low</td>
<td>1</td>
</tr>
<tr>
<td>GBAO</td>
<td>Khorugh</td>
<td>Urban (centre of region)</td>
<td>High</td>
<td>12</td>
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<tr>
<td></td>
<td>Rushon</td>
<td>Rural</td>
<td>Low</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: OPM
Four types of data collection instrument were designed and used in the beneficiary consultation (available on accompanying CD), each of which included questions tailored to particular groups of respondents (Table 3.2):

1. **Household interview.** Interviews were held with 45 beneficiaries of services and 53 non-beneficiaries, drawn from a wide range of vulnerable groups.

2. **Key informant interview.** Some 48 key informant interviews were conducted with representatives of local authorities at the town, rayon or regional level; family doctors; teachers; and providers of both government-run and non-governmental social services.

3. **Focus group discussion.** In each rayon one focus group was conducted with beneficiaries and one with non-beneficiaries. This format allowed for an exchange of ideas among participants which was not possible with the household interview. It also allowed a space for people to talk openly and in confidence away from their homes which reduced the possibility that their answers were influenced by the presence of other family members or neighbours.

4. **Scorecard.** These were used to provide a quantitative assessment of people’s perception of their own well-being in comparison to other households in their area and nationally. Each respondent of the household interview completed a scorecard.

<table>
<thead>
<tr>
<th>Region</th>
<th>District</th>
<th>Interview</th>
<th>Focus group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Key informant</td>
<td>Beneficiary</td>
</tr>
<tr>
<td>RRP</td>
<td>Dushanbe</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Hisor</td>
<td>6</td>
<td>6</td>
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<td></td>
<td>Rudaki</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Soghd</td>
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<td>Khatlon</td>
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<td>7</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Danghara</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>GBAO</td>
<td>Khorough</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Rushon</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>48</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Source: OPM. Note: Interviews in Rudaki were added as a substitute for information that was unavailable in Hisor.
3.2 Data limitations

Primary data presented in this report was collected by the research team during the mapping exercise and the beneficiary assessment. Secondary data that informed the preliminary desk-based situation analysis drew on a range of published and ‘grey’ literature as well as on data made available from official sources. It should be noted however that almost all reports examining the situation prevailing in Tajikistan express concern about the reliability of the secondary data available and mention the absence or poor quality of data as a major concern. Significant under-reporting of demographic events exists because of deficiencies in the civil registration system\textsuperscript{6}. There appear to be data inconsistencies between the Statistical Agency and ministries, as well as between central authorities and regions. Moreover, contradictions arise not only between public institutions that collect statistical and administrative data, but also between this data and surveys carried out by independent organisations.

The absence and inconsistency of data make it difficult to analyse the situation and quantify issues. For example, there is an absence of data on services for children with disabilities. The basic demographic data for children available through the official statistics agency Tajstat provides population data for 0-19 year olds with sub-groups of 0-4 year olds, 5-14 year olds and 15-19 year olds. UNICEF monitoring focuses on 0-17 year olds (those who have not yet turned 18 years of age) as this is the internationally recognized definition of a ‘child’ under the United Nations Convention on the Rights of the Child. This means that it is not always possible to compare data on children provided by Tajstat with other international data sets, although this kind of bench-marking can often be useful. Some data is available for the country as a whole, but not disaggregated for each region. Under these circumstances, it is difficult to draw definite conclusions across the available data-sets and provide tailored and detailed recommendations on each vulnerable group. It is possible however to draw broad conclusions and identify trends and patterns that can help to inform the development of a possible set of indicators as well as the planning and implementation of social services system development in the future.

Having sourced and cross-referenced information from a wide range of source, the research team believe they covered all existing social services in Tajikistan during the mapping exercise. However it would be wrong to guarantee that the mapping is 100% accurate at the time of publication, either because some services may have been invisible in information sources and have missed or because, since the data was collected, some services may have closed (or new ones opened).

4.1 Estimating demand - what is needed, where and for whom?
4.1.1 Regional demand for services among adults and children – estimates of variations
4.1.2 Meeting basic needs – beneficiary perceptions on demand for services
4.1.3 Estimating the extent of demand for social welfare services – key considerations

4.2 Provision of social services – meeting demand
4.2.1 Distribution of service provision by beneficiary type and region
4.2.2 Distribution of different forms of service provision by region
4.2.3 How different forms of social services are used in relation to beneficiary categories in each region
4.2.4 Reach, coverage and accessibility of social services across districts
4.2.5 Strategies for coping with excess demand for social welfare services
4.2.6 Eligibility for receipt of services
4.2.7 Availability of information about social services and referral systems
4.2.8 Experiences of applying for social services
4.2.9 Beneficiaries’ perception of the quality of services
Social welfare services – estimated demand and current patterns in supply

As discussed in Section 2.2, social services are defined in the legislation of the Republic of Tajikistan as those services which support citizens of Tajikistan who are living in difficult life circumstances to overcome the barriers that prevent them living a normal life. The term ‘social services’ is used in relation to provision of services for those with emergency needs, complex needs or from vulnerable groups and can also be categorised as ‘social welfare services’ including therapies, social work, social pedagogy and social care activities in line with the indicative Taxonomy of Social Protection (Annex C).

The development of social services provision has had little strategic orientation in recent years but has emerged as a legacy of the soviet system; new developments have largely been driven by government, donor, and non-governmental responses, often opportunistically, to the specific needs of different vulnerable groups. This has led to significant variations in the kinds of services being provided, their quality, duration, and geographical coverage. Moreover, data and knowledge about these services is limited, as the government system of monitoring the provision of social services requires development and there is little consolidated information available about social services established and operated by non-state actors.

4.1 Estimating demand - what is needed, where and for whom?

This section reviews the demographic data in each region of the country which is relevant to the target beneficiaries of the system of social services provision and offers a ‘ball-park’ estimate of the demand for social services. This estimate is further refined through insights gained from the consultation with beneficiaries and potential beneficiaries of the system. In the following section, actual patterns of meeting this demand are reviewed through a detailed analysis of current social services provision based on the mapping exercise and the beneficiary consultation.

The mapping of services identified 18 categories of service beneficiary and a 19th category ‘families of service beneficiaries’.
For the purposes of this analysis, discussion of services and existing/potential beneficiaries is being organised as far as possible under two headings:

1. Beneficiaries of children’s services; and
2. Beneficiaries of adult’s services:

While there may be some adults benefiting from ‘children’s services’ – for example the parents, grand-parents or older siblings of ‘socially vulnerably families and their children,’ ‘children with disabilities’ and ‘children without parental care’ – the services are mainly aimed towards achieving results for the child beneficiaries. Similarly, where there may be children benefiting from adult services – for example ‘victims of domestic violence’ – again, the services are aimed mainly at achieving outcomes for adults.

<table>
<thead>
<tr>
<th>Beneficiaries of children’s services</th>
<th>Beneficiaries of adult services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children without parental care</td>
<td>Victims of domestic violence</td>
</tr>
<tr>
<td>Child-orphans</td>
<td>Adults with disabilities</td>
</tr>
<tr>
<td>Children with disabilities</td>
<td>Adults living with HIV</td>
</tr>
<tr>
<td>Children in conflict with the law</td>
<td>Intravenous drug users</td>
</tr>
<tr>
<td>Street children and working children</td>
<td>Homeless people</td>
</tr>
<tr>
<td>Girl children – victims of violence,</td>
<td>Sex workers</td>
</tr>
<tr>
<td>exploitation and trafficking</td>
<td></td>
</tr>
<tr>
<td>Care leavers from children's</td>
<td>Ex-offenders</td>
</tr>
<tr>
<td>institutions</td>
<td></td>
</tr>
<tr>
<td>Child users of intravenous drugs</td>
<td>Older people without family support</td>
</tr>
<tr>
<td>Children living with HIV</td>
<td></td>
</tr>
<tr>
<td>Socially vulnerable families and their children</td>
<td></td>
</tr>
</tbody>
</table>

Source: OPM

4.1.1. Regional demand for services among adults and children – estimates of variations beneficiary needs assessment

Ideally, for the purposes of determining demand for services in each district and in each region of the country, a detailed statistical breakdown of the numbers of each category of existing and potential beneficiaries is required. The data that is currently available from Tajstat and other sources such as UNDP and UNICEF is not always detailed enough to allow for a detailed analysis at district and regional level as it is mainly aggregated at the national level.
Often, only broad conclusions can be drawn based on national data sets for some vulnerable groups. These conclusions, however, when triangulated with the detailed records of service usage documented by the mapping exercise and the beneficiary consultation, help to identify gaps or weaknesses in service provision as well as areas where service provision may be at adequate levels.

In assessing this first broad estimate of demand, data sets have been used that permit at least some examination of potential demand in each geographic region of the country. For example, it is assumed that children under 15 and older people over 60 years of age are potential users of the social welfare services. Similarly, people who receive different pensions may be more likely to be vulnerable and therefore more likely to be in need of social services. Where regional breakdowns of population sub-groups (e.g. adult/child intravenous drug-users, children/adults living with HIV, children with disabilities) have not been available, it has been possible to reach a reasonable estimate of demand, by focusing more on the actual supply of services being delivered to these groups as recorded in the mapping exercise documenting service usage in 2010 as well as broader national level indicators.

GBAO has a slightly higher proportion of people aged over 60 years of age than other regions and a noticeably lower proportion of children under the age of 15. Otherwise the proportions for each region are largely uniform and as a basis for planning, each region can expect to plan for similar proportions of its population to require child or adult services. However the overall population sizes of the regions differ significantly as can be seen in Figure 4.2.

**Figure 4.1** Proportions of population (aged over 60 or under 15 years of age) in each region and proportion of pensions’ recipients, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Benefits recipients % of whole population</th>
<th>Elderly population % of adult population</th>
<th>Child population % of whole population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tajikistan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khatlon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sugd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RRP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GBAO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dushanbe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: OPM, Tajstat, 2010b and author’s calculations
The data in Figure 4.1 suggests that each region requires a similar proportion of basic services for adults, children and older people (i.e. does not need to consider a vastly different balance between children's and adult's services), but the population data in Figure 4.2 highlights the extent to which the scale and reach of delivery has to vary in each region in order to ensure accessibility of services to much larger numbers of each population group. Khatlon, as the most populated region is almost certainly going to need to plan for a higher volume of service provision by a larger number of service providers than GBAO or Dushanbe, for example, in order to provide for a larger number of potential beneficiaries. Currently, the mapping exercise has shown, however, that there is approximately the same number of service providers in each region (see Table 4.2). Whereas GBAO and Dushanbe appear to have above-average rates of service users per 100,000 population, the more populated regions appear to be significantly under-provided with social services.

![Figure 4.2](image)

**Figure 4.2** Actual numbers of each population group in each region in 2010

<table>
<thead>
<tr>
<th>Region</th>
<th>No of service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dushanbe</td>
<td>50</td>
</tr>
<tr>
<td>GBAO</td>
<td>48</td>
</tr>
<tr>
<td>Khatlon</td>
<td>59</td>
</tr>
<tr>
<td>Sugd</td>
<td>56</td>
</tr>
<tr>
<td>RRP</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: OPM, Tajstat, 2010b and author’s calculations
Estimating regional demand for adult and child disability services

Lack of available disaggregated data on specific beneficiary groups does not permit detailed analysis of potential demand for services for each group in each region. One group about which it is possible to draw conclusions from readily available official data is people with disabilities. Disability data provided by MLSPP in Tajstat reports gives an overall number of disability pension recipients in the country but does not disaggregate children from adults or give a breakdown by region.

The estimates of numbers of recipients of disability pension in Figure 4.3 are based on Tajstat data which states that 92,900 people received pension from the state in 2008, which is 17% of state disability pension recipients in Tajikistan as a whole (Tajstat 2010b). In order to understand how many disability pension recipients there are in each region an assumption is being made, for the purposes of this analysis, that the variations in distribution of the population of older people who are over 60 years of age are most likely to match the patterns of distribution of recipients of disability pension. A percentage of the overall number of disability pension recipients in each region (also Tajstat, 2010b) has been adjusted to take into account the regional variations in the population of older people. In Sugd and GBAO, for example, an additional 1% and 2% of disability pension recipients were added respectively to the national average of 17% in order to reflect variations in the population over 60 years of age.

![Figure 4.3](image-url)
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Estimating demand for children’s services

Data on child protection is gathered regularly by the UNICEF TransMonee database and can be used to track some key relevant indicators linked to social services provision for children. The population data in Figure 4.2 indicates that the distribution of children in each region is roughly the same, with GBAO being the only region with a slightly smaller proportion of children between 0-14 years of age among its population as compared to other regions. An assumption can be made, therefore, that children without parental care, children in formal care (residential or family-based) and children with disabilities are relatively evenly distributed across the whole country, at least at the point before they entered the care of the state if they are without parental care.

Figure 4.4 Number and rate of children aged 0-17 years in formal care in Tajikistan in 2010

<table>
<thead>
<tr>
<th>Of which:</th>
<th>Per 100,000 child population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children in care</td>
<td>In residential care</td>
</tr>
<tr>
<td>15,104</td>
<td>11,156</td>
</tr>
</tbody>
</table>


TransMonee records that of the 11,156 children in residential care in Tajikistan in 2010, 1,744 were children with disabilities. Official government records (Tajstat, 2010a) state that 467 young people committed crimes in 2008. Transmonee also gives a figure of 467 juvenile offenders in 2008, 415 in 2009 and 374 in 2010. 610 young people were recorded as being in correctional facilities at the end of the year in 2010.

Overall around 15,000 children (471 per 100,000 child population) are in formal care nationwide. Some of these children are living in family type care. Others are in long-term residential care but may actually need to be living in their families with home-based and day-care forms of service provision available locally. This level of demand is probably the absolute minimum that can be estimated as it does not include children with disabilities or children who are from socially at risk families that are living in their families and in need of home-based and day care forms of service provision.
Estimating demand for social services for people with HIV/AIDS

Apart from adults with disabilities and older people mentioned above in the context of regional estimates for adult social services, people living with HIV/AIDS are a growing group of vulnerable young people and adults in need of day-care and home-based forms of social services. TransMonee records a cumulative total of 2,857 cases of HIV since 1998 of which 1,004 new cases among both adults and children were recorded in 2010, which is more than double the number of new cases recorded in 2009. The UNDP report on Tajikistan’s progress towards meeting the MDGs (UNDP, 2010) indicates that as at 1 June 2010, 2,204 people were living with HIV/AIDS across the whole country.

The focus of most HIV/AIDS programmes has been on raising awareness and Tajstat, as well as UNDP, monitor levels of awareness. A Tajstat report from 2010 (Tajstat, 2010a) states that 68.5% of the population aged 15-49 years in 2007 were aware of HIV/AIDS, but only 52.8% of women in RRP were aware of HIV/AIDS and over 50% of women in the same region did not know of one main method for preventing HIV infection. The UNDP MDG progress report states that progress in extending coverage of prevention programmes to vulnerable groups, mainly injecting drug-users and sex-workers, is slow due to difficulties in accessing these groups and stigma and discrimination against them. The same report also mentions low levels of knowledge of HIV/AIDS as a particular challenge in prevention work.

This data on HIV/AIDS programmes and services indicates that the level of demand for services by people living with HIV/AIDS is currently at around 3000 cases across the whole country and the rate of increase is high with 1/3 of these cases having been recorded in 2010. The data also indicates that prevention work has not been effective with low awareness among some population groups and some regions and with slow progress among those most at risk. Level of demand can therefore be expected to increase in the coming years by at least 1000 cases per year unless the awareness raising and prevention programmes become effective and start to have an impact on the infection rate.

4.1.2 Meeting basic needs – beneficiary perceptions on demand for services

Needs reported by respondents in the beneficiary consultation differ very little across the regions but are quite distinct for specific groups.

There is low awareness of social services generally and the types and forms of social services that are currently available in the country. Awareness is, understandably, higher among those who are recipients of social services.
Most respondents understood social services to be essential universal services housing, transport, education, health care and utilities or cash assistance and other types of income support. In other words beneficiaries tend to consider social services in the broad understanding of this term as reflected in the indicative Taxonomy of Social Protection (Annex C).

Most issues relating to demand for social services as defined by this study were identified by the people who use existing social services most intensively and can be summarised as:

1. Support with income maximization for all groups with low income whether through help in claiming social cash assistance or income generating activities

2. Access to healthcare services - especially for those with disabilities. ‘Access’ refers to provision of information about health services, transport to and healthcare facilities, payment for health care services and physical access to facilities

3. Access to special means of transportation; special equipment, prosthesis and other adaptive technology for children and adults with disabilities; speech therapy, occupational therapy and physiotherapy

4. Help with obtaining documents, information on available social services, legal advice on housing and other key issues

5. Programmes to facilitate social inclusion and reduce isolation including opportunities for socialising with other members of the community; meeting other people; taking part in social activities that offer opportunities for communication

Children with disabilities require additional help and support to access education services which permit them to remain at home with their families in their own communities and do not require them to be placed in residential facilities.

Children from poor households require support with nutrition and meeting basic needs for clothing, housing and education supplies that are not provided in an institutional setting. Parents of children from poor households require training and support to find employment.

In general, material needs prevail and respondents rarely mention services or other kinds of support. Service beneficiaries – those who know what a social service is and also have more information on potential services - formulated their needs in a way that could be met through social services.
For example, caregivers of children who go to a day care centre were able to formulate needs (transportation, psychological support) and identify ways of meeting these needs (specialised transportation, wheelchairs, specialist to work with the child, speech therapist). Non-beneficiaries, who have hardly heard about social services, expressed a need for cash assistance or material support. In the case of the latter, the requests are not for cash; rather for food, medicine and medical equipment, compensation for electricity and transportation.

When asked who should provide support, the respondents considered in the first place the authorities, the non-governmental organisations (NGOs), and rich people in the region. When asked who provides the support in reality, everyone answered that they rely on relatives. Overall, the most pressing needs identified by beneficiaries and potential beneficiaries are nutrition, health care, housing and land, electricity and water, and transportation.

"Our main concerns and fears for the future are: fear of living on the streets, of losing our health, fear that we will not be able to provide education for children, to have a wedding for our children, we are afraid of the end of the world, but most of all we are afraid of winter."

FGD, Non-beneficiaries, Khujand

The needs of people with disabilities

One of the groups reported by many as being in need of social services is people with disabilities. Support is required, in the first place, for obtaining relevant and good quality medical assistance. Overall, respondents expressed dissatisfaction with both the quality and costs of the medical services. Even family doctors confirmed that the services for this group are not provided on a regular basis and few can afford the required treatment. In addition to medical services, the respondents asked for drugs, nappies, and special means of transport. Provision of special equipment and prosthesis was also mentioned. A few respondents stated they were provided the equipment by some international organisations.

"Our main difficulty is to get the treatment. If they could provide medical services that would be very good. We can’t find money to buy drugs. Medicine is very expensive and not affordable for us."

Caregiver, disabled child, beneficiary, Hissor

"My son has been bedridden for 12 years. It would be good if we could give him the opportunity to go out, but we will need a special wheelchair for this, and we have no means."

Caregiver disabled child, beneficiary, Hissor
The need for rehabilitation services was also mentioned. Some caregivers asked for services such as speech therapy, massage, reflexology and physiotherapy. While these services are available at the community level in a small number of areas they are not geographically widespread and the only alternative is residential care. But in many cases, relatives do not want to place members of the family with a disability in residential institutions. Some respondents said that they had to move from their district of origin in order to have access to these services (such as to Hissor to receive services from the Oftobak centre for children with disabilities); the family is still on the waiting list.

“There is a hospital for mentally ill people. My brother went there two or three times. It is very cold. It is terrible to look at patients who are there. The services do not meet the needs of patients. We went to visit him and he was crying and asked us to take him back home, otherwise he would die there.”

Caregiver of a disabled adult, former beneficiary of residential care, Khorugh

“My child needs treatment. When I go to the Child Rights Department I am told to place her in the special school. I believe the child should stay home with the parents.”

Caregiver of a child with disability, Beneficiary, Dushanbe

Apart from treatment and rehabilitation, this group also needs help with obtaining documents, information on available social services, and programmes to facilitate their social inclusion.

“I don’t know a single person with a disability in Khorugh who has married; this is a taboo in Tajikistan. We do not communicate with each other, we are all locked at home, no one sees us, we have no personal life.”

Disabled adult, non-beneficiary, Khorugh

Another concern expressed especially by parents of children with disabilities is the lack of education services within the community. Their concerns are, above all, about the future of these children, when they will not be able to take care of them, given that the state does not provide sufficient social protection. The limited efforts undertaken to provide inclusive education have had mixed success. A mother from Khorugh district indicated that neither the school, nor the child were ready for this experience.

The research reveals that caregivers of people with disabilities need social services as well. These refer to counselling, information and help to obtain social cash assistance, training about how to correctly care for the disabled people, and support in facilitating communication with other families with similar situations.
The needs of older people

In Tajikistan it is traditional in many communities for the younger generation to be expected to take care of older family members. Key informants mentioned that there are not so many lone older people (except for in Dushanbe) without family support. Still, there are lone older people, some of Russian nationality whose families have returned to Russia, who need social services. Some of this group receive home care social services, but not all those in need receive the service and not all needs are covered through the service.

A social service provider in Dushanbe mentioned that “almost every older person needs to buy food, medicine, to wash and clean the house. They need help with these activities because this requires strength and they are old”. A social service provider in Kurgan-Tyube believes that this group requires multiple services like medical care, and assistance with applying for medical care. To help them receive their pension, they should first be aided to obtain passports and confirmation of residence, likewise for residential care applications. Older people did confirm most of these needs: they need somebody to take care of them, help to take a bath, help “with papers and documents”, or help them apply for pensions or cash assistance. Many older people expressed the need for social interaction.

Another concern that the older people have is “being safe and protected”. They fear being abused, robbed, or becoming victims of apartment thieves. To deal with these threats, they ask for help from the militsia and local authorities.

Older people asked for legal assistance in matters related to inheritance, housing and documents to apply for cash assistance.

“I’m afraid that if I die my grandchildren will remain in the street, since my other daughter-in-law secretly and illegally registered my apartment in her name. After my death she can take this apartment from them. My granddaughter is sick, she has liver problems.”

Older person, Non-beneficiary, Kurgan-Tyube

The needs of vulnerable women

Vulnerable women represent another group in need of social services. These include women abused by husbands, brothers or mothers-in law, abandoned wives, widows, divorced women, wives of migrants, wives of ex-convicts, of drug users, second wives, mothers of children with disabilities, and other women in difficult situations. Their needs refer mainly to legal support, counselling, psychological support, emergency shelter, support with finding employment, and adult education programmes.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Most of the women-headed households who participated in the research consider themselves poor and asked for financial support, food and medicine. Since women feel they have no possibility to earn money for their families, children may be obliged to work.

“My two sons are working after school as porters. We survive mainly on their income. We can’t afford anything other than food.”

Women headed household, Non-beneficiary, Hissor

For this group, poverty is also a result of inadequate access to education and therefore to the labour market. The respondents mentioned the need for training, getting a profession, skills and abilities that might improve their employment opportunities.

“The members of our families are illiterate. We have no profession. We do not have friends in institutions and organizations, so we came here. We came with the hope of obtaining a profession. We consider that education is a way to overcome poverty; we decided to take classes in order to earn some money.”

FGD, Vulnerable woman, Beneficiary of crisis centre, Dushanbe

Women observed that, in the past, they had experienced family difficulties and the absence of support had determined their current precarious conditions. Women who went through divorce were left without a place to live, and without alimony payments for their children; some could not even get the divorce pronounced. In some cases children were given to the care of their fathers, and the women could not see their children.

“I cannot get a divorce, so I cannot receive the benefit as a single mother. I do not communicate with my husband, and I have no documents. I went to see a lawyer, first he asked for money, then he said there was no way he could help me, there is no evidence of my husband being dead or of his disappearance.”

Household abandoned by migrant, Non-beneficiary, Kurgan-Tyube

One of the beneficiaries stated that she received legal assistance through the divorce process, and she was able to buy her own apartment. Some respondents mentioned the need for emergency support, so that they “will not be thrown out onto the street together with their children by family members”. They also asked for counselling and psychological assistance for them and their children.
Social Services in the Republic of Tajikistan

The needs of poor households

The research identified a particular group of very poor households with particular needs. Largely, these households expressed as need for material support in the form of food, clothing or medicines. Many of them had received some support from authorities and/or charity institutions and organisations in the past, but not on a regular basis. Besides, they indicated the need for legal assistance to get registration, compensations, exemption from school fees for children, or a land plot, and to apply for social cash assistance.

“We asked the chair of the mahalla for help. He said we would have to have residence here to be considered for help and we should go and ask for it at the place we were registered.”

*Abandoned family, Beneficiary of residential services, Dushanbe*

Some of the households receive compensation for gas and electricity but cannot use it because they have neither electricity nor gas. Some households asked for help in placing their children in residential institutions, especially in collecting the needed documents. This demonstrates an understanding that residential institutions are one of the only forms of social service about which these families have information.

“When my daughter went to school I had no money for her new clothing and bought second hand things. She cried a lot because of this. We cannot provide her with any education at home; we are illiterate. She has a great desire to learn, she asked me to send her to a boarding school, but they required a lot of documents.”

*Poor household, Non-beneficiary, Dushanbe*

Poor households identify employment programmes, and support in acquiring skills and education as important services which they are lacking.

Needs common to people in all groups

Nutrition

Some respondents mentioned that their biggest concern is to ensure proper nutrition for the household. They have “no means to buy food for the family”; some families stated that they eat only bread with tea. This is the case mainly for women-headed households, and those with many children.

“If you have many children then you will fall in poverty, fewer children less problems. My girls do not go to school and the boys are working after school …”
Chapter 4. Social welfare services – estimated demand and current patterns in supply

The main problem is food, we don’t have enough money and have to borrow from neighbours and relatives.

Poor household, Non-beneficiary, Dushanbe

The support we need is for the purchase of flour, sugar and oil.

FGD, Non-beneficiaries, vulnerable women, Konibodom

All our money goes for food, all my clothes were bought in Soviet Union days, when I was a bride.

Poor household with many children, Non-beneficiary, Konibodom

I don’t buy clothes; I eat only bread and tea. Everything you see is old and was bought long time ago.

Older, disabled woman, Beneficiary, Konibodom

I take food in the market on credit; when I receive my pension I pay my debts. The pharmacy does not give medicine on credit to me any more.

Poor, woman headed-household, Rushon

The challenges with getting enough nutrition were almost always defined by respondents in terms of their having a lack of money to purchase food, rather than there being a shortage of food locally or difficulties in reaching the markets. Markets generally existed and were increasingly well stocked with products. This indicates that initiatives to support the income-generating activities of households would have a positive impact on the ability of the population to meet this basic need.

Health care

Many respondents are also concerned about their limited access to health care. The major health care problems that have an impact on the well-being of households generally fall into two types: sudden health shocks, including as a result of accidents, and chronic illnesses or long-term disability. Both types can result in consequential losses such as unemployment, the inability to carry out day-to-day tasks, family break-up and psychological difficulties. Several respondents in the study with a disability or chronic illness had not been able to go outside their home for many years.

When people do not take up the health care they need the reasons are not only financial, although cost is a major concern. In addition to the high costs of medical services, access is restricted because of the bad attitude of medical personnel, and physical inaccessibility to health care facilities. Households with disabled children seem to spend the most on health care, becoming vulnerable
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to poverty. Some respondents indicated that because of high costs of medicine, they use alternative medicine (znahari).

“The treatment of my son costs about 300 TJS per month. For this we use all our money, I can’t pay the electricity bills and there are cases when they cut off the electricity.”

Caregiver of disabled child, Non-beneficiary, Hissor

People are also complaining about bad attitudes and corruption in the medical system. At the same time, family doctors (as key informants) said that services are accessible to all groups of the population.

“It has been two years that my grandson has been in this condition (1st degree of invalidity). We go from one hospital to another asking for medical care but we get nothing. I don’t know what will happen to us…”

Caregiver of disabled child, Beneficiary, Hissor

If the health needs of a person are not addressed it may often fall to social services to attend to the consequent problems described above: the person may need support in day-to-day living, rehabilitation following injury and illness, counselling, assistance with finding employment, and advice to obtain cash assistance and other health services to which they are entitled. There is a clear role for social services to support children and adults with disabilities to access the health services they need.

Homelessness

Another problem raised in consultations with beneficiaries is lack of housing, but for some groups this is a bigger problem than for others. Old people who live alone mentioned that they are in constant fear of being cheated and left without their homes. This is also a reason why some older people refuse to accept help by letting a social worker enter their houses. Several respondents from a residential institution for older people ended up there because they lost their homes as a result of fraud.

“Since the death of my husband I have been alone. A young woman said that she would take care of me. I believed her. Then she brought all sorts of papers. I signed them without reading. She gave me $1,500 and said that my apartment was hers. I went to the prosecutor, but he didn’t help. […] Later, I found out that she sold my apartment for $6,000. Now I live in the asylum for elderly.”

FGD, Beneficiaries
Homelessness can also result from family separation and conflicts. The housing problem seems to be very important for abandoned women who are sent away from the houses of their husbands’ families. Women often have little assistance throughout the divorce process, and cannot claim a part of the house they lived in while married. Some live in crisis centres, some indicated that they sleep in schools, some are hosted by relatives. Women affected appear to be uneducated women, second wives, widows, wives of migrants, and women with husbands who use alcohol and drugs. In some cases they report their children are placed in residential institutions, and some are forced to work to pay rent.

“My husband beat me, I was a second wife. He eventually left me with a baby in my arms and two other children. Nobody would give me a job. I had to place my two older children in the orphanage. We were forced to sleep in the cold weather with two children in the park.”

FGD, Beneficiaries, Dushanbe

Young vulnerable families also mentioned problems with housing, which results in living separately or spending the entire income on rent.

“There is no place at my mother in law’s, so we live separately. I live with my two daughters at my parents’ place and my husband lives with our two sons with his parents. Our eldest daughter is 16; we have no home for 18 years. We have no residence. If things do not improve, I am thinking of migrating to Russia.”

Poor household, Non-beneficiary, Dushanbe

“We are 16 people living in a two-bedroom apartment, and the house is very deteriorated.”

Caregiver, Disabled child, Beneficiary, Khujand

A representative in Khujand khukumat mentioned that they had registered 3,000 applications for land plots. The situation is the same in other regions. Respondents mentioned that they have been on the waiting list for very long periods without even being informed of the state of their request.

“My problems never change, I am going to die and this will be the end of my problems. In 2004 I applied for a piece of land and they put me on the list. I don’t know what happened; they promised they would give it to us.”

Older person, Non-beneficiary, Hissor
Electricity and water
Another problem mentioned in all regions is the shortage or high costs of electricity. The shortage of electricity becomes an important problem in the winter. Since there is no central heating respondents indicated they use electricity to heat houses. The high cost leads to accumulation of debts, while the shortage of electricity contributes to the poor health of the population.

“My health and the health of my children deteriorates in winter. The child suffers from chronic bronchitis. The lack of electricity and heating has a negative effect on us.”

Caregiver, disabled family members, Beneficiary, Kurgan-Tyube

“I don’t take a bath in winter, it is impossible, I dress warmly and lay under blankets.”

Older person, Beneficiary, Kurgan-Tyube

In some districts (Danghara and Konibodom) the lack of drinking water is an essential problem.

“The water we use is only good to wash dishes. Sometimes we buy water.”

