MINISTRY OF LABOR
AND SOCIAL JUSTICE

National Authority for the
Protection of Child's Rights and Adoption

unicef
for every child

Summative evaluation of "First priority: no more 'invisible' children!"

Evaluation report

Camino

International Consulting Expertise
Initiative · Commitment · Energy

MINISTRY OF LABOR
AND SOCIAL JUSTICE

National Authority for the
Protection of Child's Rights and Adoption

unicef
for every child

Summative evaluation of "First priority: no more 'invisible' children!"

Evaluation report

Contracting Agency and Beneficiary:
United Nations Children's Fund (UNICEF), Romania Country Office

Contractor:
International Consulting Expertise in consortium with Camino Association

Evaluation Coordinators (UNICEF):
Viorica Ștefănescu, Voichița Tomuș, Alexandra Grigorescu Boțan

Evaluation Team Members:
Project Manager
Alina-Maria Uricec
Gabriela Tănase
Team leader
Irina Lonean
Evaluation Experts
Liliana Roșu
Adriana Blănaru
Alina Bîrsan
Anda Mihăescu
Ecaterina Stativă
Oana Clocotici

Camino

International Consulting Expertise
Initiative · Commitment · Energy

Bucharest
2017

Contents

List of Tables

List of Figures

Acronyms

AROP – Relative poverty rate (NIS and Eurostat indicator)
AROPE – Relative poverty and social exclusion rate (NIS and Eurostat indicator)
CCS – Community Consultative Structure
CEE/CIS – Central and Eastern Europe and the Commonwealth of Independent States
CERME – Romanian Centre for Economic Modeling (NGO)
CHN – Community health nurse
CMTIS – Child Monitoring and Tracking Information System (used in the child care system in Romania)
CPSS – Centre for Health Policies and Services (NGO)
CSI – County School Inspectorate
DPH – Directorate for Public Health
EC – European Commission
ESF – European Social Fund
EU – European Union
EUROSTAT – The statistical office of the European Union
FONPC – Federation of NGOs for Children (NGO)
GD – Government Decision
GDSACP – General Directorate for Social Assistance and Child Protection
GEO – Government Emergency Ordinance
HBS – Household Budget Survey
HHC – Hopes and Homes for Children (NGO)
ICE – International Consulting Expertise
IEC – Information-Education-Communication
ISE – Institute of Educational Sciences
LPA – Local public authorities
MoH – Ministry of Health
MoLFSPE – Ministry of Labour, Family, Social Protection and the Elderly
MoLSJ – Ministry of Labour and Social Justice
MoNE – Ministry of National Education
MoRDPAEF – Ministry of Regional Development, Public Administration and European Funds
MoYS – Ministry of Youth and Sports
NAPCRA – National Authority for the Protection of Child Rights and Adoption
NGO – Non-governmental organisation
NIMCH – "Alessandrescu-Rusescu" National Institute for Mother and Child Health
NIS – National Institute of Statistics
OECD–DAC – Organisation for Economic Cooperation and Development – Development Assistance Committee
POCU – Human Capital Operational Program
PPPeM – UNICEF Programme Policy and Procedure electronic Manual
PSI – Population Services International (NGO)
RKLA – Regional Knowledge and Leadership Agenda
RON/lei – Romanian currency
SPAS – Public Social Assistance Service
SW – Social worker
ToC – Theory of Change
ToR – Terms of Reference
UN – United Nations
UNEG – United Nations Evaluation Group
UNICEF – United Nations Children's Fund
USD – United States Dollar
WHO – World Health Organization
WV – World Vision (NGO)

Key concepts used in the evaluation

Adolescent risk behaviour – activity whereby adolescents are exposed to increased risk of harming their physical, mental or emotional state.

Aurora – a working methodology which was developed on the basis of the evidence generated by the modelling project and as a result of the recommendations made by previous formative evaluations of the project, and which was tested during the project. The methodology proposes a unitary case approach by ensuring a comprehensive identification/assessment of the situation of children and their families. It involves measuring widely-accepted indicators relevant in terms of the situation of children and their families. The first data collection corresponding to the identification service is recorded in the database as T0 (first assessment) and indicates the situation at the initial moment of assessment. According to the methodology, the household situation is reassessed every 9 months, and a new service is generated for that purpose. After every 9 months, the data collection is recorded at T1, T2,… Tn and shows the dynamics of the household situation. However, community workers may decide to update the household data earlier than the reassessment milestone, when the household situation calls for it.

The Aurora methodology is put into practice via two distinct components, namely: i) the Aurora mobile application, a software component set up on a tablet computer, which is used by community workers in their field work and which contains an interview guide for collecting data on all the members of a household, generates a diagnostic of the household children's and women's vulnerabilities, and suggests a basic services package, while providing local professionals with a useful case management tool; ii) the Aurora web-based platform, which provides data aggregation at local, county and national levels and generates reports for activity monitoring and evaluation purposes or in support of interventions, projects, policies etc.

In terms of the present evaluation, it is worth mentioning that, during the modelling project, use of Aurora at T0 occurred mostly in 2014. Nevertheless, any new case recorded by community workers is shown at T0, which means that the data for all the cases recorded at T0 was not necessarily collected in 2014. Moreover, community workers went on to record the vulnerable cases (children and women) for which they delivered basic services, irrespective of the initial database.

Basic social services – essential services every child needs which provide the necessary conditions for children's well-being, security, health, school attendance or social integration.

Community – the array of local government institutions, local services, other public and private entities, forms of association and inhabitants from a particular locality or local administrative division (town, neighbourhood, commune, village), which act together for local territorial, administrative and social development.

Community health nurse – healthcare professional who identifies the needs of vulnerable people and facilitates their access to health and social services. CHNs provide overall healthcare services, within the limits of their professional competence, and carry out community-level health promotion activities. These professionals work in collaboration with family practitioners, social services and educational services.

Community worker – according to the definition used by UNICEF in Romania, these are professionals whose main duty is to deliver services through outreach/fieldwork, i.e. social workers, outreach workers and community health nurses referred to in the present evaluation. Community workers also include health mediators, school mediators and other professionals whose activity involves delivering basic services to various population groups.

Control communities – communities which were part of the modelling project only during the first project phase, in 2011, and underwent an initial evaluation but did not benefit from other project activities. For the purpose of the present evaluation, this group served to provide comparable data for the evaluation of the model's effectiveness and impact.

County-level resource centres – structures that were set up as part of the demonstration project with the aim of strengthening the GDSACP and DPH institutional capacity to provide local authorities with support and methodological guidance, via the supervisors that were identified and trained in the project.

County supervisors – professionals from partner county institutions (GDSACP and DPH) identified and trained in the demonstration project to provide local professionals with support and methodological guidance throughout the implementation of project activities.

Directorate for Public Health – deconcentrated public service accountable to the Ministry of Health, representing the public health authority at local/county level which carries out national health policies and programmes, develops local programmes, organises health units, maintains statistical records on health issues, and ensures the planning and running of investments funded from the state budget pertaining to the health sector.

General Directorate for Social Assistance and Child Protection (GDSACP) – public institution and legal entity accountable to the County Council/Bucharest Municipality General Council, whose mission is to ensure the implementation of social policies and strategies at county/local level and of social measures designed to protect children, families, people who live alone, the elderly, people with disabilities and other people in need.

Integrated service delivery at local level – approach promoted by the modelling project whereby vulnerabilities are identified based on a comprehensive household assessment and the identified individual needs are matched to the services that can meet them, as part of a service plan. The project used this approach at all levels: a) in the design and delivery of community-based services, b) in the planning and methodological support provided by the county entities, and c) in the development of related national strategies and policies.

Intervention communities – communities in which implementation was carried out in all phases of the "First Priority: No More 'Invisible' Children!" project, up until September 2015 when the project ended.

'Invisible' children – according to the State of the World's Children UNICEF report, these are children "disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children"[1]. Thus, 'invisible' children lack access to health, education and social assistance services. On this basis, the demonstration project initially called "Helping the 'Invisible' Children", later renamed "First Priority: No More 'Invisible' Children!", applied this concept in reference to **children in vulnerable situations**, whose vulnerabilities, however, were 'invisible', unknown to professionals working in their communities, but could be identified through outreach work.

Given the above operational definition, the target group of the project undergoing the evaluation becomes clear when the various types of vulnerabilities are considered. Based on the experience accrued during the demonstration project implementation and on the evidence generated by the formative evaluations of the project, the record of vulnerabilities was enhanced and their definitions refined. The table below provides an overview of the list used in the project, by dimension, vulnerabilities and subcategories of vulnerabilities:

1 UNICEF, 2006. *The State of the World's Children – Excluded and Invisible*, p. 35, available at: https://www.unicef.org/sowc/archive/ENGLISH/The%20State%20of%20the%20World%27s%20Children%202006.pdf

Table 1. Vulnerabilities defined in the modelling project to assess the needs of 'invisible' children

Dimension	Vulnerability	Vulnerability Subcategory
Poverty	Child living in poverty	Child living in a household in income (monetary) poverty
		Child living in a household in extreme poverty
Health	Child not registered with a family physician	
	Child aged up to 1 year, in a situation of risk	Child with low birth weight
		Child not vaccinated
		Child not given vitamin D and iron
		Child under 6 months not exclusively breastfed
		Child over 6 months not receiving complementary feeding
		Child not meeting development standards
	Child aged 1 to 5 years, in a situation of risk	Child not vaccinated
		Child not given vitamin D
		Child not meeting development standards
	Child with chronic disease or living in a household whose members have chronic diseases	Child with chronic disease
		Child living in a household whose members have chronic diseases
	Pregnant woman in a situation of risk	Pregnant woman not registered with a family physician
		Pregnant woman not having undergone prenatal checkups
		Unwanted pregnancy
Education	Child not enrolled in school, who dropped out of school or is at risk of dropping out	Preschool child not enrolled in kindergarten
		Child aged 6 to 10 years, not enrolled in school
		Child aged 11 to 15 years, not enrolled in school
		Child at risk of dropping out of school
		Child with special educational needs (SEN), at risk of dropping out of school
		Child who dropped out of school
Risk behaviour	Adolescent/child with risk behaviour	Adolescent with risk behaviour in terms of healthy lifestyle (nutrition and physical activity)
		Adolescent with risk behaviour in terms of sexual activity
		Pregnant adolescent girl or teenage mother
		Adolescent with risk behaviour in terms of substance use
		Child at risk of violent behaviour
		Child living in a household prone to violent behaviour
	Child living in a family prone to child violence, abuse or neglect	Child living in a family prone to child violence
		Child living in a family prone to child neglect
Housing	Child living in precarious housing conditions	Child living in overcrowded house
		Child living in unhealthy housing conditions

Dimension	Vulnerability	Vulnerability Subcategory
Family and social conditions	Child with no ID papers	
	Child with only one or no parent at home	Child with only one or no parent at home
		Child with migrant parents
		Child with no parents at home, but with an adult carer in the household
		Child with no adults in the household
	Child with disabilities	
	Child separated from his/her family or at risk of being separated from their family	Child separated from his/her family or at risk of being separated from their family
		Child at risk of being separated from his/her family – *who cumulates 7 or more vulnerabilities*
		Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care
		Child at risk of being separated from his/her family – whose mother has underage children in public care

Local Public Social Assistance Service (SPAS) – specialised entity set up by the local public authorities to ensure implementation of social policies designed to protect children, families, people living alone, the elderly, people with disabilities, as well as any other individuals, groups or communities with social needs. The local public authority is in charge of establishing, maintaining and developing primary social services, based on a needs assessment, with the main aim of supporting an individual's social function in their social, family and community environment.

Mayoralty – main local government institution. According to the Romanian administrative legislation in force, mayoralties are not legal entities, they are the mayor's administrative office/staff acting as representative of a territorial administrative unit (municipality, town, commune). Nevertheless, for ease of use, the present report refers to mayoralty staff and entities, as well as to the mayor's administrative staff, whose legal relations are established with the territorial administrative unit represented by the mayor.

Micro-grant – small grants awarded by UNICEF to local public authorities in the "First Priority: No More 'Invisible' Children!" modelling project for the purpose of supporting the implementation of small-scale projects addressing the needs of children and their families. The projects developed by local public authorities and funded by UNICEF through micro-grants included the setting up of community counselling and support centres for children and parents that enabled the provision of several activities and services for the target group identified in each community.

Minimum package of services – the set of services ensuring minimum access to health, education and social protection services, delivered via fieldwork by local professionals with the aim of enabling the realisation of children's right to development, fighting against poverty, preventing social exclusion and supporting disadvantaged families with children.

Modelling project – a specific type of "demonstration project", according to the UNICEF terminology, which gives explicit attention to documenting and measuring progress and results and which uses evidence to model best practices and inform public policies in support of their scale-up at national level. In the present evaluation, when referring to its focus, namely the "First Priority: No More 'Invisible' Children!" demonstration project, the following terms are used interchangeably: model, project, pilot project, modelling project, demonstration project.

Outreach worker – qualified person who completed a specialised vocational training programme and who works in the field of primary services (Day care centres for children, Day care centres for children with disabilities, Residential centres for children/children with disabilities, Recovery/rehabilitation centres for adults) and child protection (Residential services for children, Residential services for children with disabilities).

Public social protection institutions – central institutions (ministries, agencies, authorities) with regulatory and funding duties in the field of social protection; county institutions (agencies, authorities or decentralised or deconcentrated directorates) accountable to the county council, the prefecture or various ministries, which regulate and deliver services and benefits at the local level; local institutions accountable to the local council/mayoralty and delivering social services and benefits.

Social assistance operative – the holder of a public administration position with social assistance duties and secondary education, previously known as social worker with secondary education, sometimes employed within the local public administration as social referent (Romanian term for specialist/counsellor/adviser).

Social benefits – components of the national social assistance system which include financial redistribution measures for individuals or families who meet the legal eligibility criteria.

Social/outreach worker – within the present evaluation, in order to simplify the terminology used and make it easier to read the report, the social/outreach worker term shall refer to all local professionals with social assistance responsibilities, with different levels of training (secondary or tertiary education etc.), as well as various types of employment within the local public authority: as social workers, social assistance operatives, social referents (Romanian term for specialist/counsellor/adviser) and outreach workers.

Social services – a set of complex measures and actions carried out to meet the social needs of individuals, families, groups or communities and prevent and overcome difficulties, vulnerabilities or addictions, with the aim of enhancing quality of life and promoting social cohesion (or, according to another definition, with the aim of preventing the risk of social exclusion: a set of interdisciplinary measures and actions designed to combat social exclusion and ensure people's active participation, based on individual and family needs assessment, aimed at addressing difficult situations).

Social worker – social assistance professional working in public or private settings (non-governmental organisations) or practicing social work as a liberal profession, who identifies, delivers, monitors and evaluates social services and other types of support and conducts social surveys and other assessments of community needs in order to protect individuals, groups and communities who face special challenges and are temporarily in need and who, for economic, social, cultural, biological or psychological reasons, lack the means and capacity required to lead a normal, decent life. The term refers mainly to social welfare professionals with specialised university education.

Target beneficiary/target group – children or families with children at risk of exclusion in relation to the child's rights to development, who live in poverty or vulnerable settings generated by the family or by the economic and social context.

Theory of change (ToC) – according to UNICEF, a blueprint of the building blocks needed to achieve long-term goals of a social change initiative. It can be viewed as a representation of how results will be achieved as implementation progresses. At its core, a ToC identifies: a) the results a development effort seeks to achieve; b) the actions necessary to produce the results; c) the events and conditions likely to affect the achievement of results; d) any assumptions about cause and effect linkages, and e) an understanding of the broader context in which the project operates.

Violence against children – vulnerability related to all forms of physical, emotional or sexual abuse, child deprivation or neglect or any form of exploitation leading to actual or potential harm to a child's health, survival, development or dignity, in the context of a rapport of responsibility, trust or power.

Executive summary

Background

According to 2011 data, children and young people were seriously affected by the economic recession[2]. Moreover, the reduced public spending and the institutional reorganisation at central level during the economic crisis (2009–2011) affected the way in which public policies were able to provide an adequate response to protect the most vulnerable.

In this context, in 2011, UNICEF began the implementation of the modelling project initially called "Helping the 'Invisible' Children", later renamed "First Priority: No More 'Invisible' Children!". Based on the theory that children's welfare in Romania will improve only if and when they, especially those worst-off ('invisible'), will have enhanced access to social services (education, health and social assistance services), the modelling project aimed to provide a possible solution to increase the impact of social policies on children and their families. With the new approach and working methodology tested at the local level, the project aimed for a paradigm shift in the child protection system – from a reactive to a proactive system. Thus, in rural areas, particularly the poorest ones, the capacity of local authorities was developed to enable a rapid identification of most vulnerable children and their families, while preventing the escalation of problems such as child-family separation, by delivering the minimum package of services.

The project ensured social workers were hired to conduct a community census aiming at identifying the 'invisible' children, defined by UNICEF as children "disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children"[3], as well as their vulnerabilities. The project was initiated in 2011 in 96 communes located in the disadvantaged rural areas of 8 counties[4], promoting the social workers's outreach activities and an in-depth knowledge of local children's vulnerabilities and problems. Following the formative evaluations conducted in 2011 and 2013, the project coverage was reduced to 64 communes and later on to 32 communes, while maintaining an even distribution across all the 8 target counties. In addition to the identification of vulnerabilities and to the assessment of children's needs, the project scope was extended to include the delivery of basic social services for children, and in 2013, community health care services were added to the package of basic services and the project team was further complemented with community health nurses. While the project continued to focus on the community workers' outreach activity, starting 2014 it also included a comprehensive working methodology called Aurora, designed for the management of project activities. Aurora uses a data collection tool (a questionnaire) to build a database on vulnerable children and their families and automatically connect the vulnerabilities identified via the questionnaire to a predefined set of basic services recommended for each child and parent or main caregiver. The Aurora methodology also allows for monitoring the dynamics of children's vulnerabilities and of the services provided.

To ensure community engagement in addressing children's problems, the project also included activities to mobilise the Community Consultative Structures (CCS), as well as a micro-grant component to fund community counselling and support centres for children and their families. At the same time, in support of the work of community professionals (social workers and community health nurses), the project provided for their supervision and guidance by experts within the General Directorate for Social Assistance and Child Protection (GDSACP) and the Directorate for Public Health (DPH), as well as the setting up of resource centres at county level.

Evaluation objectives

The summative evaluation was conducted to provide project partners and decision-makers at all levels the evidence required to replicate the community-based intervention model nationwide. Designed to inform

2 Preda, M. (coord.), 2011. *Situation Analysis of Children in Romania*. UNICEF Report. HBS data, NIS. Bucharest.

3 UNICEF, 2006. *The State of the World's Children – Excluded and Invisible*, p. 35, available at: https://www.unicef.org/sowc/archive/ENGLISH/The%20State%20of%20the%20World%27s%20Children%202006.pdf

4 Counties where the project was implemented: Bacău, Botoşani, Buzău, Iaşi, Neamţ, Suceava, Vaslui, Vrancea.

about the relevance, efficiency, effectiveness, sustainability and impact of the project, throughout its implementation period (April 2011-September 2015), considering the OECD-DAC evaluation criteria and answering to 19 evaluation questions, the final evaluation report provides evidence to support advocacy for the transition towards integrated, accessible, sustainable, and child rights centred services at community level. The evaluation also makes recommendations for further action related to the sustainability, scaling up and replication of the minimum package of services at national level, while helping UNICEF fine-tune the "Social Inclusion through the Provision of Integrated Social Services at Community Level" modelling project currently under implementation in Bacău county.

