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Towards piloting Integrated Case Management in Uzbekistan

Analytical Paper

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Vienna, 2024

EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH

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The European Centre for Social Welfare Policy and Research has been commissioned by the UNDP to carry out research, analysis and mapping of integrated approaches applied in employment and welfare services in Uzbekistan within the joint initiative of the Ministry of Employment and Poverty Reduction of the Republic of Uzbekistan and UNDP "Addressing socio-economic inequalities in a time of global and regional instabilities".

Acknowledgements

This report was prepared within the framework of the UNDP project “Addressing socio-economic inequalities in a time of global and regional instabilities” with the financial support of the governments of Luxembourg and the Republic of Korea, channelled through the UNDP “Poverty and Inequality Funding Window”. It was prepared by the United Nations Development Programme (UNDP) in Uzbekistan, the Inclusive Growth Cluster. The report was prepared by a team of European Centre for Social Welfare Policy and Research experts (Dr. Anette Scoppetta and Eszter Zólyomi) and was led by Nargiza Khamidova (Project Manager at UNDP) with the extensive support of Diana Kurbanbayeva. Invaluable contributions were received from Hudoykul Hafizov (UNDP Uzbekistan), Gregory Mctaggart (UNDP RBEC), and representatives of the National Agency for Social Protection (NASP). The visual content and layout were designed and produced by the European Centre for Social Welfare Policy and Research.

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List of Abbreviations

ALMP	Active Labour Market Policy
DA	Disability Assessment
European Centre	European Centre for Social Welfare Policy and Research
EU	European Union
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
ICM	Integrated Case Management
ILO	International Labour Organization
M&E	Monitoring and Evaluation
MEPR	Ministry of Employment and Poverty Reduction of the Republic of Uzbekistan
MoU	Memorandum of Understanding
NASP	National Agency for Social Protection
PES	Public Employment Service (here: Employment Facilitation Centre)
SIA	Social Insurance Agency
SOP	Standard Operating Procedures
PIA	Pension Insurance Agency
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UZSTAT	Statistics Agency under the President of the Republic of Uzbekistan
VET	Vocational Education and Training
WB	World Bank

Executive Summary

The paper suggests the establishment of an Integrated Case Management model in Uzbekistan, initially focusing on persons with disability, including a pilot implementation in Tashkent. The recommended model applies a customer-centred approach to be employed by stakeholders in social and employment policies. Case managers will be the core of the model which will lead persons with disabilities down the entire integration pathway towards employment. In close consultation with the person with disability, they will also choose the service/s best fitting to the client's needs from both employment and social policies. The step-by-step approach presented in this paper includes partnership formation, planning, implementation and reflection and learning. The paper provides guidance towards a suggested delivery model that should enhance the employability of persons with disabilities and includes policy recommendations that would make the model effective so that persons with disabilities are supported holistically.

1 Introduction

This analytical paper is part of the project "*Addressing socio-economic inequalities in a time of global and regional instabilities",* a joint initiative of the government of Uzbekistan and the United Nations Development Programme (UNDP). The European Centre of Social Welfare Policy and Research (European Centre) has been commissioned by the UNDP to carry out research, analysis and mapping of the integrated approaches applied in employment and welfare services in Uzbekistan with a focus on enhancing the employability of persons with disabilities.

The paper is the second report within the project presented by the European Centre. While the first report (analytical report) included an analysis of mid-term and long-term state programmes in social protection and labour systems in Uzbekistan, the paper at hand aims at providing *guidance* towards the suggested delivery model of integrated case management in Uzbekistan. It builds on the findings of the analytical report and includes results from the mission conducted in Uzbekistan (15-23 April 2024).

During the mission, the following research methods were applied: interviews during on-the-spot visits[1] and participatory workshops (Participatory Integrated Case Management (ICM) Scoping Workshop on 18 April 2024 and National Stakeholder Workshop on piloting ICM on 19 April 2024; both face-to-face in Tashkent, Uzbekistan). Desk research has been conducted to complete the insights gained.

The report is structured as follows: after the Introduction (chapter 1), suggestions for the ICM delivery model in Uzbekistan are presented in chapter 2. Chapter 3 informs on suggestions for the pilot to be implemented in Tashkent and chapter 4 presents the conclusions.

2 Suggestions for the ICM model in Uzbekistan

Integrated Case Management (ICM) is understood as ***an innovative practice employed collectively by employment and social security agencies to serve the most vulnerable with all available resources from both the labour market and the social***

[1] With representatives from the "Ishga Marhamat" Monocenter located in Yashnabod district of Tashkent, "Inson centre" including Ishplus located in Almazar district of Tashkent, Employment facilitation centre/PES in Mirzo-Ulugbek district of Tashkent, National Agency for Social Protection under the President of the Republic of Uzbekistan, Sharoit Plus and UNDP.

system, and even beyond. Uzbekistan has experience with case management, primarily in social services. It lacks a comprehensively applied **integrated approach between employment and social protection,** as was discussed in the analytical report.