Vulnerable household, Non-beneficiary, Konibodom

“In this village water is a problem. Sometimes you can wait until evening to get some water. All people say that water is a big problem but people have no possibility to move to other places.”

FGD, Non-beneficiary, Danghara

Transport
Access to transportation for vulnerable groups of the population is rather restricted. Public transportation is not always available and private transport is expensive. Some respondents mentioned that because of a lack of public transport their children do not go to school. Households have difficulties in accessing medical care because of transport (most problematic in GBAO region). The situation is even more complicated for persons with disabilities. None of the respondents (beneficiaries or non-beneficiaries) receive compensation for transportation or any other kind of related support.

“Public transportation is not always available; the private one is very expensive. The population goes to work on foot. They need 4 TJS to get to work, and they would rather spend the money on bread.”

Key Informant, Kurgan-Tyube
Chapter 4. Social welfare services – estimated demand and current patterns in supply

4.1.3. Estimating the extent of demand for social welfare services – key considerations

There are few regional variations identified in this assessment of the available statistical data relating to estimating need for services. This is partly because there are few disaggregated data sets available by region and vulnerable groups.

- **Children in need** – 15,104 children or 471 children per 100,000 0-17 year olds are in state care and require high levels of state support. Around 1700 children lost parental care in 2010 although this number was much higher in previous years so could be estimated closer to the 5000 cases of loss of parental care recorded in 2008 and 2009 – around 157 cases per 100,000 child population (based on Transmonee data). Around 300-400 children come into conflict with the law each year across the country and around 600 children are serving sentences.

- **People with disabilities** – around 93,000 adults and children receive disability pension across the whole country. In another words around 1219 people per 100,000 population across the whole country receive disability pensions and may require social services.

- **People living with HIV/AIDS** – around 2500-3000 people are registered as diagnosed with HIV/AIDS in the whole country and the rate of new cases rose in 2010 to 1000 new cases registered during the year. It is not clear the extent to which HIV/AIDS prevention programmes are effective in reaching those who are most vulnerable to infection or in raising awareness among the wider population.

- **Older people** – around 377,000 men and women are over the age of 60 years across the whole country, or around 5% of the population of Tajikistan. It is difficult to estimate how many of these require social services to help them lead ‘normal’ lives based on demographic data alone, but those living in poverty and without informal family support networks are most likely to need social services support of some kind.

- Demand for services is mainly for home-based and day-care forms of service provision among both **adults and children**. Only a very small level of long-term residential care is required for both adults and children – mainly intensive nursing care. All other needs can be met through supported independent living services, social housing, foster care and other forms of home-based and day-care services.
Summary of observations on potential demand for services

In the absence of disaggregated data for all vulnerable groups in all regions it is possible to draw the following general conclusions about the potential demand for social services:

1. Each region needs to be able to service roughly the same proportion of people over 60 and under 18 in its population. GBAO has a slightly lower proportion of children and higher proportion of people over 60 in its population, but otherwise all regions are demographically similar in terms of the broad groups of potential service users among adults and children.

2. The actual numbers of potential service users are significantly higher in Khatlon, Sugd and RRP, yet these regions have the same number or fewer service providers than the less populated regions of GBAO and Dushanbe.

3. More populous regions – RRP, Sugd and Khatlon – need more services to reach their vulnerable population groups. At present the numbers of service providers and staff deployed are roughly equal in all regions except RRP where they are more than half the number of other regions in spite of its large population.

4. Service users, especially carers of children with disabilities, adults with disabilities and older people can formulate a need for a range of services and express how services have to be flexible in meeting a range of needs. People who have not used social services find it difficult to frame any assessment of need in terms other than for material assistance and help in accessing universal services such as healthcare, education, transport, housing.

5. Service users and potential service users generally have a low level of awareness of existing social welfare services and what they can offer. Their understanding of social services that it is essential universal services such as social cash assistance or other types of income support, housing, transport, education, health care and utilities.

6. The rate per 100,000 population in need of services varies by vulnerable group and can be roughly summarised as follows:

• There are around 5000 older people per 100,000 overall population across the country of which the majority probably have at least some family or neighbours to support them. Those without family support are more likely to
be in need of social services support, but it is hard to estimate the extent of this need using available data. Consultations with older people show that they rely considerably on support from family and neighbours.

- Around 500 children per 100,000 children aged 0-18 (and around 200 per 100,000 overall population) are in the care of the state with around 160 children per 100,000 child population losing parental care each year. Around 15.6% of children in residential forms of care are children with disabilities.

- There are around 93,000 recipients of disability pension throughout the country which represents a rate of around 1220 per 100,000 overall population. The actual numbers of people with disabilities are likely to be higher than those claiming disability pension.

- Around 3000 people are living with HIV/AIDS and may need social services as well as healthcare and other services. This represents around 40 people per 100,000 overall population. The rate of growth of this group of service users, mainly injecting drug users or sex workers, appears to be extremely high and prevention services do not yet appear to be having a significant impact in slowing the infection rates.
4.2 Provision of social services – meeting demand

The data collected through the mapping exercise included the number of service users accessing every service across the country and categorised the data according to four main forms of service delivery (see section 3). Although service providers were in a position to identify the categories of beneficiaries using their services (see table 4.1), the numbers of beneficiaries receiving services in 2010 were, in nearly all cases, recorded as a total figure and not broken down by any category of vulnerable group. It is not possible, for example, to determine whether all older people in need of social services are receiving them, but it is possible to determine what proportion of those who might be in need of services are actually receiving them in the current system. It is also possible to determine to some extent the capacity of the current system to expand its reach to more potential service users.

In order to reach some understanding of the number of service users from each category of beneficiary (see section 4.1 for the categories of beneficiaries of the social services system identified through the mapping exercise), the number of service users recorded for each service provider has been divided evenly by the number of target beneficiary categories that the service is targeted towards. If, for example, a service provider stated that it serves 1) older people and 2) adults with disabilities and the research team recorded 300 clients in 2010, then, for the purposes of this analysis and due to a lack of sufficiently disaggregated data, the overall number of clients is divided equally between the two stated categories (i.e. 150 older people and 150 adults with disabilities). While this cannot represent a perfect representation of the numbers of each category of beneficiary being served by each service provider, it does provide a reasonable basis for identifying gaps or, for example, over- or under-provision for specific categories of existing or potential beneficiaries.

4.2.1. Distribution of service provision by beneficiary type and region

The mapping exercise recorded 38,531 clients served by social services providers across the whole country in 2010. Approximately half of social services users were adults and half were children. The distribution of social services provision between the 19 beneficiary categories (see Table 4.1) is shown in Figure 4.5. It can be seen that the majority of services were provided to children from four categories (children without parental care, children from socially vulnerable families and child orphans. It is worth noting that children with disabilities are often also included as beneficiaries by the service providers citing these three categories of child beneficiary), as well as to injecting drug users and to older people who have no support from their families.
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Figure 4.5  Estimated breakdown of services delivered to 38,531 clients across 19 target beneficiary groups cited by all forms of service providers in 2010

On the whole, children’s services are being provided more extensively than services for adults. Services for children with disabilities, older people lacking family support and intravenous drug users stand out as being at higher levels than those for other categories of beneficiary. Services for care leavers from children’s institutions stand out as being at particularly low levels. These levels, however, need to be treated with caution as they are the result of an even division of recorded service users across the categories of target beneficiaries of service providers rather than an actual record of each category of service user.

Across the country social services of at least some kind exist in every region and almost every district for different target groups (see Figure 4.6).
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Figure 4.6

Availability of social services of all types 2010

Services for children

Children without parental care

Services for adults

Victims of domestic violence
Chapter 4. Social welfare services – estimated demand and current patterns in supply
Figure 4.6 (continued)

Availability of social services of all types 2010

Services for adults
- Adults living with HIV

Services for children
- Children with disabilities
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Children in conflict with the law

Intravenous drug users
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Girl children – victims of violence, exploitation and trafficking

Sex workers
Figure 4.6 (continued)

Availability of social services of all types 2010

Services for adults

Ex-offenders

Care leavers from children’s institutions

Services for children
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Figure 4.6 (continued)

Availability of social services of all types 2010

Services for children

Children living with HIV

Socially vulnerable families and their children

Source: OPM
Chapter 4. Social welfare services – estimated demand and current patterns in supply

It is probable that the proportion of beneficiaries per 100,000 child or adult population is higher in Dushanbe due to the large number of social service providers operating in the capital which people travel to from all parts of the country. One service provider in Dushanbe provided services to 3,900 clients (adults and children) - intravenous drug users from all over Tajikistan – representing around 25% of all social services users being served in Dushanbe. With this in mind, the levels of service provision to residents of Dushanbe are probably lower than they appear, although this may not be the only explanation for the higher rates of service provision in Dushanbe. There are also services providers in both RRP and Khatlon which are serving clients from all over the country and the overall levels of service provision in both these regions are generally low (below the national average) for both adults and children.

Adults in RRP appear to be particularly under-served compared to other regions. The high rate of service provision per 100,000 relevant population in GBAO, however, reflects a higher rate of provision relative to a much smaller number of inhabitants. This picture changes if more specific population groups are examined as in Figure 4.8. Available data permits examination of the larger categories of child and adult social service users as a proportion of smaller more specific population groups;

Source: OPM.
services for older people are more extensive and widespread per 100,000 adults aged over 60 years of age than services for four groups of vulnerable children per 100,000 children under 15 years of age.

Again, GBAO and Dushanbe stand out as having higher levels of social services coverage for these population groups than other regions, probably at least partly as a result of having smaller populations with similar levels of service provision as in other regions. Each region has between 49 and 59 service providers even though their population sizes differ considerably (see Figures 4.1 and 4.2); but RRP stands out with only 22 service providers. The staffing levels in these services, and therefore the capacity to reach larger numbers of clients, vary; all regions except GBAO deploy between 1,250 and 1,550 staff across all social services whereas only 442 staff are deployed in GBAO.

Figure 4.9 demonstrates clearly how unevenly services for the four groups of children previously highlighted (see Figure 4.5) are distributed across the country. It does not, however, help in determining the extent to which there might be other children from these categories who are not enrolled in any forms of services.
Figure 4.9 provides some assistance when considering coverage of services for the population of older people. Around 1.3% of the population (1,297 per 100,000) aged over 60 years, across Tajikistan, are currently receiving social services. Given the extent to which the societal structure of Tajikistan expects families to care for older people, it seems possible that the needs of at least 98% of older people are being met by family members and that the level of demand for the kinds of services offered by the current system of social services could be as low as 1.3% of older people. It does not mean, however, that there are not greater numbers of older people in need of services. The variations in the rate of service delivery to older people are also startling; extensive rates of delivery in Dushanbe and GBAO in particular stand out with 2.7% - 3% of the population aged over 60 years receiving social services. It could be the case that the national average should be closer to the 3% rate in Dushanbe and that the other regions, particularly RRP, have a considerable task ahead of them in identifying potential service users who are currently not receiving much-needed support.

The beneficiary consultation confirms that there is a reliance on informal support networks among vulnerable groups in general and among older people in particular. Most respondents reported that they turn for support to family, relatives and neighbours, citing examples including financial support for food, information about cash assistance and services and for medical assistance. The family is considered the primary source of support and also obliged to help.

“Only my brothers help me, they send potatoes and money to pay the rent, some money to pay for school.

Abandoned household, Non beneficiaries, Dushanbe

“We get occasional help from our neighbours, they offer food, used clothing, hot meals. They ask about health, provide moral support. They can’t give us money since they are in need themselves.

FGD, vulnerable women, beneficiary, Dushanbe

People do not expect much help from the authorities. They think authorities should help, but at the same time not many report receiving it.

“We all have bad experience with the state. The organisations used to provide more support but now they are not working any more. The state can’t provide the same services that organisations used to provide, even if the state is obliged to help people.

FGD, non-beneficiaries, Khujand
Figure 4.9  Service provision rates for each beneficiary category and region per 100,000 child (0-14) or adult (15 +) population in the region

Source: OPM. Note: actual numbers of services delivered to each category, based on an even division of total service users by number of service-user categories reported by service providers.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Some people place trust only in their own powers and will not rely or seek any help.

“The first thing is to trust in yourself. Relatives, neighbours and friends are of little help. People have changed, everyone has his own concerns.”

FGD, Beneficiaries, Khujand

“Older people, who do not go out of the house and do not communicate with their neighbours don’t know about our existence. We are trying to find these people through the family doctors.”

Key informant, social service provider of home care, Dushanbe

Children with disabilities, child orphans, children without parental care and children from socially vulnerably families are being served in all regions. The very high rate of service provision for children with disabilities in Dushanbe can largely be explained by the presence of a Republican Psychological-Medical-Pedagogical Consultation in Dushanbe which serves children with disabilities from all over the country. Otherwise RRP, Khatlon and Sugd appear to be under-serving these four categories of beneficiaries compared to the other regions. There appears to be chronic under-provision of social services for adults in RRP.

Services for care leavers are completely absent in GBAO, Sugd and Khatlon; otherwise, most regions have at least some relevant services. Children and adults living with HIV as well as both child and adult users of intravenous drugs have high rates of service provision per 100,000 child or adult population, particularly in GBAO and Dushanbe. It is difficult to say whether this represents a sufficient level of provision without more detailed analysis of the HIV/AIDS, intravenous drug-using and sex-worker populations who are most vulnerable to or affected by HIV/AIDS in each region. Broadly speaking, the rough estimate of need for services, extrapolated from available data presented in section 4.1, shows that around 3,000 people (or 40 per 100,000 people) are living with HIV/AIDS across the whole country.

Figure 4.9 shows that the six categories of beneficiary most vulnerable to HIV/AIDS or living with HIV/AIDS (adults and children living with HIV/AIDS, sex workers, adult and children injecting drug users, ex-offenders) received services at a rate of 400-1200 service users per 100,000 adult or child population. This at first seems like a high rate compared to some other groups, given that there are currently only 3000 registered cases of HIV/AIDS in the whole country (40 cases per 100,000 total population). However, as the HIV/AIDS rate has risen rapidly in recent years, it is likely that regional administrations will need to forecast maintaining or expanding these current levels of service provision and ensure that they are targeted as far as possible to those most at risk.
Summary: categories of services-users being reached in each region

1. Children are being served more extensively than adults across all regions as a proportion of the child population under 15 and the adult population over 15. Older people, however, are being most extensively served, significantly more than children, as a proportion of the population over 60 years of age, except in RRP where there appears to be a chronic shortage of services for older people and for adults generally.

2. Adults and children living with HIV/AIDs and injecting drug users are receiving services at a high rate compared to other vulnerable groups. It is possible that this is an adequate rate but may need to be increased if infection rates continue to rise.

3. Children with disabilities are being served at the highest rate of all as a proportion of the child population aged 0-14 years compared to other vulnerable groups. All regions are making some provision for services for this group.

4. GBAO and Dushanbe are, generally speaking, reaching more adults and children per 100,000 adults and children than the other, more populated regions. The number of service providers is approximately the same across all regions even though the size of the populations is considerably larger in Khatlon, RRP and Sugd. RRP has half the service providers of other regions; GBAO has about 1/3 of the staff deployed in the same number of services compared to other regions.

5. Khatlon and Sugd are under-serving children compared to other regions.

6. Care-leavers and homeless people appear to be significantly under-served across all regions although some service providers in some regions do declare these groups as beneficiaries or potential beneficiaries.
4.2.2. Distribution of different forms of service provision by region

As mentioned above, the mapping exercise identified four forms of service delivery across the whole country:

<table>
<thead>
<tr>
<th>Forms of service delivery</th>
<th>Types of services provided under each form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form 1</strong></td>
<td></td>
</tr>
<tr>
<td>Social welfare services in the home (Home care)</td>
<td>social support (<em>soprovozhdenie</em>) in the family and community</td>
</tr>
<tr>
<td>Services are provided in the home of the client</td>
<td>socio-medical re/habilitation</td>
</tr>
<tr>
<td></td>
<td>day-to-day personal care and household maintenance</td>
</tr>
<tr>
<td></td>
<td>support in social adaptation through training in life skills</td>
</tr>
<tr>
<td></td>
<td>leisure and socializing</td>
</tr>
<tr>
<td></td>
<td>socio-legal support and advice</td>
</tr>
<tr>
<td><strong>Form 2a</strong></td>
<td></td>
</tr>
<tr>
<td>Social welfare services in residential facilities.</td>
<td>socio-medical re/habilitation</td>
</tr>
<tr>
<td></td>
<td>socio-psychological support and consultation</td>
</tr>
<tr>
<td></td>
<td>day-to-day social and personal care</td>
</tr>
<tr>
<td></td>
<td>support in development of physical activity (physiotherapy and occupational therapy)</td>
</tr>
<tr>
<td></td>
<td>leisure and socialising</td>
</tr>
<tr>
<td></td>
<td>representing the interests of the client with other organisations</td>
</tr>
<tr>
<td></td>
<td>professional training</td>
</tr>
<tr>
<td></td>
<td>education</td>
</tr>
<tr>
<td><strong>Form 2b</strong></td>
<td></td>
</tr>
<tr>
<td>Social welfare services in residential facilities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Temporary social welfare services in residential-care institutions (less than 3 months)</td>
</tr>
<tr>
<td><strong>Form 3</strong></td>
<td></td>
</tr>
<tr>
<td>Social welfare services in day-care centres (day care services)</td>
<td></td>
</tr>
</tbody>
</table>

Source: OPM
The mapping surveyed all social service providers (235 across the country. The vast majority of social services are delivered as day-care only (37% of service providers), long-term residential care only (27%) and home-based care only (20%). There are only six examples where temporary residential care (only) is being provided (3% of all providers). Examples include a health and rehabilitation centre for war veterans and a regional centre for the rehabilitation of victims of cardio-vascular disease, both in Sugd oblast. The latter provides medical services but also supports the social reintegration of patients to their homes and communities; the service is therefore classified not only as providing medical services but socio-medical services as well. The remaining 13% of service providers offer a combination of forms of service provision; day care (form 3) is heavily represented among service providers offering combined forms of service delivery. Figure 4.10 shows a breakdown of the forms of service delivery nationally.

The only service provider offering all four forms of service under one roof is in Dushanbe and is a City Territorial Social Service Centre for Older People and Adults with Disabilities. The mapping records all four forms of service being delivered in 2010 to 159 older people lacking family support, homeless people and adults with disabilities. Of these, 114 received day-care services, 34 received temporary residential services, 7 received home-based services and 4 received long-term residential care.
The stated aims of the centre are to provide temporary residential care to older people lacking family support and who are in need of day-to-day personal care and medical care. It can be seen to have provided its services in a range of flexible forms, probably in order to be able to meet a range of needs among a targeted group of vulnerable adults.

The definitions of forms of service provision should be treated with caution. 13 service providers claim to be offering a combination of day-care and long-term residential care across the whole country:

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boarding schools in Khatlon</td>
<td>5</td>
</tr>
<tr>
<td>Infant home in Sugd</td>
<td>1</td>
</tr>
<tr>
<td>Boarding schools in Sugd</td>
<td>5</td>
</tr>
<tr>
<td>Boarding schools in RRP</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: OPM

The proportion of people receiving day care rather than residential care varies from provider to provider although some common patterns can be identified in the use of boarding schools within a given region. In Sugd, for example, boarding facilities for small numbers of children are in some cases attached to ordinary day schools and the ‘day-care’ part of the service provision is for larger numbers of children who are only receiving meals at the boarding facility. In other cases in Sugd, larger numbers of children are living in residential facilities but go home during the holidays. In RRP and Khatlon, boarding schools tend to have larger numbers of children in residential forms of care, although the mapping records several examples where service providers state that children return to family or relatives during the summer months. Greater flexibility in the use of forms of care could indicate an approach to service provision which has the potential to be more responsive to the needs being identified at local level.

A breakdown of forms of service delivery by region in Figures 4.11 and 4.12 shows the extent to which some regions are reliant on one or other form of service provision and how some regions have a tendency towards offering a greater range of more flexible or combined forms of service provision.
Figure 4.11
Numbers of service providers offering each form or a combination of forms of service provision in each region in 2010

Source: OPM
All regions except RRP provide day-care facilities and home-based services to a fairly similar extent but as it is shown in Figure 4.11, day-care service provision is significantly under-represented in RRP. GBAO and Khatlon have very few service providers offering temporary residential care. Those that do, combine it with either day care and/or home-based services.

Figure 4.12 illustrates the extent to which long-term residential care dominates in RRP and that other forms of service are not sufficiently available.

**Figure 4.12** Numbers of service providers offering different combinations of service forms in each region

Sugd and Dushanbe can be seen to have the widest range of different combinations of forms of service provision available; in contrast, GBAO is largely reliant on single forms of service provision. Over half of services provided in RRP take the form of long-term residential care only and the majority of other forms combine long or short-term residential care with day care or home-based care. It should be noted, however, that some of the day-care provision in Dushanbe is also targeted at residents of RRP. For example, a narcology centre for the treatment of intravenous drug users in Dushanbe targets the populations of both RRP and Dushanbe. The centre combines temporary residential care with day-care and served 3,900 clients in 2010. Overall, RRP stands out as having a very limited availability of home-based or day-care forms of services but all other regions, particularly Khatlon, appear to be providing more home-based or day-care forms of service than long-term residential services, or else combining long-term residential services with other forms of service provision.
Summary: forms of service delivery by region

1. Sugd and Dushanbe appear to have the most flexible forms of service delivery with more services offering a combination of service forms. GBAO is the least flexible and most reliant on traditional, single forms of service delivery.

2. RRP is heavily reliant on residential forms of service delivery with very few service providers offering other forms of services; however some service providers are also offering a mix of forms.

3. The level of use of residential forms of care should be treated with caution. Many users of this type of service, particularly children, return home at weekends and during holidays. There are a number of providers offering day-care services based out of residential institutions in differing combinations and with differing levels of usage of each form of service in each service provider. The level of full-time use of these forms needs further investigation, particularly among children.

4.2.3. How different forms of social services are used in relation to beneficiary categories in each region

In order to gain some meaningful insight into the way the social services system is currently meeting the needs of different categories of beneficiary with different forms of service provision, it is again helpful to adopt the approach of dividing the reported number of service users evenly by stated beneficiary group categories as per section 4.2.1 and Figure 4.9. The following analysis is therefore based on a working assumption that each client group used each form of service proportionally. For example, if a service provider cites four beneficiary groups (child-orphans, children without parental care, children with disabilities and children from socially vulnerable families) and the mapping exercise has recorded 160 children receiving services in 2010, then we are working on an, albeit slightly crude, assumption that 40 children in each of the four beneficiary categories received a service.

Just as the caveats noted already inevitably lead to some limitations in being able to accurately assess demand on the basis of beneficiary category, they equally imply limitations when assessing the forms of service delivery being used by each beneficiary category. An even division of the beneficiary categories cannot give a perfect or statistically accurate picture of the numbers of each category being served by each provider, but it does help to identify which forms of services are being used to meet the needs of specific groups of beneficiaries.
Another important consideration is that some service providers are targeting the whole country with one or other form of service. The high levels of day-care provision in Dushanbe, for example, can partly be attributed to the service-provider already mentioned which has the function of carrying out disability assessments for children from all over Tajikistan. Where appropriate, for the purposes of understanding patterns of service delivery for each regional population, service users who come from all over the country to a particular service in a particular region have been eliminated from the statistics. In some cases they have not been excluded if the mapping indicates that the majority of clients are from the region in question or if other factors indicate that they should be kept in the overall service user figures.

Source: OPM
Figure 4.13 indicates that social services for older people and for adults with disabilities are largely being delivered in the home; far fewer day care, residential or temporary residential services are being provided to these service users. Conversely, children’s services, particularly for children without parental care and child orphans, are being delivered predominantly through long-term residential service forms. Day-care and long-term residential care are the main forms of providing services to children with disabilities, although there is also some provision of temporary residential and home-based forms of services. Otherwise, day-care is the service delivery form that dominates provision of services to nearly all other categories of beneficiaries.

As seen in Figure 4.10, 37% of social service providers only offer day-care forms of services; day care services are being provided at high levels among providers delivering combined forms of services. The predominance of day-care service forms can also be seen in the data on service users. Figure 4.14 illustrates that an even greater percentage (41%) of service users, who have been served by the system as a whole, received day-care forms of services.

Figure 4.14  % of service users receiving each form of service provision in 2010

Source: OPM
Figure 4.15 illustrates that:

- the main users of long-term residential care services are children without parental care or children with disabilities;
- the main users of home-based services are adults with disabilities or older people;
- a range of service users use the other forms of services, particularly day-care.

Many of the day-care service forms are newer and more recently established for groups of service users that have emerged in the last twenty years (e.g. intravenous drug users, adults and children living with HIV), whereas the more ‘traditional’ forms of services inherited from the Soviet system are serving more traditional/established groups of social service users (e.g. older people, disabled and vulnerable children). It appears that the provision of a wider range of services for children with disabilities than that which was traditional in Soviet times, including day-care services.
Although, as already noted, the even division of the numbers of target beneficiaries across beneficiary categories cited by service providers should be treated with some caution, it can provide helpful indications and fill some gaps in existing data. When looked at in broader ‘adult’ and ‘child’ groups, as in figures 4.16 and 4.17, data is more accurate and corroborates the patterns emerging so far in Figures 4.13 to 4.15.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

<table>
<thead>
<tr>
<th>Temporary residential services</th>
<th>Day care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 34%</td>
<td>Adults 48%</td>
</tr>
<tr>
<td>Child service users 66%</td>
<td>Child service users 52%</td>
</tr>
</tbody>
</table>

Source: OPM

Children have a slightly wider range of service forms available to them than adults. Day-care services are used fairly evenly by children and adults but, apart from day care, residential services are dominant among services for children. Home-based forms of service provision are dominant among services available for adults.

Figure 4.17 Forms of services provided to adult and child service users in each region

Adult service users

[Diagram showing usage of different services in different regions]
As illustrated in Figure 4.18, patterns of service delivery for children’s services are fairly similar across the regions with all four forms being used in similar proportions. GBAO offers fewer temporary residential forms of services for children than other regions and the proportion of services in Dushanbe, RRP and GBAO that are home-based for children are somewhat less than in other regions. Long-term residential care for children is used significantly in all regions; this form of service is provided in RRP, Khatlon and GBAO to a greater extent than in the other regions.

Use of different forms of service provision in adult services varies more widely from region to region, particularly in relation to residential service forms. A high proportion of residential services are being provided to adults in RRP and Sugd while GBAO and Dushanbe provide none. All regions provide home-based services to a similar extent and only RRP has very limited provision of day-care.

Figure 4.19 illustrates that within these patterns of service provision services for children without parental care (includes the three beneficiary categories: orphans, children without parental care and socially vulnerable children and their families) are largely provided in residential forms across all regions. Forms of services for children with disabilities vary more widely in each region and are less reliant on residential forms, especially in Dushanbe, Khatlon and GBAO. The exception is RRP where a large proportion of services for children with disabilities take a residential form.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Residential care for children

As discussed in 4.2.2 the definition of ‘long-term residential care’ needs to be considered carefully. This form of care is often provided in combination with other forms of day care services and the mapping provides a great deal of data on how many service users are receiving which forms of service from each service provider. In the example of one children’s institution covered by the research, the institution operates during the school year and is closed for the summer holidays. Most of its pupils are weekly boarders while some use the services during the day but go home at night. Parents who collect their child at the end of the day or week have the opportunity to talk to staff and get informal advice on caring for their child, even when advice is not formally offered as a service.
Attitudes among parents consulted for this study towards using residential care services vary widely, particularly between parents of children with disabilities and parents of poor or socially vulnerable children. Some parents express that a particular benefit of residential care for children with disabilities is the prolonged contact between children facing similar challenges. In some cases this is said to have helped them to feel more confident and less prone to teasing and isolation. In contrast, other parents of children with disabilities have tried to avoid using residential care services for fear of making their child feel abandoned, or because the level of education is not as high as in a regular school. One parent who was obliged to send her disabled child to a residential care facility remarked,

\[\text{I really want my child to be educated in a regular school, and the law allows this, but the schools won’t accept him. I am extremely upset about this because my son is capable of studying well. If I was allowed to I would definitely take him back and enrol him into the school near our house, and I’d look after him myself.}\]

\[\text{Parent of 7-year-old child with a physical disability}\]

This contrasts with the attitudes of parents from poor households who are more likely to seek placement for their child in a residential facility as a way of ensuring he or she will be fed, clothed and educated at little or no expense to the household. This form of service provision dominates services provided to children who are socially vulnerable as opposed to disabled including, for example, children without parental care or whose families are otherwise in difficulty such as extreme poverty, homelessness or where all household members are living abroad. Children may stay permanently in the facility, or may return to their families during the school holidays or at weekends. Some children may stay for a few years while other families report that they expect their children to attend the facility throughout their childhood until the age of 18.

These residential facilities, of which 59 were identified in the mapping exercise, generally focus on providing day-to-day care for children, educating them and providing basic medical care. Caregivers of children at one residential institution reported that it arranged for the circumcision of boys. Several residential institutions provide occasional material support:

\[\text{My children attend the residential facility [for deprived children]. They eat there. In winter they were given a coat and winter shoes. They get their education there.}\]

\[\text{Mother of two children in a residential facility, Dushanbe}\]
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None of the respondents in the beneficiary consultation reported any services at the residential facility to support the reintegration of the child into the family. Some of the benefits perceived by households are that they do not have to pay for transport to school, nor for any items related to schooling such as textbooks and school repairs. However, as mentioned above, the quality of education is not always the same as in regular schools.

Day care services for children

Day care services for children are being provided providing for children experiencing a range of difficulties and needs (see table 4.1) but access is limited; many districts have no day-care available at all (see Figure 4.6). Day care is sometimes attached to a school or a residential service but in many cases also run by NGO providers as a separate stand-alone service. There are 98 service providers of day care for children across the country, 27 of which are located in Dushanbe, 21 in Khatlon oblast, 7 in RRP, 18 in GBAO and 25 in Sugd oblast. Most of the services were developed for children with disabilities, children living with HIV or child users of intravenous drugs. Day care providers usually provide the following types of services: social-medical rehabilitation, social-psychological counselling and consultation, leisure and communication, advocacy support for service users with other organisations and vocational training. For more details about day care for children see Annex G.

Home-based services for children

Home-based services for children are under-developed in Tajikistan. Where they provided, they are generally emerging as an extension of the home-based services being provided for adults in some regions and are mainly being delivered to children with disabilities, children from vulnerable families and orphans. No home-based or day-centre services were identified where children in foster care or in guardianship were being explicitly targeted. Only 10 service providers across the country provide home-based services for children. Two of them are in Dushanbe and eight are in Sugd oblast. This study identified only two examples of home-based service that had been adapted/expanded to support care leavers from boarding schools and girls who are victims of violence, exploitation and traffic. Both services are available in Dushanbe only and run by NGOs. For more details about service providers of home-based care for children see Annex H.
Patterns service provision for adults also vary from region to region, as evident in Figure 4.20.