Evaluation methodology

The evaluation methodology was developed in the inception phase of the evaluation process and involved the use of both quantitative and qualitative methods, and of primary as well as secondary data, to ensure data triangulation for information verification and validation purposes, taking into account the evaluation goal and questions.

The evaluation included a counterfactual analysis of the 'invisible' children identified in the 32 communities which were no longer part of the project as of 2012. These children were to receive the services available in their communities (e.g. regular SPAS services [Public Social Assistance Services], services delivered by the Roma health mediator, community health nurses), but not the services provided under the evaluated project. Data for the counterfactual analysis were collected using a household survey focused on 64 communes: 32 intervention communes and the 32 control communes where project implementation occurred in 2011 only. The sample volume for intervention communes was 428 households, and the one for control communes was 415 households – a random, two-stage and stratified sampling. Data were collected on all household members, namely 4,243 individuals. Maximum margin of survey error is +/- 3.4 percent at 95 percent confidence level, and 4.7 percent at the intervention sample and control sample level (minimum 95 percent confidence level). Once the data collected, two databases were created: (1) a database of households, enabling comparison of services provided by the community workers in the intervention group versus the control group, and (2) a database of household members, enabling comparison of the presence and dynamics of vulnerabilities of children in the intervention group versus the control group.

To answer the evaluation questions, secondary data analysis was also used: data of the household surveys conducted in 2011 and 2013 during the formative evaluations of the model; the consolidated database created by social workers in 2012; the databases resulting from the use of the Aurora methodology during 2014 – 2016 (including after the completion of the demonstration project); the database of entries and exits into/out of the child protection system, centralised with the support of the GDSACP supervisors, and data on the work of the community health nurses, in the intervention and control communes (Botoșani county), collected with the support of DPH supervisors. Other data sources included documents made available by UNICEF, such as reports of supervisors and of professionals at the local level. In addition, interviews were conducted at all levels of modelling project implementation, according to the Theory of Change, as follows: i) at the level of children and their families, interviews were conducted with parents of vulnerable children who received the intervention; ii) at local level, both in the intervention and the control communes, interviews were conducted with local professionals (social workers and community health nurses); iii) at county level, interviews were conducted with county supervisors from GDSACP and DPH in the 8 project counties; iv) at national level, interviews were conducted with partners and decision-makers. Also, 8 focus groups were organised with relevant community stakeholders, e.g. local professionals involved in the project (social/outreach worker and community health nurse), mayoralty representatives, CCS members, other professionals and representatives of local NGOs, as well as 8 workshops with children (10–17 years), service recipients, one workshop in each of the target counties, attended, on average, by 10 children. Data collected were used in the design of 8 case studies focusing on a commune from each of the eight counties where the project was implemented.

The evaluation methodology was designed to integrate quantitative and qualitative research methods and enable data verification and triangulation. The quantitative methods were based on an analysis of representative samples, while the qualitative methods used a participatory approach aimed to reflect the views of all the partners and stakeholders, at all levels, involved in the implementation of the modelling project.

However, the evaluation has a series of limitations. First, an online survey that was planned and initiated among the 64 mayoralties in the intervention and the control communes could not be used due to a very low response rate (only 20 questionnaires out of 64 were completed in full), despite the evaluation team's repeat efforts. Second, the evaluation covered the entire period of project implementation and the limitations in this respect are a result of the discontinuity of project activities and the changes to the methodology and tools that were used in the intervention, changes that were designed to improve the project activity flow, but which also affected its evaluability.

Next, there are a series of limitations to be considered with regard to the survey conducted among children and their households in the intervention communes and the control communes. Given the differences between the two types of communes, the evaluation team had to use different sampling procedures and, despite all the measures taken when developing the methodology and tool, the two samples still presented statistically significant differences, leading to problems of data comparability for the two types of communes. To address these problems, the data were weighted so that the databases, both the one for households and the one for household members, would match the Aurora data structure. Here, one needs to mention that data weighing has its own limitations and accuracy can be affected in certain cases.

On the other hand, one must consider the difficulty to separate the modelling project outputs and outcomes from the outcomes of policies or interventions implemented by non-governmental organisations or other entities also targeting children and their families. Last but not least, there were limitations connected to the availability and quality of national/county-level data on children in public care, children and their families receiving primary health care services or specialised services.

MAIN FINDINGS AND CONCLUSIONS

Project performance at the level of vulnerable children and their families

Project is relevant in relation to the needs of children and their families

The project is designed to address, to a large extent, all the needs of the most vulnerable children. First, the evaluation shows that the project phase consisting in identifying children's vulnerabilities is key to enabling the delivery of services intended to help improve the children's situation. The interviews and focus groups that were conducted during the evaluation revealed that communities are generally aware of the existing vulnerabilities, in the sense that community members, including mayoralty representatives and other relevant local stakeholders forming the CCS, know that many families in their communes are facing social challenges. However, most vulnerabilities are not known and cannot be identified for every child and household without the aid of a tool as the Aurora. The least visible vulnerabilities are those connected to domestic violence, risk behaviour and the situation of children with only one or no parent at home.

With the introduction of the Aurora methodology, all the problems identified at target group level were reflected in a diagnosis of vulnerabilities. The evaluation did not reveal any major target group problems or needs that the Aurora working methodology failed to consider when establishing the main categories and subcategories of vulnerabilities. All vulnerabilities, with the sole exception of the risk of child-family separation (analysed in a separate chapter of the evaluation report), are assessed using nationally and internationally accepted standardised definitions based on which institutions at all levels design intervention models.

Therefore, the focus placed by the project on the needs assessment phase is relevant in terms of increasing the performance of the services delivered to children as well as enhancing the capacity of public social assistance services to deliver accordingly. In the absence of a vulnerabilities assessment, social assistance, child

protection and community health care services are delivered "blindly", they cannot be adequately targeted and delivered, nor can their effectiveness and impact be measured later on.

It should be stressed that none of the vulnerabilities foreseen by Aurora were recorded with zero cases identified, which only proves that the tool is relevant in relation to the real needs of the project's target group. In the case of vulnerabilities with relatively low incidence, such as children without ID papers, pregnant adolescent girls or teenage mothers, children with no parents at home, the issue is most serious and severe, and addressing such cases is important and relevant even if they only affect a relatively small number of children. Moreover, the model proved relevant even when tackling low incidence vulnerabilities, given that its approach is one aiming to improve child rights realisation and case management, not the statistics on vulnerabilities.

All identified vulnerabilities are considered in the design of the minimum package of basic services that Aurora automatically generates. The model is thus created to guide the community workers in addressing all the identified vulnerabilities, which makes the model highly relevant in relation to the needs of the 'invisible' children. Consequently, in view of its design, the package of services proves relevant in relation to the identified vulnerabilities, covering all these vulnerabilities with a considerable range of interventions which are customised to suit each individual situation.

Furthermore, the model is highly relevant for children who were separated from their family or at risk of separation. While the risk of family separation was defined with the aim of testing it in the modelling project and its assessment does not benefit from the same degree of confidence as the assessment of the other vulnerabilities, the model nevertheless included a special priority service designed for the most vulnerable children to ensure community engagement in the management of highly complex cases and prevent child-family separation.

Project is effective in identifying vulnerable children, assessing and addressing their needs, thus contributing to the realisation of their rights

The project proves effective to a large extent in identifying and assessing the vulnerabilities of children in disadvantaged rural areas. According to the data from the databases that were used successively during the implementation of the model, as well as the community workers' statements, the number of children identified with vulnerabilities increased once Aurora started being used (in 2014), even though the identification of new cases was no longer a priority at that point[5]. Thus, the introduction of the Aurora methodology, which is highly complex, with clear and compulsory steps, enabling several methods for verifying the community workers' activity, determined an increase of both the number of children identified with vulnerabilities – which led to a higher effectiveness of the identification component and a growing number of children to receive services – and of the quality of the data related to children's needs and vulnerabilities, thus allowing for a better service tailoring to each particular situation encountered in the field.

The data recorded by the Aurora in 2015 are highly reliable and are confirmed by the survey conducted in 2016, particularly in terms of vulnerabilities related to: children's access to education and school attendance, risk behaviours related to substance abuse, poor housing conditions, lack of ID papers, disabilities, risk of child-family separation, for children with siblings who do not live in the household, including because they are in public care.

The minimum package of services covers all vulnerabilities, while the net number of people having received services is much larger in the project communities compared to people from the communes in which the model was not implemented, recipients in the first category also expressing their satisfaction with the services received as being to a great and very great extent. An analysis of the Aurora data shows that each of the identified vulnerabilities was correlated with services tailored to the needs of the vulnerable persons.

5 After 2014, the model focused on providing an accurate and complete assessment of the cases that had already been identified and on delivering social services based on the minimum package of basic services generated by the Aurora for the cases that were identified and assesed.

The data also shows that information on the local and county resources available to the vulnerable person was the service delivered most often. The sets of services delivered for each and every type of vulnerability indicate that vulnerabilities were targeted with different interventions:

– information (over 79 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– counselling (over 70 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– referral (over 65 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– accompaniment and support (over 60 percent of the cases affected by any one of the vulnerabilities recorded in the database).

However, it is worth noting that part of the services generated within the minimum package of services, such as some of the accompaniment and support services, could not be delivered. The accompaniment and support services and part of the referral services could not be delivered because specialised services were innaccessible or not available. These deficiencies of the social assistance system at national level affected the effectiveness of the intervention at local level. An analysis of the needs that were identified and of the services that could not be provided would be useful to determine the need for service development.

A noticeable outcome of the prevention services is the fact that some vulnerabilities have 'disappeared', between 23 percent for children living in precarious housing conditions or children with only one or no parent at home, to 100 percent for children not registered with a family physician. Therefore, all children not registered with a family physician at the time of the first vulnerabilities assessment were registered over the following 9 months. Even poverty-related vulnerabilities were addressed in 80 percent of the cases recorded, which proves the effectiveness of the services delivered with the aim of ensuring the realisation of rights, including with regard to the receipt of social benefits.

The present evaluation provides evidence regarding the outputs and outcomes registered by the minimum package of services in relation to the identified vulnerabilities. Certain vulnerabilities could be tackled in a relatively short period of time, particularly the administrative ones related to obtaining ID papers or other official documents (such as the disability certificates) and ensuring access to social benefits, but also, in part, those related to poverty and housing and ensuring access to primary health care services. The survey conducted in 2016 shows statistically significant differences for the number of persons with ID papers, 99 percent of the persons in the intervention communes having ID papers, versus only 94 percent in the control communes. The differences are even bigger when it comes to obtaining a disability certificate, which persons with disabilities need in order to receive the benefits they are entitled to: from 84 percent in the intervention communes, to only 56 percent in the case of control communes. Also, the counties where the model was implemented register significant disparities with regard to the number of services that were recommended by Aurora but were eventually not carried out. One can notice, on the one hand, the positive influence of the county supervisors' proactive attitude, in terms of the large number of services carried out, and on the other hand, the importance of the community social workers' specialised training. Thus, the smallest number of services not carried out is recorded in Botoșani county where all the social workers that were hired had specialised training/studies and where the county supervisors were very active both in identifying and selecting the social workers and in guiding and monitoring them throughout the model intervention.

Therefore, overall, the model is effective in ensuring the delivery of basic social services and community health care services via community workers' fieldwork. The information and counselling services are more effective than the referral, accompaniment and support services. Moreover, the more comprehensive counselling services provided by the community counselling and support centres for parents and children within the micro-grant projects were well regarded by all community workers as well as by the children and parents interviewed as part of the evaluation. Three times more people in the intervention communes versus the

control group believe they can count on the community workers' support and three times more families received their help in the intervention communes versus the control ones.

The integrated approach proved effective and useful particularly in ensuring access to and information about health services

Integrating the activities of the community workers was possible due to the design of the working tools used in the model. Aurora was used both by the social workers and by the community health nurses (CHN), consisting of questions that covered all relevant areas, including the health of children and pregnant women, and generating services in all relevant fields. In the communes in which a CHN was available within the SPAS, delivery of various health services fell to him/her, while in the communes without a CHN, those services were delivered by the social/outreach workers, within their competence, with the guidance and support of the DPH supervisor.

The evaluation brings evidence to the community workers' perception of the integrated approach. Even though at first they lacked the practical skills related to working in teams and approaching cases in an integrated manner, social/outreach workers and community health nurses rated their teamwork highly and even when there were disagreements, they managed to put them aside as the need to solve the cases prevailed. Many of the community workers particularly appreciated the fact that teamwork provided them with a chance to exchange views and to consider a case and approach service delivery from different professional perspectives.

The project generated significant positive impact at the level of vulnerable children and their families

The project generated considerable impact on its target group in terms of vulnerability identification, access to social services, including specialised services for children with disabilities, and access to community health care. For service recipients, the access to primary health care (particularly vaccination) increased compared to their previous situation, while risk behaviours and situations of child abuse, violence or neglect decreased.

On the other hand, the project has a moderate impact on protecting children from being separated from their family, given also the limitations related to defining this risk and, therefore, to identifying the vulnerability.

Still, in all cases, even where improvement of children's situation is not statistically visible, the intervention of the social worker and of the community health nurse, where available, helped vulnerable families to a considerable extent. Even where some vulnerabilities still persist, the moral support received by children and individuals who otherwise felt lonely and insecure was a factor that improved quality of life and could have long-term impact.

All these cases revealed a need for long-term interventions, early preventive actions and linkages between the basic services delivered via the model and specialised services available and accessible to vulnerable children and persons living in rural areas, sometimes hundreds of kilometers away from the county capital towns.

However, vulnerabilities related to behaviours and attitudes, such as violence against children or adolescent risk behaviour, need to be addressed through long-term interventions in order to reach the intended outcome. Although local professionals, representatives of local authorities and county supervisors believe that the behaviour of the 'invisible' children and their families changed significantly, in terms of improving parenting practices, risk behaviors, the survey conducted for the present evaluation still reveals alarming data: 73 percent of the children in the intervention group are sometimes left home with no adult present, in a situation of neglect; 49 percent of the children in the intervention group are disciplined through use of abusive methods: physical violence (3 percent), verbal violence (16 percent), emotional violence – threats (7 percent) or privation (23 percent). The risk of violence, abuse or neglect is not only difficult to identify, but once identified it is also very hard to address, as indicated by the interviewed community workers, despite the progress they've recorded in the Aurora.

Project impact on increasing access to education for vulnerable children was limited, as shown by the Aurora database entries, the survey conducted in the intervention and control communes and the quality research. The risk of dropping out of school and actual dropout are vulnerabilities which were reduced especially among the Roma children where they were high, but the proportion of school age children not enrolled in school did not decrease as well, which is a sign that future similar projects will have to have a stronger component on education services.

Project performance at the level of local public authorities and county institutions

Project is relevant in relation to how the child protection and social assistance systems are organised at local and county levels

To increase the SPAS capacity to deliver social services through outreach work, particularly since these public social assistance services will often (and most of all in rural areas) lack dedicated social work staff, several social/outreach workers were hired as part of the modelling project.[6] The training sessions organised and the development of standardised working tools for the social workers involved in the model were relevant project activities designed to address the problems resulting from the fact that most of the resources the SPAS hired were not specialised social workers with a degree in this field.

In addition, the project focus on coordination between SPAS, on the one hand, and the GDSACP and the DPH, on the other, as well as on increasing the capacity of county-level specialised staff to provide adequate support to community workers is relevant in addressing the existing inter-institutional communication problems.

Project is effective in developing the authorities' capacity to provide the minimum package of integrated services

Hiring social workers charged with fieldwork duties and training them contributed to increasing the SPAS capacity to deliver social services. During 2011–2015, the project was effective in increasing the capacity of the SPAS, GDSACP and DPH. In connection with the model effectiveness in increasing the SPAS capacity to deliver social services throughout the model implementation period, four aspects need mentioning first: (1) capacity building for community workers, most of whom were without specialised studies, through training sessions which provided them with skills and competencies to carry out a modern-day social assistance work; (2) systematic use of the Aurora, a modern standardised electronic system for identifying vulnerabilities and conducting case management; (3) establishment of community centres which enabled service delivery as well as helped increase community worker capacity through experience exchanges with professionals providing specialised services (psychologists, counsellors); (4) enhanced cooperation at community level and among county-level institutions.

Project is partially effective in reducing pressure on the child care system

As a result of the comprehensive work of identifying vulnerabilities, the model led to the identification of a large number of 'invisible' children, bringing the problems of children and their families to the attention of local authorities, families and the community overall. At first sight, the UNICEF model appears to increase rather than reduce the pressure on the system, since the increased focus on identifying and addressing vulnerable cases has made these 'visible'. However, case files are much better prepared and communication between the SPAS and the county deconcentrated and decentralised services is very good, which is why

6 Social workers or referents are hired part time or have other administrative duties in addition to their social work. This lack of staff is often a result of funding shortage. Local public authorities are bound by the law on social assistance to set up social assistance services in the form of functional departments, with no legal personality. However, salaries for SPAS staff are to be paid from the local budget which, in small and poor communities (with no tax-generating economic activities), is often insufficient to cover wages for all the staff categories that should be hired according to the laws governing administrative activities.

even if a larger number of children enter public care, the GDSACP workload related to cases from the intervention communities is bound to be somewhat smaller.

Not least, the evaluation highlights a decrease of the pressure on the protection system owed rather to children's reintegration into their family, the absolute value for reintegration in the intervention communes is higher than the one recorded in the control communes (44 vs. 35). This can be accounted for by the fact that reintegration is possible only when the family is ready for it and when the community has the necessary services to support the family and enable it to ensure an environment that fosters child development.

Project is sustainable at the level of the communities in which it has already been implemented

According to the interviewees at local, county and national level, the positive outcomes reducing children's vulnerabilities are unlikely to continue once the minimum package of services ceases to be delivered, given that multiple and complex vulnerabilities can be effectively addressed only through long-term interventions, and the preventive service delivery carried out for 4 years (2012–2015), with more planning and intensity during 2014–2015, does not suffice. As such, sustainability of results depends on activity continuity. Both project staff and key community stakeholders show motivation to continue delivery of the minimum package of services, while service beneficiaries are responsive.

As the analysis of the model efficiency also shows, the costs associated with implementing the model in each commune are quite low, which allows for continuing the implementation. Community engagement, use of a standardised case management tool (Aurora) and teamwork created an enabling environment for continuing the intervention. Nevertheless, SPAS staff capacity still needs building, additional social workers need to be hired and all community workers need to be trained to ensure optimal model implementation.

Project generated significant positive impact by building spas institutional capacity to deliver the minimum package of services

The model generated the planned impact, building capacity to deliver social services, increasing the community level of information about child rights, supporting the most vulnerable children and their families, determining an increase of the interinstitutional cooperation in support of social services and a moderate increase of the population information level about children's rights and their families' rights and obligations.

The community counselling and support centres for children and parents complemented the spas capacity to deliver the minimum package of services and influenced the capacity building for local professionals, the quality of services provided, and particularly the improvement of the situation of children and their families

Community centres providing counselling and support to children and parents were set up in all 32 communes in which the model was implemented until 2015, as a direct output of the projects funded via micro-grants. Their activity aided the delivery of the minimum package of services a great deal due to the involvement of specialists such as psychologists and physicians who provided information and counselling. The centres were a good lesson of cooperation and increasing strength and quality of locally-delivered services, but their sustainability depends on availability of funding, whether from the state budget or from a donor (NGO, European funds, etc.). According to the survey that was conducted for the evaluation, over 60 percent of the respondents from the intervention communes took part in the activities organised by the Community Centre, invited by one of the community workers. 50 percent of all the respondents from the intervention communes, including those who participated in the activities of the Community Centre, said their family's life improved to a great or very great extent as a result of the project, which proves the project effectiveness and impact due to this component. In addition, the assessment regarding family life improvement rated significantly higher in the intervention communes than in the control group.