A core element suggested for the implementation of the ICM model in Uzbekistan is the **customer-centred approach** that should be applied by all actors of social and employment policies (see, for instance, the European Commission, 2023). This means that persons with disabilities are placed at the centre of all concerns. Persons with disabilities are a **heterogeneous group** with diverse needs. We, therefore, suggest a **targeted approach** that builds on the **needs of each individual person with disability, including their families and carers.**

During the Participatory ICM Scoping Workshop (18 April 2024) and the National Stakeholder Workshop (19 April 2024), participants agreed that there is no single institution that can address the various needs of the vulnerable group of persons with disabilities alone. There was a **mutual understanding that a collaborative approach** for locally embedded services must be applied. During the workshops, policy interventions were reflected at the macro-, meso- and micro-level with the results that:

- *at the macro-level,* systemic links between policies (e.g. active labour market policy (ALMP) and social security) should be developed and strengthened;
- *at the meso-level* (the organisational level), both persons with disabilities and stakeholders involved in delivering ICM should experience (institutionalised) ways of collaborative work (the case manager acts as the key person for the person with disability, their family and their carers; and
- *at the micro-level* (the beneficiary level), persons with disabilities should receive support via services and measures from both employment and social policy in an integrated way provided by case managers.

Moreover, the joint understanding that the participants generated during the workshops was that, while participation in ICM for persons with disabilities is voluntary, services must be offered on a broad (expanded) scale to serve the varying needs of the target group.

Policy and practice solutions should target both the inclusion of persons with disabilities into society and their inclusion into the labour market, including **long-term perspectives** (over various phases of life, intergenerational, considering the life-course perspective), following a **preventive approach**, including the **family perspective** of persons with disabilities and examining the **quality and sustainability of jobs** filled.

The workshop participants comprised approximately 60 stakeholders per day for both events from both the management and implementation levels. The workshops

were vital for setting up ICM in Uzbekistan and implementing the ICM pilot in Tashkent. The participant's satisfaction with the workshops was high (the average overall satisfaction rating was 4.85 on a five-point Likert scale). Please see further information on the participants below.

Workshop participants (ICM Scoping WS and National Stakeholder WS)	
Expert level/professionals	Policy designers and managers at central governance levels, counsellors (PES), social workers (Inson Centres), VET trainers (Monocentres), professionals working with persons with disabilities (e.g. at Ishplus), recruitment specialists (e.g. at PES, Monocentres), and others more.
Stakeholders	Ministry of Employment and Poverty Reduction (MEPR), National Agency for Social Protection (NASP) and their offices, Inson Centres, Monocentres, Public Employment Service (PES; referred to in Uzbekistan as the Employment Facilitation Centres), social service providers such as NGOs (e.g. Sharoit+ including the project Ishplus), Federation of Trade Unions of Uzbekistan, Confederation of Employers of Uzbekistan and beneficiaries, namely persons with disabilities.

During the meetings held prior to the workshops (16-17 April 2024), potential implementing partners in Tashkent, namely the Inson Centre in Almazar district, the Monocentre in Yashnabod district and the PES in Mirzo-Ulugbek district of Tashkent, stated their **need for extended information exchange** and **interest in intensified collaboration**.

Given the diverse territorial contexts in Uzbekistan such as the different locations of the above-mentioned actors at the local and regional levels and, consequently, the varying offers that can be made to persons with disabilities by the institutions, different institutions might act as the **primary anchor point (hub)** for the implementation of ICM across Uzbekistan during the upscaling phase of the pilot.

2.1 Current pathway of integration of a person with disability

The pathway of integration of an ICM model can be viewed as a sequence of actions. The creation of a **journey map** assists in simulating the client's route through the general journey of integration including service components. The services offered often include the following components:

Outreach

→ Onboarding

→ Registration and Case opening

→ Assessment and profiling

→ IAPs - Individual Action Plans[2]

→Referral/s (if applicable) and provision of services AND benefits

→ Intermediation and accompanying the client

→ Reflection
with the client (individual level) and between local institutions (institutional level) to enable policy learning and adjustment of measures, including

→ Monitoring and Evaluation (M&E)

→ Case closure

For a smooth pathway of integration, the first contact of a person with disability with public authorities is key. As we have learnt during the mission, persons with disabilities are normally contacted by social workers at the mahallas, provided by the Inson Centres. Specific insights were gained during the mission's meetings regarding the **service components towards** their **integration into the labour market**[3]**,** which included the following:

- *Outreach* to the target group (here: persons with disabilities) is done by **social workers at the mahallas** (by Inson Centre staff). They enter relevant data into the Inson Centre's internal database, which can be viewed by the desk officers at the Inson Centre.
- *Onboarding/Registration* is done using digital, semi-digital (digital first rationale) and non-digital methods at the Inson Centre.
- The primary *assessment* at the Inson Centre is the Disability Assessment (DA), which is **primarily** conducted **by medical professionals** (social workers have been reported to be consulted in some cases).[4]

[2] In literature this component is frequently also referred to as Individual Development Plan or Individual Integration Plan.