The vast majority of residential services for adults are provided in RRP with nearly all other regions providing mainly home-based service forms and/or temporary residential services. There are proportionally fewer day-care or community based drop-in forms of services being provided for older people lacking family support and even fewer for adults with disabilities. The reliance on home-based care, while possibly preventing the institutionalisation of highly dependent adults, may be contributing to the isolation and social exclusion of older people in Tajikistan which was highlighted in the UNDP report on social exclusion in 2009 (UNDP, 2011). Centre-based day-care or drop-in services can offer opportunities for social participation that home-based care services do not.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Home care for adults

Most users of home care services for adults live alone and have no family to support them. The main types of services provided as part of home care are consistent across all local authority home care departments and are focused on support for day-to-day living and hygiene: cleaning the home, washing and ironing clothes, buying groceries and medicines, preparing meals, and helping the person to bathe. Some carers carry out activities that require considerable physical labour, such as structural repairs to property. Many help to promote beneficiaries’ sense of inclusion in society by sharing the latest news and reading newspapers to them. In some cases carers who have developed more informal relationships with their beneficiaries will provide additional services such as taking them to hospital, collecting their pension, paying bills and writing letters on their behalf.

Service providers and service users alike report that the home care service is generally offered two or three times per week to each beneficiary for about two hours at a time, however this can vary. Some service users report receiving visits every day, especially if the carer lives locally or has known them for a long time. Variations to the regular twice-weekly schedule seem to be arranged informally rather than as part of a formal assessment of need; some respondents felt that they were in need of more frequent visits, while others were visited regularly but indicated that they did not have a strong need for a frequent service. Home care is provided indefinitely; in departments where all staff are fully occupied, new clients can only join the service when an existing beneficiary dies. This can mean that people who begin to receive a service when they have a particular need for support can continue to get home care long after the urgent need has stopped. One head of a home care service reported that when she was first appointed she spent a considerable time cleaning up the list of actual and potential beneficiaries to eliminate those who did not still need the service, reducing it by several dozen names.

Home care services for adults are also provided by units attached to residential facilities such as the residential institution for older people and the disabled in Khujand. These services are essentially the same as those offered by the district home care departments but, in the case of Khujand, the team also has access to professional maintenance staff who can go to the beneficiary’s home and carry out repairs. They - and some NGOs providing home care services - also have access to lawyers who can provide consultations to home care users.

Day care services for adults

Day care services for adults with disabilities, or for older people, are not yet widespread. The research identified examples of these services run by providers who also offer other forms of service, either home care or residential care.
In the case of one home care service provider (an NGO), service users are invited to spend one day per week at the day care centre to use the bathing facilities and come together for a social club one day each month.

One residential institution for adults with mental disabilities also provides day care services for individuals who need counselling and medical support but not 24-hour residential care. These users have more freedom of movement around the institution than permanent residents and are able to help with housework and gardening.

**Residential care for adults**

As illustrated in Figure 2.20 residential facilities exist for adults with physical and mental disabilities, and for older people, in all regions except for GBAO and Dushanbe; the vast majority of services are concentrated in RRP. Once admitted, adults often remain in residential institutions for the rest of their lives.

One institution covered by this study provides residential care for older people and adults with physical disabilities and who cannot be looked after by relatives. It does not provide services for people with mental disabilities or infectious diseases. Services are divided into those for individuals who are confined to bed and those who are mobile. People who are bedridden receive help with basic personal, hygiene and medical care, including getting dressed, washing and eating; they, also receive physiotherapy. Those who are able to move do physical exercise and some receive occupational therapy.

For adults with mental disabilities residential services are similarly focused on personal care and medical care. Few opportunities are reported in relation to supporting employment for adults with disabilities. There are some major differences between the services provided for people with mental and physical disabilities; in the institution for adults with mental disabilities covered in the beneficiary assessment, about one-third of adults are held in solitary confinement with no opportunities for socialisation. They are not allowed out of their rooms without a straitjacket and without being accompanied. Other residents are not allowed to go outside unaccompanied but are not physically constrained. Some respondents expressed distress at the conditions of patients in facilities for people with mental health problems.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Section summary

1. Services for older people and adults with disabilities are predominantly provided in home-based forms. There are relatively few day-care forms of services for these groups which could help to reduce isolation in the home or community. Patterns of service delivery forms for adults vary across the regions more than for children.

2. Patterns of service delivery for children’s services are fairly similar across the regions with all four forms being used in similar proportions.

3. Services for children who are without adequate parental care or socially vulnerable are largely provided through long-term residential forms. There is a distinct lack of community based family support services available to these children and families in the centre-based or home-based forms. No foster care services were identified, although children living in foster or guardianship families are probably accessing services for orphans or children without parental care.

4. Services for children with disabilities are mainly provided as day-care or in long-term residential forms. There are some regional variations in the proportion of long-term residential forms and day-care.

5. Services for people living with HIV/AIDS and injecting drug users are predominantly provided in day-care form with a small provision in some places for temporary residential care.

6. Consultations show that service delivery forms tend to be rigid in meeting needs of specific groups of service users and are not based on assessment of individual need.
4.2.4 Reach, coverage and accessibility of social services across districts

The analysis so far has focused at national and regional levels. It appears, with the caveats already expressed regarding data and methodological limitations, that in almost every region some forms of social services are available to most target beneficiary groups (see Map 4.21). Within each region however, the coverage, reach and accessibility of services varies greatly. The online mapping resource developed as one output of this piece of research identifies quite clearly the districts and target groups which lack services or are heavily under-served. For example the following districts in RRP lacked services of any form in 2010 (see map 4.21): Jirgitol (18), Rogun (21), Fayzabad (24), in Khatlon oblast in such rayons as Norak (47), Baldzhuvan (53), Khamadoni (57), Khovaling (61), Khursav N. (46), in Sughd oblast in such rayons as Zafarobod (31).
The following observations indicate the extent to which service delivery can be characterised as uneven and inaccessible to a vast majority of individual target beneficiaries and the extent to which district and regional authorities, along with service providers, need to develop a system of referrals and needs assessment in order to ensure that social services are reaching those most in need in each local area.

Reach, coverage and accessibility - Dushanbe

Most of the service providers in the city are concentrated in Sino and Firdavsi districts including a large number of service providers serving the whole Republic of Tajikistan (See map 4.22). If we exclude those service providers which are providing services to people from other regions of Tajikistan, then the picture would be different as illustrated on the right hand side of Figure 4.22. In this context, only Firdavsi district stands out as providing a high level of service provision, per 10,000 population to Dushanbe citizens in 2010.

In Ismoili Somoni district, existing children's services are NGO run and funded – there are no basic child and family support services for children with disabilities or children from vulnerable families provided by the local authority. There are two service providers in Ismoili Somoni providing education and training services to young people and children, but not services that address problems related to ensuring adequate parental care.

The only service provider in Shokmansur that is dedicated to serving only the local district population is the home-based service for older people and disabled adults. All other services are either targeting the whole country or the whole city of Dushanbe.

The majority of services in Dushanbe are financed by non-government sources. The network of state funded services is uneven in its coverage of a range of beneficiary groups – only the district home-based services for older people and the disabled are funded in every district of the city. There are several examples where service providers funded by the district or city budget are serving the population of the whole country.
Social Services in the Republic of Tajikistan

Figure 4.21 Coverage of all forms of social services in Dushanbe (including services serving people from across the country), 2010

Source: OPM
Reach, coverage and accessibility - RRP

Figure 4.23 shows the coverage of all forms of social services per 10,000 population in RRP. There are three districts within the region - Jirgatol (18), Rogun (21), Fayzobod (24) - where no forms of social services exist at all.
As illustrated in Figure 4.25, home-based services, which are mainly provided for older people and adults with disabilities, are concentrated in two districts, Vahdat (13) and Rudaki (15) of RRP. There is no access to home-based services for people living in four other districts of Hissor area and in all seven districts of Rasht region.
Long term residential care is available for both children and adults in RRP. There are 15 service providers delivering this form of care. As demonstrated in Figure 4.26, the highest rate of residential care per 10,000 population is provided in Tavildara (22) district where a Republican Boarding School for orphan and children deprived of parental care is located. This service provider also accepts children from the other districts of RRP. In fact this is the only social service provided in Tavildara district. RRP hosts six service providers serving children with disabilities and which are open to children from across Tajikistan; the services are located in Hissor region (two providers of long-term residential care services), Rudaki (two providers) as well as Varzob and Vahdat districts (one provider in each). These providers undoubtedly make some provision for children with disabilities residing in their respective localities but the remaining districts of RRP offer no local services for children with disabilities. Of the 15 institutions across the region, only three are for adults: Residential institution for the elderly and disabled in Vahdat (13), Residential institution for mentally disabled people in Hissor district (14), Residential institution for the elderly and disabled in Tursunzoda (16) district. Each of the providers accepts individuals from across Tajikistan.

Temporary residential care services are underdeveloped in RRP. As it shown in Figure on the map four below only in Varzob (12) and Vahdat (13) districts such services are available and for children only. In Varzob (12) district such services provided by National rehabilitation centre for children and adolescence “Chorbog” and in Vahdat (13) – by Republican children’s rehabilitation centre.
Most of the day care services in RRP are for children with disabilities and are available in the following districts (Figure 4.28): Nurobod (19), Shahrinav (17), Rasht (20), Vahdat (13) and Hissor (14). Community based services for children with disabilities, which do not require travel outside the locality in which they live, are concentrated in Hissor (14) district in the form of one centre providing 64 children with day care services and 17 children with home-based care. In Vahdat (13) district one day care service was developed for adolescent drug users and young people with HIV/AIDS. Another day care service in this district provides a service for children from vulnerable families and children without parental care. In Nurobod (19), Shahrinav (17) and Rasht (20) districts day care services are provided by residential institutions as additional services to the long-term residential care that they already provide. These institutions are: Republican Boarding School for Orphan-children of Nurobod (19) district, Republican Boarding School for Orphan-children of Rasht (20) district and Republican Boarding School for Orphan-children of Shahrinav (17) district. Another community based day care service operates in Shahrinav (17) district run by an NGO which also provides day care services for young people up to 21 years old.
Chapter 4. Social welfare services – estimated demand and current patterns in supply

Reach, coverage and accessibility – Sugd Oblast

Figure 4.24 shows that social services of some kind or another are available there is only in all but one district of Sugd oblast (Zafabobod district).
As illustrated in Figure 4.30 home care services are distributed unevenly in Sugd oblast and serve a range of service-user groups. Home-based services for children, attached to services for adults with disabilities and older people, are available in Konibodom (33), Asht (26), B. Gafurov (27) including Kayrakum city, Isfara (32) and Pandjakent (35) districts. However, rates of service users per 10,000 population who received this form of service in 2010 are very different between these districts. No locally accessible home based services for children with disabilities are available in the remaining nine districts. In Khujand city some limited day-care provision is available for children with disabilities through one NGO, several schools and residential services however no dedicated home-based services exist. In Ayni (25), Ganchi (28) districts and Chkalovsk city, home based services are available only for adults. Ayni district has the highest rate (36.3) of home-based service provision per 10,000 of population.
Vulnerable children and their families are being served, as an add-on, by some home-based services for adults in Pandjakent (35), Isfara (32), Asht (26), Ganchi (28), B. Gafurov (27), Konibodom (33) districts and Kairakum city but the coverage of this form of service is very limited. Figure 4.30 illustrates that there are seven districts in Sugd oblast where no home care social services of any kind for any category of beneficiaries were available in 2010.

Long-term residential care services are available for both children and adults in Sugd oblast and are being delivered by 20 service providers. The services primarily being provided through a state run boarding schools for orphan-children and children from vulnerable families and by institutions for older people. As shown in Figure 4.31, the density of coverage of this form of service is not very high in Sugd oblast, the only exception being in Khujand city and Kukhistoni Mastchoh (29) district where a boarding school for orphans and children from vulnerable families is situated (Mehron town).
This school provides 67 children with education and other services. Although the rate of coverage in this district appears to be very high, it should be noted that the population is very low. As Mehron is located in the valley between the Turkestan and Zarafshan mountain ranges, many of the villages are remote and many children in the area reside at the school.

The following long-term residential care services are being provided for children with disabilities in Sugd oblast:

- Boarding school for deaf and hearing-impaired children situated in B. Gafurof (27) district;
- Complex special kindergarten-school for blind and visually impaired children of Khujand city, which also provides other forms of services;
- State special baby home of Sugd oblast, based in Khujand city;
- Preschool educational institution № 26 based in Khujand city (provides services for children with disability from across Sugd oblast);
- Specialised state educational institution: Supporting Boarding School of Khujand City;
- State institution "Inter-rayon baby home" based in Dzhamoat Communism of Istaravshan (37) district.

In addition there the following residential institutions serve both children and adults with disabilities: State Institution for the Elderly in Panjakent (35) district and State Institution for the Elderly and Disabled «Dekhmoy» in Dzhabbor Rasulov (30) district which.

Apart from a territorial centre for older people and disabled adults in Khujand city (only serving the local community), all residential services for children and adults with disabilities in Sugd accept people from across the oblast.

Only one provider of long-term residential care in the oblast (Sanatorium Boarding School № 40 in Konibodom (30) district) serves children with HIV/AIDS. As illustrated in Figure 4.31, more long-term residential care provision is available in Khujand city than elsewhere in the oblast.
Temporary residential-care services are very underdeveloped in Sugd oblast as is evident in Figure 4.32. Temporary residential-care services are only available in Khujand city and delivered by five service providers. They provide services for children, veterans of World War II, homeless people, female victims of violence, exploitation and trafficking, and people with disabilities. Some of the services are provided both for adults and for children under the same roof. Only one provider of combined day care and short term residential care – the ‘Children’s Rehabilitation Centre of Child’s Rights Protection’ provides services exclusively for children.
As illustrated in Figure 4.33, day care services are fairly equally distributed across the Oblast with some concentration in Khujand city, Panjakent (35), Ayni (25) and Insaravshan (37) districts. No day-care services are available in Zafarodod (31), Kukhistoni Mastchoh (29), Spitamen (36) and Jabbor Rasulov (30) districts. Most of day care services available in Sugd oblast are provided for different groups of children; most of the services are provided by boarding schools, in addition to long-term residential care, or by non-governmental organisations. Day care for adults is mainly provided by state run territorial centres in addition to home care services. These services are available in Ganchi (28) and Istaravshan (37) districts and in Khujand city. Provision of day care services targeting people (including children) with HIV/AIDS are available in Sugd oblast, including in B. Gafurov (27), Isfara (32), Istaravshan (37), Panjakent (35), Kukhistoni Mastchoh (29) districts as well as in Khujand city.
Reach, coverage and accessibility - Khatlon

It is clear from Figure 4.34 that no service provision of any sort is available in Norak (47), Baldzhuvan (53), Khamadoni (57), Khovaling (61) and Khursav N. (46) districts. Most of the services are concentrated in Kurgan-Tyube city (by far the highest coverage per 10,000 population), Shurobod (62), Kulob (56) and Vakhsh (41) districts. Although coverage of social services in general is high in Kurgan-Tyube city, no social services are available for children without parental care or for children with disabilities.
Although the home-based services in Khatlon are more developed compared with RRP and Sugd oblasts, most of the services are for adults only. In Qubodiyn (44) district the only available social service of any kind is long-term residential care for 38 children coming from the immediate area and from Shahritus (51) district. Only one or two service providers are active in most of the districts in Khatlon oblast and are delivering services to a very limited range of target beneficiary groups, usually older people and/or adults with disabilities. This is the case in Danghara (55), Abdurrakhmoni Jomi (39), Jillikul (42), Qumsangir (45), Panj (48), Jaloliddin Rumi (43), Sarband (49), Farkhor (59), Khuroson (50), Shurobod (62), Shahrituz (51) and Yovon (52) districts. Home-based services for older people and residential institutions for children are available in most of these districts. State run home-based services are only available in Kurgan-Tyube city; this serves adults with disabilities and older people who are lacking family support.
Long-term residential care services are a less developed form of service in Khatlon oblast compared with RRP for example. The majority of providers are situated in Shurobod (62), Temurmalik (60), Vose (54), Kulob (56), J. Rumi (43), Yovon (52), Muminobod (58) and Vakhsh (41) districts. 17 service providers are delivering long term residential services for adults and children. Some of the boarding schools for children including Boarding School for Orphans and Children Deprived of Parental Care «Ozodi» in Bokhtar (40) district, Boarding School for Orphan-children in Vakhsh (41) district, and Boarding School for Orphan-children and Children Deprived of Parental Care in Muminobod (58) district also provide additional day care services. Four boarding schools (republican schools) in Khatlon oblast (in J.Rumi, Kulob, Yovon and Shurobod districts) accept children from across the country. The schools in Yovon (52) and Shurobod (62) districts provide a combination of long term residential care and day care for children. The Boarding School for Orphan-children in Shurobod (62) district is one of the largest residential institutions in Tajikistan with a capacity to accommodate 366 children.
As evident in Figure 4.37, temporary residential-care services are only available in Bokhtar (40) district. There is only one provider of this form of service in Khatlon, a territorial centre for elderly and disabled people. This organisation also provides other forms of services including home-care and day-care; review of case records has shown that in 2010 short-term residential care services were provided for homeless people.
Provision of day care in Khatlon oblast is patchy; Figure 4.38 shows that services are only available in nine districts and in Kurgan-Tyube city, where the concentration is highest (rate of coverage is 280). There are 27 service providers of day care services in Khatlon oblast; eight of them are situated in Kulob (56) district (including Kulob city), four in Kurgan-Tyube city and Vakhsh (41), three in Bokhtar (40) district, and one or two across the remaining six districts.

In addition to day care provided by boarding schools in Vakhsh (41), Muminobod (58), Shuroobod (62), Yovon (52), Bokhtar (40) and the Territorial Centre for Social Services for the Elderly and Disabled in Bokhtar (40) district, which is provided alongside long-term residential care, day care services in Khatlon are also provided by NGOs. The majority of day care services are for children, including children with disabilities, orphan-children and children deprived of parental care. Other day care services focus on female victims of domestic violence, people living with HIV/AIDS, injecting drug-users and sex workers (including children).
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Reach, coverage and accessibility of social services - GBAO

The overall rate of social service provision in GBAO looks quite high in comparison with other regions of Tajikistan. This is because the population of GBAO is relatively small and the networks of long-term residential care (boarding schools) for children and home care (social assistance at home units) for adults are extensive. On one hand this means that every district of GBAO provides these forms of services for older people, adults with disabilities and/or children without parental care but, on the other, no social services at all are currently being provided for victims of domestic violence, girl-child victims of violence, exploitation and trafficking or for care leavers. Services for children with disabilities are only available in Khorugh town and in Shughnon (11) district.
Every district of GBAO has home care services (Figure 4.40) which mainly target older people living alone. However, home care services for children with disabilities are only available in Khorugh town. One service provider in Rushon (10) district delivers services for people living with HIV/AIDS, drug users, sex workers and people who have been released from prison. Among the home care service providers in GBAO oblast, only are non-governmental organisations: NGO “Nur” and NGO “Volunteer”. All the other services are provided by social assistance at home units which are managed and funded by local government authorities.
As already noted long-term residential care services are widely available across GBAO with some concentration in Murghob (8) district (Figure 4.41) where seven residential services attached to schools serve 183 children without parental care. The district covers a vast of territory with a low density population. Due to the geography and lack of alternative service delivery, most children in the district have little option but to use boarding schools in order to access secondary education, irrespective of whether they have families to care for them. There are no long-term residential care services for adults in GBAO at all.
Temporary residential care services in GBAO are only available in its regional capital, Khorugh town and are provided by two service providers: the “Narcological Centre of GBAO” funded by the local authority and the “Marifat” centre run by a local NGO. Both providers offer temporary residential care in combination with day-care. The former provides services for injecting drug users (children and adults) and the latter serves people living with HIV/AIDS, injecting drug users, sex workers, as well as people who have been released from prison and their family members.
Figure 4.43 shows that day-care services of one kind or another are available in all districts of GBAO except Roshtqala (9) district. Khorugh town has the highest concentration of day care services in the autonomous oblast with 10 service providers operating; indeed this is the highest concentration of day-care in Tajikistan with the exception of Firdavsi district in Dushanbe city. Day care services in Khorugh town focus mainly on adult and children who are injecting drug users and/or living with HIV/AIDS, ex-offenders (prisoners), children with disabilities, children in conflict with the law, street children and working children, orphan-children, children deprived of parental care, girl victims of violence, exploitation and trafficking, and sex workers. Four providers of day care services in Shughnon (11) district cover the same target groups as providers in Khorugh town. Almost all day care service providers operating in the autonomous oblast are non-governmental organisations apart from state run HIV/AIDS prevention centres which were set up in almost all districts of GBAO except Vanj (5) and Roshtqala (9) districts.
4.2.5. Strategies for coping with excess demand for social welfare services

The inconsistencies in the provision of services across all districts of the country mean that many services have more eligible applicants than available places. When this is the case, providers generally use one of three strategies:

1. **Establishing waiting lists**

Waiting lists for publicly provided services are often maintained by departments of labour and social protection of the Khukumat, for organisations controlled at the district level or by the SASPEM for republican institutions. NGOs generally maintain their own lists but if they are contracted to deliver state-funded services
then the district social protection agency may control the waiting list. Providers use several different methods for determining who should next be enrolled from the waiting list when a place becomes available:

- prioritising the person or household that has been on the list for the longest;
- prioritising people or households who have not yet received any assistance that year. This was reported in relation to material aid;
- taking into account the economic and social situation of applicants, including their income and the number of family members who may be able to provide alternative support. This was reported particularly in the case of home care.

2. Referring applicants to other organisations

Organisations are most likely to refer applicants to other places for support where services are less specialised. Households in need of material aid such as food and clothing are sometimes referred by district-level departments of social affairs to local mosques, private companies or individuals. Local public authorities and NGOs regularly report exchanging lists of needy households amongst themselves and with mahallas.

Occasionally applicants for in-kind services are referred elsewhere if the service provider cannot enrol them for support but it is rare that there are similar services with equally qualified personnel working in the same geographical area. One exception is when NGOs and local government provide home care services within the same district, and potential beneficiaries can be referred from one service to the other.

One district reported inviting young people and other volunteers to carry out home care:

“If we have 10 people, and we can only help five of them, then schoolchildren, students, and people who are proud to assist their country help the others. We work very closely with them... But although teenagers and young people help, they don’t know how to do it properly and how to take proper care of ill people. We need experienced workers.”

Key informant interview

One respondent suggested that people who have already received a service, such as advice, might be able to share their knowledge with others who are waiting to receive professional advice. In some contexts this might work, though it would be important for people not to be put at risk by receiving guidance from others who are unqualified. One possibility might be for some organisations to put in place a system of volunteering by former recipients of a service.
3. Enrolling applicants into the service but for a shorter period of time.
There is limited experience of enrolling people in a service for a shorter time. One
day-care centre for children with disabilities has recently reduced the length of
time during which its beneficiaries may receive support, from one year down to
six months, to allow more people to get basic access to the service. One service
that provides day care for older people also limited the number of months that
beneficiaries could receive the service.

Some services have not yet reached the maximum number of beneficiaries
that they can support. This is the case with several centres that provide drop-
in services, legal advice and counselling, rather than long-term residential care.
In these examples the providers can offer assistance to everyone that asks for
it but they may still prioritise the order of those cases, such as to respond to an
emergency before dealing with existing but not life-threatening cases.

4.2.6. Eligibility for receipt of services

Perceptions of services users and other stakeholders on the extent to which the
current system is able to meet demand for services in discussions with social service
providers the study tried to find out how they assessed the needs of beneficiaries.
There is rarely a clear mechanism to elicit the particular needs of individual
clients. Many social services providers said that the needs of beneficiaries were
identified through general discussion. Other providers talked about identifying
needs through studying the files of the potential beneficiary:

“We work as we used to work under the Soviet system.”
Key informant, social provider home care, Konibodom

Some providers offer services based on pre-defined schemes or according to the
regulations drafted and approve by authorities without considering the particular
needs of beneficiaries.

“We need to provide more than just legal assistance. We also need to provide
financial assistance to help people get through the crisis.”
Key informant, social service provider, Konibodom
The needs of beneficiaries were estimated at the beginning by our leading organisation in Dushanbe. Ten years ago. The scheme of social service provision was imposed.

Key informant, social provider, Kurgan-Tyube

There are however some best-practice examples of providers applying an individual approach to each beneficiary, using a case management method to identify needs. This was mentioned by organisations in Hissor, Rushon and Khorugh, which are providing services for children with disabilities and for adult drug users. One day-care centre for children with disabilities reported a thorough 12-day process which includes a visit by the social worker to the home of the child to assess family relationships, material conditions and the safety of the home.

The method for assessing when service provision should be terminated is variable. Some services are provided for a fixed length of time unrelated to need, while others are indefinite. In some cases the respondents complained that their assistance or cash assistance were withdrawn without explanation.

Before we used to receive some help, we received it based on a card. One day, they came and took it, they said that it was to check how much help we got, they never returned it.

Poor, large household, Non beneficiary, Dushanbe

A large part of the population is identified as being in need of some form of social services. All respondents complained about material needs and essential services, particularly about the financial barriers to accessing medical services. Apart from general needs the research identified specific needs for some priority groups that could be addressed through the provision of social services (see Figure 4.31).

4.2.7. Availability of information about social services and referral systems

Lack of information about social services is one of the key reasons why vulnerable people do not seek assistance. Many respondents recognise the importance of active awareness-raising in communities. This serves two purposes. First, it maximises the uptake of the service by people most in need. Second, it makes clear what services can and cannot be provided, in order to manage expectations. Local authorities understand that people are confused about what social services are and that they will be disappointed if they imagine, for example, that a home care service exists to repair blocks of flats. This is a common phenomenon recognised by social services planners internationally.
People may be attracted to, or referred into, services that already exist, even if they don't need them, an effect sometimes referred to as ‘net-widening’. Effective, carefully targeted planning based on full assessments of need can help to ensure that only the services that are needed will be developed and that only those who need these services are directed into using them.

Despite the importance of disseminating information, the way people find out about social services is often haphazard. Respondents reported many different ways of spreading knowledge or learning about social services, ranging from unofficial conversations through to formal referrals (Figure 4.32). Service providers and local authorities often reported that they had systematic outreach programmes but beneficiaries were more likely to say they heard about services through informal channels such as through friends who work there.

In some cases respondents ended up receiving a service through a chance conversation, even by pure accident:

“I was visiting my mother. The director of the centre was going to people’s homes to register ill children. She meant to knock on the door of our neighbour, who has a disabled child, but she came to us [by mistake]...We said that we had a disabled child too.

Beneficiary, caregiver of child with disability

Discussions with key informants during the beneficiary consultation confirmed that teachers, family doctors and others such as the chair of the mahalla are able to identify and provide information on vulnerable people in their community. They are currently used as an identification mechanism for provision of some forms of state cash assistance such as education assistance (school compensation), home care service, residential care.
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Teachers hold information on poor households with children, and on children in need of social services. They are in a position to make a recommendation to place a child into residential institutions. Doctors keep lists with vulnerable families, poor households, people in difficult situations, persons with a disability, and people living with HIV/AIDS, and they report that they update these lists regularly. Social services providers reported that people that are usually difficult to reach can be found only through family doctors.

On the other hand, family doctors and teachers do not take much initiative in collaborating with social service providers. They do not know them and are not able to direct people in need.

In relation to formal publicity campaigns and referrals, three key points have been highlighted through the study:

1. Media campaigns such as television programmes may reach better-off households. Television programmes are used by both government and non-government organisations, and several beneficiaries reported having heard about services by this means, including for the home care service, residential institutions and crisis centres. However, almost all the respondents who had heard about social services from the television considered their well-being to be average or above average compared with others in their community. This is consistent with the fact that poorer households may not have electricity or a television.

2. There is a mixed opinion about the appropriateness of community outreach. Some service providers went out into communities to talk to heads of mahallas, mosques and community groups to advertise their service. Some respondents of the home care service said that they had found out about the service when social workers came to the door to offer help. But another provider said they would not conduct community outreach in case their motives were misinterpreted.

3. Formal referral processes are not yet widespread. The main use of formal referral procedures was in relation to the child rights department: children who were picked up by the militia or the Department for Minors were referred to the child rights department to be assessed for support. For other services there was little mention of referral or formal coordination between professional agencies. For example, many respondents with disabilities received a disability pension, but none said that at the time of applying for the pension they had been given any information about in-kind social services.
4.2.8. Experiences of applying for social services

Households in difficult situations that were interviewed for this study fall into three categories: those that have never applied for services, those that have applied but not received services and those that have applied and received them. Their perceptions of the ease of applying for services vary widely.

Experiences of non-applicants

Five main reasons were given for households not applying for social service provision. These are:

1. **Lack of awareness of services.**
   Many of the non-beneficiaries interviewed were not aware of their rights or had never heard about social services. When asked why they did not look for assistance they replied that they did not know that assistance was available.

   “Many of our beneficiaries didn’t know about us. How would they know of social services? We have to go and look for these women.
   
   Key informant, Social services provider, Dushanbe

   Access to social services for a particularly vulnerable part of the population is restricted because these people are in some cases illiterate.

   “I don’t know how to write, I never tried to write an application. I don’t even know that these services exist … because I am illiterate I could not apply for the orphan pension that should be given to my children.

   Poor household, Non beneficiary, Dushanbe

2. **Difficulties of physical access.**
   Some respondents have limited access to social services owing to where they live. They consider that there is no point applying because the services are too far away or too difficult to get to. From this point of view social services are practically unavailable in rural areas. Some groups, like people with disabilities and older people sometimes cannot physically access the existing services.

   As highlighted already, the reach of social services is often extremely limited. For example, one day-care centre for children with disabilities reported that its beneficiaries come from no more than six or seven kilometres away which clearly represents a barrier in terms of transport for those children living further away who might otherwise be eligible for the services of offer at the centre.
3. **Embarrassment at asking for help.**

Stigma, shame, fears are other reasons for not accessing social services. Family members of people with a disability confessed that they were ashamed to look for support. In the same situation are people that have problems with drugs, ex-convicts, and people infected with HIV/AIDS.

“I don’t know who would like to help this sort of people? (referring to her disabled child.)

*Caregiver of disabled child, Beneficiary, Hissor*

“There are a lot of people that might need our assistance, but they are not coming, we have no waiting lists. It is considered a shame to get this kind of service, people are afraid to come…”

*Key informant, Social provider, crisis centre, Dushanbe*

“Some people are shy; some think that getting help is a disgrace. Some do not consider themselves in need, even if they are. Some husbands forbid their wives to ask any kind of assistance.

*Key informant, Family doctor, Dushanbe*

One respondent felt that she would be judged critically by her neighbours for turning to the local authorities for help instead of relying on her children. In small communities there is a concern that news about a person’s attendance at, for example, a clinic for drug users would not remain confidential, and would quickly become known.

4. **Complexities in the application process.**

Many people in need cannot access support because they have difficulties, or expect to have difficulties, in getting the documents for the application. Some have no passport or residence, and others complained that they had no money to travel or to pay for various certificates.

“It’s going to take a lot of running around. And who is going to look after this old lady [while I run around]?

*Non-beneficiary, disabled man who is caregiver of his disabled sister, Danghara*

5. **Lack of trust in the authorities.**

Many respondents mentioned the lack of belief that local authorities would be able to help them or could be trusted to provide the service. Others expressed a fear that their homes would be taken away. Some thought it unlikely that their case would be considered if they did not have personal connections.
Experiences of rejected applicants

Households that had applied for services but had been rejected did not experience the first three difficulties in the above list. They had found out about services, were aware that they could get physical access to the service they needed, and had got over the embarrassment of asking for help. For these households, the barriers to receipt of services are the last two: the complexities in the application process, and the lack of trust in the authorities.