Importance of project at national level

Project is relevant in relation to national, regional and european policies

Since it was designed to help increase the performance of the child social and community health care service systems in rural areas, the project is also relevant in relation to the national, regional and European policies, which is essential in view of its subsequent scaling up and adopting by the Government as a public project with budgetary funds. The implementation of its activities is an opportunity for piloting the community-level implementation of the provisions set forth in the National Strategy for the Protection and Promotion of Children's Rights 2014–2020, the National Strategy on Social Inclusion and Poverty Reduction 2015–2020, the National Health Strategy 2014–2020, National Strategy on Reducing Early School Leaving, Government Strategy for the Inclusion of the Romanian Citizens Belonging to the Roma Minority 2015–2020. At the same time, building the capacity of local public authorities to deliver child social and community health care services and increasing the capacity to organise, monitor and evaluate such services at all administrative levels are project outputs which contribute to the implementation of the Strategy for Strengthening the Public Administration 2014–2020, therefore mainstreaming the model nationwide is relevant in terms of social policy as well as administrative reform.

Project helped strengthen national strategies, focusing on preventing child-family separation and violence against children

The substantiation reports underlying relevant regulatory documents as well as the interviews conducted with representatives of the central government authorities with duties related to child protection, social assistance, community health care and youth show that the "First Priority: No More 'Invisible' Children!" model informed and influenced national policies significantly. Even if a scaling up of the model is not yet envisaged as such, model good practices were nevertheless included in the strategic planning for promoting child rights, social inclusion and poverty reduction, health, reducing early school leaving, and inclusion of the Romanian citizens belonging to the Roma minority. The strategies that were adopted plan for building the SPAS capacity and developing social services focusing on identifying vulnerabilities and on prevention (as opposed to last minute intervention and cash benefits). Also, as a result of the model implementation, combating violence against children was given higher priority, relevant strategic documents included the concept of "minimum package of social services", and the work of the community health nurses was promoted, in conjunction with that of the social workers involved in service delivery.

Already there are several regulatory documents which take into account the experience accrued in the model, such as Government Decision 691/2015 for approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and of the Working Methodology for GDSACP-SPAS collaboration and of the standard model for the documents developed by these two institutions, and the Draft Law on community health care.

Project is replicable at national level

Model scaling up is feasible at all levels (local, county and national), however, for a viable nationwide model, the current model still requires piloting on a larger scale first particularly to test county and national management of the intervention. On the other hand, such piloting at a broader level is already in progress, in Bacău county, also with UNICEF support. Nevertheless, a successful scale up strategy requires enhanced cooperation between UNICEF and the Ministry of Labour and Social Justice and testing different intervention options that would address several social assistance and child care as well as health care system gaps related to the reduced availability and capacity of qualified human resources, the lack of comprehensive methodologies and the underfunding of the child protection system, particularly at the local level. UNICEF is already piloting this in 45 rural and urban communities of Bacău county.

Project makes efficient use of resources, including compared to other projects or standards

Project use of material resources was economical/efficient, with actual costs of less than 220 lei/child per year. Aurora was an unexpected initial outcome of the model. The community health care component used many of the resources allocated to the social assistance component, which resulted in a highly efficient integrated approach. Compared to the cost standards for social services set out in Government Decision 978/2015 and to the ESF projects funded in Romania, the model approach based on delivery of a minimum package of services and on micro-grant projects implemented by the SPAS community workers proved very efficient, as the costs per beneficiary per year were at least 12 times lower in the preventive model than for reactive social services (for instance, versus the standard costs set for payment of professional foster carers or of residential care centres).

Project can be replicated and extended nationwide with financial implications that can be covered by the state budget

Should the model be extended nationwide, the impact on the general consolidated budget would be nearly 300 million lei for implementation in both rural and urban areas of both social and community health care components. A limited part of these funds could be ensured from external sources such as the European Social Fund (via POCU), the World Bank, Norway and EEA Grants, in an initial scale up phase covering only communities rated at high social risk. However, a full nationwide scale up can only be supported from the general consolidated budget, but such support is less than 1 percent of the current budget available to the Ministry of Labour and Social Justice.

LESSONS LEARNED

The importance of a systematic use of the aurora methodology

As early as 2011, the model underlined the importance and value of identifying vulnerabilities, assessing the situation of vulnerable children and their families and monitoring this situation. Interviewed community workers and county supervisors unanimously agreed that it was necessary to continue using Aurora, the methodology that enabled the needs assessment as well as the generation of service packages perfectly adapted to the identified vulnerabilities.

Aware that their communities have other cases of 'invisible' children they have not yet identified or that new cases emerge with time, several community workers recommended that community censuses be carried out at the beginning of the intervention, using Aurora, to enable an accurate selection of the group of beneficiaries. On the other hand, all the interviewees underlined that such an action would require mobilising a considerable amount of human resources/staff, not available in the modelling project.

Need for early and long-term interventions and for ensuring available specialised services for most serious vulnerabilities

Identifying cases of child violence, abuse and neglect was one of the biggest model challenges, as shown by all those involved in its implementation, from UNICEF representatives to local professionals and key community stakeholders. For community workers, identifying cases of child abuse and neglect was a gradual process whereby they first gained the trust of the beneficiaries who gradually started to reveal the problems they were having and began to grasp the serious nature of certain instances of abuse or neglect which some of the communities treated as "normal". By organising various campaigns against violence as well as counselling sessions, the modelling project helped community workers, key community stakeholders and project beneficiaries increase their knowledge and understanding of the phenomenon. However, despite the progress made, the instances of violence, abuse and neglect are still frequent (even the lowest incidence of the phenomenon recorded into Aurora in 2015 is of concern) and providing an accurate assessment of them continues to pose a challenge.

Also, the model registered a limited impact on the adolescents' level of information about risk behaviours and on reducing the incidence of these behaviours. In all these cases, lessons learned indicate the following: (1) the importance of carrying out prevention interventions and information and counselling services before the vulnerabilities become serious and the risks high; (2) the importance of carrying out long-term interventions, as reducing vulnerabilities involves changing target group risk behaviours; (3) the need to be able to access specialised counselling or recovery services which are often unavailable to disadvantaged rural communities.

RECOMMENDATIONS

The recommendations of the present evaluation were shared with the demonstration project main partners and further fine tuned based on their suggestions. Key priorities resulting from the evaluation as well as from the consultations held with partners at different levels refer to the legislative and funding framework, the working methodologies and tools and, not least, the human resources involved and the need for training. The main recommendations are outlined below, not necessarily in the choronological order of priority.

Recommendations for Unicef

– Continue the advocacy efforts to ensure that national public policies cover not only the identification of vulnerabilities but also the standardised assessment of the identified vulnerabilities and the minimum package of services. With regard to a potential new project for modelling community-based interventions, it is recommended to continue using the same project design and similar strategy, focusing on the use of the Aurora methodology for the delivery of community-based services in rural areas, and making sure to: (a) add an education services component, (b) add a component that provides community workers with information on the available specialised services they can refer to when necessary (a map of specialised services), and (c) allocate a longer implementation timeline to enable monitoring of preventive services and repeated long-term delivery of the services that are required on a recurrent basis in order to effectively address vulnerabilities.

– Promote the minimum package of services and the component of vulnerabilities identification and needs assessment, by using Aurora nationwide as a modern tool that enables the identification of children's problems and needs, including those less visible to community members (i.e. situations of violence, abuse and neglect or risk behaviours among children and adolescents), as well as the planning of the necessary services for those children – a tool accessible to all social/outreach workers within the SPAS. However, for institutions and organisations interested in replicating the model to be able to use all the good practices, it is necessary to document the working methodologies, the implementation approach and calendar, the required coordination staff etc.

– Test the possibility of identifying all 'invisible' children in the communities, by conducting a comprehensive identification of community households and children. Local professionals can use Aurora to identify all households in a community, by carrying out a community census. The evaluation shows the need to identify all vulnerable/'invisible' children at community level by mapping out their needs so as to ensure that the social worker tasked with the fieldwork (with the delivery of social services) knows all the households and all children in the community and identifies the households with vulnerable children that require an in-depth needs assessment. This could be achieved if the social worker initially uses a screening questionnaire for all community households, possibly integrated into the Aurora, such as the Observation Data Sheet set out in Government Decision 691/2015 (conducting a community census using a simplified tool). This would allow for identifying the households that will require a full use of the Aurora methodology for in-depth needs assessment and service package generation. Unlike applying the full Aurora methodology to all households, use of a simplified tool would cover a shorter period of time, increasing activity effectiveness and efficiency.

– Fine-tune the Aurora application to better serve the case management methodology, by improving the

way cases are being managed and the flagging of services recommended in the minimum package of services. Also, to increase the capacity to accurately assess the effectiveness of service package delivery, Aurora should be revised to allow for better monitoring of services carried out or not carried out, indicating the specific reasons why services where not carried out – service was no longer required/was not available/was inaccessible – for a more clear assessment of the basic or specialised services needed in every community as well as at county level. For best case management, the platform should also enable flagging of services whose repeated delivery is recommended.

– Develop a new Aurora application module that provides a platform for reporting on the micro-grant project activities, to facilitate the monitoring of and reporting on activities funded through the micro-grants. To increase effectiveness and evaluability of activities micro-grant funded at the community counselling and support centres, community workers and their county supervisors need project management skill-development as well as micro-grant project management procedures, including an online standardised activity reporting module.

– Test the working hypotheses related to the definition of the risk of child-family separation by using data on a larger number of children than the one covered in the demonstration project (where only 25 children were separated from their family and recorded in the Aurora database, to enable a risk situation analysis). An adjusted definition should, in turn, serve to adjust the priority zero service designed to prevent child-family separation. Also, the working hypotheses need testing in another model, to generate a definition of the risk of child-family separation that would serve to promote the "priority zero service" at national level as a standard service in the SPAS portfolio to ensure prevention of the actual separation and of the child entering public care. Similarly, it is necessary to consider the possibility of adding to Aurora a series of indicators of the pressure on the community health care system, such as the number of hospitalizations in the past 9 months (i.e. the period of time between the two uses of the Aurora questionnaire).

– Strengthen cooperation with the Ministry of Labour and Social Justice/the National Authority for the Protection of Child Rights and Adoption and pilot the model in various formulas for comparison purposes, while considering different intervention options to address several social assistance and child care system gaps. All the findings of the present evaluation can be used in the advocacy process at all levels associated with model scale-up.

Recommendations for the Government of Romania

To address the problems of the child care system that were identified in the evaluation and increase its effectiveness in addressing children's vulnerabilities, the Government of Romania, particularly the Ministry of Labour and Social Justice and the Ministry of Health, should consider the following recommendations related to using or adapting the good practices proposed by UNICEF:

– Operationalise the concept of minimum package of basic social services for children and families, including by developing documents, procedures and working methodologies to be made available to all the SPAS, to ensure all vulnerabilities affecting children and their families are addressed, by replicating/scaling up the Aurora methodology or by developing new tools at national level.

– Consider options, including by testing a reward mechanism, to incentivise specialist workforce (social workers, community health nurses), particularly in rural areas. Develop working tools for ensuring an integrated delivery of social and community health care services. To this end, we recommend the development of integrated working methodologies and tools to assist GDSACP and DPH in working together at county level and social workers and community health nurses, at local level.

Recommendations for the GDSACP and other county-level structures

– At GDSACP and DPH level, set up departments with adequate staff specialised, among others, in the field of project management, to ensure monitoring and methodological supervision of SPAS staff.

Strengthen the capacity of county institutions to develop multidisciplinary teams (starting from the provisions of Government Decision 49/2011), tasked with providing methodological support at the local level and with identifying solutions to specific cases. Build capacity of human resources, including by organising further education and training courses, to enhance specialised skills of county supervisors in relation to community-based social and health care services.

Recommendations for mayoralties

– Continue using the Aurora and carry out the identification of vulnerabilities on a regular basis, according to the methodology, and continue delivering the services included in the minimum package of services. In the communes in which the model was previously implemented, continue the Aurora-based activities, continue to support the outreach/fieldwork activities, by hiring the responsible social worker full time, and continue ensuring coordination between the social worker and the community health nurse (where available).

– Hire SPAS-level professionals – social worker and community health nurse, for integrated outreach work primarily. The number of local professionals assigned to focus on fieldwork should be sufficient to cover the needs of the respective community. Also, it is necessary to continue using the methodologies developed for the community counselling and support centres and maintaining sustained cooperation with the community consultative structure.

I. EVALUATION BACKGROUND, OBJECTIVES AND DESIGN

1.1. EVALUATION BACKGROUND

1.1.1. The situation of children in Romania and its evolution

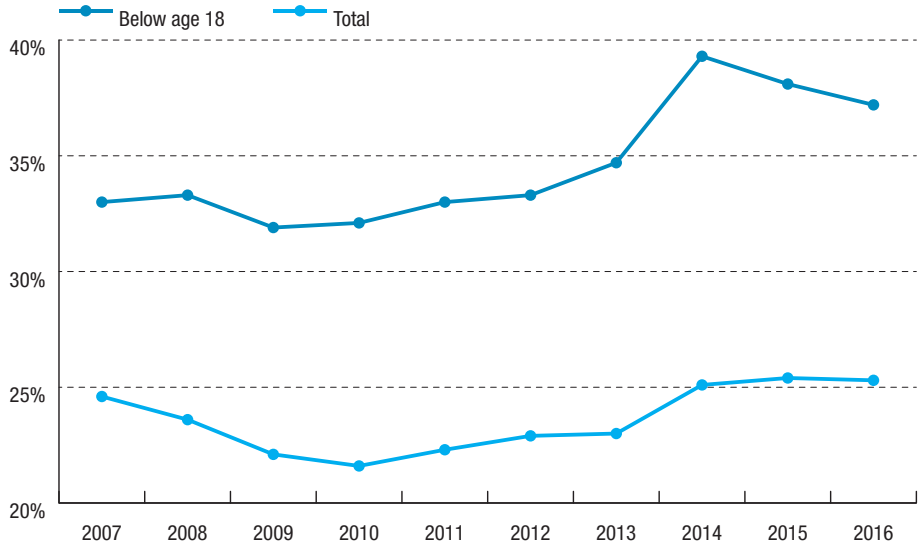
In the context of the 2008 economic crisis, across the European Union, fiscal consolidation measures have had a strong impact on social service accessibility and quality, especially for vulnerable groups[7]. In Romania, children were one of the most affected groups as one-third of them lived in poverty. Moreover, the crisis hit rural and Roma children the hardest.

As an outcome of the rising poverty rate and of the limited budgets for family services, in 2011, for the first time in 15 years, the number of institutionalised children increased[8]. The socio-economic conditions and the absence of adequate social services threatened children's social inclusion and right to achieve their full potential.

1.1.1.1. Evolution of children's situation according to statistics and related literature

According to Eurostat data, at the beginning of the modelling project, the percentage of children at risk of relative poverty was at the same level as the one recorded prior to the 2008 economic crisis, and, until 2014, it registered a rising trend followed by a slight decline. Thus, in 2008, nearly 38% of Romania's children were faced with this risk, and for them, the risk was one and a half times higher than for the general population.

Figure 1. Relative poverty rate[9], by age, 2007 – 2016 (%)



Source: Eurostat

**data for 2016 are provisional and may be subject to changes and revisions*

Several factors account for the high relative poverty rate among children, compared to the rate computed for the total population, such as: the inefficiency of social benefits for children and their families, the households with low work intensity, the higher than average number of children in households with low income.

7 European Commission, 2011. *The social impact of the economic crisis and ongoing fiscal consolidation*. Third report of the Social Protection Committee, available at: http://goo.gl/ZiHjM8

8 2011 data according to the Ministry of Labour, Family and Social Protection, General Directorate for Child Protection. The number of children in residential care was 23,240 in 2011 versus 23,103 in 2010.

9 Relative poverty rate is defined as the share of people living in households where the equivalised disposable income is below the poverty threshold set at 60 per cent of the median equivalised disposable income (after social transfers).

Despite social and economic progress, child poverty in Romania did not decline over the last few years, being closely linked to education, employment and housing issues. The table below shows the fluctuations of the two main poverty indicators: relative poverty rate and relative poverty and social exclusion rate.

Table 2. Fluctuations of relative poverty and social exclusion rate[10] and of relative poverty rate among children, by age group (%)

Age	**Relative poverty and social exclusion rate**				
	2008 (%)	2014 (%)	2015 (%)	Fluctuation 2014/2008 (%)	Fluctuation 2015/2014 (%)
< 6	48.8	44.5	42.4	-9.7	-5.0
6–11	51.6	51.6	43.6	0.0	-18.3
12–17	50.8	53.2	52.0	+4.5	-2.3
Age	**Relative poverty rate**				
< 6	31.4	31.9	32.5	+1.6	1.8
6–11	34.6	39.6	36.4	+12.6	-8.8
12–17	32.4	43.2	42.4	+25.0	-1.9

Source: Eurostat

Eurostat data shows that the poverty and social exclusion rate for children aged 0–5 years is registering a constant decline. However, for higher age groups (6–11 years and 12–17 years), the poverty and social exclusion rate have been varying significantly over the last 9 years and are currently higher than prior to the economic crisis. At the same time, poverty and exclusion is increasingly affecting adolescents.

Moreover, there are disparities determined by area and region of residence as well as by ethnicity. As shown in the background study for the National Strategy on Social Inclusion[11], one in two children in rural areas lives in poverty. In 2012, in terms of the risk of poverty, there were significant disparities between children living in rural areas (50 %) and those in urban areas (only 17 %). Therefore, nearly three quarters of all poor children in Romania live in rural areas. Ethnicity is another important predictor of risk of poverty. Roma have a higher risk of being in poverty, regardless of their age, education, or area of residence. "Based on the national absolute poverty threshold measured using the consumption level from 2013, Roma citizens have a ten times higher risk of being poor than the rest of the population (the rate for the Roma population was 33 percent versus only 3.4 percent for the whole population). What is worrying is that the poverty risk is extremely high for Roma children – their poverty rate is 37.7 percent, while the national poverty rate is only 4.3 percent"[12].

Despite the family support measures planned and taken, the percentage of children in public care has remained constant over the last decade. Due to the limited availability of community-based services, children with disabilities are most often placed in public care, whether in institutions or foster care. For these children, reintegration into the family is a challenge. According to the data reported by the National Authority for the Protection of Child Rights and Adoption (NAPCRA) as of 31 December 2015, there were 57,279 children in public care, of whom 20,291 in residential care and 36,988 in family-type care.

In terms of health, although the neonatal mortality rate and the infant mortality rate have dropped, compared to past trends, they still maintain higher levels than those recorded in other EU countries. According to Eurostat, Romania registered a 14.3 percent decrease between 2010 and 2014, two times the EU average of 7,5 percent. Even so, Romania continues to be listed as the country with the highest infant mortality rate across the European Union, twice the European average. This rate is constantly higher in rural areas versus

10 Relative poverty and social exclusion rate (AROPE) is a composite indicator adopted at EU level under Europe 2020 which promotes social inclusion and poverty reduction, representing the share of the total population which is at risk of poverty or social exclusion. The AROPE indicator refers to people who find themselves in at least one of the following situations: they have disposable income below the poverty threshold; they are severely materially deprived; they live in a household with a very low work intensity.