[3] See, for instance, ILO 2021, European Commission 2023 as well as https://www.jobsanddevelopment.org/about-the-jobs-group/

[4] In most EU Member States, it is the Social Insurance Agency (SIA) that administers disability benefit/pension, which oversees disability assessment. Exceptions to this include, for instance, Austria, where a specific agency (Kompetenzzentrum) is carrying out the assessment, Estonia where it is the Unemployment Insurance Fund, France where the Sickness Insurance Fund is in charge of the disability assessment and Sweden and Finland, where the SIA and the PES are responsible for the assessment (SIA for medical, PES for work capacity assessment).

- *Referral*: The social worker at the Inson Centre is informed about the decision made by the DA Commission. If a person with disability is categorised as employable by the doctors, a **referral letter** is issued by the Inson Centre and submitted either to the Monocentre if training is foreseen or to the PES. There is **no integrated database** shared by the Inson Centre, the PES and the Monocentres (PES and Inson Centres have their own databases).
- *Service offers towards integration into the labour market*:
    - The information that the PES receives from the Inson Centre is reported to include **essential information** only, comprising, for instance, the identification of the client, the DA decision and related information about the categorisation of the client (disability group I-III) and the required action (e.g. training in a certain profession).
    - There is no information available on the **client's interests**. After the referral, the PES implements its actions (profiling, service offers, placement) based on the information previously provided by the client.
    - Core components such as the *needs assessment* and *profiling* are completed by each institution **separately**.
    - There is no institution responsible for the *intermediation* between the institutions.
    - **Empowerment measures** such as *activation, job orientation, coaching and counselling services* are not clearly designated as a service component implemented by staff.
    - *Individual Action Plans (IAPs),* including **information sharing along the entire pathway of integration,** are not implemented (within ICM, the case manager should develop these together with the client).
    - Additional **key services** that have proven to assist the integration of persons with disabilities into the labour market in other countries and are important for ICM to function effectively **are missing,** such as *workplace integration assistance, inclusion assistance, inclusion bonus for apprentices, career guidance, start-up funding for the self-employed, youth coaching, and vocational training assistance programs*.
    - Either the PES or the Monocentres guide *and accompany the client, implement job search and matching, and support jobseekers to open a business*.
    - The Monocentres follow an inclusive approach by offering three-month VET training sessions for groups of persons with disabilities (upon request by the PES/Inson Centres) and by integrating individual persons with disabilities into the courses. Their **collaboration with employers** seems to be well-developed so that persons with disabilities can benefit from their activities. The Monocentres even reported accompanying and following up with persons with disabilities after they have received training/jobs.
    - Matching of clients to jobs is done for occupations. **Information on competencies** seems not to be gathered. Moreover, certain types of employment services are missing such as *measures to prevent*

job losses, job-to-job assistance and reintegration of women after care leave.
    - All service offers are stated to be offered under the **freedom of choice** for the client.
- *Reflection* with persons with disabilities (individual level) is said to take place, especially at the Monocentres and Ishplus. Reflection between local institutions (institutional level/**policy learning**) and between policy makers (to adjust measures), including **M&E based on reliable data** gathered on persons regarding their integration pathway, seems not to be practised or to a limited extent only.
- *Follow-up activities*, i.e. consulting and checking back with persons with disabilities after referral/placement are implemented by certain partners (Monocentres, Ishplus).

Coordination between stakeholders, especially between the Inson Centres, the PES, the Monocentres and the Sharoit+ with its project Ishplus, is done based on specific requests where an institution, for instance, calls another. The Monocentre in Yashnabod is reported to coordinate concerns also with the mahalla. Case conferences or **regular meetings between partners are not practised** (even if the partners are in the same building, as is the case with the Monocentre in Yashnabod district and the PES) and a coordinating body is missing.

However, there are **Memoranda of Understanding (MoUs)** signed between individual partners, such as between the Monocentre in Tashkent and hotels (for practical training) and between the Monocentre and Sharoit+. Moreover, cooperation agreements are developed where liability issues need to be determined. Private sector cooperation is established especially by the Monocentres, the PES and Ishplus. The collaboration between Sharoit+ and Safia Cafe & Bakery[5], a private sector employer, may serve as a **promising example** of an integrative employer.

2.2 Towards an improved pathway of integration: building a fruitful environment

Participants in the meetings and workshops reported various areas for improvement in service delivery and presented ideas for smoother integration of persons with disabilities into the labour market. These included enhanced barrier-free access in daily life; mechanisms for the functioning of stakeholder systems; the creation of a Key Performance Indicator (KPI) system for evaluating services provided; efforts to control and monitor the conditions for quotas for new jobs; the establishment of a system of inclusive workplaces; campaigns and media coverage of employed persons with disabilities; awards for good practice employers; an intensive training workshop

[5] https://safiabakery.uz/ru/about

with staff of relevant institutions in all regions of Uzbekistan; and legal assistance and information on which entity should be approached in the event of labour violations.[6]

When introducing ICM to Uzbekistan, we recommend working on the following key areas, which were addressed during the workshops:

- Upskilling existing and/or hiring skilled *case managers* (e.g. via argos.uz[7]) that serve as **THE contact** for the client and assist persons with disabilities with services and benefits from both employment and social policy.
- Coordinating, adapting and/or introducing (new) *components of case management,* including onboarding, profiling, needs assessment, IAPs, etc., and **integration chains** of services.
- Developing *targeted employment measures* for persons with disabilities that comply with the UN CRPD, including, for instance, workplace integration assistance, empowering and activation measures, counselling services, coaching, job orientation, inclusion assistance, inclusion bonus (e.g. for apprentices), start-up funding for the self-employed, youth coaching, etc.
- Reforming *the Disability Assessment:* Building a **capacity-based model of disability with multidisciplinary teams** involved in the assessment.[8]
- *Establishing a coordinating body or similar* that would assist (local) institutions in their information exchange regarding the steps taken, the challenges faced, the solutions found, and the learning generated on the varying integration pathways of the clients.
- *Policy coordination at the central governance level*, especially between employment and social policies, to ensure smooth ICM implementation at local levels. Strengthening interagency cooperation also helps the country

[6] The flip charts from the workshop, including the ideas discussed and presented, are available upon request to UNDP Uzbekistan.

[7] The Agency for the Development of Public Service under the President of the Republic of Uzbekistan is the authorized government body for public service, responsible for the implementation of a unified state policy in the field of human resources development and personnel management in government bodies and organizations.

[8] We recommend building on the GIZ project that is currently being implemented regarding Disability Assessment and including additional professions for the work capacity assessment such as social workers, occupational experts, PES representatives, vocational rehabilitation experts, interest groups of persons with disabilities such as Sharoit+ (or Ishplus) and others more. While in most EU Member States the assessment is conducted by doctors, medical boards and health units of the SIA (Social Insurance Agency) or Pension Insurance Agency (PIA), in some EU MS other actors (i.e. multidisciplinary teams) are increasingly involved in the assessment process. Examples are Austria where in addition to medical and occupational assessors, a representative from the PES and the Centre for Vocational Education and Rehabilitation are consulted; Hungary where a rehabilitation expert and a social expert are part of the assessment team; Cyprus, where the committee includes ergonomists, psychologists and occupational therapists in addition to medical experts; Italy where the Medical Commissions is comprised of physicians, social workers and specialists; and the Netherlands where doctors and occupational experts decide.

in other ways such as social partnership and better coordination of strategies/goals/targets.

- Development of an *integrated information system* such as a database *("Single integrated interagency information system"),* which is updated by mouse click, can be accessed and completed by respective agencies in charge of the integration of persons with disabilities into the labour market, and which informs about all services and benefits offered to the client, and contains the relevant information about the client's interest and steps taken by the case manager.[9] The pilot does not rely on an integrated information system to function well. As described in the analytical report (Scoppetta & Zólyomi, forthcoming 2024), case conferences or similar can be implemented that are multidisciplinary meetings of professionals working with a client to share necessary information on the client.

Many lessons can be learnt from Ishplus, a project set up by the NGO Sharoit+, which is located at the Inson Centre in Almazar district and offers necessary services for persons with disabilities. Ishplus advises both persons with disabilities and employers on services and grants available from the government. We have learned that Sharoit+ is consulted and invited to participate in policy reflection meetings to improve policy delivery. We strongly recommend **continuing to work closely with Ishplus/Sharoit+** when setting up the ICM pilot (see below).

3 Suggestions for the ICM pilot in Tashkent

Participants in the meetings and workshops were interested in improving the service delivery model in Uzbekistan, and especially in setting up the ICM pilot in Tashkent. All participants see a need to further integrate employment services with the existing frameworks and to empower recipients of social welfare to graduate from the dependency trap.

It is important to point out that the pilot project alone cannot solve all the challenges raised at the meetings. However, the pilot is a first step towards improved service provision, which can be upscaled if successful. The upscaling process could include its expansion to other territories in Uzbekistan, other policy areas (e.g. health, education) and other target groups such as low-income families and/or persons at

[9] Please see the Kosovo example referred to in the Analytical paper presented within this project or directly at Birtha, M., Scoppetta, A., & Sandu, V.,2022.

risk of, or affected by, poverty. As stated in the analytical report, evidence suggests that case management is a particularly effective approach for those groups of society that require tailored and specialised support and services from more than one provider, as is the case with persons with disabilities (OECD, 2023).

The discussions held with partners also revealed their **interest in intensifying collaboration**. Moreover, all partners shared the joint understanding that their institution alone cannot assist the client (persons with disabilities) to the extent required. This **shared view** as well as **the willingness for and interest in change** are a promising starting point for the establishment of the ICM pilot project.

Due to **NASP's strong commitment** to implementing the project together with UNDP, we propose that the agency be responsible for **overseeing the pilot implementation**. This task includes guiding the partners, defining the corresponding political framework conditions by the central government and supporting the partners in their implementation.

During the mission, we explored which institution could best serve as the initial anchor point (hub) for the service delivery model by gathering opinions from all stakeholders. Although many partners were interested, we received special attention from the Inson Centre in Almazar district and from the Monocentre in Yashnabod district. For a smooth kick-off of the pilot, we suggest that the Inson Centre serves as the **initial anchor point for the ICM pilot in Tashkent.** The **Inson Centre** already practices case management and their social workers at the mahallas frequently serve as the first contact point for the client.