In respect of the application process, some respondents were unclear about what the procedure was for examining their application. They had been on a waiting list for a long time without being informed of the status of their application:

“I don’t know who would like to help this sort of people? (referring to her disabled child.)

Caregiver of disabled child, Beneficiary, Hisor

The lack of a permanent address can add to the complexity of the application process since a person living in temporary accommodation in one location may be told that they are ineligible to apply in the area where they are staying. This is a particular difficulty for people whose need for services arises from homelessness.

As for the attitude of the authorities, several respondents reported that they had had a bad previous experience. One respondent had tried asking for help from the local authority and had simply been told that there were lots of people with problems and not everyone could receive help. Another had been mistakenly informed that she was not eligible for aid. Some said they were constantly humiliated and mistreated. Many said that the system was corrupt and one should have family ties or friends (“connections”) to get any support.

“I went to the head of the district twice, in 2009 and 2010. I asked for assistance for my daughter. He asked me how old she was; I told him she was 5 years old. He said “your daughter eats only kasha and drinks milk, you should have money for that”. He meant that I am a beggar and went there for food. When my husband found out he forbade me from looking for any other assistance. He said “as long as I live you will not ask for help around, even after my death, try to cope by yourself.

Caregiver of a disabled child, Non-beneficiary
My wife is disabled, she can’t work. I went to doctors in Dushanbe to obtain a certificate of her degree of disability. The doctor asked for US$ 300 for the certificate. Where can I get that amount of money? If we had the certificate we would apply for a disability pension.

Poor household, two members of the household with disability, Non-beneficiary, Hissor

Experiences of successful applicants

Households that receive services are quite consistent in their view that application processes are very straightforward which could indicate that those who are actually receiving services are in fact less in need of support and better able to overcome barriers. Or it could indicate that having successfully received support, the difficulties of the application process are forgotten. Sometimes a beneficiary indicated that they had had to overcome an initial difficulty to receive the service, such as by overcoming the shame of applying:

“...Asking for help the first time is hard. You think, how am I going to be received? Then you get worried and you’re embarrassed to reveal your problems. But then you get used to it.

Beneficiary, Khujand

Occasionally beneficiaries went to considerable lengths to improve their chance of receiving a service, such as by moving house to be physically closer to the facility, particularly in relation to disability services.

More commonly beneficiaries did not report any problems at all. The application process was often reported to be easy, no beneficiaries said they had spent time on a waiting list, and local authorities were said to be approachable. Social assistance, and especially the disability benefit, was also reported by many beneficiaries to be easy to obtain.

This suggests that either they did not experience the obstacles faced by non-recipients, or they did not perceive them to be obstacles. As one beneficiary remarked, ‘It’s easy when you’ve got all your documentation to hand.’ One service provider noted that,

“It’s easy to enrol in our centre. Parents just have to write their application, collect all the documents confirming the disability and join the waiting list.

Key informant, service provider, Hissor
One may perhaps conclude that the application process is broadly the same for everyone but that households differ in their ability to comply with the requirements and that there is little support available for those who are less able to comply.

4.2.9. Beneficiaries’ perception of the quality of services

Although some providers may have developed monitoring systems to varying extent, there is no overall system of quality assurance which corresponds to identified social welfare goals or objectives. Therefore, exploring the perceptions of service-users is a useful way to get a broad insight into current levels of quality and to feed into the on-going development of quality assurance mechanisms including standards of different types such as professional codes of practice.

Beneficiaries across many forms and types of service reported being pleased with the care that they received. As one remarked, ‘I really don’t know what they would have to do to provide a better service.’ This sentiment was often reported even if a service did not cover all of a user’s needs, or was not really necessary, because they generally appreciated that they were receiving any service at all. This is common where there are few criteria controlling the entry of beneficiaries into services and where there could be a ‘net-widening’ effect.

The main exception to this tendency was in the area of mental health where it was reported that in centres for people with mental health difficulties there was little to do and the services were ineffective.

Both providers and beneficiaries measure the quality of a service by two main criteria:

1. **Whether it delivers good results.**
   For example, children with disabilities may improve their speech or range of movement; adults who receive counselling may stop being suicidal. Where services were considered not to be good, this was because they achieved no result for the user.

2. **The attitude of the staff.**
   Many beneficiaries appreciated the fact that staff were polite, attentive and conscientious. This was particularly important for adults who felt poorly treated within their own families:
The social workers do their job very well... They are very polite. If we need help and we ask them the help us straightaway. There has never been a case when they were rude to anyone...This is what we value, because we feel abandoned.

*Beneficiary, home care, Danghara*

When they took me into their shelter they treated me like one of the family.

*Beneficiary, women’s centre, Khujand*

Conversely, where services were considered to be poor, one reason was the negative or neglectful attitude of staff. For example, at one mental health facility staff reportedly tied patients up and allowed patients to be aggressive towards one another.

3. Beneficiaries added a third measure of quality: the absence of any pressure to make informal payments in order to receive services.

The main complaint regarding services was the quality of the buildings and living conditions which reflects a tendency among beneficiaries to understand ‘services’ as places rather than the actions of people interacting with the service user. Many beneficiaries and caregivers remarked on the intermittent electricity supply and lack of heating in day care and residential services. However, beneficiaries rarely used this as a criterion for judging whether a service was good: they tended to say that the service was good, but it was a pity that conditions were so poor.

**Participation of beneficiaries in planning is variable.** The extent to which users can determine what kind of service they get is highly variable. Some local authorities and providers of residential care said that beneficiaries play no part in determining what services are delivered. In other cases service providers have developed systems for getting either one-off or regular feedback to elicit suggestions for improvement.

These systems include:
- a book where visitors to the facility can record their observations;
- a notebook where users write a score reflecting their opinion of the service;
- home visits or telephone calls to users;
- questionnaires; and
- a parents’ committee that takes an active role in planning.
Some beneficiaries said that they used these systems to make suggestions and that their ideas had been taken into account, leading to improved results. There was almost no indication that formal mechanisms were in place to handle complaints; no respondent had tried to complain, and only one provider described a grievance mechanism (involving written submission of a complaint to the director of a service).

**Limited flexibility in home care provision.** Regardless of whether or not beneficiaries are involved in planning there is an issue about whether service providers are flexible in tailoring the service to each beneficiary’s needs. Most service providers operate within a framework which sets out the basic services they provide to all beneficiaries. For example, several providers of home care note that they are expected to attend two beneficiaries per day, for two hours each.

People are more likely to receive a service that meets their specific needs if they have the confidence to ask the service provider directly, particularly in relation to home care. The difficulty is that because users may be embarrassed to ask for help, they sometimes do not voice their needs even when they know they would prefer a different type of service to the one that they receive. They feel grateful for any help at all. For example, one user of the home care service said that it was nice that social workers came round to tidy the house though it would be perfectly possible for their own relatives to do it.

Failure to respond flexibly to the needs of beneficiaries can have an extremely severe negative effect on their ability to observe basic conditions of hygiene and sanitation:

> I need to have a shower, get my hair and nails cut, and change my clothes. I took a shower at the end of September when it was warm. Now I’ll wait until April. They [the social workers] work very well, but I need someone to wash my arms and legs and put my socks on for me, because my hands can’t reach as far as my feet. I’m happy with what they do at the moment, but I don’t know what their duties are.

*Beneficiary, home care*

Other beneficiaries said that they would like to have help at night so they could go to the toilet, or assistance to leave the house since they had not left their home for several years. This indicates that, for some people, basic needs are not being met even though they are in receipt of a social service. It will be important to consider how social service provision can be made more flexible to accommodate these basic needs.
In summary: key findings in relation to current demand and supply of social services

1. The main client groups being reached consistently across all regions of Tajikistan are:
   - older people without family support and adults with disabilities
   - children with disabilities
   - children without parental care or at risk of losing parental care
   - people living with HIV/AIDS and/or injecting drug users

2. Within some regions provision of these services is limited to only a few districts and some districts have no services for these core client groups at all.

3. Care leavers and homeless people stand out as being among the most underserved beneficiaries when looked at as a proportion of the child or adult populations.

4. Children with disabilities, child orphans, children without parental care and children in vulnerable families have among the highest rates of service users per 100,000 child population, however most services for these groups of children are provided in residential settings. Only children with disabilities have access to day-care and home-based forms of services reasonably consistently across all regions – although some districts within nearly all regions offer no access to services at all.

5. Older people over 60 years of age without family support have some of the highest rates of service use among adults across all regions. Nearly all provision for these adults is in the form of home-based care with very little day-care forms of provision that could help to facilitate social participation. Home care is reported as not always meeting individual needs.

6. Services for children and adults with HIV and intravenous drug users are also being delivered in every region, but it is not clear to what extent they are being ‘over-delivered’ as demand is probably not the same in every region. The rates of provision of services for children and adults who are HIV+ and/or intravenous drug-users is high. This could be a reflection of donor policies and investment in the development of services for these specific groups and can be seen as an ‘adequate’ level of provision given the current infection rates.
7. RRP has very few services available to its own population as it is serving the whole country with a large concentration of long-term residential forms of care. RRP has a chronic shortage of home-based services for adults with disabilities or older people.

8. Nearly all long-term forms of residential care for adults are located in RRP.

9. Most services, apart from temporary residential forms of services appear to be ‘clogged’ up with a static client base which is receiving on-going, long-term services whether in home-based, day-care or residential form.

10. There is a marked absence of criteria and assessment for enrolling clients into services or ensuring that clients cease to receive services as their needs are met or change.

11. This lack of criteria also compounds the very marked general lack of awareness of social services among beneficiary and potential beneficiary groups. Other factors that hamper the self-referral of vulnerable people include lack of support in meeting the application requirements for services.

12. There is notable proportion of service providers that offer a range of forms of service under one roof. This could indicate that there is the potential to build a range of forms of service provision across all regions on the basis of existing mono-service forms. For example home-based service providers could start to develop day-care or drop-in services for isolated older people or adults with disabilities in order to expand opportunities for social interaction and participation.

13. Respondents indicate a healthy opportunity for engaging volunteers in the provision of out-reach, home-based or centre-based services for children and adults.
FEATURES OF EXISTING SOCIAL SERVICES PROVISION - KEY OBSERVATIONS
Features of existing social services provision – key observations

This section makes some key observations about the features of the existing system of social services provision based on the findings of the research. It sets out the intention of the existing legislation and then examines the extent to which these intentions are being realised through the current system based on data collected during this research.

Firstly it is important to view the current system in the context of a reform process. The current social services system has emerged from a Soviet system of service provision influenced, in more recent times, by development agendas of donors and international organisations targeting specific vulnerable groups. The system which exists today in Tajikistan is therefore based to a large extent on residential and home-based services left-over from the Soviet system and temporary residential care and day-care provision which has developed in the last 20 years. The latter are often funded by - and usually delivered by – NGOs, however there are now a few cases where these services are operated with government funding.

The intention of the legislation governing social services provision set out in Article 3 of the Law of Republic of Tajikistan “On Social Services” is to:

- Promote equal opportunities for all members of society, aimed at strengthening social cohesion and preventing social exclusion;
- Ensure a dignified and safe life and participation in society;
- Assist citizens in overcoming difficult life situations which they are unable to resolve by their own means.

Responding to need – strategic planning

Although there is no over-arching strategy driving the development of the social services system, there is a specific piece of legislation which lays out the underlying intentions of the system in broad terms. It is clear from this legislation that the inherent aim of social services in Tajikistan revolves around the provision of a range of services that can meet a range of diverse needs among people who are living in difficult life circumstances and require support in order to overcome
the barriers they experience that prevent them from leading a normal life, however that is defined. A system that can be based on assessing and responding to the client’s own perception of ‘normal life’ and ‘barriers’ can go a long way towards meeting the highest standards in social services delivery worldwide, especially if the interventions that respond to the assessment of need are also defined and implemented by the client, with the social services provider playing a supportive and facilitating role.

At present the system of social services appears not to be responding primarily to the needs of target beneficiaries, nor identifying and meeting the needs of those who are most vulnerable or in need, nor is it aiming to fulfil the rights of children or adults with specific vulnerabilities. Rather, the system appears to be offering patchy coverage of some forms of social services to a largely static segment of the population in each region and organised in a rather ad hoc network.

The data from the study demonstrates conclusively the extent to which district and regional planning for the system of social services delivery is absent. The complete lack of services in some districts for some categories of service users is notable – particularly in RRP.

**Availability of a range of different services**

A partial transformation of the system of service provision can be observed where service providers that were designed to deliver mono-typical forms of services have started to add different forms of service delivery to the main form of service delivery specified in their statutes. Some providers of home-based services for older people and adults with disabilities, for example, are developing facilities for temporary or long-term residential services or for day-care services and extending their reach to children with disabilities or children without parental care. Similarly, some long-term residential care providers are developing day-care or home-based forms of service delivery. This development shows that parts of the system in some regions are changing in order to respond to gaps in services. This is an encouraging foundation for assuming that, if some service providers in some parts of the country can make these changes, similar service providers in other parts of the country can also make these changes to existing forms of service provision. In GBAO, for example, where the majority of service provision takes the traditional former Soviet forms of residential care for children and home-based care services for older people and adults with disabilities, there is considerable scope for learning from other regions where greater numbers of hybrid services have started to emerge.

Services for the homeless and for care leavers appear to be being delivered at a significantly lower rate than services for other groups and the levels of delivery
of services to older people, adults with disabilities and children with disabilities all probably need to be increased at least to the highest rate of delivery currently recorded in Dushanbe and GBAO. Respite services for the carers of children and adults with complex functional disorders are only available in the form of residential services and limited day-care provision. The absence of community based family support services of any kind for children who are socially vulnerable or who are without parental care is a clear gap that needs to be addressed, as is the absence of any services of any kind in some districts.

Geographical availability of services

The network of service providers that currently exists is widespread but does not provide sufficient coverage in all districts. If there is even one service provider in a district, this offers an opportunity for a diversification of service forms in order to reach out to wider groups of people in need of social services without necessarily creating new structures or needing to make new investments in capital resources such as buildings. The study has found that this is already beginning to happen in some regions; in Khatlon, for example, service providers that have traditionally been focused on delivering home-based services to older people and adults with disabilities have begun to systematically deliver similar services to children with disabilities. The beneficiary consultation demonstrates that these services may not yet be based on objective and consistently applied assessments that can respond to the individual needs of service users, may be overly-focused on medical models of disability and not sufficiently based on an understanding of social models of disability, but they nevertheless exist and represent a resource for expanding the capacity of the system of service provision.

In other countries of the region, in Russia for example, the Soviet era services offering home based care services to older people and adults with disabilities have developed to become district centres for the provision of a range of both home-based (out-reach) and centre-based (drop-in or day-care) services to a range of vulnerable target groups, both adults and children. In the drive to ensure accessibility of services without increasing capital costs, these centres have developed a number of models of outreach forms of service. These include the traditional home-based care forms, mobile multi-disciplinary teams moving from district to district on a rota basis (but managed from the main district centre), community based (uchastkovie) social workers focused on particularly vulnerable groups of children and adults operating along similar lines to community based health or police services and other models for organising services that can be rooted at the community level, gain an understanding of community needs and be in a position to respond to those needs. These forms of outreach service provision, where the service providers is tasked not only with delivering services, but also with proactively seeking out those most in need of services, are important
for ensuring that people who have limited capacity of various kinds are able to access the services to which they are entitled, and which have been created to serve their needs.

This report and the extensive online mapping resource http://www.mehnat.tj/mapping has documented in detail the geographic gaps in service provision, the gaps in the provision of some forms of services for some groups of beneficiaries and has identified and documented the regional variations of these gaps.

Accessibility of services

The current system of social services is currently over-subscribed for some forms of service delivery and under-subscribed for others. A general observation based on the data from this study with its acknowledged limitations - both the quantitative mapping data and the qualitative data from the beneficiary consultation – is that the service forms that have waiting lists are those about which potential beneficiaries are more aware, including home-based services for older people and adults with disabilities, residential services for socially vulnerable children and all forms of services for children with disabilities. Overall, there appears to be uneven service provision to different groups of service users.

A further general observation is that the services which have fewer clients than their capacity allows for are newer services, often run by NGOs, which may not be widely known about, or which may be perceived as being shameful to approach, by potential beneficiaries. Examples of these types of services are those targeting ‘newer’ categories of beneficiaries such as victims of domestic violence, sex workers, injecting drug users and are usually delivered in the form of centre-based day-care or drop-in services. It is not clear to what extent thorough assessments of need for the services themselves have been carried out prior to their set-up and part of the reason for a lack of clients could be that the level of need is not as great as originally anticipated.

A government report (Tajstat, 2010b) for 2009 provides a summary of results in relation to a network of 18 crisis centres for women who are victims of violence. The report states that during a period of nine 9 months in that year the network of centres provided services to 3,860 women and men (91% of applicants for support) who needed support with issues including legal advice on housing, alimony and other legal issues, support with employment disputes, and advice on children’s issues. Only a relatively small number of problems presented by applicants were related specifically to violence. This appears to be a case of services having been planned without due consideration of the scale, type and prevalence of particular needs and/or service providers being pushed into
Social Services in the Republic of Tajikistan

broadening their target groups and widening services in order to fulfil expected demand for services or perhaps to coincide with the priority themes and agendas of funding partners.

Other factors affecting the reach of services relate specifically to the geographic location of service providers and the barriers they face in reaching out to other districts or that potential clients face in reaching them. The absence of services in RRP is of particular note and seems to point to a chronic lack of planning for service provision.

Effective in promoting social inclusion

While home-based services for older people and adults with disabilities may be keeping some older people out of residential services, they do not appear to be addressing issues of social isolation. Some older people and adults with disabilities may require the kind of 24-hour care that is offered in long-term residential care but have to make do with home visits 2-3 times a week as no residential services are available. Similarly, some older people who took part in the beneficiary consultation for this study report that they have ended up in long-term residential care because of issues such as housing fraud, which could have been addressed by home-based services. Stronger assessment and targeting of services could help to ensure a greater reach to more service users and more effective outcomes from service provision.

There is an over-reliance on residential forms of service delivery for children. The system of social services currently makes almost no provision for services to children and their families while they are living at home. Children have to become resident in an institution of some kind, whether a sanatorium, boarding school or children’s home, in order to access a range of services which would better serve their interests if delivered in the family home with the child attending local education services. A priority in planning must be to balance out the provision of day-care and home-based services for socially vulnerable children and reduce reliance on harmful forms of institutional care. Preventative family support services based in the community tend to be less resource heavy and can ease pressure on more resource heavy forms of service delivery such as residential care. De-institutionalisation of services for children can be achieved through a planned process of shifting human, financial and capital resources from residential forms of service provision to community based, out-reach, day-care and home-based forms of service provision.
INDICATORS FOR POTENTIAL USE IN MONITORING SOCIAL SERVICES

6.1 Social exclusion and social services
6.2 Measuring the performance of social services
6.3 Indicator sets for specific target groups
6.4 Considerations for moving forward with planning, delivery and monitoring of social services
6.5 Specific actions for consideration (short to medium term)
Indicators for potential use in monitoring social services

The previous section discussed the fact that there is currently no strategic overview of social services provision in Tajikistan but that some aims of the system can be derived from the specific social services legislation, namely:

- Universally accessible social services for those who need them
- A range of different forms of service that can respond flexibly to a range of needs identified by beneficiaries themselves
- Social services which are effective in promoting social inclusion and quality of life for people who are marginalised or at risk of being marginalised

The system can also be assumed, as discussed in section 1.6.1 above on definitions and terminology in social services provision, to be targeting three groups of the population:

1. Vulnerable groups who need support in accessing universal services
2. Those with complex needs
3. Those who are in crisis or in emergency situations

If we take the goals relating to social inclusion and the first of the target groups that requires support in achieving social inclusion, we can assume that one of the functions of the system of social services provision in Tajikistan is to promote social inclusion and reduce social exclusion. However, measuring baseline and progress toward increasing social inclusion is a very challenging task which requires a set of prerequisites to be in place which many countries with advanced economies struggle to achieve. This section therefore begins with a discussion of the challenges inherent in measuring social exclusion and inclusion and then examines a range of options for developing sets of indicators appropriate to the social services system in Tajikistan, which capture some elements of measuring social exclusion but also view the social services system and undergoing a process of reform which also needs to be measured.
6.1 Social exclusion and social services

The use of social exclusion indicators has emerged as an alternative to traditional income indicators, which were recognised as inadequate measures of resources and outcomes. Individuals’ income might not accurately reflect wealth and resources, and ability to convert resources into outcomes may greatly differ. A disabled person, for example, may need more resources to achieve the same standard of living as an able-bodied person. Equally, resources may not be converted to outcomes due to external constraints, such as market inefficiencies or poor access to services. In addition, income-based indicators may be inadequate for monitoring policy outcomes. Policies promoting social inclusion may be focusing on access to services, educational performance, labour market participation, rather than income per se.

The measurement of social exclusion/inclusion began quite recently, with the European Union at the forefront of the discussion on social development. The EU adopted in 2001, and revised in 2006, a set of indicators for social inclusion, generally referred to as the Laeken indicators (the full list of indicators is presented in Annex E). The indicators were chosen based on a set of criteria which included comparability based on sound EU harmonised data, policy responsiveness, clear normative interpretation, and a focus on outcomes, and are used by member states in their National Action Plans on Social Inclusion to monitor social developments.

The Laeken indicators and other established social exclusion measures, such as the UK Opportunity for All indicators, measure distribution of poverty, as well as access to services such as employment, health, education and housing. Unlike the Laeken indicators, the UK Opportunity for All framework includes indicators which measure outcomes for particular groups at risk such as children living in disadvantaged areas, people with a disability, sole parents, and ethnic minorities. It is important to note that both in the EU and in other developed countries with advanced statistical and data collection systems, the issues of measurement and comparability of indicators is discussed continuously, as important pre-requisites which must be met in order to measure social exclusion.
Collecting data on social inclusion

In order to measure social exclusion, some pre-requisites must be met. Cross-ministerial and cross-departmental co-operation is required, since social exclusion is a cross-cutting and multi-dimensional issue. In order to build policy-relevant social exclusion indicators, data must be disaggregated. Furthermore, data sources such as the household budget survey (HBS) and labour force survey (LFS) also need to be of high quality, capable of being de-composed into various social groups and localities. Linking data from various sources (particularly from national and sub-national register systems) can help measure social exclusion.

The task is challenging for two main reasons. National statistical offices have limited capacity to produce disaggregated data in areas beyond poverty, such as social participation and social networks. Furthermore, institutional settings often make it difficult to combine various data sources to produce multi-dimensional results.

Some countries have been successful at putting together social exclusion measurements. In Poland, for example, social exclusion estimates are based mainly on ‘administrative’ data collected by the National Statistical Office from public and private entities (about 80 per cent of all data), or based on statistical data collected by local administrations. These data are disaggregated by territory down to the lowest level of public administration and, in some cases, down to the city district level.

Source: Adapted from UNDP (2011) ‘Beyond Transition: Towards Inclusive Societies’

Social exclusion in Tajikistan

As discussed earlier in this report, in 2011, the UNDP published a flagship report on social exclusion in post-socialist countries of Europe and Central Asia. The report proposes a methodology for quantifying social exclusion in these countries, through the Multidimensional Social Exclusion Index, which includes 24 indicators of exclusion along three dimensions: economic exclusion, exclusion from social services, and exclusion from civic participation. It then applied this methodology to collect social exclusion data through nationally-representative household surveys, which were conducted in 2009. In Tajikistan, the survey included household interviews with 2,700 people, as well as focus group interview with people in major vulnerable groups.

The report indicates that social exclusion is pervasive in Tajikistan. Seven out of 10 persons are socially excluded. Percentage of excluded persons is particularly high in the area of financial services, access to water and sewage, and civic participation. The survey dataset can serve as an important resource to assess the situation of socially excluded groups in Tajikistan. Although the survey does not focus specifically on the exclusion of people with disabilities, it does provide some data on attitudes towards inclusive education and other variables of interest.

The UNDP is currently discussing with the Tajikistan Agency of Statistics the possibility of measuring social inclusion regularly, through a module of the household budget survey. This would allow analysing social exclusion over time. This could also represent an opportunity to include one or two indicators of interest specifically in relation to monitoring the role of social services (according to the definition given in this report) in reducing social exclusion.

Questions could focus on the role that social services is playing in facilitating social inclusion. For example:

> Have you needed support in accessing health, social assistance, education or transport services in the last year? If yes, has this been provided?

or

> Has a state or non-state organisation provided the support you need to access health, social assistance, education or services in the last year?

Depending on the policy developments relating to defining disability discussed below, a question such as these could be preceded by a screening question on functioning in order to determine levels of disability.

Social exclusion and social services

Social exclusion is a complex, multi-faceted phenomenon, driven by a number of varied causes. In general, two sets of factors influence levels of social exclusion:

1. **Economic and social changes.** These include the influence of the global economy, shifts in the relative importance of certain industries, and change in social and cultural attitudes that affect communities and households.
2. **Government policies, working methods and coordination.** Social exclusion can be affected by all Government policies, including growth policies, employment regulation, education, health, social assistance, youth policy, law enforcement, etc. Moreover, many social exclusion issues are cross-cutting and traverse the boundaries between different sectors and institutions.

The first set of drivers is often outside the immediate reach of government policies. Nevertheless, the Government can monitor such developments and try to prevent or reduce the level of social exclusion brought about by economic and social changes. To achieve that, it is important that Government has a sound system for collecting evidence, which allows disaggregation across regions, by gender, and by various other categories of interest, that policy concentrates on outcomes rather than process, and that investments are sustained rather than short term.

As discussed elsewhere in this report, social services can play an important part in preventing or reducing social exclusion by providing timely assistance to specific vulnerable groups, as well as in reducing social exclusion levels by re-integrating those who become excluded back into society. In developing, implementing, and evaluating the performance of social services, however, it is important to keep in mind that such services can address certain social exclusion issues only partially, and outcomes for people may depend on the interaction of a number of policies and authorities outside the reach of the social services system alone.

### 6.2 Measuring the performance of social services

Social services, including social work, social pedagogy and social care (as described in Annex C), are a relative newcomer to performance measurement. Performance measurement in social services is principally concerned with comparison and with qualitative methods that can capture the perceptions of service users about the effectiveness, appropriateness or quality of services. Progress on achievement can be compared with a standard, which denotes when performance is considered acceptable or when there is a need to consider remedial action. Comparison with other regions, districts or countries can also help to flag up areas where further enquiries may need to be made and action taken, although care has to be taken to compare as far as possible like with like and take into account the economic, social and policy factors that can influence the environment in which social services are implemented.
In measuring the performance of social services, and based on the assumptions stated above about the goals, intentions and target groups for social services in Tajikistan, several important considerations have to be kept in mind:

- Social services have to be well-targeted and reach the population in need;
- Social services are more effectively and efficiently provided at the local level;
- Social services can be provided by both public and private organisations;
- Social services should be flexible in order to adequately respond to the dynamic changes in society and to differing and changing individual needs of the beneficiaries.

In a country where social services delivery systems are still being developed, such as Tajikistan, measuring the performance of certain reform actions should also be taken into account such as reforming residential institutions into day-care centres or outreach services. The mapping exercise undertaken for this study has helped to fill a gap in key administrative data and increase understanding of the outputs and outcomes of service delivery. Some key indicators of performance of the system, based on the set of assumptions stated above and elsewhere in this report about the goals and intentions of the system, have emerged from the mapping exercise.

**Agreed definitions of key social policy concepts** are needed that can underpin not only a strategic framework for the development of social services, including indicators, but also the gathering and analysis of data for monitoring indicators. The conception of disability in Tajikistan, for example, continues to be based mainly on a biomedical model where disability is denoted through a medical diagnosis that then triggers access to a range of social assistance and services. The ‘normalisation’ goal explicit in the legislation on social services implies a move towards a more ‘environmental’ or social model of disability. If this is the intention of the policy-makers, then a definition of disability is required for social services that reflects an understanding of disability as an in interaction between the person and the environment around him or her and can therefore be relative and situational (Tosebro et al, 2004). Internationally, the publication of the International Classification of Functioning, Disability and Health (ICF) by the World Health Organisation in 2001 and the children and youth version (ICF-CY) published in 2007 represent a significant milestone in moving towards a more social model of disability at a global level and continue to be used by national policy-makers worldwide for both defining national concepts of disability and monitoring statistical data on disability. The ICF acknowledges that every human being can experience a decrement in health whether through ageing or some other life event and thereby experience some degree of disability.

Chapter 6. Indicators for potential use in monitoring social services

http://www.who.int/classifications/icf/en/ and http://apps.who.int/classifications/icfbrowser/
Once agreed, definitions of key social policy concepts can then inform the way in which the target groups for some social services are identified and subsequently monitored. Similar conceptual challenges and issues need to be addressed at the macro level in relation to the needs of children, older people and other people with specific vulnerabilities and could form part of national policies or action plans for each group.

A joined-up view on data collection and evaluating the system is needed across a whole range of Ministries at national level, which can ensure a greater understanding of needs and the formulation of a strategic vision for reform. At present the legislation on social services provides the main basis for defining the overall strategic goal of the system of social services delivery. Many existing data gathering mechanisms, however, currently link into other policy initiatives, monitoring, for example, Tajikistan's commitments in terms of meeting the MDGs and HIV/AIDS reduction policies at a national level and don't generate usable data for planning and monitoring social services delivery at the district and regional level.

Disaggregated data-sets that can provide reliable demographic data from district through regional and up to national levels are required for key segments of the target beneficiaries of the system of social services delivery. Tajstat already gathers the majority of the required data, but further disaggregation is required particularly to distinguish levels of need in terms of: adults, children and young people at different ages; disability (adults and children); particular vulnerabilities (HIV/AIDs, violence, poverty, mental health issues, other health issues).

### 6.3 Indicator sets for specific target groups

In the absence of an overarching strategic or policy plan that establishes the goals and objectives of the social services system, indicator sets for specific target beneficiary groups that exist internationally can be used as a basis for developing indicator sets for monitoring some aspects of social services provision in Tajikistan. This sub-section offers a brief overview of some of the key indicator sets that have been developed internationally for particular target beneficiaries of social services and discusses how they could be useful in the context of monitoring social services system reform in the Republic of Tajikistan. Where a number of international indicator sets exist, or where no single set recommends itself, a set of indicators based on conclusions from the mapping exercise and rooted in the existing system of social services provision is proposed. This section assumes that indicator sets for beneficiary groups such as children and adults living with HIV/AIDS, sex workers, intravenous drug users, homeless people and girl victims of trafficking are dealt with in other government policies and are therefore not addressed here.
Chapter 6. Indicators for potential use in monitoring social services

Children in formal care

The UN Alternative Care Guidelines\(^\text{11}\) which were ‘welcomed’ by a resolution of the UN General Assembly in November 2010 set out guidance for national governments on providing care and support to children without parental care. The Guidelines provide a definition of ‘without parental care’ and ‘formal’ care (ordered by a judicial or administrative procedure) and ‘informal’ care (provided without official orders). The guidelines strongly recommend that loss of parental care should be prevented as far as possible and factors such as poverty, disability or distance from school should not be a reason to remove children from the care of their parents, or only parent. Implementation guidance including a monitoring framework is in the process of being developed, but in the meantime, UNICEF and the Better Care Network has published a Manual for the Measurement of Indicators for Children in Formal Care which offers a framework of fifteen indicators for children in formal care including four ‘core’ indicators. Twelve of the indicators are quantitative and three monitor policy or implementation. The full set of fifteen indicators is presented in Annex H. Several of the indicators could be useful for monitoring the development of the formal care system within the wider social services reform process in Tajikistan (see Table 6.1).