11 *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*, approved based on Government Decision 383/2015, p. 24

12 Idem, p. 26

urban ones, and the gap has increased over the last years. According to the background data outlined in the National Health Strategy 2014–2020[13], more than half (57 percent) of all infant deaths occur primarily within the first month of life, and a significant share of under-one child deaths occur at home, in the absence of medical care for the illness that led to the child's death.

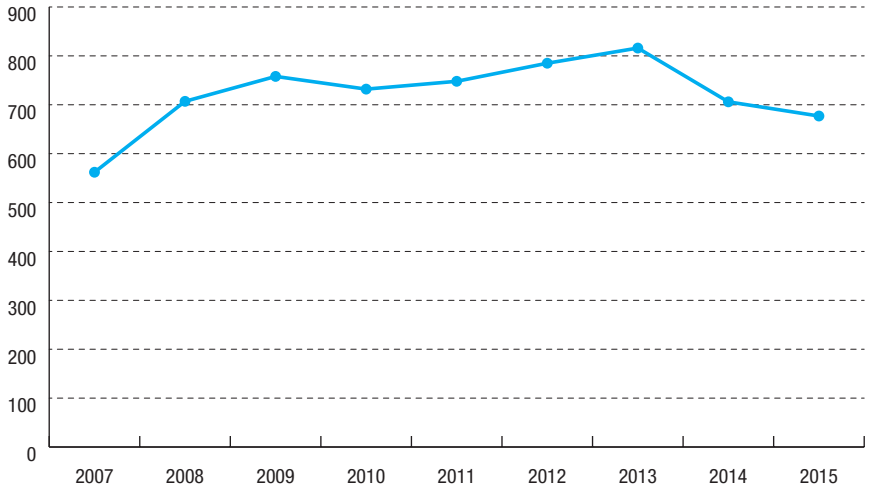
According to the National Institute of Statistics, in 2015, of 1,780 deaths recorded among under-five children, 84 percent occur in the first year of life, while the remaining 287 cases occur between ages 1 and 4. Considering that most of these deaths occur as a result of injuries caused by accidents and respiratory diseases, they could be prevented to a large extent through adequate support and care.

Furthermore, the vaccination uptake has dropped over the last years, including of the mandatory vaccines provided under the national immunization programme, resulting in a high number of vaccine-preventable disease outbreaks among children[14].

As shown in a UNICEF report[15], risky behaviours among adolescents (10–18 years of age) have reached high levels. 42 percent of children over 10 years of age drank an alcoholic beverage at least once, while alcohol consumption is more common among teenagers aged 14 and older (more than half of them having drank alcohol, versus 21 percent of adolescents under 14). Nearly a quarter of the adolescents smoked tobacco at least once in their lifetime, a higher percentage being recorded again among the 14–18 age group (33 percent of teens over 14 versus 6 percent of those under 14). As for drug use, the same study shows that 3.8 percent of adolescents have used some kind of drug at least once, with a high 5.4 percent of teens in the 14–17 age group.

At the same time, it is worth mentioning that Romania is one of the EU countries with the highest rates when it comes to teenage mothers, although the trends show a slight decrease lately. According to 2013 Eurostat data, the percentage of teenage mothers (15–19 years of age) in Romania was 15.6, versus the European average of 5.4. National data reveal that, over the last decade, the number of children with mothers under 15 years of age has increased. Adolescent mothers cumulate vulnerabilities and risks such as school dropout, low likelihood of earning an adequate income, financial and welfare dependency, high risk of poverty and social exclusion.

Figure 2. Number of children with mothers under age 15



Source: NIS

13 *National Health Strategy 2014–2020*, approved based on Government Decision 1028/214, Annex 1, p. 11

14 *National Health Strategy 2014–2020*; European Centre for Disease Prevention and Control. *Annual Epidemiological Reports on Communicable Diseases in Europe 2007–2011*

15 Abraham, D. (coord.), 2013. *State of Adolescents in Romania. Final report*. UNICEF, Bucharest. Study available online at: https://www.unicef.org/romania/UNICEF_Study_State_of_adolescents_in_Romania.pdf

A WHO survey[16] on adverse childhood experiences, conducted on a representative sample of students in Romania, has shown that abuse and neglect are daily experiences for children, 26.9 percent of whom reported physical abuse, 18.5 percent physical neglect, 23.6 percent emotional abuse and 26.3 percent emotional neglect. Corporal punishment was reported by 31.7 percent of respondents as being a widespread disciplinary method. Boys are exposed to physical violence more than girls. The experience of sexual abuse was recorded for 9 percent of the survey participants (10.9 percent of girls versus 5.6 percent of boys reported exposure to at least one type of sexual abuse). The survey also identified the context of abuse, highlighting household dysfunctions: alcohol consumption by family members, mother treated violently, parental separation or divorce, and mental illness of one or more family members.

Also, a national sociological study on Child Abuse and Neglect[17] (2013) developed by Save the Children Romania used two samples: one comprised of 1,436 households and representative at national level, and one consisting of 1,120 children, representative of the school population. According to this study, 38 percent of the surveyed parents admitted to physically abusing their children. In contrast, 63 percent of the surveyed children reported having been exposed to a form of physical abuse. Important differences are reported in connection with severe physical abuse forms. Whereas one percent of parents admit to having beaten their child with an object at least once over the last year, up to 39 percent of the children said they were hit with a stick, a belt or a wooden spoon.

On the other hand, to ensure the social inclusion of all children, regardless of their area of residence, gender or ethnicity, it is important that they have equal access to education. Despite the reforms and progress encountered in Romania's education system, school dropout, absenteism and grade retention as well as difficulties in attending higher education continue to pose complex challenges for the education system. These issues can be explained by multiple social, economic, educational and family-related factors.

School attendance of children in Romania has dropped over the last four years, affecting mostly school-age children in rural areas, as can be seen in the table below.

Table 3. Enrolment rate of school-age children, by school years

	2011/2012 (%)	2012/2013 (%)	2013/2014 (%)	2014/2015 (%)	2015–2016 (%)
Total	**69.1**	**69.7**	**70.0**	**63.0**	**61.6**
Male	68.6	69.2	69.3	62.4	61.1
Female	69.6	10.2	10.7	63.6	61.1
Urban	88.2	89.3	90.8	82.5	81.2
Rural	49.8	50.0	49.5	43.8	42.4

Source: NIS, as presented by ISE

Furthermore, as shown in an OCDE study,[18] participation in compulsory education (for a total duration of 11 years, between the preparatory grade and grade 10) is not universal. NIS data (see below) also show that school dropout, currently on a rising trend, is a cause for concern, with highest rates recorded in upper and post-secondary education.

16 World Health Organization, Regional Office for Europe, 2013. *Survey of Adverse Childhood Experiences among Romanian University Students*

17 Save the Children Romania and the Ministry of Labour, Family, Social Protection and the Elderly/Directorate for Child Protection, 2013. *Child Abuse and Neglect: National sociologic study*

18 OECD and UNICEF, 2017. *OECD Reviews of Evaluation and Assessment in Education. Bucharest*. Available at: https://www.unicef.org/romania/OECD_Reviews_en_pt_web.pdf

Table 4. Dropout rate by education level and school years

	2011/2012 (%)	2012/2013 (%)	2013/2014 (%)	2014/2015 (%)	2015/2016 (%)
Primary and lower secondary education (except for special education), of which:	1.8	1.8	1.4	1.5	2
Primary education	1.6	1.6	1.1	1.3	1.8
Lower secondary education	2.0	1.9	1.7	1.9	2.1
Upper secondary and vocational education	4.2	4.2	2.9	2.9	3.5
Post-secondary and foremen's vocational education	6.3	6.1	8.9	7.9	10.7

Source: NIS, as presented by ISE

1.1.1.2. Regulatory and institutional framework

The "First Priority: No More 'Invisible' Children!" modelling project was developed and began implementation at a time when the poverty rate in Romania, particularly among children, registered an upward trend. 2011 data showed that children and young people had been strongly affected by the economic recession[19], a negative trend which was likely to continue, according to the forecasts for the upcoming years[20]. Moreover, the reduced public spending during the economic and financial crisis (2009–2011) and the institutional reorganisation at central level – which also led to the dissolution of the National Authority for Child Rights Protection (2010) – affected the way in which public policies were able to provide an adequate response to protect the most vulnerable.

Based on the theory that children's welfare in Romania will improve only if and when they, especially those worst-off ('invisible'), will have enhanced access to social services (education, health and social assistance services), the demonstration project aimed to provide a possible solution to increase the impact of social policies on children and their families.

In line with the European Commission Recommendation "Investing in Children: Breaking the Cycle of Disadvantage" (2013) as well as with the Europe 2020 objectives, Romania sought solutions to the situation of its most vulnerable children and their families and, starting 2014, it developed a series of multidimensional strategies focusing on ensuring child wellfare and promoting equal opportunities, to enable all children to reach their full potential. Re-establishment of NAPCRA also prompted the completion and endorsement of the *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*[21], which promotes investment in child development and well-being aimed at ensuring respect for children's rights, coverage of children's needs, and universal access to services. At the same time, the *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*[22] designed in accordance with the country's national targets for reducing poverty and social exclusion set out in the Europe 2020 Strategy, aims to break the intergenerational cycle of poverty and prevent the recurrence of poverty and social exclusion. In turn, the *National Health Strategy 2014–2020*[23] identifies specific areas of intervention which are highly relevant to poor or vulnerable groups, prioritizing support for delivery of health services in disadvantaged communities and enabling the adoption of an integrated approach to social service provision, by setting up integrated intervention community teams. All these strategies, described in more detail in the present evaluation report chapter that discusses the relevance of the model in relation to national policies (Chapter III, section 3.1.3. "Relevance of the model in relation to national, regional, European and international child protection policies"), promote an integrated and holistic approach to the situations that the most vulnerable children and their families are faced with, support a transition to interventions likely to prevent vulnerable

19 Preda, M. (coord.), 2011. *Situation Analysis of Children in Romania*. UNICEF Report. HBS data, NIS. Bucharest.
20 Stănculescu, M.S., Marin, M., 2011. *Impacts of the international economic crisis in Romania 2009–2010*. UNICEF Report, Bucharest.
21 Government Decision 1113/12 December 2014
22 Government Decision 383/27 May 2015
23 Government Decision 1028/18 november 2014

situations rather than treat the outcomes of exclusion, and place special focus on increasing community-based capacity to assess and meet people's needs.

On the other hand, in-depth reviews conducted in preparation of the above-mentioned strategies also highlight the fact that local administrative capacity to implement the measures set out in the strategies varies a great deal and generally requires development, strengthening and enhancing in order to have valid impact on the welfare of children and their families. An analysis of the status of all General Directorates for Social Assistance and Child Protection (GDSACP) and of the Public Social Assistance Services (SPAS), based on an assessment of their enforcement of related legal provisions, has found a high level of disparities among the organisational structures in the field and the working procedures they use[24].

At county level, for instance, the role of GDSACPs in strategic planning, methodological guidance and coordination for the SPAS, as well as in monitoring and evaluating service providers requires developing and strengthening. According to various previous reports, 60 percent of the GDSACPs have developed strategies, plans, procedures or methodologies; only 53 percent of them use the case management method or have developed related procedures, and only 61 percent have case managers whose average caseload is 74 cases each; 61 percent of the GDSACPs have set up a social marginalization prevention department, 65 percent have set up a social service quality management and only 29 percent have set up a department for the coordination and support of the SPAS in their county[25].

The capacity of the SPAS, which are organised within the local public government on the basis of Law 292/2011 on Social Assistance, seems to be rather poor. The *National Strategy for the Protection and Promotion of Children's Rights 2014–2020* mentions the functional difficulties encountered at SPAS level, mostly a result of the lacking human resources and administrative capacity[26] required for a full enforcement of the existing legislative framework. The SPAS are poorly developed, particularly in rural areas where they lack specialised staffing, and make little use of working methodologies. A SPAS census conducted by the World Bank in May 2014 shows that more than a third (34 percent) of the local administration entities in rural areas and 8 percent of those in very small towns (below 10,000 inhabitants) have not set up such services and instead they assigned additional duties to their existing staff.[27] Furthermore, the salary scale of social workers makes it difficult for the local authorities to maintain and recruit specialised workforce.[28]

The focus groups conducted as part of the present evaluation also revealed that, despite the decentralisation of duties, budget transfers from the national/central level to the local level are limited, which is bound to significantly diminish the SPAS capacity to provide child-family separation prevention services. Previous reports indicate that SPAS-level social workers dedicate most of their time to granting social benefits, which means they focus less on preventing child-family separation as well as on the identification, assessment, case management and monitoring of children at risk of separation. Thus, most of the services designed to prevent child-family separation and keep the family together are concentrated at GDSACP level, contrary to the essence of decentralisation and the principle of subsidiarity in social work, while the SPAS stick to granting benefits.

Last but not least, it is worth mentioning that the strategies designed to promote children's well-being require a good coordination of all stakeholders at central, county and local levels, as well as a cross-sectoral and multidisciplinary approach. The capacity of authorities at all levels to plan, implement, monitor and evaluate public policies in an integrated manner is often limited by the regulatory framework which, though advocating for integrated and intersectoral approaches, provides methodological guidance strictly related to the activity sector it specifically refers to. Fragmented adjustments to the legislative framework

24 MoLFSPE and SERA Romania (2012), p. 219, apud the *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*, approved based on Government Decision 1113/2014

25 HHC Romania (2011), MoLFSPE and SERA Romania (2012), and FONPC (2012), apud the *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*

26 MoLFSPE and SERA Romania (2012), p. 219, apud the *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*

27 *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*, approved based on Government Decision 383/2015

28 Ibid.

occuring rather sector by sector did not enable the development of integrated interventions at county or local level. In addition, mechanisms for funding services in different sectors, such as health, education, social assistance etc., do not foster the development of integrated services.

In the *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*, one key intervention in the field of social services is "developing integrated intervention community teams for the delivery of social services in education, employment and healthcare, and of community-based social intermediation and facilitation programmes, especially in poor and marginalised, rural and urban, Roma and non-Roma areas, by: i) developing clear methodologies, protocols, and work procedures for community-based social workers , and ii) developing, in the marginalised areas, multi-functional community centres to provide integrated services to (primarily though not exclusively) families in extreme poverty". The "development of integrated services" is also part of the measures envisaged in the *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*. However, to operationalise the objectives and measures included in these strategies, it is essential first to improve horizontal coordination within and between ministries, as well as vertical coordination between central, county and local levels.

Given the policy and legislative framework support to ensuring child welfare, one should also seek other innovative solutions to rendering the strategies operational. Demonstration projects, testing and follow-up of pilot intervention results that could contribute to reaching set targets need to be supported and replicated at regional and national level. Of relevance in the context of the present evaluation report is the new modelling project called "Social inclusion through the provision of integrated social services at community level", implemented in Bacău County starting 2014 on the basis of lessons learned and evidence accumulated by UNICEF and partners during previous interventions at the local level, including the project addressed by the present summative evaluation. The Ministry of Labour and Social Justice (MoLSJ) and NAPCRA, the Ministry of Health (MoH), the Ministry of National Education (MoNE), the Ministry of Youth and Sports (MoYS) and the Ministry of Regional Development, Public Administration and European Funds (MoRDPAEF), all agreed to contribute to several stages of preparation or implementation of the new model intervention which tests the concept of integrated community-based service delivery and which will provide the necessary documentation and lessons learned to translate this concept into methodologies, norms and standards of practice, programmes and legislation. The results of this modelling project are expected to input the development of public and EU-funded national programmes and inform future strategies on social inclusion designed to positively impact the lives of as many families and children as possible.

1.2. Overview of the "First priority: No more 'invisible' children!" evaluated model

1.2.1. Analyzing the theory of change formulated in the project: Objectives, activities, expected outcomes

Implementation of "First Priority: No More 'Invisible' Children!" (initially called "Helping the 'Invisible' Children" - HIC) started in 2011, in 96 communes located in disadvantaged rural areas which the situation analysis revealed as needing intervention most. The project aimed to increase the impact of social protection policies on the most poor and vulnerable ('invisibile') children and their families, by testing an intervention at the local level, based on outreach and prevention.

In view of the previously described national context, the high poverty and social exclusion rate, the health and school attendance issues affecting children and their families, and, not least, the poor development of social assistance services at local level, the Theory of Change (ToC) developed in the "First Priority: No More 'Invisible' Children!" modelling project and outlined in Annex 1 to this report started from the hypothesis that the project aim will be reached only when all children and their families will have access to services, using an approach focused on outreach and on developing working methodologies at the local level. The ToC is in line with the provisions of the UNICEF Child Protection Strategy according to which successful child protection begins with prevention, as well as with the provisions of the UN Convention on

the Rights of the Child[29], embedding 'the best interest of the child' principle into the pilot project design and using a child rights-based approach in shaping its building blocks (e.g. approaching the minimum package services in terms of how these services address child rights).

The ToC was developed in 2012 in a format which provides a clear picture of how results would be achieved in the demonstration project. It focuses on the expected increased impact of social protection policies on vulnerable children and their families in Romania and includes activities, outputs and outcomes to be achieved especially in the social protection area, considering mainly social assistance services developed at community level with special focus on prevention. Subsequently, based on generated evidence and recommendations of the previous two formative evaluations of the project, the ToC was adjusted so as to reflect the changes to the project resulting from reducing its geographical coverage, adding the community health care component and adopting an integrated approach.

This section of the report explains the evaluation team's understanding of the ToC and how the evaluation will address its various elements, including the components that were revised during project implementation, while the following section will focus on the model assumptions and risks within the ToC.

The evaluation will explore the causal linkages between various ToC elements and will identify any significant fracture between theory (as defined by ToC) and the model assumptions, on the one hand, as well as changes occurring at different levels (individual, community, county and national level).

The ToC was developed in consultation with national and county partners and involving all three levels in the modelling project, from the very start:

– Community level: the 'invisible' children and their families, the social workers recruited and trained in the project, other professionals who deliver social services (community health nurs, health mediator e etc.), mayors and community consultative structures (CCS);

– County level: the GDSACPs (supervisors and executive directors) and, starting 2012, the directorates for public health (DPH);

– National level: the MoLFSPE (General Directorate for Child Protection – which became the NAPCRA in 2014), the MoH, the MoNE.

Relevant partners were invited to participate in every phase of the demonstration project which was developed based on an ongoing learning process, progressing on the strength of good practices identified and of fine-tuning problem areas for highest impact of results.

The ToC design involves multiple layers, including resources, activities, immediate as well as impact results at 1) individual (children and their families), 2) community, 3) county and 4) national levels. At the individual level, the ToC underlines the target group – 'invisibile' children and their families, with special focus on the vulnerable groups, considering all their age, gender and ethnic characteristics. In operational terms, the target group is "children affected by one or more vulnerabilities and reached by social workers through fieldwork", but also children known to be in a vulnerable situation but, nevertheless, 'invisible' to the government, local institutions, and the community itself.

For 2011–2015, the planned project budget was over 7 million lei, of which only 4.5 million lei were actually spent, as the activities were organised such as to enable savings, while the integrated approach allowed for obtaining results without spending some of the amounts that were initially planned. An in-depth analysis of the project budget is available in Chapter III, section 3.3.1. "Efficiency of resource use".