In most EU Member States, the **PES** however is usually the first point of contact for employment integration. The PES is involved in the initial assessment in several EU Member States and oversees the provision of ALMPs, which facilitates the path towards integration into the open labour market. PES in EU countries carry out **further assessment of jobseekers' needs**. This helps to clarify the work capacity and identify the most suitable measure/s. In most EU countries, where vocational rehabilitation services are available, these are also administered or signposted by the PES. There are different models of needs assessment practiced by the PES across the EU Member States such as in specific units at the PES that provide services directly to jobseekers with disabilities. Such a model exists in Denmark, Sweden, France, Malta and Italy. The PES in Germany have an integration officer in their job placement sections while in Luxembourg, a specific desk allocated at a local PES accomplishes the first interview with clients. In the United Kingdom, a work coach in Job Centres is responsible for that.

To sum up, there is **no uniform model applied within the EU**. Nevertheless, PES are the entry points in most EU Member States and often act as the **single point of contact** although countries use different models (depending on the degree of integration with social/welfare services such as one-stop-shops). In some countries,

clients are referred to a case manager within the PES after the first interview/work capacity assessment or are referred to social services, but **the case officer at PES remains the single point of contact** and coordinates with other social providers. There are also countries where PES case officers and social services **jointly make decisions** on the next steps.

While the Inson Centres are the first contact point for persons with disabilities in Uzbekistan, the PES and the Monocentres have well-developed links to employers. The suggestion for setting up the initial anchor point for ICM in Tashkent at the Inson Centres consequently should not limit other partners such as the PES and the Monocentres to serve as a hub when upscaling the practice across Uzbek territories. On the contrary, it could enrich knowledge and support the integration of people with disabilities, especially in areas where other facilities are lacking or where the link between the PES and the client is strong.

Cooperation between institutions is required, regardless of whether the hub is operated by the Inson Centres, the Monocentres, the PES or other actors. Consequently, **coordination mechanisms** must be set up between all partners, detailing their roles and tasks (see the following chapter).

3.1 Partnership formation and work arrangements

We suggest creating an **ICM Board** for the pilot in Tashkent comprising the Inson Centre/s, the Monocentre, the PES, Sharoit+ (including the project Ishplus) and the NASP office. The ICM Board is completed with the UNDP, which should take on an advisory role, follow up with the institutions after they pass milestones of pilot implementation, and might also facilitate the process via knowledge transfer regarding international promising practices. The ICM Board shall discuss, define and agree on:

- the **partners** in the partnership (INSON and Monocentres, PES and NASP as primary actors of ICM together with NGOs and other partners)[10];
- the **rationale** for the collaboration between partners as well as the **aims and objectives** of the partnership;
- the **strategy of the partnership** (short-, mid- and long-term strategy, including the mutual understanding of problems and ways to jointly overcome these problems);
- the **timeframe of the agreement** (e.g. semi-annual, annual, bi- or multi-annual partnership agreements);
- the **target group** (here: persons with disabilities);

[10] The partnership should be open to new partners (e.g. bringing on board the Society of deaf people, etc).

- the **work programme** of the partnership for ICM, including detailed planning of actions (with information about the ICM model, including milestones);
- the overall **partnership budget** (if any);
- the **roles, responsibilities, structures, budget and contribution of each partner** in fulfilling the work programme of the partnership;
- **jointly defined indicators** to measure the anticipated impact of the partnership and its actions (e.g. on an annual basis, such as the expected number of jointly solved/proceeded cases, etc.);
- the **rules of procedure** for the partnership and its actions: details on the partnership coordination and **details on the coordination of the actions** in the work programme; and
- information about the **monitoring and evaluation** of the partnership and its work programme.

While partnership agreements are binding multi-lateral contracts, MoUs are often signed between two partners only. We suggest the **NASP take over the leading role in developing the partnership agreement** of the pilot in Tashkent and thus the setting up of the ICM Board.

Working arrangements between partners of the partnership are frequently agreed in the form of **Standard Operational Procedures (SOPs)** for ICM components if required.[11] For instance, SOP referral forms and SOP case closure forms have been developed within the ILO project "Improving coordination of social protection and employment service delivery in Armenia and Tajikistan" and can be viewed in Sandu & Scoppetta, 2022 and Scoppetta & Sandu, 2022.[12]

3.2 Step-by-step approach

The step-by-step model outlined below serves as an initial orientation only and comprises different elements of the ICM system that should be adjusted to local/regional contexts. We recommend the development of ICM standards[13] that are applied by local/regional actors. We also suggest they **jointly discuss, develop and agree upon an ICM model with all partners** at a local level (e.g. during partnership formulation) to ensure ownership. The partners should together develop a pool of actions from which case managers can choose fitting measures.

Suggestions for implementing the ICM include the following steps:

[11] See also Davern & Platita, 2022

[12] https://www.euro.centre.org/projects/detail/4261

[13] See, for instance, https://www.cmsuk.org/uploads/page/000standards-2nd-ed-hoZc.pdf

»»» STEP 1: Partnership formation

It is recommended to form partnerships that go beyond ICM (e.g. joint activities for other vulnerable groups in society). Partnership formation is the preferred option over the development of MoUs since they describe the interaction between many partners. They are thus discussed in a separate section (see above).