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**Table 6.1**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children entering formal care</td>
<td>Number of children entering formal care during a 12-month period per 100,000 child population</td>
</tr>
<tr>
<td>Children living in formal care</td>
<td>Number of children living in formal care on a given date per 100,000 child population</td>
</tr>
<tr>
<td>Existence of individual care plans</td>
<td>Percentage of children in formal care who have an individual care plan</td>
</tr>
<tr>
<td>Use of assessment on entry to formal care (gatekeeping)</td>
<td>Percentage of children placed in formal care through an established assessment system</td>
</tr>
<tr>
<td>Review of placement</td>
<td>Percentage of children in formal care whose placement has been reviewed within the last 3 months</td>
</tr>
</tbody>
</table>
| Existence of legal and policy framework for formal care | The existence of a legal and policy framework for formal care that specifies:  
- Steps to prevent separation  
- Preference for placement of children in family-based care  
- The use of institutionalization as a last resort and temporary measure, especially for young children  
- Involvement of children, especially adolescents, in decisions about their placement |

Source: BCN/UNICEF Manual for the Measurement of Indicators for Children in Formal Care, 2009

This study has highlighted that residential forms of services are the main response for children living in poverty and in vulnerable families and there are very few services in place to prevent separation of children from parents when the key problems facing the family are poverty, disability or remoteness. Placement in residential institutions appears to be seen by parents, particularly parents of families living in poverty, as a way of providing their children with better opportunities than are locally available. Many residential institutions are sending children home to their families during holidays and at weekends and there are very few services for supporting care leavers, which could be because most children in residential care are actually children with families to whom they return after their period in care. Key issues for reform in relation to these forms of services and client groups, and which the indicators in Table 6.1 could usefully monitor, are therefore:

- clear criteria being introduced for entry into and exit from the residential care system;
- development of family support services in the community that obviate the necessity of entry into residential forms of care;
- a focus on prevention and family support emerging as a policy priority.

The introduction of care plans which are regularly reviewed can help to form the basis of strong gatekeeping systems and ensure that children are not entering residential forms of care and then remaining in these institutions through inertia, but that the system of social services is actively working on their reintegration with their families or their placement into alternative, family-based, forms of care.

The most critical of these indicators, is probably the first indicator which can help to provide a picture of whether prevention work with families and children is effective and successful overall in keeping children in their families and out of residential forms of care.

**Child protection**

UNICEF developed a manual for measuring violence against children as part of the UN Secretary General’s study into violence against children in 2006. The manual offers a number of useful indicators for monitoring violence against children at home, in school and in other settings. Some of the indicators are well-established in WHO and other international systems of monitoring data. The child protection system indicators could be useful and relevant to the current context of social services development in Tajikistan.
Chapter 6. Indicators for potential use in monitoring social services

### Table 6.2

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Official reports of violence against children</td>
<td>Number of children officially reported as victims of violence to authorities during a 12 month period per 100,000 children</td>
</tr>
<tr>
<td>Substantiated cases of violence against children</td>
<td>Number of substantiated cases of violence against children during a 12 month period per 100,000 children</td>
</tr>
<tr>
<td>Child victims referred to services</td>
<td>Percentage of child victims referred to Recovery, Reintegration, or Psychological Support Services during a 12 month period</td>
</tr>
<tr>
<td>Use of services by child victims</td>
<td>Percentage of child victims who used Recovery, Reintegration, or Psychological Support Services during a 12 month period</td>
</tr>
</tbody>
</table>

Source: www.unicef.org

If the system of child protection is not yet able to readily gather data related to child protection systems, then the basic morbidity and mortality indicators proposed in the manual can also help to monitor child protection at a fundamental level, but less directly related to the system of social services delivery itself.

### Older people

Examples of policies on care and services for older people can be drawn from a range of countries around the world. At a global level, the United Nations Principles for Older People adopted in 1991, provides an internationally recognised basis for building policy frameworks including indicator sets.

### Table 6.3
United Nations Principles for Older People, 1991

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence</td>
<td>Older persons should have access to food, water, shelter, clothing, health care, work and other income-generating opportunities, education, training, and a life in safe environments.</td>
</tr>
<tr>
<td>Participation</td>
<td>Older persons should remain integrated into community life and participate actively in the formulation of policies affecting their well-being.</td>
</tr>
</tbody>
</table>

13 Child homicide rate; Emergency room visit rate due to assaults in children; Hospital discharge rate due to assaults in children
Social Services in the Republic of Tajikistan

Table 6.3 (continued)

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>Older persons should have access to social and legal services and to health care so that they can maintain an optimum level of physical, mental and emotional well-being. This should include full respect for dignity, beliefs, needs and privacy.</td>
</tr>
<tr>
<td>Self-fulfilment</td>
<td>Older persons should have access to educational, cultural, spiritual and recreational resources and be able to develop their full potential.</td>
</tr>
<tr>
<td>Dignity</td>
<td>Older persons should be able to live in dignity and security, be free of exploitation and physical or mental and be treated fairly regardless of age, gender and racial or ethnic background.</td>
</tr>
</tbody>
</table>

Source: http://www.unescap.org/ageing/res/principl.htm

Principles such as these translate, for example, in aged care in the UK into policies and a monitoring system that focuses on indicators that follow administrative efficiency (containing costs), maintaining care in community-based settings rather than institutions, and monitoring responsiveness to consumers\(^\text{14}\).

The study undertaken for this report in Tajikistan shows that some key indicators for services for older people should, like those for children in formal care, focus on achieving a more even balance of service forms for all potential clients. Key areas for monitoring would be continuing to maintain care community-based settings while increasing opportunities for participation and self-fulfilment.

Table 6.4

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people living in long-term residential care</td>
<td>Number of older people living in long-term residential care on a given date per 100,000 population over 60 years of age</td>
</tr>
<tr>
<td>Older people accessing day-care and centre-based services</td>
<td>Number of older people using day-care services on a given date per 100,000 population over 60 years of age</td>
</tr>
<tr>
<td>Responsiveness of home-based services to the needs of older people</td>
<td>% of service users reporting home-based and day-care services are able to meet their changing needs</td>
</tr>
</tbody>
</table>

Source: www.unicef.org

Chapter 6. Indicators for potential use in monitoring social services

System indicators such as the existence of individual care plans for each home-based, day-care or residential care users could also help to monitor the quality of the developing system, but obviously would require policy decisions requiring service providers to carry out the assessments for these types of plans.

Adults and children with disabilities

Services for adults and children with disabilities, within the assumed policy framework in Tajikistan discussed above, are focused at present on a principle of ‘normalisation’. Monitoring therefore should also focus on the underlying normalising goal of the existing system. If policy decisions are taken to move the system towards a less medical and more environmental or social model of disability, then the indicators for monitoring would also require a similar shift.

There are two important underlying issues in social services for children and adults with disabilities which need to be taken into consideration. One is the issue of ensuring a system of support that continues throughout the life cycle and focuses on the changing needs of the infant, young child, older child, adolescent, young adult, mature adult and older adult with disabilities. At the point when parents are taking their child with disabilities home from the maternity hospital, if they know what their child can roughly expect in terms of kindergarten, school, further education, employment and independent living as an adult, they are more likely to take their child home confident that they will be able to cope. It can therefore be difficult to draw lines between child and adult services for the disabled as a continuum is fundamental to ensuring that services can meet changing needs. A feature of disability services which make them distinct from services for children and families that are socially at risk or in crisis, is that services are long-term in nature and designed to accompany the child (and his or her family) through into adulthood and then old age. The second issue which needs consideration is the inherently inter-sectoral and multi-disciplinary nature of disability services. Children and adults with disabilities require not only social services, but also health and education services. Issues to do with accessibility of transport and housing as well as adapting other aspects of the physical environment to their abilities are also important. Any system of measuring the effectiveness of social services has to therefore be linked into the systems that are measuring health and education interventions as well.

As with services for older people above, the mapping undertaken for this study has shown that social services for adults with disabilities in Tajikistan are currently largely focused on home-based forms of service delivery which might help to maintain independence in the home, but do not necessarily support participation in the community and could be leading to isolation in the home and
high levels of social exclusion. Services for children with disabilities are more varied in form than those available to adults, but are over-reliant on residential forms of education provision. Many of the formal care indicators discussed above for children in formal care also apply to children with disabilities and should be disaggregated accordingly. Other indicators for measuring development in services for adults and children with disabilities, assuming the existing policy goals discussed above are accurate, and that a bio-medical diagnosis continues to be the main definer of ‘disability’ for the purposes of accessing services, could include some or all of those outlined in Table 6.5.

Table 6.5
Possible indicators for monitoring social service delivery for adults and children with disabilities (in addition to the formal care indicators for children above)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with disabilities living in long-term residential care</td>
<td>% of adults with disabilities living in long-term residential care on a given date</td>
</tr>
<tr>
<td>Adults with disabilities accessing day-care and other centre-based services</td>
<td>% of adults with disabilities using day-care services on a given date</td>
</tr>
<tr>
<td>Responsiveness of home-based services to the needs of adults with disabilities</td>
<td>% of service users with disabilities reporting home-based and day-care services are able to meet their changing needs (annual survey)</td>
</tr>
<tr>
<td>Responsiveness of home-based and day-care services to the needs of children with disabilities</td>
<td>% of parents of children with disabilities using home-based and day-care services reporting that services are able to meet their changing needs (annual survey)</td>
</tr>
<tr>
<td>Support for carers of adults and children with disabilities</td>
<td>% of full time carers reporting they have adequate support in caring for children or adults requiring full-time care</td>
</tr>
<tr>
<td>Access to education, employment and supported independent living for older children and young adults with disabilities</td>
<td>% of young people aged 15-17 and young adults aged 18-35 with disabilities who are accessing education, employment and supported independent living services based in the community</td>
</tr>
<tr>
<td>Access to assistive technology for children and adults</td>
<td>% of children and adults with disabilities accessing relevant, individually fitted assistive technology that increases functioning</td>
</tr>
<tr>
<td>Early intervention services for very young children with disabilities</td>
<td>% of children aged 0-3 years with disabilities or developmental delays benefiting from early intervention services that can increase functioning</td>
</tr>
</tbody>
</table>

Source: OPM
Not all of the services described in these indicators currently exist in Tajikistan, so it may not be appropriate to begin collecting data until a full disability policy or national strategy is developed. The indicators in Table 6.5 assume that decisions have been taken at the policy level that focus on a strategy of deinstitutionalisation of disability services; the development of a range of community based services that meet individual needs and are focused on normalisation and increasing functioning. As discussed elsewhere in this report, the universality of access to these services can be monitored through disaggregated data sets for each district and region of the country.

6.4 Considerations for moving forward with planning, delivery and monitoring of social services

This section summarises the findings and discussion from the report and sets out some key points for consideration on how best to move forward with implementing and monitoring social services development in Tajikistan.

Strategic decisions

Legislation is in place in Tajikistan that can support the development of a system of social services provision which is responsive to the individual needs of citizens who are vulnerable for a variety of reasons, including disability, old age, exposure to risk and neglect, and are experiencing difficult life situations. Achieving sufficient coverage of a minimum suite of services is an important next step in taking forward the development social services delivery as intended in the existing Law on Social Services.

Explicit strategic decisions are required from the government to drive forward towards key outcomes for specific target beneficiary groups. Priority geographic areas for reform are RRP, Khatlon and Sughd where service delivery levels are lowest and most uneven. Key outcomes could be focused on the following five priorities:

1. Greater social inclusion for older people without family support and adults with disabilities. This could include greater use of volunteers, community based drop-in or day-care forms of services, and transforming existing residential services to offer a greater range of non-residential services.
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2. Reduced reliance on large-scale residential service forms and greater access to outreach, community based forms of family support for children who are without parental care or at risk of losing parental care.

3. Reduced reliance on residential service forms for children with disabilities as a means to receiving education and health services; greater access to family support, health and inclusive or specialist education services in the community.

4. Increased access to flexible packages of support with early intervention, physiotherapy, occupational therapy, speech therapy and technical aids that can meet the individually assessed needs of children and adults with disabilities in order to increase functioning as far as possible.

5. Access to specialised and/or accessible transport to aid access to universal services in the community for children and adults with disabilities and older people isolated in their homes.

These decisions will help to inform subsequent decisions about the minimum suite of services that should be implemented in each district and region and accessible to all those who need it.

Role of the state in social services provision

Legislation permits the development of a mixed market of social care where both NGO and state providers can be funded by the state to deliver services. At present this market is still at an embryonic stage of development with most NGO services being delivered mainly with funding from international donors or with private funding. This currently means that quite large parts of the social services system are being developed and delivered outside of a system of government regulation, although some are organised through various forms of state partnership. An overall policy decision needs to be taken about how the government takes account of the segment of social service delivery being delivered without state funds, but as part of a wider system of state and non-state service provision.

Currently, day-care services to a number of beneficiary groups, for example, are being provided mainly by non-state providers without state funding and yet form a meaningful part of the overall system of social services provision. One clear path forward is to provide clear mandates to non-state providers to continue to provide a part of the services the state wants to offer to specific groups.
and ensure the meeting of a set of minimum standards in the provision of these services through a basic regulatory system that sets standards and then licenses and monitors providers.

If the long-term goal is to move to a fully mixed market of social services provision where the state defines the need for services and commissions and funds their delivery from both, state and non-state, commercial and non-profit, providers, then an explicit strategic decision is required to build the capacity of both the state and non-state sector to operate within such a system. The strategic decision should trigger investment in the growth of a mixed market of social care and the regulatory framework of standards, results-based budgeting, licensing, contracting, monitoring and inspection which is a pre-requisite for the development of this system. Attention may also need to be given to the development of NGO capacity to meet the requirements of state contracting of services. Until such a decision is made, an interim step where the state defines the scope and scale of the services that it requires to be delivered and commissions those services, could represent a constructive way of standardising levels and quality of provision across the country and across all vulnerable groups. The state could license and mandate providers through a self-assessment, voluntary procedure, without necessarily allocating funding.

**District and regional assessments and planning**

Without detailed needs assessments which examine disaggregated data sets for each vulnerable group in each district and region it is difficult to determine the exact shape of the system of social services – which types and forms of services are needed in each district and which should be given priority as there are limited available resources to fund service provision. If the national government, however, can develop an outline of the core strategic objectives, depending on the levels of need identified in each district and region, then a minimum basic package of services which each district is likely to need to be able to offer can be defined. Based on the data examined so far in this study it is likely that all districts are likely to need the capacity to deliver the following minimum suite of services:
### Services for children

<table>
<thead>
<tr>
<th>1.</th>
<th>Family support for children with disabilities and for children and families socially at risk</th>
<th>Centre-based and home-based outreach services</th>
<th>Outreach social workers, individualised packages of support to address immediate problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multidisciplinary teams providing full multi-faceted assessment and planning flexible packages of support for children with disabilities and their families including day care, short breaks (^{15}) and provision of technical aids</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Early intervention services for infants and young children with disabilities or at risk of developmental delays for social reasons</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rehabilitation – intensive therapeutic programmes for children with disabilities and children with other special needs (^{16})</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Practical support – income maximisation (^{17}), legal advice, housing, facilitating links to education and health services, mediation, independent representation and strengthening capacity for self representation (i.e. empowerment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Parent education about children's needs at different developmental stages and parenting skills training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counselling – family counselling, individual consultations for children and parents</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Crisis intervention family support services for children who are at immediate risk of entering care – targeting children in the family where they may be at risk of harm or on the street</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intersectoral coordination to provide socio-medical support for children and families suffering from dependency on alcohol, drugs and other substance abuse and other conditions requiring combined medical and social responses such as parents with mental health problems which are affecting the ability of parents to fulfil their parental responsibilities.</td>
</tr>
</tbody>
</table>

\(^{15}\) Also known as 'respite care'

\(^{16}\) For example children living with HIV/AIDS, children who have been abused, children who have mental health problems and others

\(^{17}\) For example support with claiming cash assistance, support in accessing professional skills training/re-training or employment services and direct material support
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Child protection services</td>
<td>Centre and home-based outreach services</td>
</tr>
<tr>
<td>3.</td>
<td>Strengthened reproductive health services</td>
<td>Infant abandonment prevention and family planning</td>
</tr>
<tr>
<td>4.</td>
<td>Emergency and short-term foster care services</td>
<td>Full cycle of recruitment, preparation, matching and in placement support</td>
</tr>
<tr>
<td>5.</td>
<td>Adoption, long-term foster care and guardianship services</td>
<td>Recruitment, preparation, matching and post placement support</td>
</tr>
<tr>
<td>6.</td>
<td>Specialized residential care services</td>
<td>Based on key-worker systems and small, family-type groups</td>
</tr>
<tr>
<td>7.</td>
<td>Care-leaving services</td>
<td>Housing, employment, education, independent living training and support</td>
</tr>
</tbody>
</table>

Source: OPM

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18 The recruitment of foster carers should be carried out in such a way that they meet the individual needs and characteristics of individual children.
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### Services for adults

1. **Shelter**
   - Crisis Accommodation
   - Child, Youth and Women’s Shelters (crisis, and Protection from child and family violence, Trafficking protection)
   - Independent living advice, training and support

2. **Basic Vocational training**
   - Basic vocational education and training for livelihood
   - Entry-level vocational training
   - Employable skills development
   - Literacy and language acquisition

3. **Support in accessing employment**
   - Mediating access to employment services to secure employment and a living income
   - Career Advice and Guidance
   - Employment services and subsidies
   - Re-training programs
   - Sheltered Employment

4. **Support in accessing legal aid and information**
   - Mediating access to justice and legal services
   - Information and essential legal assistance, including Family Law - Marriage, Separation, Divorce;
     - Property settlement;
     - Maintenance, custody and guardianship of children and other dependents
     - Inheritance
     - Access to land for women
     - Protection from Family and Domestic Violence

5. **Social-care**
   - Emergency, Temporary, Respite, short and long-term care
   - Mental health care
   - Day Centre
   - Home-care
   - Meals services
   - Aged and Disability care
## Chapter 6. Indicators for potential use in monitoring social services

<table>
<thead>
<tr>
<th>6.</th>
<th>Habilitation and Rehabilitation, Integration and Re-integration</th>
<th>Habilitative, Rehabilitative, Integrative and Re-integrative services for temporary, short-term chronic, and enduring conditions including physical, mental and social conditions</th>
<th>Social Work and counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Speech, Physical, Occupational, Psycho-social Therapies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Pedagogical, Optometric, Podiatric, Orthotic and Prosthetic services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation aids and devices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home renovation and adaptation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Income generation support</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Protection of people who are older, disabled or otherwise vulnerable</td>
<td>Protection from various forms of violence, abuse and exploitation; particularly aged, disabled or other vulnerable people</td>
<td>Social Welfare services, including small community-based programs, services and facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small community-based programs, services and facilities</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Access to public transport</td>
<td>Specialised transport including medical transfers</td>
<td>Wheel-chair and stretcher– accessible taxis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ambulances and Clinic cars</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transport to access services</td>
<td>Transport reimbursements, subsidies and concessions</td>
</tr>
<tr>
<td>9.</td>
<td>Social participation and leisure</td>
<td>Promotion of cultural and recreational activities for social well-being</td>
<td>Buildings and Facilities provision and maintenance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provision of equipment and leadership</td>
</tr>
</tbody>
</table>

Source: OPM
Social Services in the Republic of Tajikistan

6.5 Specific actions for consideration (short to medium term)

Key actions required to move from the current situation, as documented in this study, towards a system of social services that reflects the intentions of legislation and policy should include:

1. The development of a strategic framework specifying key strategic decisions and priorities that operationalises the existing legislation over a determined time period and is based on a projection of resources that are expected to be available. This could not only serve as a strategic plan for social services development, but could also clarify the role of the government as a commissioner of the overall system of provision of social services. The strategic plan could provide a basis for focused co-operation and collaboration with non-state actors who are already delivering social services or who are planning to deliver social services. Successful development and delivery of such a plan can also raise the profile of this area of social policy and, if it can be proven to be effective, give it greater prominence in the fight for limited state resources.

2. Development of district (Rayon) plans for social services provision for adults and children that are based on detailed needs assessments that examine in as much detail as possible the needs and strengths of each potential target beneficiary. As well as taking into account the rights of citizens to inclusive, responsive social services, the plans need to consider the cost, effectiveness and efficiency of services in meeting needs. Where, for example, there is a low level of need for more specialised types of services at village level, service provision can be established at district level, or for clusters of villages. In this case, all the associated costs of ensuring that service-users can gain access to the services (e.g. by including transportation costs) need to be taken into account. Where possible, a balance needs to be found between ensuring that services are easily and locally accessible without being prohibitively expensive to provide. This is particularly relevant for more remote areas but can also be important and relevant in urban areas.

3. Development of regional service development plans that can define where meeting the needs of smaller, more dispersed groups, can be clustered into district or regional centres or where it can be provided at the point of demand. This also means planning more specialist services in areas which are more evenly dispersed throughout the country and which reflect areas of greatest need.
Chapter 6. Indicators for potential use in monitoring social services

4. Both district and regional plans should take into account gaps in service delivery and any current over-reliance on some forms of services for some categories of beneficiary. Generally speaking, residential care should be used as a last resort for most adults and older children and not used at all for young children. From this study the most urgent gaps appear to be the absence of services of any kind in some districts and the lack nationally of community based family support service for children who are socially vulnerable or who are without parental care and therefore the over-use of residential forms of service provision for these groups. Similarly there is a need for services to focus more on reducing the isolation of older people and adults with disabilities without family support. Services for the homeless and for care leavers appear to be being delivered at a significantly lower rate than services for other groups and the levels of delivery of services to older people, adults with disabilities and children with disabilities all probably need to be increased at least to the highest rate of delivery currently recorded in Dushanbe and GBAO.

5. Another area of concern is respite services for the carers of children and adults with complex functional disorders which are only available in the form of residential services and limited day-care provision.

6. A pro-active programme of sharing experience, lesson learning and resources across regions will help to capitalise on best practice models and ensure faster, more effective reforms in areas where reforms have yet to move forward.

7. Monitoring the rates of service usage proportionate to the relevant target population. Services for children with disabilities, for example, should be monitored in relation to the number of children with disabilities in the given district or region.

8. Systematic recording and monitoring of key data including management information, by all service providers so that administrative data for planning, management and performance monitoring purposes is routinely available. Data is likely to include numbers of referrals/intake in a defined period, staffing ratios, cost efficiency, length of time services are delivered to each client, reasons for non-acceptance of applicants and outcomes for service users. Service user satisfaction measures (e.g. surveys) can also be instituted to help ensure constant improvement to service delivery and effectiveness.
As strategic priorities for social services delivery are ultimately a matter of constrained choice for responsible state structures and have to be informed both by understanding of needs and of resources (own and external) that are expected to be available over a given period, indicators for monitoring the effectiveness and impact of social services need to be developed that directly correspond to goals, objectives and expected results chosen by the government as part of a formal strategy/action plan for the further development of social services. Proposals for specific indicators related to each beneficiary group have been discussed earlier in this report. Ultimately, they cannot be used if the goals and objectives to which they relate are not established in a clear strategic framework as indicated earlier in this section. Key concepts and principles also need to be defined at the national policy level, for example ‘disability’ and ‘formal care’. Key recommended indicators, therefore, at this stage of social services development in Tajikistan relate to the following areas that have been highlighted by this study as presenting a challenge to fulfilling the intentions of the existing Law on Social Services:

<table>
<thead>
<tr>
<th>Table 6.6</th>
<th>Monitoring social services system reform in the short to medium term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>Existence of a national plan for social services development outlining the key strategic priorities for a given period</td>
<td>The strategic priorities for social service delivery are clearly outlined for each beneficiary group receiving services at the outset of the report.</td>
</tr>
<tr>
<td>Each district and region has a social services development plan in place that addresses services for 19 vulnerable groups</td>
<td>Each plan outlines the actions that the district or region will take to even out provision of services across its geographic territory in order to ensure that those most in need are able to access the services they need. Each plan describes how it will develop the basic suite of services identified as necessary in order to achieve the national objectives and meet the priorities laid out in the national plan.</td>
</tr>
<tr>
<td>Tajstat disaggregates data to meet the monitoring needs of national, regional and district plans</td>
<td>Data is disaggregated for age, gender, disability and other key variables and collected regularly. Data gathered for adults and children living with HIV/AIDS, injecting drug users, sex workers, homeless people and trafficked children are disaggregated by region and district of origin.</td>
</tr>
</tbody>
</table>
### Chapter 6. Indicators for potential use in monitoring social services

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children entering formal care (BCN indicator 1)</strong></td>
<td>Number of children entering formal during a 12 month period per 100,000 child population (disaggregated also for children with disabilities)</td>
</tr>
<tr>
<td><strong>Use of assessment on entry into formal care (gatekeeping) (BCN indicator 8)</strong></td>
<td>Percentage of children placed in formal care through an established assessment system (disaggregated also for children with disabilities)</td>
</tr>
<tr>
<td><strong>Existence of legal and policy framework for formal care (BCN indicator 13)</strong></td>
<td>The existence of a legal and policy framework for formal care that specifies (including for children with disabilities): steps to prevent separation</td>
</tr>
<tr>
<td><strong>Older people and adults with disabilities accessing day-care and centre-based services</strong></td>
<td>Number of older people using day-care services on a given date per 100,000 population over 60 years; % of adults with disabilities using day-care services on a given date</td>
</tr>
<tr>
<td><strong>Responsiveness of home-based services to the needs of clients</strong></td>
<td>% of older people and adults with disabilities reporting that home-based and day-care services are able to meet their changing needs</td>
</tr>
<tr>
<td><strong>The number of service users of each form of service is proportionate to the need identified for each potential beneficiary group in each region</strong></td>
<td>Service provision for all vulnerable groups of children and adults is even per 100,000 relevant population and no group stands out as being significantly over or under-served</td>
</tr>
<tr>
<td><strong>All districts provide a suite of basic services for all 19 beneficiary groups</strong></td>
<td>Service delivery rates show coverage extended to all districts for all groups; reduction in reliance on residential forms of care for children (% of children in residential forms compared to other forms); increase in provision of day-care for adults as per indicator 7.</td>
</tr>
</tbody>
</table>

Source: OPM

All of these indicators are proposed as they are relatively easy to monitor using existing data-gathering systems, with some adjustments necessary to ensure suitable levels of disaggregation. Other indicators, that may require greater resources to gather, can be drawn from the sets of indicators discussed further up in this report.
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http://www.voluntaryarts.org/uploaded/map990.pdf [12 September 2011]


[12 September 2012]


ANNEXES

Annex A  Conceptual framework for the analysis
Annex B  Access to universal services and other factors in the operating environment of social services provision
Annex C  Indicative Taxonomy of Social Protection
Annex D  Organogram of the system of public management in the area of social services and social security, 2010
Annex E  The Laeken indicators
Annex F  Indicators for Children in Formal Care – Better Care Network and UNICEF, 2009
Annex G  Day care services for children by types and regions
Annex H  Home-based services for children by types and regions
Income poverty – an overview

Definitions of poverty

- **Income poverty**
  Poverty is an important dimension of vulnerability and is measured as the income or consumption gap to a fixed threshold which is usually called the poverty line. There are subjective and objective approaches to measuring poverty. The subjective poverty level is self or community defined. The objective approach measures, in monetary terms, the income/consumption of a person and places it against a pre-defined threshold (minimum consumption basked, subsistence minimum, absolute or extreme poverty lines, etc.).

- **Relative poverty**
  A measure of relative poverty defines “poverty” as being below some relative poverty threshold (like the median equivalized household disposable income).

- **Extreme poverty**
  A measure of poverty as being below some fixed poverty threshold. In 2005 the World Bank defined extreme poverty as living on less than US$1.25 a day.

- **Multidimensional poverty**
  Multidimensional poverty reflects both monetary and non-monetary deprivation. Non-monetary deprivation incorporates dimensions like education, health, life expectancy, provision of public goods, freedom and security (UNDP).

- **Functioning (Sen definition)**
  Sen has consistently emphasised the need to view human development as an enterprise that is inherently multidimensional, and deprivation in any number dimensions can result in the failure of an individual to achieve well-being (Alkire, 2002; Sen, 1993; Robeyns, 2005; Alkire and Santos, 2010). For Sen well-being is the “wellness” of an individual’s personal state of being as seen from the person’s own perspective. The constituent parts of this “wellness” differ by person and are derived from an individual’s different opportunities to achieve desired outcomes, which Sen calls functionings.
A.1.2 Poverty trends

One is considered multi-dimensionally poor if living below the fixed threshold against at least one of the vulnerability indicators. One indicator is income poverty (see above for the definition of different poverty indicators). Income poverty is addressed through social cash assistance, employment programmes, social works programmes, etc. Multidimensional poverty, which in addition to income/consumption level also measures access to health and education, can be tackled through social services. This section considers income poverty and presents the main poverty trends and poverty indicators in Tajikistan, with a focus on vulnerable groups as defined in Sections 1.5 and 1.6 above. In Annex A we address other dimensions of poverty, namely access to education, health, housing and other services.

The main instrument for gathering data on poverty in Tajikistan is the Tajikistan Living Standards Survey (TLSS), with data collected by the Tajikistan Agency of Statistics (TAS) in 1999, 2003, 2007 and 2009 (the 2009 survey presents panel data). The TAS also collects data on revenues, expenditures and savings of the population on a monthly basis.
With a Gross National Income per capita of US$700 (World Bank, 2009), Tajikistan remains one of the poorest and most vulnerable economies in the world. In recent years, economic growth driven by consumption (mainly due to remittances) had a significant contribution to poverty reduction: the World Bank estimates that relative poverty decreased from 72% of population in 2003 to 54% in 2007, and extreme poverty decreased from 42% to 17% during the same period. In 2009, relative poverty dropped further to 47%. A recent MDG 2010 progress report also notes progress in poverty reduction, estimating that from 1999 to 2009, extreme poverty decreased at an average annual rate of 3.2%.

Figure A.2 presents the trends and indicators of relative and extreme poverty in rural and urban areas. The rate of poverty reduction has slowed down, with an increase in extreme poverty in rural areas, which could be explained by the decline in remittances as a result of global economic crisis. Poverty, in relative terms, is concentrated in rural areas where 73.7% of population lives. This is explained by the low income of households working in agriculture, which is the main occupation in rural Tajikistan.
There are striking differences in poverty levels (both relative and extreme) among regions (Gorno-Badakhshan Autonomous Oblast has a relative poverty account which is 28 percentage points higher than in Dushanbe). Figure A.3 presents the regional distribution of poverty. There is no analysis of causes of regional discrepancies in poverty; one explanation could be the remoteness of localities from pockets of economic activity.
The World Bank finds that the main factors correlated with monetary poverty are the size of the household and the geographical location. In 2007, the poverty level of households with three or more children was 33 percentage points higher than that of households with no children. The MDG 2010 progress report, citing TLSS 2009, estimates that 53.9% of women compared to 53.1% of men lived in relative poverty and respectively 22.9% compared to 16% lived in extreme poverty.