29 Of relevance: Art. 9 – the right to grow up in a family environment, Art. 28 – the right to education, Art. 24 – the right to the enjoyment of the highest attainable standard of health, Art. 27 – the right to an adequate standard of living, Art. 26 – the right to social security, Art. 31 – the right to rest and leisure

1.2.2. Model implementation

1.2.2.1. Geographical coverage

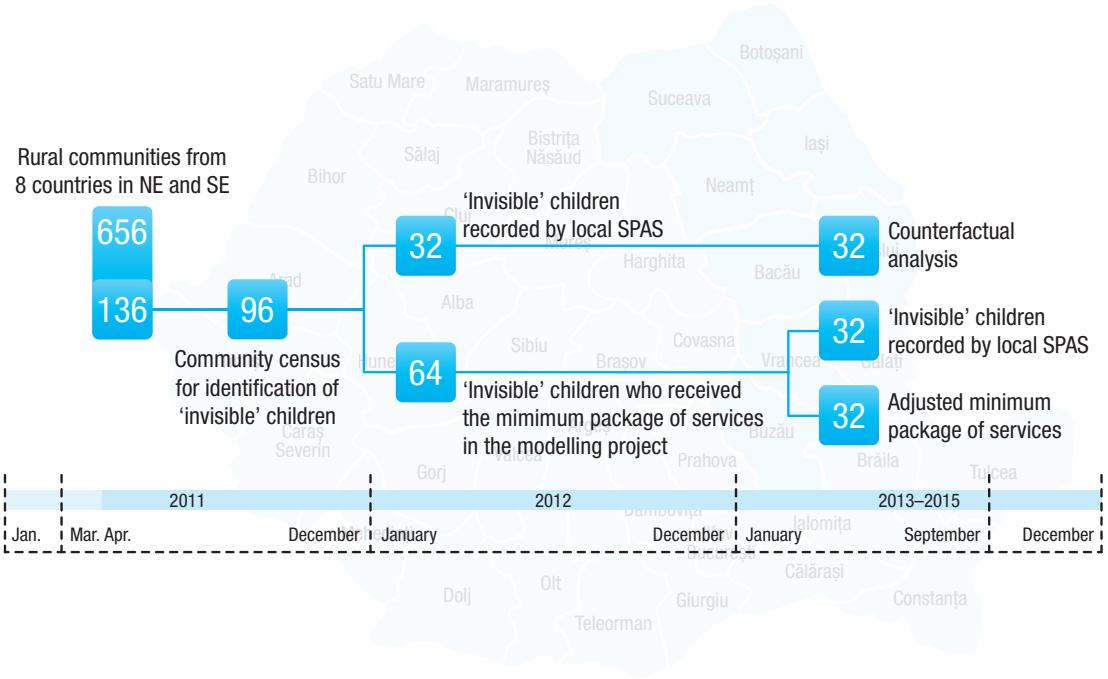
"First Priority: No More 'Invisible' Children!" was implemented during 2011–2015 by UNICEF in Romania and its national, county and local partners, in 8 counties of the country's North-East Region: Bacău, Botoșani, Buzău, Iași, Neamț, Suceava, Vaslui and Vrancea.

During its first implementation phase (2011–2012), the project covered a total of 96 communes selected based on specific criteria[30] which took into account the existing social vulnerabilities, on the one hand, and the local public authorities' openness towards social problems, on the other. A list of all the communes that were part of the project and the corresponding project phase they were in is available in Annex 2 to the present report.

Following the findings of the first formative evaluation of the project conducted at the end of 2011, to ensure sustainability of the model and increase project effectiveness and future evaluability, the number of communes was reduced to 64, based on criteria related to the model's efficiency and effectiveness in the specific context at that time and in relation to the project activities as well as to the existing vulnerable groups.

The second formative evaluation produced evidence and lessons learned according to which the project required a geographical concentration of its implementation. As a result, between 2013 and 2015, the intervention covered only 32 communes, while the rest of the communes were retained as control communes for evaluation purposes.

Figure 3. Modelling project geographical coverage and implementation phases



Source: UNICEF, MoLFSPE, CERME, Helping the 'invisible' children (HIC) – Second Evaluation Report.
Note: Boxes indicate the number of rural communities included in the project

1.2.2.2. Model development and implementation partners

Main partners at each administrative level were institutions responsible for ensuring observance of child rights as well as those working in social assistance and protection of children and their families. At national level, the MoLFSPE, via **NAPCRA**, was the main partner and representative of the central public administration, providing significant contribution throughout the modelling project, from the early stages

30 The selection methodology and list of communes are available in Stănculescu, M. S. (coord.), 2012, *Helping the invisible children –Evaluation* Report. UNICEF, Bucharest. pp 125–129, https://www.unicef.org/romania/Raport_HIC_engleza.pdf

to the development of the methodological support for the local and county project stakeholders. This collaboration enabled the evidence generated during project implementation to inform a series of changes to the primary and secondary legislation which were required to ensure the basis for a prevention-centred intervention, as well as the identification of potential funding sources.

At county level, UNICEF closely collaborated with county institutions involved in representation, supervision and coordination. To note, the **Prefecture** was the main county partner, on the basis of collaboration agreements concluded with the Prefectures in the 8 project counties.

Starting 2011, the **GDSACPs** in the 8 counties were included in the project, with the primary role of providing technical and methodological support, mainly for the social/outreach workers in the project, but also for the SPAS and other professionals involved in identifying solutions for vulnerable groups at the local level. A GDSACP professional was selected in every county and assigned the role of supervisor in the demonstration project. County supervisors helped document project progress, participated in the formative evaluations and contributed their own experience to the fine-tuning of key evaluation recommendations, including to the consecutive revisions of project activities. As of 2013, when the project was added the community health care component, the **DPHs** in the 8 counties were brought on board as project implementation and development partners. Following the already tested model of the GDSACPs, their role was that of providing methodological support to the community health nurses in each and every project locality, through selected DPH supervisors.

In addition, local public authorities (LPA) in the communes of the 8 project counties were key in implementing the model, thanks to the activity of the **SPAS** and, more specifically, of the social workers recruited and trained within each mayoralty, but also due to the input of other professionals involved in ensuring child welfare (mainly the community health nurse and health mediator) as well as the support of other local community members (teachers, doctors, priests, local entrepreneurs, policemen etc., all under the CCS umbrella).

Last but not least stakeholders involved in the implementation of the demonstration project were **the 'invisible' children and their families**.

During implementation, consultations were conducted at various stages with other entities at central (the Ministry of Health, the Ministry of Education and Scientific Research) or county (the County School Inspectorate) levels, which were tasked to address a specific issue or phase of the project.

Of note is the role other non-governmental institutions and organisations played in the development and implementation of the project, such as: the Centre for Health Policies and Services, Population Services International (PSI) Romania, the Romanian Centre for Economic Modeling (CERME), as well as the tehnical team of IT experts, whose contribution was key in fine-tuning the project and developing and implementing its various components and working methodologies.

1.2.2.3. Flow of main model activities

The goal of the "First Priority: No More 'Invisible' Children!" modelling project was to contribute to an increased impact of social protection policies on children and families most poor and most at risk of social exclusion, while the project underlying hypothesis was that this goal would be achieved only if and when local government authorities will employ professionals able to identify vulnerable children and their families, mainly through prevention-focused outreach activities.

To this end, in 2011, a selection was made of the most vulnerable rural communities[31] from the following eight counties: Bacău, Botoșani, Buzău, Iași, Neamț, Suceava, Vaslui and Vrancea. To obtain an accurate picture of the needs of children and their families, the first phase of the demonstration project, initiated in 2011, involved employing and training social/outreach workers and implementing specific activities: i)

31 The selection methodology and list of communes are available in Stănculescu, M. S. (coord.), 2012, *Helping the invisible children – Evaluation Report*. pp. 125–129, https://www.unicef.org/romania/Raport_HIC_engleza.pdf. The most vulnerable communities were selected from eight counties of Romania's poorest region – the North-East region.

conducting a census to identify 'invisible' children and their vulnerabilities, ii) identifying and implementing solutions/services to meet the assessed needs of children and their families (services were delivered as part of a minimum package of services which underwent several adjustments during project implementation, based on the formative evaluation recommendations), with CCS support. Under GDSACP supervision, these workers delivered basic social services to nearly 3,000 'invisible'[32] children identified during the first year of implementation (2011), which represented 2.7 percent of all children in the target communes, addressing key bottlenecks for an equitable child-friendly social protection system.

Given the lack of national-level methodologies and tools to guide professionals in the identification of vulnerable children, the project developed and tested its own tools (including electronic versions) and procedures/methodologies for use in collecting, storing and updating the information on households that was being gathered during fieldwork. Although steps to ensure a unitary approach were taken (i.e. standardised tools and procedures, training of social workers etc.), previous formative evaluations highlighted the risk of biased interpretation during data collection and subsequent data recording errors.

After the first formative evaluation (2012)[33], several adjustments such as geographical coverage being reduced to 64 communes (leaving the other 32 as counterfactual for future evaluations) and definition of a minimum package of services were incorporated within the modelling project, while the focus of social workers' interventions shifted from community census for identifying needs and evaluating vulnerabilities of children and their families to delivery of basic social services for the identified vulnerable children. A minimum package of services relying on community resources started being tested. The community-based package with a preventive role was modelled and delivered by the end of 2012 to 5,700 'invisible' children and their families. It included the following seven categories of basic social services: identification, needs assessment, information and education, counselling, accompaniment and support, referral, and monitoring and evaluation. At county level, the main activity was increasing the capacity of the GDSACP and, later on, of the DPH supervisors, with the aim of strengthening their methodological support to professionals working in the local communities and in the CCSs.

Starting 2013, the modelling project aimed at developing community-based basic social services and initially called "Helping the 'Invisible' Children" was renamed "First Priority: No More 'Invisible' Children!". The second formative evaluation (2013)[34] provided recommendations for further adjustments to the project, such as: i) concentrating the geographical coverage to only 32 communes; Ii) modelling integrated services by adding a community health care component[35] to the social assistance provided by social workers; iii) awarding micro-grants to all 32 communes in the project; iv) introducing a methodology for the identification of invisible children and for case management, and v) new interventions addressing improved knowledge, attitudes and practices that impact the development and protection of children and adolescents, with a focus on reducing all forms of violence against children within family and community. It also strengthened advocacy for addressing bottlenecks and increasing impact of social protection and health policies for poor and most vulnerable children and families.

In this context, in 2013, 2014 and 2015 until September, the demonstration project was implemented in 32 communes of the 8 selected counties. The Theory of Change[36], objectives and specific activities were once more refined after several consultation processes at national, county, and local level. Main adjustments focused on the definition of a new methodology for the identification and diagnostic of vulnerabilities and on its use by social workers (data validation, training, database design, monitoring and evaluation). To this end, the Aurora methodology was introduced as a tool to ensure a unitary approach to the identification

32 'Invisible' children are those who are "disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children" (SOWC 2006, UNICEF, p. 35)

33 Stănculescu, M. S. (coord.), 2012, *Helping the invisible children – Evaluation Report*. UNICEF, Bucharest. Available at: https://www.unicef.org/romania/Raport_HIC_engleza.pdf

34 Stănculescu, M. S. (coord.), 2013, *Helping the 'invisible' children – Second Evaluation Report*. UNICEF, Bucharest. Available at: *https://www.unicef.org/romania/HIC.eng.web.pdf*

35 In 2012, in parallel with the modelling project, another initiative was launched to help increase access to community health care, focusing rather on policy advocacy and on refining the legal and regulatory frameworks for community health care.

36 The initial theory of change can be found in the Second evaluation report, Stănculescu, M. S. (coord.), 2013, pp. 23–25.

of vulnerabilities by all community professionals and across all communities and facilitate the generation of an integrated service plan for children and their families to be provided by the community professionals. This methodology was developed by CERME, with CPSS support, following the findings and recommendations of the previous formative evaluations of the project and based on fieldwork evidence. Also, a technical team[37] of software engineers was involved in order to translate all indicators and algorythms into a useful and easy-to-use tool. The **Aurora methodology** is put into practice via two distinct components, namely: i) the Aurora mobile application, a software component set up on a tablet computer, which is used by community workers in their field work and which contains an interview guide for collecting data on all the members of a household, generates a diagnostic of the household children's and women's vulnerabilities, and suggests a basic services package, while providing local professionals with a useful case management tool; ii) the Aurora web-based platform, which provides data aggregation at local, county and national levels and generates reports for activity monitoring and evaluation purposes as well as in support of interventions, projects, policies etc.

The demonstration project was defined so as to allow for national scale-up and to gradually address key bottlenecks in the Romanian child protection system, in terms of legislative provisions, institutional design, resource allocation, monitoring and evaluation. Of note is that the common element across all demonstration project activities was the professionals' active presence among the vulnerable households and the participation of children, adolescents and their parents and families, as opposed to the deskwork that prevailed within the mayoralty prior to starting project implementation.

Not least, the Exit Strategy developed in 2015 for the modelling project in consultation with major stakeholders was a planning tool which outlined the achievements until end of 2014 and identified interventions required until end of 2015, as well as a strategic road map for continuing advocacy for mainstreaming the evidence generated by the model into national policies and practices, funded by state and/or local budget or European funding. Moreover, the exercise of developing the exit strategy also highlighted barriers and bottlenecks identified in the determinant analysis performed for the child protection intermediate results of the 2013–2017 Country Programme[38]. Those results were only partially addressed through the modelling project, but had a significant influence especially on the sustainability and scaling up objectives that were incorporated into the Mid-Term Review process and report adjusting the Cooperation Programme for 2016, 2017 and beyond.

1.2.3. Project underlying assumptions and risks

A series of underlying assumptions that were developed and tested thru the "First Priority: No More 'Invisible' Children!" project, as well as associated risks, were highlighted during the development of the present evaluation, particularly in the focus groups conducted with the main stakeholders. These include:

– Harmonised capacity and understanding of concepts, tools and procedures used in the project at local and county level.

  Given the available adequately-trained human resources at local level, as well as the varying social assistance practices, UNICEF underlined the different degree of uptake of new intervention methodologies. In this respect, one needs to consider community professionals' distinct capacity to acquire the training they receive under the project with regard to the common methodology and tools to be used, and, based on that, to carry out fieldwork, identify vulnerabilities and deliver services in a coherent and unitary manner.

– Natural, smooth and effortless acceptance and processing of novelties introduced by the project, as well as of the modelling according to the ToC.

37 The technical team involved in the development of the technical component of Aurora consisted of software engineers Andrei Blaj, Alexandru Artimon and Cătălin Moroşan.

38 National integrated social protection system and other stakeholders provide effective quality continuum of services, and support protective norms and behaviours for children and families, with special focus on protection against and prevention of any form of violence, especially child-family separation.

Although some of the model components were easily accepted and applied, others required sustained effort. For instance, integrating the social/outreach worker's activities with those of the community health nurse received opposition among various stakeholders, despite the fact that this was approached via a multitude of activities designed to increase the capacity and cohesion of the intervention delivered by the two categories of specialists.

– Harmonised practice at county level in terms of supervision and methodological support to local professionals.

  UNICEF identified a series of county institutional practices which are the outcome of varying biased and bureaucratic factors, given the system being organised based on the principle of decentralisation.

– Development and testing of a minimum package of services to help reduce pressure on the child protection system and on the healthcare system.

  Both UNICEF and implementation partners underlined that the evidence generated by the project proved the development and delivery of prevention-focused community-based services can lead to increased awareness of risks and vulnerabilities, which actually precedes a rise in the pressure on specialised services.

– Increased impact of national policies can be obtained in a relatively short period of time.

  Given the context in which UNICEF carried out its advocacy activities for policy change, it became clear that volatile policy commitments and frequent priority changes need to be considered when estimating the extent of the outcome impact. Moreover, local stakeholders' commitment level is a risk likely to affect intervention in the community, particularly the mayor's openness towards social problems, the understanding of professionals' active role within the community, as well as the CCS members' involvement in supporting the community team's work.

– Changing social norms, a phase not initially included in the project or the ToC, is key in obtaining results.

  Changing attitudes and behaviours requires time and significant resources. While knowledge can be improved in a relatively short period of time such as the duration of a project's implementation, behaviour change requires lengthy intervention. Also, addressing attitudes and behaviours needs to be a key priority later on, in a long-term scaling up approach.

Focus group with the main stakeholders showed that children's needs and vulnerabilities have become visible enough to the professionals involved in the modelling project, but also to the local authorities. Nevertheless, in the absence of nationally regulated methodologies and tools, needs assessment depends on the understanding and implementation capacity of the locally available staffing whose initial training varies a great deal.

In addition to the resistance towards integrating/combining social and health activities mentioned above, the lack of funding in view of nationwide scaling up could slow down the multidisciplinary approach proposed under the ToC. According to the focus group participants, the presence and integrated activity of social/outreach workers and community health nurses will not be possible without sustained reform and long-term strategy.

1.2.4. Main findings and recommendations of previous evaluations

According to the first formative evaluation, the initial assumption underlying the model proved relevant and the approach effective and efficient, both in project partners' opinion and in relation to performance indicators.

Identification of vulnerable children, 'invisible' to the child protection system or to the health care system, as well as identification of new vulnerabilities among children already in a form of public care represented

the main strength of the modelling project first phase (2011) and continued as a consistent activity until project completion. First formative evaluation[39] showed that the number of vulnerable children was significantly higher in project communities versus communities that were not part of the project, which increased the official statistics and, as a result, the system's efficiency in terms of bringing to light the unknown cases of children in need of support. However, the process by which vulnerabilities were identified was affected by a series of factors such as the lack of specialised human resources within the SPAS in rural areas, the bureaucratic overburdening of the available staff, social workers' lack of fieldwork practice, the existing social norms and high tolerance towards abuse, violence and poverty.

According to the second formative evaluation, in 2012, after service delivery started being tested in the project, service coverage was important, but overall performance was rather low, particularly due to the poor connection between diagnosed vulnerabilities and services delivered. Even so, in 2012, in the project, 75 percent of the cases of 'invisible' children changed for the better or were solved. Furthermore, in the intervention communities, 82 percent of the 'invisible' children belonged to a household which had good or very good relations with the social/outreach worker and was satisfied or very satisfied with that professional's work.

The second formative evaluation[40] also showed that the modelling project remained highly relevant and efficient, though effectiveness and sustainability posed problems. In terms of costs, the costs per child in a day care centre are three times higher than the prevention costs demonstrated by the project, while residential care is at least ten times more expensive, which makes the project highly efficient. The same evaluation showed there is clear evidence to support the argument that community-based prevention services are more effective and considerably more affordable not only in theory, but also in everyday practice.

Availability of human resources at community and county levels was regarded as highly important for the project. The project proved that implementation of a minimum package of services is possible even with a network of less experienced social workers. However, to improve project performance, social workers require better continuous training, increased county-level methodological support, as well as tools, guides and procedures to enhance their work. County coordination of social workers should be accompanied by central-level constant monitoring, key in reducing the significant performance differences between counties.

Project activities activated the CCSs and showed that these structures can be efficient in identifying local solutions for vulnerable children, even though clearer operational procedures and detailed responsibilities are required. On the other hand, whether the CCSs continue to remain functional after project completion depends, to a certain extent, on the availability of the local professionals trained in the project.

Micro-grants for community projects, as well as financing of the GDSACP Resource Centres registered a highly positive impact, and the recommendations of the second formative evaluation were to maintain the financial support for these activities. Nevertheless, the evaluation also pointed out that, given the current budget allocation to the GDSACPs, maintaining the centres is not going to be easy once the project ends, and extending their activity to all the SPAS in the county would require significant efforts, in terms of new regulations, working procedures and the distribution of the input on the part of the GDSACPs and the mayoralties in rural areas to ensure these county centres keep running.

Last but not least, considering the integrated approach promoted by the modelling project, the formative evaluations drew attention to the need to improve inter-institutional cooperation. Vertical and horizontal cooperation and coordination among structures, professionals and decision-makers is key.