»»» STEP 2: Planning of ICM actions

A clear plan should be developed for the necessary steps to be taken when implementing an ICM system. Case management is a ***collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health, care, educational and employment needs, using communication and available resources to promote quality cost-effective outcomes.***[14]

The ICM Board together with its partners should develop a clear step-by-step Interagency ICM structure with stakeholders. Agreements need to be made on:

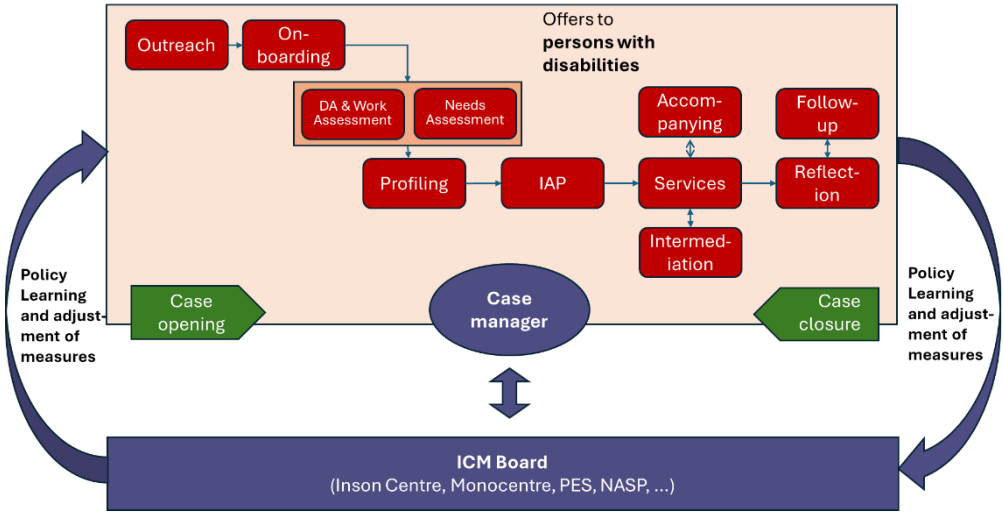
1. The institutions providing case managers for the pilot in Tashkent, including an agreement on the profile of case managers (roles, responsibilities, actions, budget, etc.; see also the following section).
2. Recommendations for ICM standards to be applied – see, for instance, CMSUK Standards & Best Practice Guidelines[15] - including the development of interagency work processes (SOPs; see above)
3. The broader scope of ICM, i.e. the institutions to be involved, consulted and informed on the planning, implementation and monitoring process.
4. Clarification about feedback loops and actions to improve the ICM model.
5. Budgetary consequences and implications for all partners involved.

Step 2 thus consists of the development of an **Action plan for the ICM pilot** in Tashkent, to get **skilled staff on board** and enable upskilling (if needed) for the staff in the institutions, including the case managers, assess the stakeholders, including employers (type, when to involve, where, and how), and plan for the implementation of **SOPs for interagency interaction** (see, for instance, Sandu & Scoppetta, 2022 and Scoppetta & Sandu, 2022).

When implementing the ICM pilot in Tashkent, we further recommend achieving clarity within the partnership on the components listed in section 2.1 and adjusting them to the local context. The components can also be viewed in figure 1 (below), which presents a potential scheme of the ICM pilot including the sequence of components.

[14] https://www.cmsuk.org/uploads/page/000standards-2nd-ed-hoZc.pdf (page 8)
[15] ibid

Figure 1: *Scheme for the ICM pilot*



As presented in figure 1, the key components of ICM need to be agreed upon between the partners. These concern the following, in particular:

- *Outreach and onboarding*: Clarification on *how* and *when* the case manager (employed by the partnership/Inson Centre) takes over from the social worker of the mahalla (if not done by the same person). An SOP regarding this referral phase should be drawn by the ICM Board, if needed.
- *Needs assessment (as well as DA and Work assessment)*: The case manager conducts a needs assessment with the client. The case manager's primary objective is to identify problems, interests, and risks to the success of the person with disability.[16] Clarification is needed *when* the case manager sends the person with disability to the DA and work assessment and *how* this assessment is accomplished (change from the medical to the social model; involving the case manager in the assessment). Clarification is also needed on *which* data are shared by *whom* (adjusted/reformed DA Committee) and *how* (database, case conference, etc.). It must be ensured that the case manager and the person with disability have a say and receive the information from the Committee.
- *Individual Action Plan*: After profiling, the case manager draws up an individual action plan together with the client (and his/her family and carers). The IAP details the service offers to the client as well as the sequence of the offers (if in an integration chain) including the timeline and foreseen steps as well as the agreed goals. Clarification is needed regarding *how* the information is shared and with *whom* (which institutions have

[16] See, for instance, https://www.bonterratech.com/blog/case-management-process-guide

access to the information). It is important to note that all information shared with other institutions is made transparent to the client.