Inequality is relatively low, with the Gini coefficient falling below 30% in 2007 (World Bank, 2009). The CIA World Factbook 2009 estimates the Gini coefficient at 32.6% for 2009. Figure A.4 shows the trends in the Gini coefficient in Tajikistan over the last decade.

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24 World Bank, Report No. 56593-TJ Republic of Tajikistan Delivering Social Assistance to the Poorest Households, 2011, p. 4

Despite the relatively equal distribution of income and positive GDP growth, during 2007-2009 extreme poverty remained unchanged, with basically no increase in consumption of the poor rural households. The share of income/consumption of the poorest quintile in the total income/consumption accounted for 7.8% (2008). Figure A.4 illustrates the trend in GDP growth (left scale) and the consumption of the poorest 20% of the population (right scale). The chart suggests that GDP growth does not necessarily translate into higher incomes of the poorest part of the population.

Despite the high poverty rate, Tajikistan has the lowest share of social spending in GDP in the Europe and Central Asia region (the consolidated budget for social assistance was only 0.2% of GDP in 2009). Furthermore, the contribution of social assistance programs to poverty reduction is negligible – 0.3 percentage points (World Bank simulation). This is explained by the small amount of the cash assistance and poor targeting (the poorest quintile receives only 20% of all cash assistance). The impact of social cash assistance on poverty is discussed in more detail in Section 0 on social assistance. In addition, the provision of social welfare services in Tajikistan is scarce. For example, even if a family is willing to pay for a disabled child to get professional personal assistance, it is almost impossible to find such services due to inexistant private offer of such services.

### A.1.3 Poverty among selected vulnerable groups

#### Children

In the last several decades, Tajikistan has experienced a continuous demographic boom, with a population annual growth rate (2000-2009) of 1.5% and a crude birth rate of 28 per 1000 people (UNICEF, 2009). The country has the highest rate in CIS of children under 14 years old to the population aged 15 to 49. More than 65% of households have four or more children. UNICEF estimates that children are in a greater risk of poverty compared with adults: 66% of children live in poor households as opposed to 53.5% of the overall poor population. This is to be expected as, on average, the ratio of young dependents to working-age adults increases in large families.

Following the general trend, child poverty is greater in rural areas. As mentioned above, the main determinant of child poverty is household size; the most exposed to poverty are children who live in households with three or more children. Other determinant factors include region, parent education and employment status. Also, children in women headed households are more vulnerable than those in men headed households. With parents’ divorce children usually stay with their mothers who have lower incomes. Children from families abandoned by the migrant father are in a similar situation.

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26 Tajikistan Partnership Program Snapshot, World Bank 2011
29 Child protection in Tajikistan, mapping actors, roles, benefits and costs, Maastricht Graduate School of Governance, 2008
30 Child poverty analysis, UNICEF 2007
Social Services in the Republic of Tajikistan

Child labour phenomenon is one of the consequences of child poverty. The Labour Force Survey (LFS, 2004) states that 2.7% of children aged 12-14 work a full working week as a hired labour and 97% of working children live in the rural areas. UNICEF estimates that 10% of children aged 5 to 14 are involved in child labour activities (2000-2009). Another consequence of child’s poverty is the high child criminal rate estimated at 8% (children committing offences to all children), of which 95% are thefts of food. Poverty is also a push factor to place children into residential institutions, families being convinced that in the institution the child is better off.

Older people

In Tajikistan, people live in extended families; older people live in the same household with children and grandchildren. Taking care of an older parent is a moral obligation imposed by the society and customs. As mentioned above, poverty increases with household size. Even if they have no children, families with more adults are more likely to be poor. For example, the poverty rate in a household of two adults is 28.9% compared to 52% in a household with 3 and more adults (at US$ 2.15 poverty rate).

The main source of revenue for older people is the old age pension. All persons are eligible to receive the benefit; if the person did not contribute to the pension fund he/she receives the minimum guaranteed social pension. According to official statistics, in 2010, the number of pensioners was 561,547 or 8% of the population (people who are 58 years old and more). Table A.1 presents the number of pensioners, pension amount and pension expenditures. The average monthly pension is 102.5 TJS (app. US$ 11, 2010 data); this is almost 4 times less than the poverty threshold of US$ 40 per person per month. Pensioners cannot rely on pension to cover their expenditures: it covers 8.7% of the expenditures in the 1st quintile and 3.5% of expenditures in the 4th and 5th quintiles (Table A.2, 2007). Thought the amount of the average pension is growing, it covers a lower proportion of household expenditures (a decrease of 3.5 percentage points from 2003 to 2007). The MLSPP data indicates that arrears on pension payments reach 20% at national level; in the rural areas pensions are being paid with a 2-3 months delay. The upper limit of pension benefit is regulated by the government, and cannot exceed 400 TJS (US$ 90), an amount that could cover only food expenses.

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32 Tajikistan Country Gender Profile, JICA, Tajikistan Office, Dushanbe, April 2008.
33 Understanding the child poverty in South-Eastern Europe and CIS, Innocenti social monitor 2006
34 It is not clear from the figures from adults how many are older people; considering the family structure at least one older person is considered to be in the household.
35 MLSPP data
36 MLSPP data
## Table A.1

<table>
<thead>
<tr>
<th>Pension system in Tajikistan</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of pensioners</td>
<td>520,443</td>
<td>525,816</td>
<td>529,161</td>
<td>537,696</td>
<td>553,985</td>
<td>561,547</td>
</tr>
<tr>
<td>Minimum monthly pension (TJS)</td>
<td>12</td>
<td>20</td>
<td>20</td>
<td>60</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Average monthly pension (TJS)</td>
<td>27.5</td>
<td>42.3</td>
<td>45.2</td>
<td>87.4</td>
<td>90.7</td>
<td>102.5</td>
</tr>
<tr>
<td>Annual pension expenditure (TJS, millions)</td>
<td>171.4</td>
<td>267.1</td>
<td>287.1</td>
<td>563.7</td>
<td>603</td>
<td>698.1</td>
</tr>
<tr>
<td>Annual pension expenditure (% of GDP)</td>
<td>2.4</td>
<td>2.9</td>
<td>2.2</td>
<td>3.2</td>
<td>2.9</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Source: MLSPP

## Table A.2

<table>
<thead>
<tr>
<th>Adequacy of Social Protection Cash assistance (cash assistance as % of household expenditures)</th>
<th>2007</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile (pre-transfer)</td>
<td>Old age benefit</td>
<td>Disability benefit</td>
</tr>
<tr>
<td>1</td>
<td>8.3</td>
<td>5.5</td>
</tr>
<tr>
<td>2</td>
<td>4.6</td>
<td>2.2</td>
</tr>
<tr>
<td>3</td>
<td>4.0</td>
<td>3.0</td>
</tr>
<tr>
<td>4</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td>5</td>
<td>3.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Poverty pre-transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-poor</td>
<td>3.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Poor</td>
<td>6.2</td>
<td>4.2</td>
</tr>
<tr>
<td>All beneficiary households</td>
<td>5.1</td>
<td>3.6</td>
</tr>
</tbody>
</table>

People with disabilities
The total number of people with disabilities in Tajikistan is difficult to estimate. Firstly, social attitudes and stigma compel some families to deny the existence of disability. Secondly, low levels of knowledge, high documentation costs, and low levels of cash assistance results in a high number of people not registering their disability or the disability of a family member. Thirdly, there is no comprehensive government monitoring system. As a result, data presented by different authorities can vary, and differences between administrative data and Figures identified in independent studies are even larger. One study indicates that the number of people with disabilities in Tajikistan amounts to 146,000, which is about 10% of the population, of which 3% are children with disabilities, compared to 20% the world average, 15.7% the EU average and 8.8% in Russia.

People with disabilities are considered at a higher risk of poverty compared to other groups in the society. It is proved that consumption by families with a disabled member is higher than consumption in other households of the same size due to higher expenses for health care, including for rehabilitation treatments, and drugs (European Disability Report, 2010). Another reason for high poverty in households with a disabled member is the unemployment of one of the adults, due to the need to take care of the disabled person (especially in case of severe disability).

People with disabilities are also exposed to an increased risk of poverty because of the non-inclusive social model. Children are placed into special schools with no opportunity to get proper education, skills and later have no possibility to access the labour market (please see the education section). Disabled adults cannot access special education, re-orientation trainings or other social services to help them integrate into the labour market. Therefore, people with disabilities are highly dependent on social services provision, which is by far insufficient.

Women
Differences in opportunities, due to socio-cultural norms, customs and practices, religious precepts, expose women more than men to poverty. Women have less education and fewer qualifications, therefore less chances to enter the labour market. General unemployment rate among women of 30-44 age cohort is almost double than that for men in the same age cohort. The majority of working women are employed in the agricultural sector (about 63% of all employed). Rural women have even fewer opportunities to get education and training since they have to work on the family adjacent land plots; 86% of rural women are employed in agriculture with 56% are working the subsidiary plot.

Perhaps as a result of these factors, female-headed households are considerably poorer than male-headed households (Table A.3).
There is a significant gap between women and men wages, amplified by regional differences. There is horizontal segregation-employment of women in traditional sectors with lower wages like education, agriculture, health-and vertical segregation with men holding the majority of management positions. The most vulnerable are single mothers, divorced women, and women living in unregistered marriages.  

### Table A.3: Rates of Poverty by Gender of Household Head

<table>
<thead>
<tr>
<th>Gender of head of household</th>
<th>% below poverty line</th>
<th>% below extreme (food) poverty line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>53.8</td>
<td>20.1</td>
</tr>
<tr>
<td>Female</td>
<td>63.5</td>
<td>28.2</td>
</tr>
</tbody>
</table>

Source: MLSPP
Access to universal services and other factors in the operating environment of social services provision

B.1 Access to healthcare

Figure B.1 Key points: healthcare

- The healthcare system in Tajikistan faces significant problems, such as low wages and deficit of qualified personnel, deteriorated infrastructure of health facilities, outdated equipment and supplies, and inefficient administration procedures. In addition, an important barrier in accessing healthcare is high cost of services to be covered with out-of-pocket payments.

- Deficiencies in the healthcare system result in inappropriate hospital admissions, long lengths of stay, and inappropriate and ineffective treatment. Consequently, the main health outcomes, particularly of vulnerable groups with specific healthcare needs, are quite poor in Tajikistan. For example, child and maternal mortality is highest in the CIS region.

- Vulnerable groups, such as people with disability are more exposed to poverty, therefore have less funds to cover heath care expenses. At the same time, studies estimate that a disabled person spends 20% and more of their income on medicine. This situation is further complicated by lack of specialised assistance and treatment and high transportation costs.

B.1.2 Healthcare provision in Tajikistan

The healthcare system in Tajikistan preserved the structure of the soviet healthcare system, the state being the provider of healthcare services. At the same time, the financing of the system is mostly private, individuals covering the majority of their health expenses. The state is covering the maintenance of health care facilities and salaries for medical personnel. The private healthcare provision is limited to dental and pharmaceutical sectors; there are very few physicians officially working outside the public system.
Primary healthcare is provided at the local (community) level and the law calls for universal coverage. In the rural area, the primary care is provided through nurses’ posts and small rural clinics. In the urban area, these services are offered through policlinics. Generally, primary care covers diagnosis and referral to secondary care institutions; it is also used as a statistics collection source. Access to primary care in rural areas is ensured through 2300 nurses’ posts, rural clinics, medical houses. This data should be interpreted with caution, however, as it is not clear how many of these clinics are functioning and how many patients they assist.

Secondary health care is offered through specialised hospitals at rayon and oblast levels and more complex care at national level. The secondary level is an in-hospital service provision system that includes rayon and oblast hospitals, specialised hospitals (dispensaries) and ambulance services. Their capacity is measured in the number of beds and patients are distributed among these institutions based on specific diseases.

The health system suffers from under-financing. The spending in healthcare was 1.7% of GDP in 2009 (compared to 5% suggested internationally), and covers only salaries of the personnel and limited maintenance of the hospitals. The average salary of a doctor is US$ 38 per month. Because of low wages and poor working conditions, a significant number of medical personnel leave the system. Currently, only half of positions for family doctors are filled, while the number of paediatricians decreased by one third between 1998 and 2008.

The shortage of doctors is not the only impediment to accessing health care. The costs of services make them even less accessible. A World Bank report finds that 72% of patients’ health expenditures are covered out of their pocket. This is confirmed by the findings of a WHO report, which puts the share of out-of-pocket expenditure at 76%, the highest share in Europe and Central Asia. This is a big burden for household’s budget, especially for the poor households. A UNICEF report presents an analysis of the health utilization rate and shows that the poor make many fewer visits to the doctor than the less poor, with a slow improvement in indicators in 2007 compared to 2003.

In addition, healthcare facilities are in very poor conditions, with deteriorated infrastructure, insufficient and outdated equipment, and inefficient administration procedures. Under-investment in the health system in the last 2 decades has resulted in inadequate sanitary and hygiene facilities, as well as severe shortages of water and sewage, electricity, and heating. The limited purchase of equipment has been largely directed to urban hospitals (Health Systems Review, 2010). Financing is disproportionally oriented to oversized highly-specialised hospitals, at the expense of primary health services, which lack essential inputs, such as drugs and medical supplies (PETS, 2008).
All these factors, combined with lack of modern treatment protocols and guidelines, especially in rural areas, often result in inappropriate hospital admissions, long lengths of stay, and inappropriate and ineffective treatment. Consequently, the main health outcomes, particularly of vulnerable groups with specific healthcare needs, are quite poor in Tajikistan, as explained below.

**B.1.3 Basic healthcare indicators**

**Nutrition**

Under-nutrition is considered a poverty multiplication factor, and addressing nutrition issues is especially important at a critical age in the first years of person’s life, the so called the under-nutrition opportunity window. Malnutrition among children is a major concern in in Tajikistan which causes later health problems, including impaired cognitive development and loss in productivity at an adult age. The 2009 Micronutrient Status Survey (MNSS) showed that 29% of children have a low height-for-age (stunted growth). Children in Khatlon were significantly more likely to have low height-for-age (37%), while Dushanbe had the lowest indicator of malnutrition, with 21.8% of children registering low height-for-age.

Maternal malnutrition, which leads to adverse perinatal outcomes, including low birth weight, and maternal mortality and morbidity, is also a problem in Tajikistan. The 2009 MNSS shows that around 7% of women in Tajikistan are underweight (Body Mass Index <18.5 kg/m2) compared to 9% of women in 2003 (MNSS, 2003). GBAO and Dushanbe recorded the highest prevalence at 9% and 8.1% respectively.

The 2008 Joint Food Security, Livelihoods, Agriculture and Nutrition Assessment finds that the rate of stunting among children under five was significantly correlated with household food consumption and food security status: 24% of children in food-insecure households were stunted compared to 14% in food-secure households. In addition, the national nutrition survey makes a link between child malnutrition and inappropriate feeding practices.

The same assessment also identifies income (or assets) and geographical location as important determinants of food insecurity. Typically, food-insecure households lack assets and rely heavily on external sources for their cash income and food (gifts, borrowing, purchase on credit, etc.), with almost 30% of these households relying either on self-employment or on remittances for their income. The situation is particularly difficult for people with disabilities and older people, who receive an income from public transfers that is not sufficient to provide for
Annex B. Access to universal services and other factors in the operating environment of social services provision

a minimum subsistence standard of living, and at the same have higher health-care costs. A study found that almost 40% of people of pension age receive private transfers to supplement their income; one-fifth of the pensioners receive money from NGOs or churches (Falkingham et al, 2009).

Morbidity and mortality

Health-related MDGs on child and maternal mortality are some of the basic indicators to determine outcomes in the delivery of health services. As Figure B.2 indicates, infant and under-five mortality has been decreasing steadily in the last decade. Nevertheless, this is still the highest child mortality rate compared to other CIS countries.

The high levels of infant and under-five mortality in Tajikistan are attributable to preventable causes. The main determinants of child mortality, identified in a recent study by the World Bank, are poor nutrition, poor availability of antenatal and postnatal health services, and low contraceptive use (Table B.1). Efforts such as this provide evidence of the multi-sectoral nature of the constraints preventing the achievement of lower child mortality rates as well as the various entry points where policy makers can concentrate action (World Bank, 2009).
Table B.1 Determinants of child mortality in Tajikistan

<table>
<thead>
<tr>
<th>Direct determinants</th>
<th>Indirect determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Short exclusive breastfeeding duration</td>
<td>• Household poverty</td>
</tr>
<tr>
<td>• Late vaccinations</td>
<td>• Low maternal education</td>
</tr>
<tr>
<td>• Low use of ORT for diarrheal diseases</td>
<td>• Household food security</td>
</tr>
<tr>
<td>• Low level of antenatal care visits</td>
<td>• Rural households</td>
</tr>
<tr>
<td>• High level of micronutrient deficiencies</td>
<td>• Region of residence</td>
</tr>
<tr>
<td>• High numbers of miscarriages</td>
<td>• Use of unsafe drinking water and sanitation</td>
</tr>
<tr>
<td>• Low contraceptive use/family planning</td>
<td>• Long distance to a health facility</td>
</tr>
</tbody>
</table>

Source: World Bank, 2009

Maternal mortality is also high in Tajikistan – at 86 per 100,000 live births, it is almost three times higher than the national MDG target for 2015. Maternal mortality is conditioned by poor quality of service in antenatal, delivery and postnatal care, the lack of a functioning referral system, the lack of means of transport (especially in rural areas), and inadequate access to emergency obstetric care (MDG Progress Report, 2010).

In the last several years, following the increased incidence of some preventive diseases, and with donor support, the government introduced nation-wide immunization programmes. As a result, the prevalence of preventable diseases has decreased significantly since the late 1990s. However, as indicated by the 2010 polio outbreak, when 458 cases of polio have been reported, immunization services remain weak, due to the low level of awareness among the population, poor knowledge of healthcare workers, informal payments, and inadequate vaccine storage.

The poor health outcomes due to the general problems in the healthcare system are further exacerbated by the low level of knowledge of the population about basic hygiene and public health practices. Approximately 70% of parents are not familiar with general signs of danger concerning the health of their children, and some 75% of children are hospitalized based on self-referral.
Annex B. Access to universal services and other factors in the operating environment of social services provision

Data from the 2007 TLSS show self-medication and financial barriers are the two major reasons for not seeking health care for those who reported need. In the 2009 survey, the majority (33%) of people stated that they did not seek out a health care service when they needed it because they could not afford it. Some 30% felt that they could get better without doing anything whilst 20% resorted to self-medication.

B.1.4 Healthcare for people with disabilities

Disabled persons who need access to healthcare and rehabilitation services on a regular basis face serious challenges accessing this and other kinds of services since they require special transportation, assistance, adapted infrastructure to reach healthcare facilities.

As discussed above, people with disabilities are more exposed to poverty, therefore have less funds to cover health care expenses. JICA 2001 estimates that a disabled person spends 20% or more of their income on medicine. The state provides free of charge healthcare to children with disabilities and partially covers health expenditures for adults with disabilities. However, JICA (2002) estimates a huge deficit in what authorities are supposed to provide and the real spending. The Department of Health of the city of Dushanbe, in 2002, spent 2.4 TJS (US$ 0.6) for drugs for an adult with disability and about 0.11 TJS (US$ 0.03) for a disabled child. At the same time, the report estimates that the average cost per treatment for disabled with cerebral palsy is 40 TJS (US$ 40). The provision of medical care, special equipment, rehabilitation treatment is also very limited.

Another analysis of the situation of children with disabilities in Tajikistan also finds access to health services to be particularly acute problem for poor families living in rural areas, where medical facilities lack the specialist health workers to provide specialised assistance and treatment. The remoteness of health facilities also restricts access, causing parents to have to spend a substantial amount of time and funds on transport, accommodation and food when a child has to undergo tests in a specialised urban preventive health care institution (UNICEF, 2002).

B.2 Access to education

This section analyses access to education by education cycles, focusing on identifying the excluded groups and reasons of being excluded, with a particular focus on children with special needs and access to education for girls.
Figure B.3 Key points: access to education

- Access to education in the general education cycle enrolment rate is rather high in the primary level, with a 97% and 98% completion rate. Enrolment in the professional cycle drops dramatically, especially in the higher level and especially for girls. In the general cycle the ratio of enrolment of girls to boys is 91% but at the age of 17 (professional cycle) only 48% of girls go to school.

- Only about 2,000 children with disability attend regular schools. Even though legal provisions require that regular schools are equipped to allow access of children with disabilities, in reality, these do not have the necessary conditions and cannot enrol these children. Consequently, children with disabilities are most often enrolled in residential care facilities, but they do not receive the same level of education and skills which could help them integrate into the labour market and become dependent on social provisions.

- Poor access to good quality education leads to very high unemployment rate. Young people are caught in a vicious circle: poor access to education results in unemployment and increases the risk of poverty and migration.

Children

The right to education is universal in Tajikistan; the state has the obligation to ensure access to education of all children. The education system is organised in four cycles: pre-school training and education, general, professional and post diploma education. General education cycle is divided in three levels - primary, basic and secondary education. The pre-school education is provided though kindergartens, while general education is provided through general schools, gymnasiurns, and lyceums, usually from age 7 to age 18. Professional education is also divided into three levels – primary, secondary, and higher. It comprises vocational schools, colleges, special secondary schools, universities, and academia. The enrolment age in the professional cycle is 16 years old. The post diploma education includes masters, doctoral, and post-doctoral courses.

Although the state has assumed the obligation to provide free education in the first two cycles, in practice, the education sector is underfinanced. Total expenditure on education accounts for 3.5% of GDP, the lowest in the region. In the last five years, spending on education has increased on the account on external finding (more than US$ 81 million in loans and grants or 1.6% of GDP). Despite the modest increase in funding, the quality of education remains poor, school infrastructure getting worse and schools overcrowded.
Some 80% of schools require major repairs. Some of maintenance expenses are covered by the state but in practice, a major part is expected to be covered by parents. This situation increases the risk of drop outs, especially among children from poor families.

Pre-school education is rather undeveloped in Tajikistan; according to officials from the Ministry of Education, currently only 10% of demand for kindergartens is satisfied (TLSS data 2007 show that 18% of children in urban area have access to preschool education and only 3% in the rural). The Ministry has declared as a priority to develop alternative forms of child care, like private kindergartens, home based kindergartens (private persons to take care of children during the day in their own home), inclusive kindergartens for children with special needs. However, to achieve this, specific measures have to be taken and sources of funding identified.

In the general education cycle enrolment rate is rather high in the primary level, with a 97% and 98% completion rate (2009). The Ministry of Education reports more than 100% enrolled children, the extra units being explained by the fact that children without birth certificate are registered in order to be able to attend school. While accessing primary education school does not seem a problem in Tajikistan, some children face problems in enrolling in the secondary education level. The enrolment in the secondary level drops to 84% (comparing with enrolment in primary level); an OECD report estimates that 30 to 50% of children do not continue education after grade 9. There is also a significant gender discrepancy in secondary level enrolment which is discussed below.

Although no comprehensive data on school attendance exists, anecdotal evidence indicates that attending school can be difficult for some groups of children. The largest part of the country’s territory is covered with mountainous areas, and a significant number of localities is situated in remote areas with very limited communication and transportation means, which makes accessing school very difficult, especially in winter.

The quality of education is also an issue with a shortage on teachers, their qualification, overcrowded schools and poor school infrastructure. A study in education system in Tajikistan finds that there is vacancy rate of teachers on 10% in the primary schools and 15% in the secondary schools. The same study shows 50% of all teachers do not have higher education and about 35% are not specialised in the subject they teach.

Enrolment in the professional cycle drops dramatically, especially in the higher level. Higher education requires significant spending for Tajik families. The World Bank’s Tajikistan Partnership Program snapshot 2001 finds that university
education is largely inaccessible for medium and low-income households. About 72% of universities’ students come from reach families. In response, the government instituted the National Testing Centre, an institution aimed at giving opportunities to talented poor students to access University education. Ministry of Education reports about 40% of all students being provided scholarships without specifying if these students come from poor families.

Poor access to good quality education leads to very high unemployment rate. A minimum of 150,000 jobs per year should be created to maintain the same employment level (absorb the young people coming into the market). To maintain the same unemployment rate as in 2009 the annual employment rate has to increase with not less than 7 per cent points. However, the current employment rate growth is only 0.9%. Young people are caught in a vicious circle: poor access to education results in unemployment and increases the risk of poverty and migration.

Persons with disabilities

According to MLSPP data, there are 19,101 children with registered disabilities (under the age of 16); about 16% of whom are enrolled into the educational programs of the Ministry of Education. Children with disabilities have three options for education: home schooling, mainstream classes, or special classes within mainstream schools and special schools.

As stated in the National Plan of Measures to Protect Children with Disabilities, a large number of disabled children live in the family, without access to education at all. Even though the state provides 16 hours a week of home schooling (the teachers from regular schools teach children at home), if some parents are not aware of such a possibility, disabled children are at risk of being excluded from the educational system altogether.

The integration of disabled children into mainstream classes is not a usual practice either; only about 2000 children with disabilities attend regular schools. Even though the legal provisions require that regular schools are equipped to allow access of children with disabilities, in reality, these do not have the necessary conditions and cannot enrol these children.

With the support of international organizations, the government makes efforts to develop inclusive education, which will offer the possibility of enrolling disabled children into regular schools. This approach implies adapting curricula, adapting infrastructure, providing materials for children with special needs, training support staff and professionals etc.
The most common way of providing education for children with disabilities is to place them into boarding schools (the residential system). A UNDP study estimated that there are 1,898 children (1,269 children by OECD) in 13 special boarding schools. The curricula in the special schools is the one used in regular schools but with adjustment to “particular characteristics of the boarding school”. In reality the boarding school suffers from lack of funds, of properly trained teachers, materials. As a result, disabled children do not receive the same level of education and skills which could help them integrate into the labour market. They become dependent on social cash assistance.

Women and girls

Accessing to education is more challenging for girls than for boys in Tajikistan, especially for girls coming from poor families. In the general cycle the ratio of enrolment of girls to boys is 91% but at the age of 17 (professional cycle) only 48% of girls go to school. The girl’s drop-out ratio in the general cycle differs from region to region (from 1% to 8% in the primary education level and around 12% for secondary level). The gender parity index developed to measure the MDGs progress, at age 16 is 76% (as percentage of children who attend school), with major discrepancies among the regions.

The reasons for not continuing school (in the general secondary and professional cycles) are not straightforward. According to Tajik socio-cultural norms a girl should help with household chores, get married at an early age and is discouraged from going to school. Therefore a girl has fewer chances to go/continue schooling than her brothers. Data (TLSS 2007) show that expenditures on boys’ education are greater among all quintiles than expenditures on girls’ education. This has several causes one might be the lower return on girls’ education. After dropping the school, girls stay at home and help with household chores and/or attend religious classes.

B.2.3 Vocational training and adult education

Tajikistan traditionally has a very high population growth rate, the highest among CIS countries (Figure B.4). The country’s labour resources grow almost in the same proportion as the population, with a 17.8% growth during 2001-2005. Still, the unemployment rate is going down. The TLSS 2007 reports 7%, the National Agency of Statistics calculated a 2.6% unemployment rate for 2006 (0 presents the general unemployment rate). The relatively low unemployment rate can be explained by a very high labour migration rate; nevertheless, the Figure B.5 looks rather optimistic.
Figure B.4  Population growth in CIS countries

![Population growth in CIS countries](image)

Source: OECD 2009

Figure B.5  Unemployment rate

![Unemployment rate](image)

General unemployment rate, in %

Source: DCI 08-18 Labour market review and migration survey, 2009. Data for 2010 from EconomyWatch Econ Stats database, based on IMF data
Annex B. Access to universal services and other factors in the operating environment of social services provision

With the increase in population, the absorption of labour force could be a challenge, while the inclusion in the labour market of special groups, like disabled, children and young people, and women is even more difficult. The unemployment among youngsters (15-29 age cohorts) is 60 %. The report on adult education shows that young people enter labour market without any professional education, therefore any skills. Table B.2 presents the number of persons that received a basic education diploma, number of persons admitted into professional education cycle and the number of person with no professional education entering the labour market.

About 122 secondary professional schools and professional technical education institutions currently function in the country and there are about 55 thousand enrolled students. While vocational education is offered on free basis, families have no means to support a child in the cycle that implies that the child will live somewhere else than home. At the same time, the returns on vocational education seem to be rather low; the vocational education system is considered out of date, cannot meet the current requirements of the labour market. Restructuring of the system is set as a priority in the PRSP 2005-2006 and in the National Development Strategy for Tajikistan 2015.

Attempts to include particular groups into the labour market are being made in a sporadic way. The Adult Education Agency of Tajikistan with the support of international organisations is offering training classes to women to improve their access to labour market. There are also orientation training offered to unemployed, all being small scale initiatives. There is no information on disabled adults being trained to acquire some skills; even if such programs exist the data is not available at the national level.

<table>
<thead>
<tr>
<th>Table B.2</th>
<th>Education and labour market</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thousand 2002</td>
</tr>
<tr>
<td>Received general basic education diplomas</td>
<td>05</td>
</tr>
<tr>
<td>including girls</td>
<td>7</td>
</tr>
<tr>
<td>Total admitted in educational institutions of professional education</td>
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</tr>
<tr>
<td>including girls</td>
<td>8</td>
</tr>
<tr>
<td>Total entered labour market without professional education</td>
<td>5,7</td>
</tr>
<tr>
<td>including girls</td>
<td>9</td>
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</table>

B.3 Housing and living conditions

<table>
<thead>
<tr>
<th>Figure B.6</th>
<th>Key points: housing and living conditions</th>
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</thead>
<tbody>
<tr>
<td>• The organisation of the housing, utilities, and transportation sectors are mostly oriented to meeting the needs of residents in the upper quintiles, while shortage persist for the rest of the population.</td>
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<tr>
<td>• According to the law, 50% of the housing available is reserved for the preferential access of priority groups. However, given the economic difficulties and fiscal constraints, public housing represented only 6% of the total housing stock, and a transparent income-based subsidy system has not been developed to meet the housing needs of the vulnerable segments of the population.</td>
<td></td>
</tr>
<tr>
<td>• For many people utility bills represent a significant part of their income, while the poor quality of services, due to the physical degradation of infrastructure and losses through leaks, makes people refuse paying for what they perceive as overpriced services. At the same time, social assistance programmes are small and poorly-targeted, making it particularly hard for vulnerable groups to pay for utility services.</td>
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</tr>
<tr>
<td>• Local authorities subsidize trips in public transportation for veterans, pensioners, and people with disabilities, but no such subsidies are available in the more widespread private transportation network. Even though the law provides that both public authorities and private organisations are obliged to ensure that social infrastructure (houses, schools, hospitals, sports arenas, and other buildings) and transportation means are fit for the access of people with disabilities, including in wheelchairs, in reality very few such facilities means are wheelchair accessible.</td>
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</tbody>
</table>

Housing and living conditions in Tajikistan are difficult, particularly for vulnerable groups. Although data on the particular situation of children, people with disabilities, older people, and vulnerable women in this area is scarce, the organisation of the housing, utilities, and transportation sectors are mostly oriented to meeting the needs of residents in the upper quintiles, while shortage persist for the rest of the population. As these sectors are being reformed, particular attention should be given to affordable options for the vulnerable populations groups, such as social housing, social assistance payments, and transportation subsidies. In the sections below, general issues in housing, utilities, and transportation are analysed, and specific problems of vulnerable groups are raised where data exists.
B.3.2 Housing

The housing sector in Tajikistan has undergone significant changes in the last two decades. During Soviet rule, the housing system was centralised and the State was directly involved in housing production and distribution. Following Tajikistan’s independence and the introduction of market-oriented reforms, the housing sector was liberalised and by January 2010, 93% of the housing stock had been privatised. Since the mid-1990s, housing developments have been predominantly market-led, resulting in expensive housing developments fuelled by remittances from labour migrants, and the spread of unauthorised private housing construction, particularly in the rural areas. At the same time, the poor management of communal spaces and limited maintenance of existing infrastructure led to the degradation of existing housing. Although a slight increase in Government intervention and a more strategic approach to housing policy has been integrated into national policy documents starting 2007, access to housing services remains a serious issue.