39 Stănculescu, M. S. (coord.), 2012
40 Stănculescu, M. S. (coord.), 2013

2. SUMMATIVE EVALUATION OVERVIEW

Key evaluation elements

The summative evaluation provides partners and decision-makers at all levels with the evidence required to replicate the intervention model at the community level. The evaluation also brings evidence to support advocacy for the transition towards community-based accessible, sustainable and child rights-centred integrated services and formulates recommendations for further action related to the sustainability, scaling up and mainstreaming of the minimum package of services at national level.

At the same time, the evaluation will help UNICEF adjust its new "Social inclusion through the provision of integrated services at community level" project, currently undergoing implementation in 45 communities of 38 rural and urban localities in Bacău County.

2.1.1. Evaluation objectives

The overall goal of the present summative evaluation is to assess the impact of the "First Priority: No More 'Invisible' Children!" demonstration project in addressing the challenges faced by children and their families from rural areas, particularly disadvantaged communities, in accessing basic services. The evaluation also aims to address the evaluation questions, based on the following OECD-DAC criteria: relevance, effectiveness, efficiency, sustainability, impact and lessons learned.

According to its Terms of Reference (Annex 3), this evaluation will independently assess:

– the impact of the modelling project and the extent to which the intervention and all its components have contributed to improving children's welfare through enhanced access of children and their families to basic social services (education, health, and social assistance services), particularly in the selected rural disadvantaged areas;

– whether the modelling intervention was relevant to the target group, as well as in the national and international contexts;

– how results and evidence generated by the model contributed to improving the impact of social protection policies on the poorest and most vulnerable children and families in Romania;

– effectiveness in terms of results obtained during project implementation;

– the lessons learned, key bottlenecks and good practices;

– how efficient the model was in developing new services and improving the life of children and their families;

– how effective the model was in producing the expected results;

– sustainability of model at the local, county and national levels;

– the extent to which the model could be replicated at national level through the revision and/or development of the normative framework, standards, methodologies, budgets etc.

2.1.2. Evaluation coverage

The evaluation is designed to cover the entire project implementation period, namely **April 2011 – September 2015**, based on the ToC and all the adjustments that occurred during this timeframe. The evaluation will also consider the key findings of the previous two formative evaluations conducted in 2012 and 2013.

To assess which of the outputs and outcomes are due to implementation of the modelling project, the summative evaluation focused on the **32 intervention communes** which were active all throughout the project until its completion and which included the children and their families who were identified through out-

reach work and received the minimum package of services, while also considering the **32 control communes in which the modelling intervention was implemented in 2011 only** (the community census which provided the baseline for the 'invisible' children) and where, as a result, children and their families received only SPAS services. The control group provides useful information in determining what would have happened to the individuals in the intervention communes had they not received the services and support ensured by the modelling project.

2.1.3. Evaluation questions

To address the evaluation objectives and considering the OECD-DAC evaluation criteria, the Terms of Reference for the summative evaluation defined 19 questions corresponding to the six evaluation criteria. Previous formative evaluations examined the relevance, effectiveness and efficiency of the project, and the second formative evaluation also assessed the impact. The present summative evaluation, which covered the entire period of project implementation, assess relevance, effectiveness, efficiency as well as sustainability, impact and lessons learned.

For each of the evaluation questions, the report sections on evaluation findings will provide a brief account of specific approaches to facilitate the reading of the evaluation text. The evaluation questions for the present summative evaluation are provided below, organised per evaluation criteria:

Relevance

– To what extent does the modelling project address the needs of the most vulnerable children and reduction of inequities (with reference to the 'invisible' children)?

– To what extent is the model relevant vis-à-vis the overall goal and the achievement of its expected outputs and outcomes in the given period of time?

– To what extent is the modelling project relevant to national policies, programmes (including National Reform Programme and ESF Programme 2014–2020), sectoral and cross-sectoral strategies and to UNICEF's Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) Regional Knowledge and Leadership Agenda (RKLA) Results Areas on a child's right to a supportive and caring family environment, as well as on a young child's right to comprehensive well-being and a child's right to social protection?

Effectiveness

– Does the modelling project contribute to the realisation of child rights (by vulnerabilities)? Does the minimum package of services address all vulnerabilities? Which component was most successful? Is there added value resulting from the integrated approach?

– Does the modelling project help develop local authority capacity to deliver the minimum package of integrated services (compared to the 32 communities where model interventions occurred only in 2011)?

– Does the modelling project contribute to reducing the pressure on the child care system? And on the health care system?

– Does the modelling project help strengthen national strategies and focus on prevention of child-family separation? And on prevention of violence against children?

Efficiency

– Does the modelling project use resources in the most economical/efficient manner to achieve expected results? What are the benefits of the integrated approach from a financial point of view?

– How do project costs compare to those of other similar programmes or standards?

– How efficient was the model in terms of results for the recipients of the minimum package of services and of social benefits compared to individuals who received only social benefits?

– What are the cost implications of scaling up? What are the implications in terms of national mainstreaming?

Sustainability

– To what extent is the current context more or less favourable to continuing such approaches in the near future?

– Are modelled interventions and impact on the most vulnerable children likely to continue when external support is withdrawn?

– Is the modelling project replicable? As a whole or only certain components? At local, county or national level? What are the prerequisites for replication? Are any model adjustments required to enable replication?

– What recommendations could be made to UNICEF and to the Government of Romania with regard to replicating and scaling up such a model?

Impact

– What change did the modelling project determine or influence for beneficiaries (children and their families), communities, professionals, public government – at local, county and/or national level?

– To what extent did the modelling project increase institutional capacities to ensure that the most vulnerable benefit from the minimum package of services in a way which contributes to prevention of child-family separation and prevention of violence against children?

– To what extent has the modelling project increased the impact of social protection policies for the poor and most vulnerable children?

Lessons learned and unexpected outcomes

– What are the lessons learned at each level of intervention that should be taken into account for further modelling projects and action related to scaling up and mainstreaming the minimum package of prevention-centred services at national level?

– Are there any unexpected outcomes worth considering for reducing capacity gaps and/or addressing remaining bottlenecks?

2.1.4. Approach to stakeholder engagement

Demonstration project stakeholder groups include representatives at the following levels: 'invisible' children and their families, local, county and national level. All stakeholders participated in the summative evaluation via discussions, consultations, comments on draft deliverables, and some are expected to provide feedback to the recommendations made by the evaluation in the management response.

Table 5. Stakeholders and approach to their involvement in the summative evaluation

Level covered	Stakeholders	Approach (methods used to involve stakeholders in the evaluation)
'Invisible' children and their families	'Invisible' children (0–17 years old)	Workshops for children Household survey Interviews
Local level	Community professionals	Interviews Focus groups at local level LPA survey

Level covered	Stakeholders	Approach (methods used to involve stakeholders in the evaluation)
County level	GDSACP supervisors DPH supervisors	Interviews
National level	Public governmental institutions: MoLFSPE NAPCRA MoH Non-governmental institutions and organisations: CERME CPSS PSI	Focus group at national level Interviews

2.2. Evaluation methodology

2.2.1. General approach, by evaluation phases

The evaluation methodology was developed in the inception phase of the evaluation process and took into account the evaluation goal and questions. The methodology aimed to reflect the views of all partners and stakeholders at all levels, ensuring a participatory approach to the evaluation as well as data triangulation for information verification and validation purposes. The evaluation matrix (Annex 5) shows specific linkages between evaluation questions, methodology – mixed quantitative and qualitative methods – and data sources, including selected evaluation indicators. The entire evaluation approach followed a phase design, a specific methodology being developed for each phase. The following is an overview of the steps taken in preparation of the present report. The overview groups the steps taken in the first two evaluation phases (inception and desk review), representing the evaluation planning stage, and the data collection and analysis phases, for each research method employed, in order to enable a unitary view of the strategy used in the evaluation for each and every method.

The evaluation applied the UNEG standards and guidelines regarding the evaluation criteria[41] and the ethical approach to evaluation[42], including the UNICEF Procedure for Ethical Standards in Research, Evaluation, and Data Collection and Analysis (effective as of 1st April 2015), in order to ensure quality of evaluation process.

Figure 4. Evaluation phases, activities and deliverables

Inception phase	Desk review	Data collection	Data analysis	Reporting	Dissemination
Initial meeting Initial focus group Drafting of inception report	Key literature and information review Development of research tools	Pre-testing of collection tools Field data collection	Detailed analysis of collected data	Report preparation, submission and review according to suggestions received	Development of communication materials and dissemination Launch of evaluation report
Inception report	Evaluation background Research tools	Pre-testing report Databases Collected data/ information	Case studies Analyzed data	Draft evaluation report PPT presentation Final evaluation report	Advocacy document Dissemination meeting

41 UNEG Norms for Evaluation in the UN System. 2005, available at: http://www.uneval.org/document/download/562
42 UNEG Ethical Guidelines for Evaluation. 2008, available at: http://www.uneval.org/document/download/548

2.2.2. Inception phase, desk review and research tool development

2.2.2.1. Inception phase

To confirm and clarify the evaluation objectives, the methodology to be used in data collection and analysis, and the project in-the-field environment at the time of initiation of the evaluation process, the evaluation team used the inception phase to prepare a series of key evaluation documents, of which the evaluation matrix is the most important, and to plan the experts' detailed activities and duties. The documents were designed following a first review of publicly available and UNICEF-provided relevant literature and information materials, as well as on the basis of the meetings between UNICEF and the team of evaluation experts.

At the same time, to verify and validate the working hypotheses as well as the feasibility of the methodology that was proposed in the inception phase, a focus group was conducted (in April 2016) for the national stakeholders concerned with the model implementation and results. The list of focus group participants is available in Annex 8 to the present report.

From the outset, the focus group demonstrated the demonstration project relevance to and capacity to shape several national strategies and their implementation, given that the plans for their implementation are regarded as rather vague. As such, according to the focus group participants, the activities developed and tested during the UNICEF demonstration project need to be included into the action plans for those strategies. The same focus group underlined the need to identify project-related challenges and bottlenecks so as to enable the planning of more effective and sustainable future interventions at national level.

Following the focus group, the team prepared the inception report, which included an overview of the evaluation background, evaluation strategy, matrix and methods, data sources and indicators. The inception report was submitted on 30 April 2016 for review and the final version was submitted on 30 May 2016.

2.2.2.2. Desk review and research tool development

In the desk review phase, the team reviewed the main model documents and main documents describing the model background, and developed their research tools. The desk review served as basis for designing the field research tools and analysing the evaluation background. The relevant literature and information review (together with the interviews conducted) also helped answer the evaluation questions on project relevance, effectiveness and impact in relation to national, European and international public policies, as well as on model efficiency. Not least, the desk review enabled the formulation of findings and conclusions regarding project performance in relation to the limitations of social assistance, child protection and community health care systems. A full list of the documentation consulted in this phase is available in Annex 4 – Bibliography, including: i) national legislation, policies, action plans, county and local strategies; ii) previous formative evaluations of the modelling project, as well as other studies and research conducted during project implementation; iii) UNICEF programme materials (e.g. country programme documents, strategies, RKLA Results Areas, project proposals and reports to donors); iv) modelling project documents such as reports of community workers and supervisors and reports on the micro-grant implementation by local public authorities.

The desk review phase also identified the main databases used in the current evaluation secondary data analysis, namely:

– database resulting from using the Aurora methodology,

– database of the survey conducted in 2011 under the second formative evaluation of the model,

– consolidated database created by social workers in 2012,

– community data sheets developed in 2011.

Based on the available information and data review, the team developed research tools for each of the field data collection methods that had been envisaged: questionnaires, interview guides, focus group guides, instructions for organising workshops with children, structure of observation reports and case studies. These were revised according to the observations and comments received from the main evaluation beneficiary (UNICEF) and subsequently pre-tested in October 2016.

2.2.3. Data collection and analysis

2.2.3.1. Household survey

The survey focused on 64 communes: 32 intervention communes, and the 32 control communes which had undergone project implementation in 2011 only. Considering that the target population consisted of households with most vulnerable children, designing the representative samples for this population was a complex sub-phase of the evaluation process, as the method that was used was an experimental one. Initially, the survey was designed to cover 1,000 individuals, but in the end, to allow for comparison with previous evaluations, the decision was to conduct a survey whose sampling unit was the household, which entailed data collection from minimum 800 households and information on all household members.

For the **intervention communes**, the sampling targeted the households that had received the intervention and had been recorded in the Aurora database made available to the evaluation team. The sample was random, two-stage, and stratified by number of beneficiaries in each commune. Two villages each for every commune were selected: the village which was the centre of the commune and another village in the commune, where the number of beneficiaries was large enough to enable efficient data collection.

For the **control communes**, the sampling included households similar in structure to those recorded in the Aurora database. The sampling was random, two-stage and stratified using the random path method. Here too, two villages each for every commune were selected, the village which was the centre of the commune and another village belonging to the commune. To ensure similarity of structure to households in the intervention communes, a screening questionnaire was used with 5 simple indicators which could provide a picture of the household situation as basis for sample entry.

The questionnaire that was developed (see Annex 11.1) was pre-tested in Cluj county, in communes with demographic structure similar to the ones in which the demonstration project was implemented, and then adjusted based on the evidence generated in the pre-testing.

The structure of the resulting samples is available in Annex 7. The sample volume for intervention communes was 428 households, and the one for control communes was 415 households. Data were collected on all household members, namely 4,243 individuals. Given the form of research tool used and the type of questions included in the questionnaire, it must be noted that the survey generated two databases: a database of households and a database of household members.

Maximum margin of survey error is +/– 3.4 percent at 95 percent confidence level, and 4.7 percent at the intervention sample and control sample level (minimum 95 percent confidence level).

During October – December 2016, trained field interviewers conducted data collection through face-to-face household interviews with the child carer.

The screening procedure used in selecting individuals for the control sample resulted in a sample structure similar to that of the target sample. Nevertheless, due to the different selection procedure used for the two samples, variables like the number of individuals living in the household, ethnicity, and gender of reference person registered certain statistically significant differences, which led to the need to weigh the data. Weighing was carried out based on the structure of the data recorded in the Aurora database at T0 moment in time. For data comparability, both databases were weighted (households database and household members database):

– weighing of the databases of 843 households occurred using the Aurora database structure, according to: main respondent, household size (number of persons living in the household) and ethnicity;

– weighing of the databases of 4,243 individuals occurred using the Aurora database structure, according to: age groups, ethnicity and education (highest level of educational attainment, only for individuals over age 9).

Upon drafting the report, the final data following the weighing were analysed especially with regard to children, with special focus on potential differences in terms of their vulnerabilities and services received, by gender, age and ethnicity.

2.2.3.2. Online survey of mayoralties

To assess local authorities' capacity, before and after project implementation, to provide prevention-based social and community health care services, an online survey was conducted in all 64 communes (32 in the intervention group and 32 in the control group). The research tool developed for this purpose (see Annex 11.2) was uploaded on the Surveygizmo e-platform and the link was communicated via e-mail to mayoralties in the 64 communes, together with the fill-in request and instructions.

The response rate was very low. Of the 44 mayoralties which responded to the evaluation team requests, only 20 completed the full questionnaire – 17 from the intervention communes and only 3 from the control communes.

Given the low response rate (32 percent), the results of this survey were not used as they could not have been extended to all the communes. More about this will follow in the section on the limitations of the present evaluation.

2.2.3.3. Interviews

To ensure data triangulation, interviews were conducted at all levels of modelling project implementation, according to the ToC, as follows: i) at the level of children and their families, interviews were conducted with parents of vulnerable children who received the intervention; ii) at local level, both in the intervention and the control communes, interviews were conducted with local professionals (social workers and community health nurses); iii) at county level, interviews were conducted with county supervisors from GDSACP and DPH in the 8 project counties; iv) at national level, interviews were conducted with partners and decision-makers, as shown in the table below.

Table 6. Interviews conducted

Level	'Invisible' children and their families **32 communes**	Local level **8 counties, 32 intervention communes and 32 control communes**	County level **8 counties**	National level **Representatives of the following institutions[43]:**
Stakeholders	14 interviews with parents[44]	27 interviews with social workers from project communes 14 interviews with community health nurses from project communes[45] 16 interviews with social workers from control communes	8 GDSACP county supervisors who participated in the project 7 DPH county supervisors who participated in the project[46]	– MoLSJ – NAPCRA – MoH – MoYS – UNICEF – 3 interviews during the evaluation inception phase – CERME – CPSS – PSI
Number of interviews	**14 interviews** with parents	**57 interviews** with social/ outreach workers and community health nurses	**16 interviews** (2 interviews * 8 counties)	**10 interviews** (1 interview with each of the 7 stakeholders and 3 interviews with UNICEF)[47]

Separate research tools were developed for each level and are presented in more detail in Annexes 11.3 – 11.8. Considering the different situations and aspects targeted by the summative evaluation, semi-structured interview guides were used. Where interviewees provided their consent, the discussions were recorded.

The interviews per se were conducted during September – December 2016 by evaluation team experts.

2.2.3.4. Focus groups

During the inception phase of the evaluation (prior to drafting the inception report), a first focus group was organised with representatives of public authorities, project partners and other non-governmental organisations working in the field of child protection.

In the communities in which the project was implemented, the focus groups were conducted in an intervention commune selected from each of the 8 counties, therefore, overall, 8 focus groups took place. Focus group participants included relevant community stakeholders such as local professionals involved in the project (social/outreach worker and community health nurse), mayoralty representatives, CCS members, other local professionals and NGO representatives. The local-level focus group guide is available in Annex 11.9. Each focus group with a duration of 2 to 3 hours had 2 to 10 participants.

Throughout the process, county supervisors provided their full support to the organisation of the focus groups, both in terms of logistics and provision of recommendations and suggestions.

To validate the evaluation report, the plan included two focus groups with experts (expert panels), with representatives of decision-makers and with representatives of NGOs involved in child protection. Given how long the evaluation itself had taken and the fact that the same factors had been consulted both in the inception phase and in the data collection phase, the evaluation team and UNICEF decided to organise one expert panel in one of the counties in which the model had been implemented, involving the implementation partners and stakeholders at county level, organized in July 2017 in Suceava County.

2.2.3.5. Workshops with children

In order to learn about the views of the 'invisible' children who had received the model intervention, 8 workshops were organised, one in each county, involving adolescents aged between 10 and 17 years whose parents had provided written consent. The workshop guide is available in Annex 11.10.

The workshops were organised by the evaluation experts during the field visit stage, each workshop being attended, on average, by 10 children. Although several techniques were considered initially, in the end the choice was to use only the collage technique – children were asked to illustrate their life by creating and presenting a poster. An analysis of the collages the children prepared served to identify issues related to project effectiveness and impact.

2.2.3.6. Observation

Evaluation experts prepared observation reports in all the 32 intervention communes. The observation report structure is available in Annex 11.11. The information obtained provided background/contextual data and clarified certain issues related to the local model implementation environment, where necessary.

2.2.3.7. Case studies

The present evaluation design also included 8 case studies, each of them focusing on a commune, from each of the eight counties, where the intervention occurred until the very end of the project (September 2015). Case studies followed a unified format available in Annex 10. Although at first, the selection criteria was the number of vulnerable children in the community, in the end, the case studies were conducted in those communities which provided most information during the research – i.e. where interviews with the authorities, with social/outreach workers and with parents were conducted, as well as focus groups and workshops with children.