- *Services*: Though the **services might be offered by different partners** such as the PES, the Monocentres, NGOs, etc., the case manager will accompany the client and follow up with her/him on a regular basis. The **case manager is always THE key contact for the client**. If warranted, the case manager will raise issues of concern to the partners (PES, Monocentres, NGOs, etc.) and try to find solutions with the partners (intermediation).
- *Follow-up and reflection as well as policy learning*: The case manager will follow up with the client regularly and reflect on his/her progress. The case manager, together with the client, may also **adjust the IAP**, if needed, and accompany the client throughout the integration pathway. Important lessons learnt regarding the service offers and potential adjustments to the offers (policy learning) are communicated to the partners and discussed jointly between the institutions (for instance, within the ICM Board).

Please note that the roles and responsibilities of each partner, including the case manager, must be clearly defined and agreed upon in the partnership. Clarity is also needed about the functions and duties of ICM and each action undertaken to ensure sound time-planning of the actions.

Case management thereby fulfils three core functions, namely **Advocacy** (representation of the client's interest), **Gatekeeper** (ensuring access and efficient use of resources) and **Broker** (procurement of needs-oriented services).

»»» STEP 3: Implementation

The implementation of each ICM action, such as needs assessment, individual action plans, etc., must be adjusted to the clients' needs and the resources, offers and measures available.

Clarifications might be needed regarding the following aims:

1. To gather data on challenges (obstacles) and success factors of the actions.
2. To discuss intermediate results and challenges encountered.
3. To discuss and jointly agree on adaptations to the actions during their implementation, e.g. the involvement of additional actors, changes in processes and workflows, etc. (See also Step 4 below.)

In step 3, the persons with disabilities are included. The step also consists of cooperating with other actors and co-creating with additional service providers. Moreover, the development of SOPs for interagency interaction is put in place.

»»» STEP 4: Reflection & Learning: Feedback, Quality assessment, M&E

Given the importance of feedback loops and monitoring of all actions, the reflection and learning phase is particularly highlighted.

ICM and each single ICM component should be monitored and evaluated constantly, for instance **by the NASP (by order of the ICM Board)**, including quality assessment of all actions. It is important to reflect on the actions and processes and to ensure that lessons learnt are fed into the implementation of new actions of the ICM system. It is also essential to discuss and jointly agree on any adaptations that need to be made to the ICM model itself.

The learning includes using **data, gathering evidence and conducting scientific analysis** to learn about clients' and case managers' experiences and draw conclusions to inform and **enhance the ICM service delivery model**.

3.3 Case managers: Tasks and qualifications[17]

Case managers are the core of any ICM model. They coordinate the services for the pathway of the clients throughout the entire integration chain. As stated, in most EU Member States, the PES are the driving force for case management between employment and social policies. However, case managers could also be employed by other institutions, (here: Inson Centres, Monocentres, etc.). As mentioned above, we suggest upskilling the case managers who are already employed by the Inson Centres for the implementation of the pilot in Tashkent and/or hiring new skilled staff. To enable the pilot kick-off, we suggest **applying a pragmatic approach by starting with already skilled case managers** who are constantly upskilled during pilot implementation.

Case managers use all locally available services of the partners in the partnership, especially those of the Inson Centres, PES and Monocentres. Their goal is to assist the client progressively in the integration process.

Empowerment measures and low threshold offers, such as self-confidence training, are key instruments used in many countries to help vulnerable groups to (re-) integrate, engage with other members of society and achieve their overall well-being.

Case managers advocate on behalf of their clients and ensure that gaps in services are brought to the attention of higher management levels (policy designers, policymakers). They are responsible for the overall supply of services to the client (e.g. needs assessment, individual action/activity plans, access to the labour market, etc.).

[17] See Scoppetta, A., Leichsenring, K. & Lelkes, O. (2018).

The **qualifications and prior experience** required of case managers vary in literature according to the specific area of ICM. In general, preferred qualifications for a case manager include a bachelor's or master's degree in health, social work, or education services. In certain areas of ICM, one or more years of experience may be needed in case management in areas such as homelessness, addiction problems, mental illness, and HIV+ persons. It must be ensured that case managers have the appropriate skills, education and competencies to deliver the services needed by clients. In addition to formal criteria, there are several additional informal criteria. The case manager needs to have a high level of personal integrity to be able to deal effectively with a variety of conflicting influences and demands and needs to always behave in an ethical and professional manner. In addition to overall qualifications criteria, case managers have a duty to ensure that their skills match each case. It is the personal responsibility of the case manager to ensure that their skills, competencies, experience, and qualifications match the requirements of the case.

Key competencies of case managers include familiarity with the system and (i.e. case manager as a system expert) knowledge of how the different services connect, (also at the interface of benefits administration and work integration support) so that he/she can provide support for specific individual cases (i.e. tailored to the needs of the client) and coordinate with the various services. Moreover, the case manager needs skills in moderation/mediation techniques, conflict resolution, conducting interviews with the client as well as knowledge of data protection to protect the client's vulnerability.