According to official statistical data, the Tajik housing stock grew slowly to approximately 63.5 million square meters in 2010, with an increase of just over 20% since 1991. Rural and urban stock account for 60% and 40%, respectively. About 25% of the population lives in multifamily housing, and 75% in single-family housing. Some 40% of the multifamily buildings are located in Dushanbe. Many people live in overcrowded housing, and the average per capita total floor area in 2008 was 8.6 square meters, significantly below the official standard is 12 square meters (UNECE, 2011).

In 2008, self-built single-family housing made up almost 87% of the total housing output in Tajikistan. The growing trend towards self-help construction is driven by limited opportunities for many households to improve their housing situation, but also the community tradition in rural areas, whereby families assist each other with the construction of houses. Many self-built houses, however, are not in conformity with formal building regulations, due to the residents' limited financial resources and the inadequacy of knowledge and training on building regulations. Thus, many self-built houses do not provide good quality and safe accommodation for the inhabitants.

According to the Housing Code, the government is responsible for the provision of social housing for households in need. The Housing Code provides the categories of people who have the right to improved housing conditions, as well as priority groups, which can benefit from state housing assistance first. Such priority groups include:
• Veterans of armed conflicts and holders of state orders;
• Persons with disabilities (degrees 1 and 2);
• Persons with severe forms of chronic illnesses;
• Pensioners and single persons, if their revenue is lower than the guaranteed minimum; and
• Families with 5 or more children or twins.

In addition, people with disabilities and children without parental care residing in an institution are entitled to receive housing assistance the moment they leave the institution. After reaching the age of 18, these groups have the right to preferential treatment in gaining access to housing.

According to the law, 50% of the housing available is reserved for the preferential access of priority groups. However, given the economic difficulties and fiscal constraints, a transparent income-based subsidy system has not been developed to meet the housing needs of the vulnerable segments of the population. Public housing in 2010 was less than 4 million square meters, which represents only 6.3% of the total housing stock. Expenditures allocated to housing and municipal services represented 3.8% of total budget expenditures in 2009, a slight increase of 0.2 from previous year’s allocation.

As part of post-Soviet reforms, housing functions have been decentralised from the national to local government. Thus, the bodies in charge of allocation of housing to priority groups are the local assemblies (Majlis). Data at the local level is even more limited than national-level data, making it very difficult to analyse the access of vulnerable groups to housing and to identify specific problems in this regard. Interviews with local authorities carried out as part of this research indicate that housing is the top issue raised by vulnerable people that seek help from local authorities. Yet no comprehensive housing programs that would provide shelter to needy persons or will rent on special prices to vulnerable groups have been identified. Local budgets can rarely cover the cost of the envisaged housing cash assistance. That being said, some local authorities interviewed indicated that they do provide limited housing support in the form of land allocations for self-help construction, or temporary shelter for the homeless.

Recognising the important problems in the housing sector, the Government has introduced some provisions on housing in strategic policy documents. Tajikistan’s Poverty Reduction Strategy for 2007-2009 (PRSP-2) provides that the Government will seek to promote public housing construction projects and increased access to housing and municipal services for the low-income and socially-vulnerable population. In July 2010, the Government has adopted a Concept for the reform of the housing and public utilities sector for the period 2010-2015, which provides for measures to improve the system of housing cash assistance and its targeting.
Although the general legislation framework for housing exists and is being updated, there is a lack of guidance and financing for its implementation.

### B.3.3 Public utilities

The public utilities infrastructure in Tajikistan has largely been built during Soviet times. Poor maintenance and lack of investments has led to a significant degradation of the existing infrastructure, and the majority of it has either become inoperable or is working at the limits of its capacity. This leads to inefficiencies of operation and huge losses, with significant implication for both individual households and the economy at large.

Public utilities provided to the population include water and sewerage, electricity, natural gas, and heating. The legacy of universal provision of utilities during the Soviet time affects both the consumption habits of the population and the willingness to pay for services, with many perceiving utilities as an unlimited and free resource. At the same time, for many people utility bills represent a significant part of their income, while the poor quality of services, due to the physical degradation of infrastructure and losses through leaks, makes people refuse paying for what they perceive as overpriced services.

The social assistance system in Tajikistan is small. One of the two types of benefits provided to vulnerable groups is the electricity and gas compensation. However, the targeting performance of the electricity and gas compensation is rather weak. A targeted social assistance programme, based on means-testing, could help vulnerable groups pay for services, including utility services. Over 2011, the government has developed and designed a pilot targeting, registry, and payments mechanism, and has begun piloting this mechanism as a vehicle for channelling poverty-targeted social assistance transfers in two districts (Yavan and Istravshan).

### B.3.4 Water and sanitation

Although Tajikistan is relatively rich in water resources, the water and sanitation supply in Tajikistan is irregular and of poor quality, which has significant repercussions on the health and well-being of the population. The situation of drinking water and sewage service supply differs considerably across different types of settlements. In Dushanbe, almost 100% of the population is covered by centralised water supply and about 75% have access to wastewater services, while in small towns with a population under 50,000, the coverage falls to 55% and 40%, respectively (UNECE, 2011). According to the Water Sector Development Strategy of Tajikistan for 2006-2015, 61% of the population uses water from centralised
water supply systems, and 39% uses water directly from rivers, canals, small irrigation systems, and other water sources that do not correspond to sanitary norms. Only 15% of the population have access to sewage systems.

Approximately 30% of the water supply systems in Tajikistan are dysfunctional, while the effectiveness of water treatment plants is under 40% (Water Sector Development Strategy of Tajikistan for 2006-2015). According to the National Development Strategy of the Republic of Tajikistan, over 50% of the centralised water supply systems available in Tajikistan did not comply with sanitary norms. This leads to an increased frequency and severity of outbreaks of water-related epidemics, such as hepatitis A, typhoid fever, dysentery, and cholera, especially in the rural areas (UNECE, 2011).

The Government has been working with development partners to improve urban and rural water supply and water purification systems. This has resulted in improved clean drinking water supply, most notably in Dushanbe and Khujand. Although utility payments for water are relatively low, many refuse to pay for what is perceived as poor quality of service. For example, per capita water consumption in Dushanbe is 10 times more than the European average, due to inefficient and wasteful use of water and substantial losses of water through leaks.

As mentioned above, there are no income-targeted social assistance programmes, or specific cash assistance to support vulnerable groups with water and sewage access. The situation of people with disabilities that do not have access to centralised water supply systems is particularly difficult.

### B.3.5 Electricity and gas supplies

In 2009, about 90% of the urban population had access to electricity (UNECE, 2011). Electricity supply in Tajikistan has been problematic. The deficit of electricity is particularly large during the winter, when electricity produced by hydropower plants in Tajikistan is not sufficient to cover the increased needs of the population. The import of electricity from neighbouring states is impeded both due to technical and political considerations. In addition, the physical degradation of the utility grid, lack of housing maintenance, inadequate electricity re-distribution within houses and under-developed metering leads to significant losses of electricity. The GoT has been prioritising the construction of the Rogun hydropower plant and implementing energy-saving initiatives, but the situation remains difficult, particularly in rural areas.

In 2009, about 30% of Tajik households had access to gas supply, mostly in urban areas (UNECE, 2011). Almost all the natural gas is imported from Uzbekistan, but adequate gas supplies have been unaffordable to both businesses and
households due to sharp increases in prices in the last several years. District heating and hot water supply systems are severely outdated, and only 10-15% of households in multifamily units in Dushanbe are now being supplied with district heating and hot water during the winter (UNECE, 2011).

The problems with both electricity and natural gas supply have compelled the population, especially in rural areas, to search for alternative energy sources, and autonomous generators are widely used for electricity supply, while wood and coal is used for heating.

As mentioned above, electricity and gas compensations are targeted at poor families connected to the electricity and/or gas network. The amount of the benefit is equivalent to the cost of a basic allocation of electricity and natural gas. The basic allocations differ per season (winter vs. summer) and whether a household uses gas, electricity or both. The compensation is financed from the republican budget. Although the objective is to cover 18–20% of the population, the republican budget does not reflect this rule (UNICEF, 2011). Moreover, the targeting performance of the electricity and gas compensation is rather weak (see A 1.2).

Since many of the poorest households in Tajikistan live in high mountain areas and are not connected to an electricity or gas supply, they are, by definition, excluded from receipt of this transfer. Poor households not connected to the electricity or gas grids are not eligible for the compensation.

**B.3.6 Transportation**

Tajikistan has a mountainous landscape, and mobility between various parts of the country is limited. Because of the relative underdevelopment of the railway network, more than 90% of the passenger and cargo transport within the country is carried out via ground transportation (UNECE, 2011). At the same time, road infrastructure has deteriorated due to under-investment in the 1990s, while mountain highways are often impracticable during the winter months due to snowfall.

Following the liberalisation of the transport sector, a large proportion of passenger transportation begun being carried out by privately owned means of transportation, mostly by minibuses. According to the Strategy for the Development of the Transport Sector of Tajikistan for 2010-2025, almost 10,000 buses and mini-buses ensure passenger transportation, and 600 rural localities (73%) are connected through bus routes. Though transport liberalisation provided a partial solution to problems of transportation in large cities, especially in Dushanbe, the increasing number of minibuses, coupled with the
Social Services in the Republic of Tajikistan

canstantly soaring number of private cars, has started to create air pollution and traffic congestion. At the same time, both the safety and affordability of public transportation has also declined.

Various laws and regulations provide for a facilitated access of certain vulnerable groups to transportation services. The local authorities subsidize trips in public transportation for veterans, pensioners, and people with disabilities, but no such subsidies are available in the more widespread private transportation network. The access of people with disabilities to transportation is limited by inadequate infrastructure. Even though the 2010 Law on the Social Protection of People with Disabilities provides that both public authorities and private organisations are obliged to ensure that social infrastructure (houses, schools, hospitals, sports arenas, and other buildings) and transportation means are fit for the access of people with disabilities, including people in wheelchairs, in reality very few such facilities are wheelchair accessible. The costs for ensuring accessibility of social infrastructure and transportation means is to be borne by the owner of the facility, while at the same time there are guidelines and rules for building or buying accessible means are rarely enforced, which results in continued problems of access for people with disabilities. This is a particular problem for people from remote areas, where few transportation options are available.
Indicative Taxonomy of Social Protection

Social Protection

With a view to developing an indicative conceptualisation of social protection and to analyse the practical linkages between different elements of the social protection system, the research team has developed an indicative taxonomy. The taxonomy maps the major elements of social policy and clusters various services according to their main characteristics.

The taxonomy identifies four basic elements of social policy (Figure C.1). They are:

- Social services (in the broad sense),
- Social assistance (as part of social services),
- Social insurance,
- Social justice.

Social Assistance and Social Insurance are often consider as elements of Social Security system.

<table>
<thead>
<tr>
<th>Figure C.1</th>
<th>Basic elements of social protection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Protection</strong></td>
<td><strong>Social Security</strong></td>
</tr>
<tr>
<td>Social Services</td>
<td>Social Assistance</td>
</tr>
<tr>
<td>Publicly or privately provided services that promote the dignity, 'well-being' of people and social inclusion, reduce vulnerability, marginalisation and social exclusion and promote territorial integrity</td>
<td>Non-contributory financial and material assistance. These transfers can be unconditional (for example, social pensions or cash benefits) or conditional (given in exchange for work on public works programmes or attendance at school, etc).</td>
</tr>
</tbody>
</table>

Source: Authors’ adaptation based Devereux and Sabates-Wheeler, 2006, IDS
Social Services in the Republic of Tajikistan

Under this framework, social services can be conceptualised as comprising a number of distinctive activities, which complement each other and can sometimes be attributed to several types of services. Social services include the following elements (Figure C.2):

- Essential services (civil defence, public utilities, and water and sanitation);
- Primary health care (water and sanitation, basic healthcare, mother and child health, health promotion, immunisation, reproductive health, and therapies);
- Social welfare (therapies, social work, social pedagogy, social care, social housing, and justice);
- Justice and policing;
- Education (preschool and school preparation, compulsory schooling, basic vocational training, and career information, guidance, and advice);
- Employment services (career information, guidance, and advice, unemployment support, labour regulation, and public works); and
- Social Assistance (public works, subsidies, concessions, and cash assistance).

According to this conceptualisation, social services are largely multi-disciplinary, without strict ownership by any domain or occupation. This means that in a policy environment, an inter-departmental effort is required to respond to problems of vulnerability and social exclusion.

The taxonomy is indicative rather than definitive. It cannot represent all of the services and every relationship between them. For example, Occupational Therapy and Physical Therapy/ Physiotherapy (and other therapies), Social Pedagogy, ‘Social-Care’ and Social Work, and other social services (and their occupations) are linked as ‘Social Welfare’ services within the field of ‘Social Services’.

Although the social protection system is directly concerned with addressing poverty and vulnerability, all elements of social policy are inter-related. In the effort of modernising social services, the MLSPP has to consider the reform of social welfare services as part of the social protection system more broadly, and at the same time provide leadership for the reform of social services in its broad sense, which involves the contribution of institutions throughout the government.
## Annex C. Indicative Taxonomy of Social Protection

<table>
<thead>
<tr>
<th>Social Protection</th>
<th>Essential Services</th>
<th>Primary Health Care</th>
<th>Social Welfare</th>
<th>Social Services</th>
<th>Social Insurance</th>
<th>Social Security</th>
<th>Social Justice</th>
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</thead>
<tbody>
<tr>
<td>Consumer Protection</td>
<td>Public Sanitation</td>
<td>Health Promotion</td>
<td>Social Housing</td>
<td>Social Services</td>
<td>Age Pension</td>
<td>Disability &amp; Other Benefits</td>
<td>Social Justice</td>
</tr>
<tr>
<td>Enforcement, Prosecutorial Oversight; Courts &amp; Tribunals</td>
<td>Public Utilities</td>
<td>Maternal &amp; Child Health</td>
<td>Social Care</td>
<td>Social Pedagogy</td>
<td>Illness, Injury &amp; Temporary Disability Insurance</td>
<td>Social Insurance</td>
<td>Essential Services</td>
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<td>Trade Unions</td>
<td>Public Transport</td>
<td>Basic HealthCare</td>
<td>Social Work</td>
<td>Social Work</td>
<td>Unemployment Insurance</td>
<td>Social Protection</td>
<td>Essential Services</td>
</tr>
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<td>Ombudsman</td>
<td>Civil Defence</td>
<td>Therapies</td>
<td>Therapies</td>
<td>Therapies</td>
<td>Disability &amp; Other Benefits</td>
<td>Social Security</td>
<td>Social Security</td>
</tr>
</tbody>
</table>

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41 Social Security is defined differently in different countries and often includes social assistance, social insurance and in some countries it includes a range of other services such as basic health care and basic education.

42 Includes fire brigade, ambulance, rescue and other emergency services.
### Social Services in the Republic of Tajikistan

#### Essential Services
- Disability & Other Benefits
- Subsidies (gas, oil, electricity etc)
- Child & Family Benefits
- Unemployment Benefits

#### Employment Services
- Public Works
- Unemployment Support
- Career Information, Guidance & Advice
- Basic Vocational Training
- Re-training

#### Education
- Compulsory Schooling
- Secondary Schooling
- Pre-School & School Preparation
- Nursery and kindergarten

#### Social Welfare
- Social Housing
- Social Care
- Social Pedagogy
- Social Work
- Therapies
- Nutrition
- Reproductive Health
- Immunisation
- Ambulance
- Water & Sanitation
- Waste collection and Management
- Basic HealthCare
- Water collection, distribution, Filtering & Sterilisation; Sewerage

#### Social Assistance
- Public Transport
- Special Transport for people with disabilities
- Civil Defence
- Fire Brigade, Rescue & other Emergency Services
- Further development in the following table

- Apart of social housing

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43 Apart of social housing
Annex C. Indicative Taxonomy of Social Protection

<table>
<thead>
<tr>
<th>Social Welfare</th>
<th>Social Pedagogy</th>
<th>Social Care</th>
<th>Justice and Policing</th>
</tr>
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<tbody>
<tr>
<td>Primary Health Care</td>
<td>Therapies</td>
<td>Home Care and Support</td>
<td>Policing</td>
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<td>Social Work</td>
<td>Social Care</td>
<td>Residential Care</td>
<td>Protection of People and Property</td>
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<td>Social Work</td>
<td>Social Pedagogy</td>
<td>Foster and Kinship Care</td>
<td>Family Matters: Maintenance, Custody etc. Guardianship of children, Inheritance</td>
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<td>Social Work</td>
<td>Social Pedagogy</td>
<td>Inclusive Education</td>
<td>Rights Defense</td>
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<td>Community-Based Case Management</td>
<td>Adult Corrections Prisons</td>
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<td>Child and Family Harm and Violence Prevention</td>
<td>Shelter and Housing</td>
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Social Services in the Republic of Tajikistan

Social security

As discussed above the two key strands of social protection are social insurance and social (cash) assistance; we collectively describe these as 'social security'. This section describes the main social programmes and benefits (social insurance and social assistance) relevant for each vulnerable group, and analyses to what extent social security alleviate poverty.

Social insurance

Social insurance is defined as a government insurance scheme(s) providing coverage for workers who have become unemployed, injured or retired; usually financed by contributions from workers and employers, as well as government from general revenue.\(^\text{44}\)

Cash assistance to compensate for the loss of income are paid through contributory social insurance schemes, where people contribute during the working period, while the amount of these cash benefits depend on the size of the contribution (years and/or amount). Social insurance comprises three main elements: (i) unemployment insurance; (ii) illness, injury and temporary disability insurance; and (iii) old age pension. Other contributory cash assistance include: maternity benefit, birth grant, childcare benefit, sickness benefit, orphans’ pension, survivor’s pension, and the old age and disability pensions. About 473,000 persons receive a contributory benefit (pension) in Tajikistan. In 2009, the average amount of the benefit was 97 TJS (US$ 24) per month. The beneficiaries are divided among 41 categories, depending on specific circumstances of awarding the payment. Some 67% of the beneficiaries receive an old age pension and another 20% receive the disability pension (MLSP, 2009).\(^\text{45}\)

Apart from the cash assistance that is provided to the household, and expected to have an impact on children’s well-being, there are also cash assistance that are provided to several categories of children considered in a difficult situation. These cash assistance are provided to orphans (children with both parents deceased), survivors (loss of a breadwinner), and disabled children. In addition, grants are provided to mothers at birth and to care for small (up to 3 years old) children.

The MLSPP data indicate that about 900 children receive orphan pensions and 87,000 receive the survivor’s pension. The average amount of the orphan pension is 103 TJS (US$ 25) and survivors pension 50 TJS (US$ 13) per month (MLSP, 2009).\(^\text{46}\) In the case the child is not eligible for social insurance (which requires parents’ contribution to the system) they are provided a social pension (social allowance), described in the subsection on social assistance below.
Older people are entitled to receive old age pensions; the old age pension provision is by far the largest social program in the country. TLSS 2007 data\textsuperscript{47} indicates that only 82% of households with an eligible person receive the old age pension, which constitutes a relatively high exclusion error considering the fact that the old age pension is guaranteed by law to all eligible persons, and the coverage should be 100%. One reason for the high exclusion error is the high documentation cost to obtain the pension.

The old age pension is strongly re-distributory. It was estimated that about 50% of the pensions go to the poorest three quintiles. This comes in contradiction with the contributory philosophy of the pension schemes and creates a strong disincentive to pay contribution which in the long run will result in decrease of replacement rate (replacement rate is the average wage in the country to the amount of the pension).

The main benefit provided to disabled persons is the disability pension. The 2009 MLSPP database shows 97,091 persons receiving a disability pension. This is significantly lower than the estimated total number of people with disabilities and it seems to indicate significant barriers to accessing the disability pension.

The disability pension differs according to the disability degree (from the most severe 1 to 3). In 2009, the value of the average disability pension for 1st degree (most severe) was 165 TJS (US$ 40) for the 2nd degree 160 TJS (US$ 39) and for the 3rd was 135 TJS (US$ 34). Considering the problems with access to education and the labour market, the pension, which is lower that the relative poverty line is often the sole source of income for persons with disabilities.

UNICEF\textsuperscript{48} finds that the disability pension is best targeted, with about 40% of the cash assistance going to the first (poorest) quintile and 57% going to the first and second quintiles together. It is not clear if this is an example of good targeting, since disabled are the most exposed to poverty they might be situated in the 1st and 2nd quintile and all provision to disabled will target poverty as well. Analysing TLSS 2003-2007, the same study finds that the number of households that receive disability pension is going down, covering 5.2% of all households.

There are no cash assistance that are provided specifically to women. There is paid maternity leave for women who are contributing to the social insurance fund, and child allowance to cover some expenses related to child rearing.
Social assistance

Social assistance is considered as non-contributory financial and material assistance, often as measures of last resort, to help people in times of need, to gain the basic necessities for life. These transfers can be unconditional (social pensions and cash benefit) or conditional (public works programmes, school attendance programmes). 49

The non-contributory cash assistance include: income support, social pension, category-based support, and other social cash assistance and allowances. In Tajikistan, about 81,000 persons receive a social pension. In 2009, the average amount of the social pension constituted 53 TJS (US$ 13) per month. The beneficiaries are divided among 36 categories, which (considering the categories for social insurance benefits) is a major burden on the social protection system in general. The administration of such a complex system is costly and facilitates inclusion/exclusion errors.

Among the categories eligible to receive the social pension are children with disabilities and children in difficulty. Approximately 47,000 children receive the disability pension. The amount of benefit is about 50 TJS per month (US$ 13). This is the same amount as the average benefit that a child in difficulty receives. The amount is meant as complementary to the household income and it is too small (considering the poverty rate of US$ 2.15 per day) to have any contribution to improving child’s nutrition, access to education or health. The amount cannot insure proper early development and human capital development.

Women who have five or more children are also entitled to the social pension; about 65,000 women receive the benefit, and which was 73.5 JTS (about US$ 19) per month, in 2009. Disabled mothers are also entitled to the social pension, about 7,000 persons receiving the benefit which was 63 TJS (about US$ 15.6) per month in 2009. War widows receive about 110 TJS (US$ 27) monthly, as social pension; about 1,400 people received the benefit in 2009. Women who did not contribute to the pension fund, but are retired, receive the social pension, which constitutes about 35 TJS (US$ 8) per month. About 8,000 women received the benefit in 2009.

As discussed above, women headed households are poor and might be eligible for income support scheme (cash assistance, school compensation). TLSS 2007 finds that 52% of female-headed households received such cash assistance compared to 30% of male-headed households.
As mentioned above, social assistance in Tajikistan, as percentage of GDP, is the smallest in the region (CIS and ECA countries). Table 1.4 presents an estimate of public spending on social assistance and its share in GDP. The greater part of social expenditure is spent on social pensions (0.25% of GDP). The World Bank (2007) estimated that 34% of the population receive cash assistance (at least one, including pension) and this percentage is continuously decreasing.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Annual budget in US$ millions</th>
<th>Share in GDP in percentage points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Assistance plus Social Pensions</td>
<td>$22.18</td>
<td>0.45%</td>
</tr>
<tr>
<td>Social Pensions</td>
<td>$12.22</td>
<td>0.25%</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>$9.96</td>
<td>0.20%</td>
</tr>
<tr>
<td><strong>Main social assistance programme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity and Gas Compensation</td>
<td>$4.87</td>
<td>0.10%</td>
</tr>
<tr>
<td>Compensation to needy families whose children study in school (Conditional Cash Payments)</td>
<td>$2.86</td>
<td>0.06%</td>
</tr>
</tbody>
</table>


There are two major cash assistance provided in Tajikistan:
- electricity and gas compensations; and
- a cash compensation for children from poor families.

The biggest, in financial terms, social assistance scheme is the electricity and gas compensation; up to 20% of the population receives this benefit. Eligible families are identified through a mix of community-based targeting and means testing. Households apply for the compensation at the community (jamoat) level, where a sub-commission prepares a list of candidate beneficiaries. The sub-commission assesses eligibility based on the household’s receipt of electricity and/or gas and the level of household income. In each district, a commission chaired by the deputy chairman of the district is responsible for the final selection of beneficiaries.

\(^50\) Questionnaire on child poverty and the crises, UNICEF based on TLSS 2007
The amount of the benefit is equivalent to the cost of a basic allocation of electricity and natural gas. The basic allocations differ per season (winter vs. summer) and whether a household uses gas, electricity or both. The compensation is financed from the republican budget. Although the objective is to cover 18–20% of the population, the republican budget does not reflect this rule (UNICEF, 2011).

The targeting performance of the electricity and gas compensation is rather weak. A survey led by the World Bank shows that there is a big exclusion error: many poor households are left outside the scheme; none of the households included in the TLSS 2007 sampling receives the compensation, though 25% of respondents are eligible.

This is partly due to lack of incentives for the commissions at the Jamoat level, who are not paid for this work, and insufficient monitoring from the district and central level. Village heads (Rais-mahalas) involved in identifying eligible beneficiaries have a conflict of interest, as they are also responsible for the collection of fees for use of electricity and gas, garbage collection and other purposes. Potentially eligible households are withheld from the list of beneficiaries unless they pay their fees. A limited understanding of the rules for selecting beneficiaries is also cited as a reason for poor targeting. Also, the households that are not connected to the electricity or gas grid are excluded from the scheme.

The second largest programme of social assistance is the compensation to needy families whose children study in school. This conditional cash payment scheme was launched in 2002 with WB assistance and is targeting the poorest 15% of households. The cash assistance are managed by local authorities and beneficiaries are selected by school association committees. From 406,000 children receiving the benefit, 4.4% are orphans, 4.2% have disabled parents, 16.3% have unemployed parents and almost 21% live in large families. However, according to a WB evaluation, the programme was proved to have no impact on school attendance because of the very small amount of the benefit - 40 TJS per year (about US$ 10)\(^1\). Moreover, coverage with the cash compensation for children from poor families is extremely limited. Although 15% of school children should be targeted, only 2% of households receive the transfer.

A number of reasons may explain this situation. First, the compensations are financed from district budgets, which receive a block grant from the Ministry of Finance. However, the block grant also includes cash assistance for Afghan War veterans and a special fund for one-time compensations for poor households.
At the central level, no separate budget exists for the cash compensation for children. As a consequence, districts are not accountable to the MoF for benefit delivery. Districts have the liberty to divert funds to other purposes. Funds are diverted to special funds and sometimes they remain unspent in a given year and can then be used for any other purpose in the subsequent fiscal year (UNICEF, 2011).

In addition, beneficiaries are selected by local school committees that prepare lists of eligible children. There is no verification of whether the list indeed includes the poorest children. Beneficiaries are paid in cash by the treasurer of the school committee, who has to pick up the money at the local bank branch. Some school principals choose not to pay the full transfer to households, thereby directly withholding outstanding school contributions from poor households (UNICEF, 2011).

In addition to low spending for social provision, the cash assistance are not targeting poverty. In order to improve the distribution of cash assistance, in 2011 the government, with support from the World Bank and the European Union, launched the Social Assistance Programme based on means tested mechanism (through proxy technique). The cash benefit is provided to poor households to compensate for the difference between the family income and a minimum pre-defined threshold (correlated with relative poverty line in Tajikistan). Currently the program is being implemented in two pilot districts (Yavan and Istravshan).
Organogram of the system of public management in the area of social services and social security, 2010

Provided on accompanying CD.
The Social Inclusion Strand of the EU Social Protection and Social Inclusion Indicators consists of 13 primary indicators, 7 secondary indicators and 13 context indicators. These are presented in the table below.