2.2.3.8. Secondary data analysis

In addition to the data collected for the present evaluation, the analysis also covered quantitative data, such as:

– 2011 database of children – results of the first formative evaluation;

– 2013 database of children – results of the second formative evaluation;

– Aurora database – covering 2014–2016 period (including the period after the end of the demonstration project);

– database of entries and exits into/out of the child protection system, in the intervention and control communes – made available by UNICEF, collected with the support of the GDSACP supervisors (the structure of this database is available in Annex 12.1);

– data on the work of the community health nurses, in the intervention and control communes (Botoșani county) – made available by UNICEF, collected with the support of the DPH supervisor (the structure of this database is available in Annex 12.2).

2.2.4. Limitations of the summative evaluation

As early as the inception of the present summative evaluation, the evaluation team identified the main risks and potential limitations of the undertaking. Most of these referred to the availability/participation of stakeholders at different levels (representatives of local authorities from the control communes, CCS members from the intervention communes, parents etc.), which, however, did not pose a problem. Still, as the evaluation advanced, the evaluation team encountered other risks which are presented next, together with the solutions that were identified and the decisions that were made.

The evaluation covered the entire period of project implementation and had to address all changes and adjustments that occurred during that period. Thus, a limitation of the summative evaluation stems from the discontinuity of project activities and the changes to the methodology and tools that were used in the intervention, changes that were designed to improve the activity flow, but which also affected its evaluability.

The format of the ToC, which provides a clear picture of the logical structure in which outputs and outcomes are to be achieved via project activities, was translated into the evaluation matrix for the purposes of the present evaluation. During the summative evaluation, due to clarification of certain model components and identification of details that could not be captured into the schematics of the ToC, the evaluation team had to make changes to the evaluation matrix, which were endorsed by UNICEF and reflected accordingly.

In terms of data collection for the summative evaluation, both qualitative and quantitative data collection methods were used. Whereas data collection through qualitative methods posed no problems, data collection via surveys raised a series of challenges. One such challenge was the online survey conducted in all the 64 communes for the purpose of assessing the local institutional capacity for service delivery. Even though refusal to participate in the survey was an issue that the evaluation team considered from the start, taking additional steps to increase participation of targeted respondents, including by contacting a large number of mayoralties directly and by phone, the overall response rate was very low (only 20 questionnaires were fully completed). As a result, with UNICEF approval, the team decided not to use the results of this survey as they could not be extended to all the communes.

Next, the survey conducted among children and their households targeted both the intervention communes and the control communes. Given the differences between the two types of communes, the evaluation team had to use different sampling procedures. For the intervention communes, the survey focused on the households which received the intervention and were recorded in the Aurora database. In the control communes, a standard random sampling procedure would not have yielded a sample similar to the one in the other communes, which is why the experimental path was taken, and, to ensure a structure similar to that of the households recorded in the Aurora, a screening questionnaire was used with 5 simple indicators which could provide a picture of the household status, particularly of the household children. However, despite all these measures, the two samples still presented statistically significant differences, leading to problems of data comparability for the two types of communes. To address these problems, the data were weighted so that the databases, both the one for households and the one for household members, would

match the Aurora data structure. Here, one needs to mention that data weighing has its own limitations and accuracy can be affected in certain cases.

Analysis of some of the project components, such as the micro-grant-funded projects, even if included in the evaluation matrix, could be carried out only partially. The evaluation team showed that the reports about these components which were going to be used in the analysis are proof that community workers and county supervisors required additional project management training in order to enable proper assessment of the component effectiveness.

Provision of answers to the evaluation questions was limited by the availability of some of the data for analysis. Thus, one problem was encountered in addressing the question on model efficiency which involved comparing individuals who received both social services and social benefits versus individuals who received only social benefits. The lack of national data and studies in this area made it difficult to conduct the analysis. As a consequence, the evaluation was based only on qualitative data which are rather about the perception of the stakeholders (beneficiaries, representatives of local or county authorities etc.).

Another limitation of the present evaluation referred to answering the question about the pressure on the child care system and on the health care system. For this analysis, UNICEF made available the data obtained from the GDSACP in the 8 counties and from the DPH in one county. The available data from the county institutions were not conclusive as far as the purpose of the present evaluation was concerned and the evaluation question could be answered only in part.

Moreover, one must take into account the difficulty to separate the modelling project outputs and outcomes from the outcomes of policies or interventions developed by non-governmental organisations or other entities also targeting children and their families. As a result, the analysis of the project implemented between 2011 and 2015 is, in fact, an analysis of the combined context and outcomes of several interventions, such as the School Attendance Initiative developed by UNICEF to increase school participation, the national programme to develop preventive health care services in rural areas, or the projects of various NGO, all these being interventions implemented in certain communities only and not necessarily coordinated. Nevertheless, the use of the control communes in analysing the situation of children and their families allowed for a delimitation of the modelling project outputs and outcomes.

3. EVALUATION RESULTS

Evaluation results are outlined based on the evaluation criteria and questions. At the same time, the presentation of the relevant data is structured according to the ToC logic, intervention levels (children and their families, community, county and national levels) and expected outputs and outcomes.

3.1. Relevance of "First priority: no more 'invisible' children!"

The evaluation of relevance refers to the extent to which the modelling project objectives meet the needs and priorities of its stakeholders and beneficiaries, as well as the extent to which the model fits the wider context of national, regional and international public policies in the field. Thus, relevance assessment looks into the validity of the model objectives in relation to the needs of its target groups, the coherence and cohesion of the activities, the expected results and the stated goal of the intervention with its long-term outcomes.

3.1.1. Model relevance in relation to increasing the impact of social protection policies on vulnerable children and their families

To what extent is the model relevant vis-à-vis the overall goal and the achievement of its expected outputs and outcomes in the given period of time?

This evaluation question requires an analysis of the intervention logic proposed by the ToC developed for the model. To answer this evaluation question we referred to the logical connection between the identified needs, the delivered services, and the expected outputs and outcomes, as defined in the ToC, both at the individual level of children and their families and at the community and county level, with indirect impact for children.

3.1.1.1. Model coherence at the level of 'invisible' children and their families

To identify the needs of children and their families and to verify whether there really are 'invisible' children, the first project phase (in 2011) consisted of identifying and assessing the needs of all children and their families by conducting a community census. The project set off from the hypothesis (confirmed by the interviews carried out during the present evaluation) that in order to ensure an adequate intervention to address the existing social problems by delivering prevention services, it is vital to identify and assess the vulnerabilities of children and their families. As such, the inception phase served to ensure the proper framework for delivering prevention social services to children and their families, starting 2012. Thus, according to the project workplan, at least one year passed between the time when vulnerable children's needs were first assessed and the time when the services for children and their families started being delivered, one year during which the initially-identified needs and vulnerabilities could have changed. The project proves relevant as the comprehensive needs assessment was constantly central to the model intervention logic, a component which underwent refining all throughout project implementation, as well as support once the Aurora working methodology was introduced in 2014.

The ToC elements, described in the table below, are clear and follow a logical sequence. The systematic assessment of children's situation leads to the elimination of "invisibility" cases, in that vulnerabilities are identified and addressed through community-based interventions.

Figure 5. 2011 Theory of Change at the level of 'invisible' children and their families

Inputs / Activities	**Assess the situation of children and their families**, targeting: 1. Children living in large families, in poverty and precarious housing conditions; 2. Children left behind by migrant parents and living in poverty or other difficult situations; 3. Children at risk of neglect or abuse; 4. Children with suspicion of severe illness; 5. Children who were relinquished or at risk of being relinquished; 6. Out of school children and children at risk of school dropout; 7. Adolescent mothers who left school and/or are at risk of relinquishing their newborn; 8. Children without ID papers or documents; 9. Other cases of vulnerable children	**Plan** services, including: 1. An individual plan of intervention with all the necessary services; 2. Delivery of the services outlined in the plan; 3. Overall case reassessment.	**Services delivered:** 1. information and counselling services; 2. health services: registration with, appointments and accompanying to the doctor; 3. educational services: enrolment, discussing with teaching staff; 4. services in connection with the right to social protection: counselling and support with preparing the social benefits application file or referral to an NGO; 5. services in connection with the right to an identity: counselling, support, accompaniment; 6. services in connection with the right to grow up in a family: counselling for reintegration into the family.
Outputs	'Invisible' children (and their families) are **identified**	'Invisible' children (and their families) receive **services** Children and their families are **informed** about their rights and entitlements	
Outcomes	I. All children are '**visible**' to their communities and to health, education and social assistance systems	II. All children have **access to health care** III. All children have **access to education** IV. All children are **protected in risky situations**	

Source: UNICEF

Given the way the intervention was designed in the first phase, with a comprehensive community "census", identifying and assessing the situation of all children in the community would have been feasible, enabling all of them, along with their needs, problems and vulnerabilities, to become 'visible'. On the other hand, neither the planning of the services in individual packages, nor the list of services in the form it was drafted can guarantee that access to health care and education and to protection in situations of risk will be ensured for all children, not when dealing with large communities – with hundreds of vulnerable children – where children have multiple vulnerabilities or where the supply of locally-available services is reduced.

Services for each child and family were planned by preparing individualised plans (which included service delivery and case reassessment). In addition to information and counselling services, the list of services initially designed according to the intervention logic as basis for preparing the individualised plans of intervention also included services connected with registering, appointments with and accompanying one to the doctor; support for preparing the documentation required in order to receive various social benefits; referral to NGOs that provide other services or benefits; support and accompaniment to obtain identification papers etc. Service provision leads to the expected output provided in the Theory of Change: 'invisible' children (and their families) receive services. Considering the findings/recommendations of previous formative evaluations[43], as of 2013, the Aurora methodology was developed and tested, establishing a logical connection between the identified vulnerabilities and the services recommended for delivery, services which were being organised automatically into a minimum package of basic services.

43 Stănculescu, M. S. (coord.), 2012, pp. 31–41; Stănculescu, M. S. (coord.), 2013, pp. 39–74.

Figure 6. 2013 Theory of Change at the level of 'invisible' children and their families

Inputs / Activities	**Assess vulnerabilities of children and their families, using the Aurora methodology**	**Plan and pre-test services using the Aurora application generated recommendations, by preparing an individual package of services to address multiple vulnerabilities**	**Implement micro-grant projects:** - **training for parents**, - specialised **psychological counselling**, - **non-formal learning** and recreational activities for children etc.
Outputs	Vulnerabilities of 'invisible' children (and their families) are **identified**	'Invisible' children (and their families) receive the **minimum package of services** Children and their families are **informed** about their rights and entitlements and have **access to basic social services**	
Outcomes	I. All children are '**visible**' to their communities and to health, education and social assistance systems	II. All children have **access to health care** III. All children have **access to education** IV. All children are **protected against separation from their family** V. All children are **protected against all forms of violence (including neglect, abuse and exploitation)** VI. All adolescents are **informed about risk behaviours**	

Source: UNICEF

With the introduction of Aurora, of the assessment conducted via the interview guide provided by the application, as well as of the minimum package of services generated by the application to address a complex list of vulnerabilities, the degree of input suitability in relation to the expected outputs and outcomes increased. Moreover, when **analysing the services suggested by Aurora and the projects funded via micro-grants, one can observe that some of the expected long-term outcomes can even be exceeded**. Services included in the minimum package ensured access to basic health care, education and social protection services, as well as accompaniment and support or referral to specialised services. In addition, activities of projects funded through micro-grants allowed for delivery of certain specialised services (i.e. psychological counselling, parental education) which enhanced the outcomes related to reducing vulnerabilities (i.e. reducing risk behaviours).

It can therefore be stated that the short-term outputs were realistically set: identification, service delivery and information. However, according to the project design, the community census was not resumed after the introduction of the Aurora, its focus being to provide a unitary identification of the already active cases and delivery of the minimum package of basic services for children and their families. Hence, there is no guarantee that **all** vulnerable children will be assessed and all will receive basic social services. On the other hand, the number of people having received additional services as a result of the micro-grants – particularly group counselling services – was limited compared to the overall number of vulnerable children and their families targeted by the model. Consequently, the Theory of Change is logic and coherent, and the planned outputs are realistic, but the outcomes that target **all** children were too ambitious.

3.1.1.2. Model coherence at community and county level

Based on the evidence generated and the recommendations of the two previous formative evaluations, the ToC underwent several adjustments between 2011 and 2015, some of which regarded the elements planned for the intervention at community and county level. As such, the number of intervention communities was reduced from 96 to 64 and, later on, to 32, while new activities and components were added, such as the community health care component, the county supervision and the Aurora methodology.

The project is designed to address existing vulnerabilities as identified and presented by professionals in this field. Initially, the intervention logic started from the hypothesis according to which hiring and training additional social/outreach workers to carry out primarily fieldwork/outreach work will help enhance SPAS capacity to meet the needs of children and their families, by increasing the effectiveness of preventive

service delivery. The experience of the first project implementation years revealed the need for working methodologies and tools, therefore various methodologies were developed and tested in the modelling project, and county methodological supervision and support was ensured. As a result, social workers' professional capacity, SPAS administrative capacity, and, generally, community capacity to deliver social services increases, which makes the intervention logic an accurate and coherent one.

Figure 7. 2013 Theory of Change at community level

Inputs / Activities	**Hire and train** 32 social workers Organise **experience exchange** field trips **Facilitate coordination** and integration of social/ outreach worker and CHN activities	Carry out mainly **outreach work and deliver the minimum package of services**	Support development of **project** proposals and micro-grant implementation	Mobilise professionals within the **community consultative structures**
Outputs	Increased **capacity of social workers and CHNs** to identify vulnerable children and their families	**Effective delivery of the minimum package of services**	32 **community counselling and support centres** for children and parents are set up	**32** functional and active **community consultative structures** in place
Outcomes	Improved **community capacity** to deliver social services and community health care services (in 32 rural communities)		**32 community counselling and support centres** for children and parents Around **150,000 people in rural areas are better informed** about child rights as well as family rights and responsibilities	**32** functional **community consultative structures** acting for the worst-off on the basis of local action plans.

Source: UNICEF

One of the activities carried out at the local level was that of mobilising the community consultative structures, which are set in the legislation and assigned a consultative role in ensuring child rights observance and avoiding child-family separation. The ToC hypothesis according to which the presence of professionals at local level is likely to mobilise the CCS members and, as a result, each commune will have a functional and active CSS, is logical and coherent. For these structures to be operational, the interest and involvement of the main local stakeholders is key, as is the information provided to them. The activity of the social workers in keeping the CCS members together and informed and in monitoring the status of the activities proposed in the CCS meetings is both necessary and sufficient to ensure the CCS remain functional.

Coherent is also the intervention logic that connects the activities established for the implementation of the micro-grant projects to the set-up and operation of the counselling and support centres for children and parents (given that these were a direct output of the projects financed through micro-grants as they were planned) and to providing communities with information on child rights and family rights and duties, considering the micro-grant projects included small-scale information campaigns in the targeted communities, as well as information and group counselling activities and non-formal education for children.

The target set to inform 150,000 people involves informing all the inhabitants of the communities in which the modelling project was implemented, with the NIS data showing there were 145,957 inhabitants in the 32 communes of intervention during 2011–2015. However, it is worth noting that, while the ToC was adjusted in relation to the number of intervention communes and community centres, the target number of 150,000 people informed was not also revisited accordingly. Consequently, should any general IEC initiatives undergo an impact assessment, the target group needs redefining so as to match the number of people in the intervention communities.

Figure 8. 2013 Theory of Change at county level

Inputs / Activities	**Train** supervisors from both social and health fields and provide them with tools for monitoring and ensuring methodological guidance at local level Organise **experience exchange**
⇩	
Outputs	Increased capacity of GDSACP and DPH to provide methodological support to local authorities
⇩	
Outcomes	I. Reduced pressure on the child special protection and specialised health services systems (in 8 counties) II. Improved capacity of GDSACP and DPH to provide methodological support to local authorities via the newly established county centres for community support

Source: UNICEF

At county level, the ToC involved increasing the capacity of the GDSACP and DPH to provide methodological support to staff with social assistance and community health care duties at local level, and, in this respect, the ToC is accurate and coherent, given that the model input is training the supervisors, organising experience exchange events and providing them with the Aurora methodology, enabling them to ensure methodological support and guidance to local professionals and to monitor their fieldwork.

On the other hand, there is no direct logical sequence between the 'reduced pressure on the child special protection and specialised health services systems' outcome and the ToC activities for the county level. The intervention logic entails an improved case management at local level and the use of a preventive approach. As such, while reduced pressure on the child protection system is a possible outcome of strengthening activities at the local level, needs assessment can lead to a larger number of cases being identified and, at first, at least until the services for preventing child-family separation prove effective, generating more cases for the specialised services. Only an analysis of the ToC planned outcome in terms of efficiency will allow for formulating a finding in this regard.

3.1.2. Model relevance in relation to the needs of vulnerable children

To what extent does the model address the needs of the most vulnerable children and reduction of inequities for the 'invisible' children?

Analysing the relevance of the model in relation to the needs of its target group involved reviewing the vulnerabilities that had been identified at the beginning of the project, in 2011 and 2012, as well as subsequently, when the Aurora methodology started to be used (as of 2014). Our findings allowed us to determine whether the project did indeed address children's major (most severe) needs.

In answering this evaluation question, we used both quantitative data which required a secondary data analysis as well as a survey data analysis, and qualitative data collected via interviews, focus groups and workshops with children. Using data from different sources and collected through multiple methods allowed us to better understand the relevance of the project: how necessary it was, how welcomed it was, why priority was given to some of the vulnerabilities or needs over others.

3.1.2.1. Relevance of criteria and tools used in the needs assessment

Model development based on evidence in the field – and particularly on the findings and recommendations of the second formative evaluation[44] – entailed changes to the list of vulnerabilities of children, both the list of indicators and especially their definitions undergoing fine-tuning during the 4 years of project implementation. The introduction of Aurora enabled tracking of clear and consistently defined indicators which were measured based on a comprehensive interview guide. The tool was used by all social workers and community health nurses for all members of the households identified.

44 Stănculescu, M. S. (coord.), 2013, pp. 89–98.

All these allow for both an in-depth analysis of the model relevance in relation to the biggest challenges faced by children and their families, and an analysis of the status of these challenges in relation to the other activities undertaken and services delivered.

With regard to the most frequently recorded vulnerabilities, the consolidated database shows that three types of vulnerabilities prevailed among the 'invisible' children, both in 2011 and in 2013, namely: (1) children living in large families, poverty and precarious housing conditions (over 72 percent of the children recorded in the database), (2) children at risk of neglect or abuse (27 percent of the children recorded) and (3) out of school children and children at risk of dropping out of school (more than 17 percent of the children recorded).

How vulnerabilities are defined directly affects the relevance of the interventions designed for children and their families. For instance, in 2011, 73 percent of the 'invisible' children identified by the social workers were living in large families, poverty and precarious housing conditions. However, according to the data of the survey conducted for the second formative evaluation of the model, 26 percent lived in severe poverty, 28 percent lived in income poverty and overcrowded houses, while 46 percent were not poor[45]. Therefore, the evaluation revealed that the number of children living in poverty and precarious housing conditions had been overestimated, both due to the biased assessment of the social workers who had interpreted the household situation based on personal opinion/experience, in the absence of a clear assessment grid and consistent indicator-measurement methods, and to the fact that 'large families' and 'poverty' were compiled into the same composite indicator. Still, poverty and precarious housing conditions remain the most frequently-recorded vulnerabilities, with an over 50 percent frequency rate among all children recorded during the model implementation.

The Aurora methodology that was later introduced into the modelling project provided a clear definition of the assessed vulnerabilities. Aurora users apply a set of no more than 214 questions to measure indicators that assess the presence of 43 sub-vulnerabilities corresponding to the 14 vulnerabilities organised according to 6 dimensions. The indicators measured are calculated based on definitions used and accepted both across Europe, including by Eurostat, for statistics on income and living conditions[46], and internationally, e.g. TransMonEE[47].