In addition, the case manager must possess the ability to create a **good quality relationship with persons with disabilities**, as this will fundamentally influence the process and outcome of case management. Professional relationships are often based on unequal power due to the position and specialized knowledge of case managers. Appropriate use of power protects the client's vulnerability. Developing and safeguarding trust is essential, and this depends on the case manager's ability to communicate clearly and openly, avoiding misunderstanding and disappointment. Moreover, respect for the client's dignity is a crucial element. The case manager needs to understand the client's culture and values and not become side-tracked by any behaviour that is not relevant to the outcome. The case manager should ensure that his/her actions and communication adequately reflect positive regard to sustain enduring empathy. Importantly, however, the case manager also must be able to ensure their own safety and physical and psychological well-being.

The professional and personal development of case managers must be ensured via a set of methods, including learning opportunities, inter-professional learning and participation in professional networks and events. Case managers need to share good practices with fellow case managers and should be offered regular supervision and feedback.

3.4 Suggested roles for the partner institutions

In summary, please find below a list of **suggested key roles for the relevant partner institutions** for the establishment of the pilot project in Tashkent:

Pilot: Suggested key roles for the main relevant partner institutions	
MEPR	• Responsible for setting up **targeted employment programs** including those for persons with disabilities • **Policy coordination and coordination** between partners • **Alignment of programs** in employment and social protection (well-coordinated programs) • **Integrated Information system**
NASP	• Responsible for the establishment of the **pilot project** and the **ICM Board** • Leading role in developing the **partnership agreement** • **Potential Coordination body for local/regional partners** • **M&E of the pilot implementation** and adjustments of ICM • Designing and implementing **social policy benefits and services** • Coordination with other partners
Inson Centres	• Lead partner of the **pilot at a local level** • Initial hub for the pilot (e.g., employer of case managers) • Constant **reflection and feedback** within the ICM Board • Coordination with other partners
Public Employment Service	• Designing and implementing **ALMP measures,** especially also for persons with disabilities, • **Providing employment service offers**, • **Matching** job supply and demand, • Coordination with other partners
Monocentres	• Providing **VET service offers**, • **Assisting with job offers at firms for persons with disabilities**, • Coordination with other partners
Sharoit+ including the project Ishplus	• **Service and knowledge provider** • **K**ey link **to persons with disabilities** and regarding the **need for new measures** • Coordination with other partners
UNDP	• **Advisory role** in the pilot • **Implementation expertise and international expertise** (potentially via the European Centre) • **Facilitation**

4 Conclusions

The paper provides *guidance on the suggested delivery model of integrated case management in Uzbekistan*. It builds on the findings of the analytical report and includes results and insights gained from the mission to Uzbekistan, which took place 15-23 April 2024.

The Integrated Case Management (ICM) model suggested for Uzbekistan and especially for the pilot implementation in Tashkent is based on a customer-centred approach that stakeholders jointly apply in social and employment policies. ICM is understood as *an innovative practice employed collectively by employment and social security agencies to serve the most vulnerable with all available resources from both the labour market and the social system, and even beyond*. Hence, a targeted approach is suggested that places persons with disabilities at the centre of all concerns and builds on the needs of each individual person with disability, their families and their carers.

The paper presents a *step-by-step* approach for ICM to be applied by stakeholders in Tashkent. This includes:

- *Partnership formation* (step 1),
- *Planning of ICM actions* that are coordinated between partners in the pilot (step 2),
- *Implementation* where each single ICM action such as needs assessment, individual action plans, etc., is adjusted to the needs of the client and the resources, offers and measures available in Tashkent (step 3), and finally,
- Step 4, which comprises *Reflection and learning* both between the case manager and the person with disability and learning at the policy level, where data are gathered and jointly discussed, quality assessment ensured, and policies adjusted based on evidence gathered through monitoring and evaluation.

Case managers are the core of the suggested ICM model, which leads persons with disabilities down the entire integration pathway towards employment. The case managers can thereby choose employment and social protection service/s fitting best to the client's needs.

It is recommended that the *National Agency for Social Protection* be the responsible body for monitoring the pilot implementation and that the *Inson Centre* in Almazar serve as the initial anchor point for the ICM pilot in Tashkent, potentially advised by and under consultation/offer provision by *Sharoit+*. Since a "no one-size-fits-all approach" can be applied in Uzbekistan, other partners such as the *Monocentres* and *PES* could serve as the ICM hub when upscaling the practice to other territories. Cooperation between employment and social policy institutions is necessary for the

ICM model to be effective. Coordination mechanisms thus must be set up between partners, detailing their roles, tasks and responsibilities.

By setting up ICM in Uzbekistan, we recommend drawing specific attention to upskilling and/or hiring skilled case managers, coordinating and adjusting the components of case management and developing targeted employment measures for persons with disabilities (key measures such as workplace integration assistance programs for persons with disabilities next to empowering and activation measures are missing in Uzbekistan). There is also a need for reforming the disability assessment by building a capacity-based model of disability with multidisciplinary teams (including work capacity assessment). To facilitate the creation of the pilot project, setting up a coordinating body is regarded as key. Finally, coordinating programs at the central governance level and developing an integrated information system for agencies of both employment and social protection would strongly support the implementation of ICM in Uzbekistan.

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