<table>
<thead>
<tr>
<th>List of indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary indicators</strong></td>
<td></td>
</tr>
<tr>
<td>At-risk-of-poverty rate by gender</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty threshold</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Persistent at-risk-of-poverty rate</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Relative median at-risk-of-poverty gap</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Long term unemployment rate</td>
<td>Eurostat/ LFS</td>
</tr>
<tr>
<td>People living in jobless households</td>
<td>Eurostat/ LFS</td>
</tr>
<tr>
<td>Early leavers from education and training</td>
<td>Eurostat/ LFS</td>
</tr>
<tr>
<td>Employment gap of immigrants</td>
<td>National data</td>
</tr>
<tr>
<td>Material deprivation rate</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Housing</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Self-reported unmet need for medical care by income quintile</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Utilisation of medical care services</td>
<td>National data</td>
</tr>
<tr>
<td>Child well-being</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td><strong>Secondary indicators</strong></td>
<td></td>
</tr>
<tr>
<td>At-risk-of-poverty rate by gender and age groups</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty rate by household type</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty rate by work intensity of the household</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty rate by most frequent activity status</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty rate by tenure status</td>
<td>Eurostat/ EU-SILC</td>
</tr>
</tbody>
</table>
## Social Services in the Republic of Tajikistan

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispersion around the at-risk-of-poverty threshold</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Persons with low educational attainment</td>
<td>Eurostat/ LFS</td>
</tr>
<tr>
<td>Low reading literacy performance of pupils</td>
<td>OECD/ PISA</td>
</tr>
<tr>
<td>Depth of material deprivation</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Housing cost overburden rate by: • gender; • age group; • poverty status; • income quintile; • tenure status; • degree of urbanisation; • household type.</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Overcrowding rate (total population) by: • gender; • age group; • poverty status; • tenure status; • degree of urbanisation; • household type.</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Overcrowding rate (population without single-person households) by gender, age group and poverty status</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td><strong>Context indicators</strong></td>
<td></td>
</tr>
<tr>
<td>Inequality of income distribution - S80/S20 income quintile share ratio</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Inequality of income distribution - Gini coefficient</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Regional cohesion: dispersion in regional employment rates</td>
<td>Eurostat/ LFS</td>
</tr>
<tr>
<td>Healthy life expectancy and Life expectancy at birth and at age 65</td>
<td>Eurostat/ EU-SILC and others</td>
</tr>
<tr>
<td>At-risk-of-poverty rate anchored at a fixed moment in time (2005)</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>At-risk-of-poverty rate before social transfers except pensions</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td><strong>Annex E. The Laeken indicators</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jobless households by main household types</th>
<th>Eurostat/ LFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-work at-risk-of-poverty rate</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Making work pay indicators:</td>
<td>OECD/ EC</td>
</tr>
<tr>
<td>• unemployment trap;</td>
<td></td>
</tr>
<tr>
<td>• inactivity trap (esp. second earner case);</td>
<td></td>
</tr>
<tr>
<td>• low-wage trap.</td>
<td></td>
</tr>
<tr>
<td>Net income of social assistance recipients as a % of the at-risk of poverty threshold for 3 jobless household types</td>
<td>OECD</td>
</tr>
<tr>
<td>Self-reported limitations in daily activities by income quintiles (activity restriction for at least the past 6 months)</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>Housing deprivation by item:</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>• leaking roof, damp walls, floors or foundation, or rot in window frames of floor;</td>
<td></td>
</tr>
<tr>
<td>• lack of bath or shower in dwelling;</td>
<td></td>
</tr>
<tr>
<td>• lack of indoor flushing toilet for sole use of household;</td>
<td></td>
</tr>
<tr>
<td>• dwelling too dark.</td>
<td></td>
</tr>
<tr>
<td>Housing deprivation by number of items by:</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>• gender and age group;</td>
<td></td>
</tr>
<tr>
<td>Median of the housing cost burden distribution (median share of housing cost) by:</td>
<td>Eurostat/ EU-SILC</td>
</tr>
<tr>
<td>• gender, age group and poverty status;</td>
<td></td>
</tr>
<tr>
<td>• degree of urbanisation.</td>
<td></td>
</tr>
</tbody>
</table>

## Indicators for Children in Formal Care – Better Care Network and UNICEF, 2009

For the purposes of the manual, children are considered to be persons between the age of 0 and 17. Age 0 begins on the day a child is born. Following their 17th birthday, children are considered to be 17 up to and including 1 day before they turn 18. Where other age ranges are used throughout the manual, the upper limit refers to all children who are currently that age, up to and including one day and including one day before their birthday. For example, children 13 – 15 years of age are included in that range from their 13th birthday up to and including 1 day before their 15th birthday.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantitative indicators</strong></td>
<td></td>
</tr>
<tr>
<td>1 Core</td>
<td>Children entering formal care</td>
</tr>
<tr>
<td>2 Core</td>
<td>Children living in formal care</td>
</tr>
<tr>
<td>3 Core</td>
<td>Children leaving residential care for a family placement</td>
</tr>
<tr>
<td>4 Core</td>
<td>Ratio of children in residential versus family – based care</td>
</tr>
<tr>
<td>5</td>
<td>Number of child deaths in formal care</td>
</tr>
<tr>
<td>6</td>
<td>Contact with parents and family</td>
</tr>
<tr>
<td>7</td>
<td>Existence of individual care plans</td>
</tr>
<tr>
<td>8</td>
<td>Use of assessment on entry to formal care (gatekeeping)</td>
</tr>
<tr>
<td>9</td>
<td>Review of placement</td>
</tr>
</tbody>
</table>

[^52]: For the purposes of the manual, children are considered to be persons between the age of 0 and 17. Age 0 begins on the day a child is born. Following their 17th birthday, children are considered to be 17 up to and including 1 day before they turn 18. Where other age ranges are used throughout the manual, the upper limit refers to all children who are currently that age, up to and including one day and including one day before their birthday. For example, children 13 – 15 years of age are included in that range from their 13th birthday up to and including 1 day before their 15th birthday.
### Annex F. Indicators for Children in Formal Care

<table>
<thead>
<tr>
<th></th>
<th>10</th>
<th>Children in residential care attending local school</th>
<th>Percentage of children of school age in residential care who are attending school within the local community with other children who are not in residential care</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Staff qualifications</td>
<td>Percentage of senior management and staff/carers working with children in formal care with minimum qualifications in childcare and development</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Adoption rate</td>
<td>Rate of adoptions per 100,000 child population</td>
<td></td>
</tr>
</tbody>
</table>

#### Policy / implementation indicators

|   | 13 | Existence of legal and policy framework for formal care | The existence of a legal and policy framework for formal care that specifies:  
  • Steps to prevent separation  
  • Preference for placement of children in family-based care  
  • The use of institutionalization as a last resort and temporary measure, especially for young children  
  • Involvement of children, especially adolescents, in decisions about their placement |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14</td>
<td>Existence of complaints mechanisms for children in formal care</td>
<td>Existence of mechanisms for formal complaints that allow children in formal care to safely report abuse and exploitation</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Existence of system for registration and regulation</td>
<td>Existence of a system of a registration and regulation for those providers of formal care for children</td>
</tr>
</tbody>
</table>
Day care services for children by types and regions

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Category of service users</th>
<th>Type of social service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dushanbe</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Day care centre for children with disabilities</td>
<td>Children with disabilities, Family members or close relatives of the beneficiary</td>
<td>Social-medical re/habilitation, Social-psychological help and consultations, Social and hygiene services, Support in development of movement activities (occupational and physiotherapy), Leisure and communication, Representation of client’s interests at other organisations, Education</td>
</tr>
<tr>
<td>2 State institution «Children and Youth centre of city Dushanbe»</td>
<td>Children with disabilities, Children in conflict with law</td>
<td>Social-psychological help and consultations, Social and hygiene services, Leisure and communication, Representation of client’s interests at other organisations, Vocational education, Education</td>
</tr>
<tr>
<td>3 Day care centre for women</td>
<td>Children injecting drugs, Children living with HIV, Family members or close relatives of the beneficiary</td>
<td>Social-medical re/habilitation, Social-psychological help and consultations, Leisure and communication, Representation of client’s interests at other organisations, Vocational education</td>
</tr>
<tr>
<td>4 Girls Support Centre</td>
<td>Girls, victims of violence, exploitation and traffic, Family members or close relatives of the beneficiary</td>
<td>Social-psychological help and consultations, Social and hygiene services, Leisure and communication, Representation of client’s interests at other organisations</td>
</tr>
<tr>
<td></td>
<td>Day care services for children by types and regions</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Day care centre ‘Nasli navras’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children with disabilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children in conflict with law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Street children and working children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Socially vulnerable families and their children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social-psychological help and consultations</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>City Centre for HIV/AIDS prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children living with HIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social-medical re/habilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social-psychological help and consultations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Leisure and communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Representation of client’s interests at other organisations</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Children and youth club</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children in conflict with law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Street children and working children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Socially vulnerable families and their children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social-medical re/habilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social-psychological help and consultations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social and hygiene services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Leisure and communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Representation of client’s interests at other organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vocational education</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Centre of early vocational orientation and social integration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Children deprived of parental care</td>
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<td>• Care leavers from boarding schools</td>
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<td></td>
<td>• Vocational education</td>
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<tr>
<td>9</td>
<td>Day care rehabilitation and learning centre «Kishti»</td>
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<tr>
<td></td>
<td>• Children with disabilities</td>
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<td></td>
<td>• Family members or close relatives of the beneficiary</td>
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<td></td>
<td>• Support in development of movement activities (occupational and physiotherapy)</td>
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<td>• Education</td>
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<tr>
<td>10</td>
<td>“Drop-in” Centre</td>
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<td>• Children injecting drugs</td>
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<td>• Social-medical re/habilitation</td>
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<td>• Representation of client’s interests at other organisations</td>
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<td></td>
<td>• Vocational education</td>
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| 11  | Republican children and youth centre of psychological health | - Children with disabilities  
- Family members or close relatives of the beneficiary | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Social and hygiene services  
- Leisure and communication  
- Education |
| 12  | Non-state organisation «League of women living with HIV/AIDS in Tajikistan» | - Children living with HIV  
- Family members or close relatives of the beneficiary | - Social-medical re/habilitation  
- Social-psychological help and consultations |
| 13  | Republican clinical Narcology centre named after professor Gulyamov | - Children living with HIV | - Social-medical re/habilitation  
- Social-psychological help and consultations |
| 14  | Non-state organisation «Guli Surh» | - Children living with HIV  
- Family members or close relatives of the beneficiary | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 15  | Republican HIV/AIDS prevention centre | - Children living with HIV  
- Family members or close relatives of the beneficiary | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 16  | Children’s preschool institution № 123 | - Children with disabilities | - Social-psychological help and consultations  
- Social and hygiene services  
- Leisure and communication  
- Support in development of movement activities (occupational and physiotherapy)  
- Education |
| 17  | Association of Parents with Children with Disabilities | - Children with disabilities  
- Family members or close relatives of the beneficiary | - Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
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<tr>
<td></td>
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<td>- Social-medical re/habilitation</td>
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<tr>
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<td>- Social-psychological help and consultations</td>
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<td>- Social and hygiene services</td>
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<td>- Leisure and communication</td>
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<td>- Support in development of movement activities (occupational and physiotherapy)</td>
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<td>- Education</td>
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<tr>
<td>19</td>
<td>Children and Youth centre of arts</td>
<td>- Children in conflict with law</td>
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<td>- Social-psychological help and consultations</td>
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<td>- Representation of client's interests at other organisations</td>
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<td>- Vocational education</td>
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<tr>
<td>20</td>
<td>Specialised kindergarten for children with communication disorders № 151</td>
<td>- Children with disabilities</td>
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<td></td>
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<td>- Social-psychological help and consultations</td>
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<td>- Social and hygiene services</td>
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<td>- Leisure and communication</td>
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<td>- Education</td>
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<tr>
<td>21</td>
<td>Secondary Mainstream School № 3</td>
<td>- Children with disabilities</td>
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<tr>
<td></td>
<td></td>
<td>- Social-psychological help and consultations</td>
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<td>- Social and hygiene services</td>
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<td>- Leisure and communication</td>
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<td>- Education</td>
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<tr>
<td>22</td>
<td>Secondary Mainstream School № 24</td>
<td>- Family members or close relatives of the beneficiary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Social-psychological help and consultations</td>
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<td>- Social and hygiene services</td>
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<td></td>
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<td>- Leisure and communication</td>
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<td></td>
<td></td>
<td>- Education</td>
</tr>
<tr>
<td>23</td>
<td>Psychological, Medical and Pedagogical Consultation</td>
<td>- Family members or close relatives of the beneficiary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Social and medical re/habilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Social and psychological help and consultations</td>
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<td>- Representation of client's interests at other organisations</td>
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<th>Location/Service Type</th>
<th>Eligibility/Services</th>
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| 24  | Children ecological centre «Payrokha» | - Children with disabilities  
- Family members or close relatives of the beneficiary  
- Social-psychological help and consultations  
- Leisure and communication  
- Vocational education |
| 25  | Non-government boarding school for orphan children and children deprived of parental care of international charity children’s foundation ‘Ozodi’ | - Children with disabilities  
- Children in conflict with law  
- Social-medical re/habilitation  
- Leisure and communication  
- Education |
| 26  | Centre «Khamroz» | - Socially vulnerable families and their children  
- Victims of domestic violence  
- Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Vocational education |
| 27  | Communication centre | - Children living with HIV  
- Socially vulnerable families and their children  
- Injection drug users  
- Sex workers  
- Family members or close relatives of the beneficiary  
- Social-medical re/habilitation  
- Social-psychological help and consultations  
- Social and hygiene services  
- Leisure and communication  
- Representation of client’s interests at other organisations  
- Vocational education |
| 28  | Children’s social and legal centre | - Street children and working children  
- Girls, victims of violence, exploitation and traffic  
- Leisure and communication  
- Vocational education  
- Education |
| 29  | Support centre for victims of domestic violence | - Street children and working children  
- Girls, victims of violence, exploitation and traffic  
- Victims of domestic violence  
- Leisure and communication  
- Vocational education |
### Annex G. Day care services for children by types and regions

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<tr>
<th>No.</th>
<th>Service Description</th>
<th>Beneficiary Groups</th>
<th>Services Provided</th>
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</thead>
</table>
| 30  | Crisis support centre for victims of domestic violence | • Girls, victims of violence, exploitation and traffic  
• Socially vulnerable families and their children  
• Family members or close relatives of the beneficiary | • Social-psychological help and consultations  
• Leisure and communication  
• Vocational education |
| 31  | Boarding school for gifted children of Vosse district | • Orphan children  
• Socially vulnerable families and their children | • Social-psychological help and consultations  
• Support in development of movement activities (occupational and physiotherapy)  
• Leisure and communication  
• Representation of client’s interests at other organisations |
| 32  | Women’s support centre Kulyab city | • Children injecting drugs  
• Children living with HIV  
• Socially vulnerable families and their children  
• Victims of domestic violence  
• Family members or close relatives of the beneficiary | • Social-medical re/habilitation  
• Leisure and communication  
• Representation of client’s interests at other organisations |
| 33  | Children’s education centre «Khurshed» | • Children deprived of parental care  
• Children in conflict with law  
• Street children and working children  
• Girls, victims of violence, exploitation and traffic  
• Socially vulnerable families and their children  
• Victims of domestic violence  
• Family members | • Social-psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Vocational education  
• Education |
| 34  | Boarding School for orphan children of Vakhsh District of Khatlon Region | • Children deprived of parental care  
• Socially vulnerable families and their children  
• Victims of domestic violence | • Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Education |
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<tr>
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<th>Service Description</th>
<th>Beneficiaries</th>
<th>Support and Services</th>
</tr>
</thead>
</table>
| 35     | Day care centre for children ‘Kabutar’ | - Street children and working children  
- Girls, victims of violence, exploitation and traffic  
- Care leavers from boarding schools  
- Children injecting drugs  
- Children living with HIV  
- Socially vulnerable families and their children  
- Victims of domestic violence  
- Family members or close relatives of the beneficiary | - Social-psychological help and consultations  
- Leisure and communication  
- Vocational education |
| 36     | Boarding School for Orphan Children and Children Deprived of Parental Care of Muminobod District of Khatlon Region | - Children deprived of parental care  
- Orphan children  
- Socially vulnerable families and their children  
- Victims of domestic violence | - Social-medical re/habilitation  
- Social and hygiene services  
- Leisure and communication  
- Representation of client’s interests at other organisations  
- Education |
| 37     | Republican Boarding School for Orphan Children of Shurobod district | - Children deprived of parental care  
- Orphan children  
- Socially vulnerable families and their children  
- Victims of domestic violence | - Social-medical re/habilitation  
- Social and hygiene services  
- Leisure and communication  
- Representation of client’s interests at other organisations  
- Education |
| 38     | State institution ‘Republican boarding school for orphan children, children deprived of parental care and children from low-income families’ of Yovon district | - Children deprived of parental care  
- Orphan children  
- Socially vulnerable families and their children  
- Victims of domestic violence | - Social-medical re/habilitation  
- Social and hygiene services  
- Leisure and communication  
- Representation of client’s interests at other organisations  
- Education |
## Annex G. Day care services for children by types and regions

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<tr>
<th>No.</th>
<th>Service Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>39</td>
<td>Day care centre for children with disabilities ‘Parastu’</td>
<td>Children with disabilities, Family members or close relatives of the beneficiary</td>
<td>Social-psychological help and consultations, Support in development of movement activities, Leisure and communication</td>
</tr>
<tr>
<td>40</td>
<td>Day care centre for children with disabilities ‘Sitora’</td>
<td>Children with disabilities, Socially vulnerable families and their children, Victims of domestic violence, Family members or close relatives of the beneficiary</td>
<td>Social-psychological help and consultations, Support in development of movement activities (occupational and physiotherapy), Leisure and communication, Representation of client’s interests at other organisations</td>
</tr>
<tr>
<td>41</td>
<td>Centre ‘Svet miru’</td>
<td>Children with disabilities</td>
<td>Leisure and communication, Representation of client’s interests at other organisations, Education</td>
</tr>
<tr>
<td>42</td>
<td>Club «Volcano»</td>
<td>Children deprived of parental care, Orphan children, Socially vulnerable families and their children</td>
<td>Social-psychological help and consultations, Leisure and communication, Vocational education, Education</td>
</tr>
<tr>
<td>43</td>
<td>‘Drop-in’ Centre</td>
<td>Children injecting drugs, Family members or close relatives of the beneficiary</td>
<td>Leisure and communication, Vocational education</td>
</tr>
<tr>
<td>44</td>
<td>Day care centre for children with disabilities «Oftobak»</td>
<td>Children with disabilities</td>
<td>Social-psychological help and consultations, Social and hygiene services, Support in development of movement activities (occupational and physiotherapy), Leisure and communication, Education</td>
</tr>
<tr>
<td>45</td>
<td>Republican boarding school for orphan children of Nurobod district</td>
<td>Children deprived of parental care, Orphan children</td>
<td>Leisure and communication, Education</td>
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<td>Social Services in the Republic of Tajikistan</td>
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</tbody>
</table>
|   | Republican boarding school for orphan children of Rasht district | • Children deprived of parental care  
• Orphan children  
• Social-medical re/ habilitation  
• Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Education |
| 46 | State educational institution ‘Republican boarding school for orphan children of Shakhrinav district’ | • Children deprived of parental care  
• Orphan children  
• Social-medical re/habilitatio  
• Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Education |
| 47 | Children ecological club ‘Lochin’ | • Children deprived of parental care  
• Care leavers from boarding schools  
• Children injecting drugs  
• Children living with HIV  
• Socially vulnerable families and their children  
• Leisure and communication  
• Vocational education |
| 48 | Republican boarding school for deaf and hearing impaired children of Rudaki district | • Children with disabilities  
• Social-medical re/ habilitation  
• Social-psychological help and consultations  
• Social and hygiene services  
• Leisure and communication  
• Vocational education  
• Education |
| 49 | Non-state organisation ‘Bonuvon’ | • Children living with HIV  
• Socially vulnerable families and their children  
• Social-medical re/ habilitation  
• Social-psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations |
### Annex G. Day care services for children by types and regions

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<tr>
<th>#</th>
<th>Organization and Location</th>
<th>Services Provided</th>
<th>Additional Services</th>
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</thead>
</table>
| 51 | Public organizaiton «Marifatpocho» | - Children living with HIV  
- Socially vulnerable families and their children | - Social and medical rehabilitation  
- Social and psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 52 | HIV/AIDS prevention centre of Darvoz district | - Children living with HIV | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 53 | HIV/AIDS prevention centre of Ishkashim district | - Children injecting drugs  
- Children living with HIV  
- Socially vulnerable families and their children | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 54 | HIV/AIDS prevention centre of Murgab district | - Children injecting drugs  
- Children living with HIV | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Social and hygiene services  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 55 | HIV/AIDS prevention centre of Rushan district | - Children living with HIV  
- Socially vulnerable families and their children | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
| 56 | Children and youth centre of arts №2 | - Children with disabilities  
- Children in conflict with law  
- Street children and working children | - Leisure and communication  
- Representation of client’s interests at other organisations  
- Education |
| 57 | HIV/AIDS prevention centre of Shugnon district | - Children injecting drugs  
- Children living with HIV  
- Socially vulnerable families and their children | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Leisure and communication  
- Representation of client’s interests at other organisations |
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<th>Organisation</th>
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| 58   | Non-state organisation «Nur» | • Children deprived of parental care  
• Children with disabilities  
• Children injecting drugs  
• Children living with HIV  
• Family members or close relatives of the beneficiary | • Social-medical re/habilitation  
• Social-psychological help and consultations  
• Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Vocational education |
| 59   | Centre «Marifat» | • Children deprived of parental care  
• Children orphans  
• Children with disabilities  
• Socially vulnerable families and their children | • Leisure and communication |
| 60   | Narcological centre of KBAO | • Children injecting drugs | • Social-medical re/habilitation  
• Social-psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations |
| 61   | Girls Support Centre | • Children orphans  
• Children in conflict with law  
• Street children and working children  
• Girls, victims of violence, exploitation and traffic  
• Socially vulnerable families and their children | • Social and psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Vocational education |
| 62   | Day care centre of social services for children ‘Nur’ | • Children with disabilities | • Social-medical re/habilitation  
• Social and psychological help and consultations  
• Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Education |
### Annex G. Day care services for children by types and regions

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<th>Type of Service</th>
<th>Target Group</th>
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| 63 | Regional HIV/AIDS prevention centre | Children living with HIV | • Social-medical re/habilitation  
• Social-psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations |
| 64 | Centre «Madina» | Street children and working children, Girls, victims of violence, exploitation and traffic, Socially vulnerable families and their children, Family members or close relatives of the beneficiary | • Social and psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Vocational education |
| 65 | Day care centre for children and adolescents | Orphan children, Children in conflict with law, Street children and working children, Socially vulnerable families and their children | • Leisure and communication  
• Education |
| 66 | Non-state organisation ‘Khayrandesh’ | Socially vulnerable families and their children | • Social-medical re/habilitation  
• Social-psychological help and consultations  
• Social and hygiene services  
• Leisure and communication  
• Representation of client’s interests at other organisations |

**Sugd region**

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<th>No</th>
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<th>Target Group</th>
<th>Services Provided</th>
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| 67 | Pre-boarding school under mainstream school №1 named after M. Shukurov | Children deprived of parental care, Orphan children, Socially vulnerable families and their children | • Social-medical re/habilitation  
• Leisure and communication  
• Hot meal |
| 68 | State boarding and educational institution under school №2 of Asht district | Orphan children, Socially vulnerable families and their children | • Social-medical re/habilitation  
• Leisure and communication  
• Hot meal |
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<td>Boarding School under high school № 7</td>
<td>Orphan children, Socially vulnerable families and their children, Social-medical re/habilitation, Leisure and communication, Hot meal</td>
</tr>
<tr>
<td>70</td>
<td>State Educational Institution «Boarding School for Deaf and Hearing-Impaired Children»</td>
<td>Orphan children, Children with disabilities, Vocational education, Education, Hot meal</td>
</tr>
<tr>
<td>71</td>
<td>HIV/AIDS prevention centre of B. Gafurov district</td>
<td>Children injecting drugs, Children living with HIV</td>
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<tr>
<td>72</td>
<td>Psychological, Medical and Pedagogical Consultation of Republican children and youth centre of psychological health</td>
<td>Children deprived of parental care, Orphan children, Children with disabilities, Children in conflict with law, Social-medical re/habilitation, Social-psychological help and consultations, Support in development of movement activities (occupational and physiotherapy), Representation of client’s interests at other organisations</td>
</tr>
<tr>
<td>73</td>
<td>Non-state organisation ‘Manbai Mekhr’</td>
<td>Children with disabilities, Socially vulnerable families and their children, Social-medical re/habilitation, Social-psychological help and consultations, Support in development of movement activities (occupational and physiotherapy), Vocational education, Education</td>
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<tr>
<td>74</td>
<td>Regional HIV/AIDS prevention centre of Sughd region</td>
<td>Children injecting drugs, Children living with HIV, Social-medical re/habilitation</td>
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<td>75</td>
<td>Social and legal centre «Sarchashma»</td>
<td>Orphan children, Children in conflict with law, Victims of domestic violence, Family members or close relatives of the beneficiary, Social-psychological help and consultations, Representation of client’s interests at other organisations</td>
</tr>
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### Annex G. Day care services for children by types and regions

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<th>Description</th>
<th>Target Groups</th>
<th>Services Provided</th>
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</table>
| 76  | State institution ‘Children rehabilitation centre on child’s rights’ of Khujand city | • Orphan children  
• Children in conflict with law  
• Socially vulnerable families and their children | • Social-psychological help and consultations  
• Representation of client’s interests at other organisations  
• Education  
• Hot meal |
| 77  | Pre-boarding school named after Dodokhoja Boymatov of Shakhriston district | • Orphan children  
• Socially vulnerable families and their children | • Representation of client’s interests at other organisations  
• Hot meal |
| 78  | Territorial centre of social care services for elderly and people with disabilities of local executive organ of public authority of Gonchi district | • Socially vulnerable families and their children | • Leisure and communication  
• Hot meal |
| 79  | HIV/AIDS prevention centre of Istaravshan city | • Children injecting drugs  
• Children living with HIV | • Social-medical re/habilitation |
| 80  | Centre for Additional Education | • Children deprived of parental care  
• Orphan children  
• Children with disabilities  
• Children in conflict with law  
• Street children and working children  
• Socially vulnerable families and their children  
• Family members or close relatives of the beneficiary | • Social-psychological help and consultations  
• Leisure and communication  
• Representation of client’s interests at other organisations  
• Vocational education |
| 81  | HIV/AIDS prevention centre of Isfara city | • Children injecting drugs  
• Children living with HIV | • Social-medical re/habilitation |
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<th>Service Area</th>
<th>Beneficiaries</th>
<th>Additional Services</th>
</tr>
</thead>
</table>
| 82   | Psychological, Medical and Pedagogical Consultation of Republican children and youth centre of psychological health | - Children deprived of parental care  
- Orphan children  
- Children with disabilities  
- Children in conflict with law | - Social-medical re/habilitation  
- Social-psychological help and consultations  
- Support in development of movement activities (occupational and physiotherapy) |
| 83   | State educational and boarding school ‘Baby home №1 of Isfara city’ | - Children deprived of parental care  
- Orphan children | - Social-medical re/habilitation  
- Leisure and communication  
- Education  
- Hot meal |
| 84   | Non-state organisation ‘Payvandi shakhvandi’ | - Children deprived of parental care  
- Orphan children  
- Socially vulnerable families and their children | - Education  
- Hot meal |
| 85   | Sector on child’s rights of Kanibodom city | - Children deprived of parental care  
- Orphan children  
- Children in conflict with law  
- Street children and working children  
- Girls, victims of violence, exploitation and traffic | - Social-psychological help and consultations  
- Representation of client’s interests at other organisations |
| 86   | Centre for Additional Education | - Children deprived of parental care  
- Orphan children  
- Children with disabilities  
- Children in conflict with law  
- Street children and working children  
- Socially vulnerable families and their children  
- Family members or close relatives of the beneficiary | - Social-psychological help and consultations  
- Leisure and communication  
- Vocational education |
## Annex G. Day care services for children by types and regions

<table>
<thead>
<tr>
<th></th>
<th>Psychological, Medical and Pedagogical Consultation of Republican children and youth centre of psychological health</th>
<th>Children deprived of parental care</th>
<th>Orphan children</th>
<th>Children with disabilities</th>
<th>Children in conflict with law</th>
<th>Family members or close relatives of the beneficiary</th>
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<th>Social-medical re/habilitation</th>
<th>Social-psychological help and consultations</th>
<th>Social and hygiene services</th>
<th>Support in development of movement activities (occupational and physiotherapy)</th>
<th>Education</th>
<th>Hot meal</th>
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<td>88</td>
<td>HIV/AIDS prevention centre of Panikent city</td>
<td>Children injecting drugs</td>
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<tr>
<td>89</td>
<td>Complex of kindergarten and special school for blind and visually impaired children</td>
<td>Children with disabilities</td>
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<td>90</td>
<td>Special state educational institution: supporting boarding school of Khujand city</td>
<td>Children with disabilities</td>
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<td>91</td>
<td>Non-state organisation ‘Centre for democracy development’</td>
<td>Children with disabilities</td>
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- Education
- Hot meal
- Social-medical re/habilitation
- Social-psychological help and consultations
- Social and hygiene services
- Support in development of movement activities (occupational and physiotherapy)
- Representation of client’s interests at other organisations
- Leisure and communication
- Social and hygiene services
- Hot meal
# Home-based services for children by types and regions

<table>
<thead>
<tr>
<th>Annex H</th>
<th>Social welfare services in the home (Home care)</th>
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</thead>
<tbody>
<tr>
<td><strong>Service provider</strong></td>
<td><strong>Category of service users</strong></td>
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<tr>
<td>1</td>
<td>State Institution ‘Vocational boarding lyceum for disable children’</td>
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<td>Learning centre «Charoli hidoyat»</td>
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<td>Girls Support Centre</td>
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<td>Family house 1</td>
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</table>
## Annex H. Home-based services for children by types and regions

<table>
<thead>
<tr>
<th>#</th>
<th>Service Provider</th>
<th>Target Groups</th>
<th>Services Provided</th>
</tr>
</thead>
</table>
| 5  | Family house 2   | • Children with disabilities  
  • Socially vulnerable families and their children | • Social supervision in family and community  
  • Social-medical re/habilitation  
  • Social and hygiene services  
  • Assistance in social adaptation by providing life-skills education  
  • Leisure and communication  
  • Social-legal support and consultations  
  • Social-psychological support and consultations |
| 6  | Republic children and youth centre of psychological health | • Children with disabilities  
  • Family members or close relatives of the beneficiary | • Social-medical re/habilitation |
| 7  | Day care centre for children with disabilities ‘Parastu’ | • Children with disabilities  
  • Family members or close relatives of the beneficiary | • Social supervision in family and community  
  • Assistance in social adaptation by providing life-skills education  
  • Leisure and communication  
  • Social-legal support and consultations  
  • Social-psychological support and consultations |
| 8  | Support centre for children with disabilities | • Children with disabilities  
  • Family members or close relatives of the beneficiary | • Social supervision in family and community  
  • Assistance in social adaptation by providing life-skills education  
  • Social-legal support and consultations  
  • Social-psychological support and consultations |
| 9  | Centre ‘Svet miru’ | • Children with disabilities | • Social supervision in family and community  
  • Social and hygiene services  
  • Leisure and communication |
# Social Services in the Republic of Tajikistan

## Rayony respublikanskogo podchineniya (RRP)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Additional Services</th>
</tr>
</thead>
</table>
| 10 | Day care centre for children with disabilities ‘Oftobak’ | - Social supervision in family and community  
- Assistance in social adaptation by providing life-skills education  
- Leisure and communication  
- Social-legal support and consultations  
- Social-psychological support and consultations |

## Gorno-Badakhshanskaya Autonomous Oblast (GBAO)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Additional Services</th>
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</thead>
</table>
| 11 | Social assistance at home unit of local executive organ of public authority of Khorug city | - Social supervision in family and community  
- Social and hygiene services  
- Assistance in social adaptation by providing life-skills education  
- Leisure and communication  
- Social-legal support and consultations  
- Social-psychological support and consultations |

## Sugd region

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Additional Services</th>
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</table>
| 13 | Children's social and legal centre | - Leisure and communication  
- Vocational education  
- Education |
<table>
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<tr>
<th></th>
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<th>Support centre for victims of domestic violence</th>
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<td>Non-state organisation ‘Manbai Mekhr’</td>
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<td>Social assistance at home unit of local executive organ of public authority of Asht district</td>
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<td>Social assistance at home unit of local executive organ of public authority of B. Gafurov district</td>
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<td>Social assistance at home unit of local executive organ of public authority of Kayrakkum city</td>
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<td>Social assistance at home unit</td>
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</table>

- Street children and working children
- Girls, victims of violence, exploitation and traffic
- Victims of domestic violence

- Leisure and communication
- Vocational education

- Children with disabilities
- Socially vulnerable families and their children

- Social supervision in family and community
- Social-medical rehabilitation
- Assistance in social adaptation by providing life-skills education
- Education

- Children deprived of parental care
- Orphan children
- Socially vulnerable families and their children

- Social supervision in family and community
- Social and hygiene services
- Leisure and communication
- Social-legal support and consultations

- Children deprived of parental care
- Orphan children

- Social supervision in family and community
- Social and hygiene services
- Leisure and communication
- Social-legal support and consultations

- Children with disabilities
- Socially vulnerable families and their children

- Social supervision in family and community
- Social and hygiene services
- Leisure and communication
## Social Services in the Republic of Tajikistan

<table>
<thead>
<tr>
<th>20</th>
<th>Social assistance at home unit of local executive organ of public authority of Kanibodam city</th>
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</thead>
</table>
|    | • Children deprived of parental care  
    | • Orphan children  
    | • Socially vulnerable families and their children |
|    | • Social supervision in family and community  
    | • Social and hygiene services  
    | • Leisure and communication  
    | • Social-psychological support and consultations |

<table>
<thead>
<tr>
<th>21</th>
<th>Social assistance at home unit of local executive organ of public authority of Panjikent city</th>
</tr>
</thead>
</table>
|    | • Orphan children  
    | • Children with disabilities  
    | • Socially vulnerable families and their children |
|    | • Social supervision in family and community  
    | • Social and hygiene services  
    | • Leisure and communication |