Table 7. Dynamics of vulnerabilities recorded between 2011 and 2016 (%)

Dimension	Vulnerability	Vulnerability Subcategory	% of children assessed as vulnerable during model implementation					
			in 2011[a]	in 2012[b]	in 2012[c]	in 2014[d]	in 2015[e]	in 2016[f]
Poverty	Child living in poverty	Child living in a household in income (monetary) poverty	Poverty-related vulnerabilities were assessed in conjunction with housing-related vulnerabilities, under the same indicator		28	41	12	
		Child living in a household in extreme poverty			26	5	1	8

45 The differences between the three types of poverty are worth noting, considering that the monthly cash income per person in households in severe poverty is 74 lei (around 22 USD) versus 81 lei in households affected by income poverty and overcrowded housing conditions, and 128 lei (39 USD) in non-poor households. The evaluation included an estimation of children's daily intake of fruits and vegetables, meat and fish, as well as of the number of available good pairs of shoes and new clothing.

46 European Union Statistics on Income and Living Conditions (EU-SILC), definitions available at: http://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions

47 Database established in 1992 by the UNICEF Innocenti Research Centre to monitor the situation of women and children in CEE/CIS, definitions available at: http://www.transmonee.org/index.html

Dimension	Vulnerability	Vulnerability Subcategory	% of children assessed as vulnerable during model implementation					
			in 2011[a]	in 2012[b]	in 2012[c]	in 2014[d]	in 2015[e]	in 2016[f]
Health	Child not registered with a family physician	Child not registered with a family physician			3	1	1	4
	Child aged up to 1 year, in a situation of risk	Child with low birth weight				4[53]	7	
		Child not vaccinated				9	12	38#
		Child not given vitamin D and iron				14	10	
		Child under 6 months not exclusively breastfed				24	12	
		Child over 6 months not receiving complementary feeding				22	15	
		Child not meeting development standards				14	4	
	Child aged 1 to 5 years, in a situation of risk	Child not vaccinated				7	5	12#
		Child not given vitamin D				59	42	
		Child not meeting development standards				5	2	
	Child with chronic disease or living in a household whose members have chronic diseases	Child with chronic disease	3[g]	5[g]		2	3	
		Child living in a household whose members have chronic diseases				10	10	
Education	Child not enrolled in school, who dropped out of school or is at risk of dropping out	Preschool child not enrolled in kindergarten				20	16	
		Child aged 6 to 10 years, not enrolled in school	17[h]	22[h]	3	1	1	
		Child aged 11 to 15 years, not enrolled in school						
		Child at risk of dropping out of school				13	11	19[h]
		Child with special educational needs (SEN), at risk of dropping out of school				4	3	
		Child who dropped out of school			1	10	8	
Risk behaviours	Adolescent/child with risk behaviours	Adolescent with risk behaviour in terms of sexual activity				24	11	
		Pregnant adolescent girl or teenage mother	2	3	2	7	5	0
		Adolescent with risk behaviour in terms of substance use				5	4	4
		Child at risk of violent behaviour				3	2	
		Child living in a household prone to violent behaviour				16	8	
	TOTAL – Child living in a family prone to child violence, abuse or neglect		27	27		44	30	
	Child living in a family prone to child violence, abuse or neglect	Child living in a family prone to child violence			32	35	22	49
		Child living in a family prone to child neglect			34	27	18	27
Housing	TOTAL – Child living in precarious housing conditions		72	73		77	72	
	Child living in precarious housing conditions	Child living in overcrowded house			74	73	69	
		Child living in unhealthy housing conditions				29	22	

Dimension	Vulnerability	Vulnerability Subcategory	% of children assessed as vulnerable during model implementation					
			in 2011[a]	in 2012[b]	in 2012[c]	in 2014[d]	in 2015[e]	in 2016[f]
Family and social conditions	Child without ID papers	Child living in overcrowded house	6	5	2	1	0,4	1
	Child with only one or no parent at home	Child living in unhealthy housing conditions			25	16	16	9
		Child without ID papers	10	4	4	5	6	4
		Child with only one parent at home			4	5	4	3
	Child with disabilities	Child with migrant parents				4	4	5
	Child separated from his/her family or at risk of being separated from their family	Child with no parents at home, but with an adult carer in the household	4	10		1	0,3	3
		Child with disabilities				1	0,2	
		Child in placement centre or foster care in risky conditions				6	7	6
		Child at risk of being separated from his/her family – who cumulates 7 or more vulnerabilities				1	1	0,5

Sources: UNICEF, CERME and ICE

a Data from the "Community data sheet" completed in 2011 and covering 64 communes. N=5,758

b Data recorded in the consolidated database created in 2012 and covering 64 communes. N=3,041

c Data collected via survey in 2012 for the second formative evaluation of the model, covering 64 communes. N=923

d Data recorded on the first use of the Aurora questionnaire (T0), most of which were collected in 2014 and covered 32 communes. N=5,171

e Data recorded on the second use of the Aurora questionnaire (T1), most of which were collected in 2015 and covered 32 communes. N=3,485

f Data collected via survey in 2016 for the present summative evaluation of the model, covering 32 communes[54]. N=1,100

g Indicators on children with chronic diseases recorded in the Aurora database were equated with the "children with suspicion of severe diseases" indicator available in the 2011 and 2012 databases.

h Indicators on children at risk of dropping out of school recorded in 2011–2012 and 2016 were defined differently than the one used in the Aurora, referring to out of school children or children at risk of dropping out of school, which therefore included the 'child who dropped out of school' sub-vulnerability used in the Aurora.

 # The total number of cases for the 'children aged up to 1 year' and 'children aged 1–5 years' sample sub-populations is small. For instance, there are 29 children aged up to 1 year in the intervention sample presented in the above table. Therefore, the high percentage of unvaccinated children may, in fact, represent a measuring threshold for small samples.

The above table shows the values recorded for the vulnerabilities assessed among children during the model implementation, both based on the tools community workers used (the community data sheet in 2011 and 2012, and the Aurora in 2014 and 2015), and on the household surveys conducted as part of the model evaluations in 2012 (the second formative evaluation) and 2016 (the summative evaluation).

It becomes apparent that once the vulnerabilities assessment was carried out more accurately, the frequency and share of children's major vulnerabilities changed. We see that the most frequent vulnerabilities are now (i) risk of living in precarious housing conditions, followed by (ii) risk of violence, abuse or neglect, (iii) living in poverty, and (iv) risk behaviours. High incidence can be noticed also for (v) children at risk of dropping out of school or (vi) who dropped out of school, as well as for

48 The total number of cases assessed (N) refers to the total number of children aged 0–17 years recorded in the databases. For some of the vulnerabilities, the total population of reference is smaller, i.e. only children unde age 1, only preschoolers, only children aged 6–9 years, or 10–15 years, only girls etc. The name of the vulnerability is a clear indication as to the category of children it refers to.

49 The survey was conducted in 64 communes, 32 in which the intervention was carried out up until 2015 and 32 in which the intervention was carried out only in 2011. For the purpose of evaluating the relevance of the model, we have considered only the data collected in the 32 communities in which the intervention was carried out up until 2015.

health risks due to (vii) inadequate child nutrition and young child's diet lacking Vitamin D and iron supplements.

The interviews conducted show that the indicators measured with the aid of Aurora during the project in identifying vulnerabilities are relevant as most of them represent **widely accepted indicators in this field, with well-established definitions**, except for the definition on the risk of child-family separation which was developed and tested in the modelling project and which will be analysed in the chapter on model effectiveness. Moreover, the list of vulnerabilities was discussed with and validated by the entire model implementation team and national partners. Everyone agreed that the list is complete and relevant in terms of the vulnerabilities that could be encountered.

Qualitative data (collected via interviews, focus groups and workshops with children) show that the problems children and their families are facing are those measured by way of indicators which were increasingly better defined once the Aurora was introduced in the modelling project. Poverty is often the first problem raised by the community workers as well as by the CCS members who participated in the focus groups, though it is hardly the only vulnerability to have been identified.

"The main problems identified in the commune are the following: poverty, overcrowded large families, and people's mentality".

Social/outreach worker, Bacău county

„The main problems encountered in the commune would be the following: parents in insecure material circumstances, there being many families who lack the means to support their children through high school in a town; lack of jobs; families who consume alcohol, though not many, are also a problem in the commune".

Social/outreach worker, Neamț county

The following are the most severe problems identified by the children who participated in the workshops in which they described themselves: isolation, long distance to town or other facilities of interest for their leisure time, lack of jobs for their parents, alcohol use in their family and community, lack of housing or poor housing conditions, lack of bathrooms and running water at home and in schools. The workshops also revealed that children were not used to being asked for their opinion and being heard, although they demonstrated being aware of their rights. The children placed school at the centre of their lives and were aware of their right to education.

The high incidence of risk behaviours, particularly alcohol consumption, and the low awareness of the vulnerabilities affecting them are some of the vulnerable families' problems that both community workers and CCS members bring up frequently. As mentioned, alcohol consumption was also flagged by the children who participated in the workshops.

"The main issue we've identified is related to the family's awareness level, to their willingness to cooperate in receiving support, which, if things happened this way, would also cut costs. However, where parents simply don't care, consuming alcohol free of any responsibility for their kids, "children are shuffled around and see more mileage than a pair of shoes" in the public care system".

Social/outreach worker, Bacău county

In some cases, access to the family physician or school is a challenge, particularly in communes with a large number of scattered villages. While some communities have difficulties in accessing the labour market as their local economy is insufficiently developed, for others the issue is that parents have poor skills and competencies which do not enable them to find jobs, thus perpetuating a vicious cycle of vulnerability.

"The main needs raised are those of the families, which in turn affect those of their children: first, there is the employment issue – a lack of jobs and means to live a decent life... Then, there is the educational issue, they're all connected, parents graduated 8 classes at most, they can't find jobs nor do they send their children to school".

GDSACP supervisor, Bacău county

"Labour force migration – parents who left home to work, not necessarily abroad, whose children are deprived of parental care. Issues related to certain social vulnerabilities, starting with deprivation in terms of education, health, housing conditions, income – all these together create a very complex set of problems for families at social risk".

Social/outreach worker, Botoșani county

Physical, mental, verbal and domestic violence, parents' low level of education and poor knowledge of positive parenting methods are some of the problems encountered at the community level, which, however, were identified and acknowledged only after the start of the project and the organisation of campaigns against violence.

As the interviews and focus groups revealed, communities are aware of the existence of vulnerable families, in that community members, including mayoralty representatives and other relevant local stakeholders forming the CCS, know that many families in their communes are facing social challenges. However, most vulnerabilities are not known and cannot be identified for every child and household without the aid of a tool as the Aurora. **The least visible vulnerabilities are those connected to domestic violence, risk behaviour and the situation of children with only one or no parent at home.**

"Emotional, verbal violence and alcohol consumption are not easily identifiable problems as people tend to internalise them and are hard to convince to share them, afraid of the consequences of the disclosure (for instance, a child who was abandoned by her mother, in her father's care, sees the outreach worker's and the GDSACP social worker's house calls as a potential threat to remove her from herfammily)".

Social/outreach worker, Bacău county

"Then there's the needs related to parental skill development; because all they know in the way of parenting involves violence".

GDSACP supervisor, Bacău county

It should be stressed that none of the vulnerabilities foreseen by the Aurora were recorded with zero cases identified, which only proves that the tool is relevant in relation to the real needs of the model's target group. In the case of vulnerabilities with relatively low incidence (e.g. children without ID papers, pregnant adolescent girls or teenage mothers, children with no parents at home), the issue is most serious and severe, and addressing such cases is important and relevant even if they only affect a relatively small number of children. The second formative evaluation also highlighted that "for all other types of vulnerabilities (e.g. children relinquished or at risk of being relinquished, children without ID documents, teenage mothers), a few hundred 'invisible' children were identified".[50]

The model proved relevant even when treating low incidence vulnerabilities, given that its approach is one aiming to improve child rights realisation through the use of case management, not the statistics on vulnerabilities.

3.1.2.2. Relevance of model services in relation to the assessed needs

In the project implementation inception phase, before the Aurora metholodogy was introduced (in 2014), social workers and community health nurses were advised to plan the intervention for each of the children they identified by: (1) running a full diagnostic of the child's vulnerabilities, (2) drafting an individual plan of intervention with the necessary services, (3) delivering the services outlined in the intervention plan, and (4) carrying out an overall reassessment of the case. According to the initial project documents, in addition to case identification, assessment and reassessment, the model also included six other types of services: (1) information and counselling services, (2) health services, (3) educational services, (4) services in connection with the right to social protection, (5) services in connection with the right to an identity, (6) services

50 Stănculescu, M. S. (coord.), 2013, p. 43.

in connection with the right to grow up in a family. For each of these types of services, target groups and delivery methods were defined.

Table 8. Social services that were part of the model design until 2013

Types of services	Means of delivery	Target group
Specialised information and counselling	Counselling and support centre for children and parents	ALL categories of vulnerable children
	Information and counselling with regard to violence, abuse, exploitation	
	Thematic support groups	
	Specialised individual counselling	
Services in connection with the right to grow up in a family	Various services aimed at achieving child reintegration into their natural family	Children who are relinquished or at risk of being relinquished
Services in connection with the right to an identity	Various information, counselling, referral and accompaniment services to obtain ID documents	Children without ID papers or documents
Services in connection with the right to social protection	Various information, counselling, referral and accompaniment services to facilitate acccess to social benefits	Children living in large families, poverty and precarious housing conditions
	Referral to NGOs working in the field of social assistance	
Educational services	Discussing with teaching staff to solve school-related problems	a) Out of school children or children at risk of dropping out of school, including children who were never enrolled in school, children who dropped out of school and children at risk of dropping out who miss school or kindergarten classes; b) children left behind by migrant parents, whose high risk of relinquishment is well-documented in previous studies.
	School enrolment	
Health care services	Obtaining the disability certificate	a) children in need of medical services, including children not registered with a family physician, children who need a disability certificate and children with disabilities or chronic diseases who need specialised care; b) children under age 2; c) teenage mothers; d) children at risk of neglect or abuse.
	Ensuring transportation to the doctor	
	Scheduling a doctor's appointment and/or acompanying the person to the doctor	
	Registration to a family physician	

Source: UNICEF

The second formative evaluation[51] underlined the need to provide community workers with more guidance and support, showing that there are significant differences in their capacity to plan and deliver services to address the vulnerabilities they have assessed. As such, Aurora assisted community workers by providing the first step in preparing the individual plan of intervention, as well as by generating a customised package of basic services based on the recorded vulnerabilities of the household children and women. Of note, specific interventions are generated for each vulnerable child, but also for his/her family members, particularly their parents or main caregiver. According to the handbook developed by UNICEF and CERME for the training of community workers, "Aurora identifies the vulnerabilities of children/women in the household (via the household questionnaire), but it suggests services for several household members: the head of the household, the parents, the child's main carer, the children. Services for the adult household members are displayed under the name of the respective adult individual (even if the vulnerability was identified for a child of that particular household)". Hence, Aurora generates both the necessary intervention package and the identification of the target beneficiary for each intervention.

51 Stănculescu, M. S. (coord.), 2013, 91–92

Figure 9. Total number of services and interventions available in Aurora

Source: UNICEF – Aurora Handbook

With the introduction of the Aurora working methodology, the number of services increased and the types of services to be delivered were fine-tuned and better defined, connected to the vulnerabilities that were identified and to the direct recipient of the services (child, parent, main carer). Aurora, therefore, includes 7 types of main services: (1) Identification, carried out when using the interview guide and determining the vulnerabilities, (2) Assessment, (3) Information and guidance, (4) Counselling, (5) Accompaniment and support, (6) Referral, (7) Monitoring and evaluation. Aurora also includes a special service: "priority zero service", generated for children at risk of being separated by the family. All these services are put into practice in the form of maximum 257 possible interventions.

"Aurora proved its effectiveness and usefulness to community workers by generating solutions to the problems identified".

Social/outreach worker, Neamț county

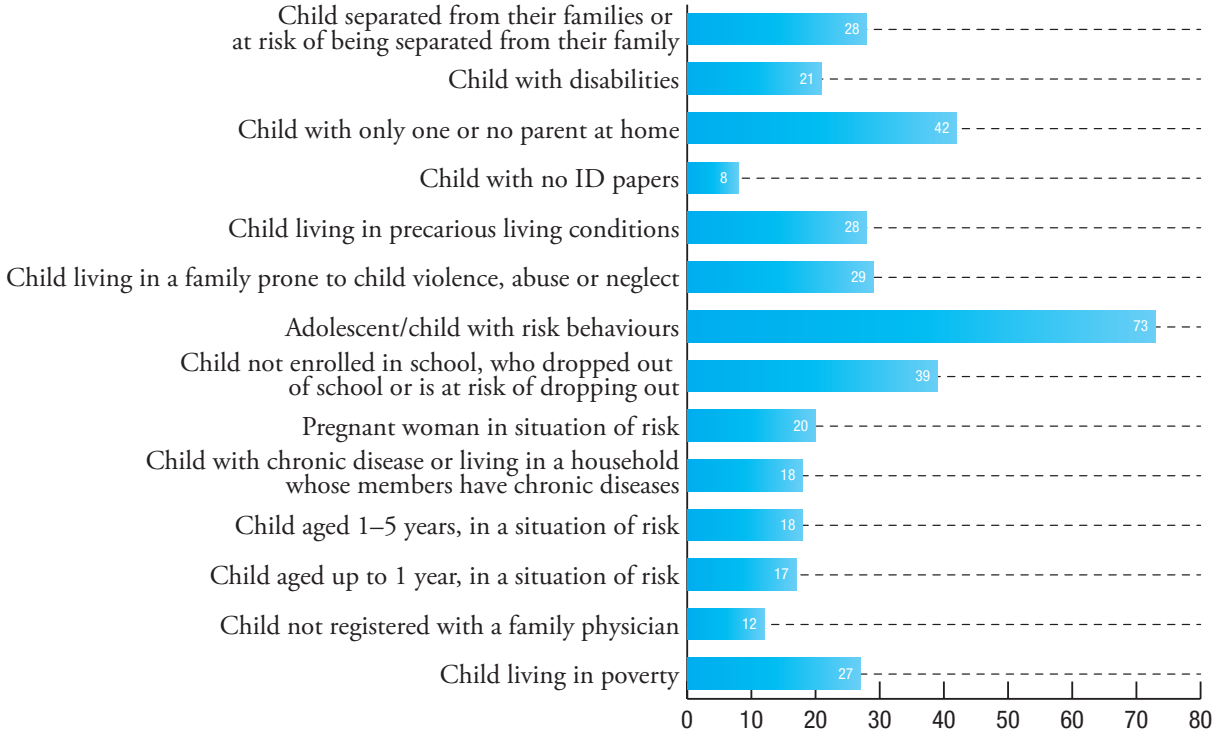
"The services are subdivisions of a service, they're individual-oriented; […] they may seem a lot at first glance, but they aren't. […] From the supervisor's perspective, that is a good thing; no one considered something like this before this project; it couldn't be better; the system they've created during project implementation has led to a successful intervention. […] Until now, there was no capacity for identifying problems before they occurred. What this project has achieved is highly efficient".

GDSACP supervisor, Buzău county

The package of services generated automatically to address the identified vulnerabilities most often includes information and counselling services, as well as accompaniment and support services and/or referral to (complementary, specialised etc.) services outside the community workers' area of competence. Monitoring and evaluation of services are essential in determining whether the delivered services yielded the planned outputs and outcomes or not. The order and specific means of delivery for each service need to be established by the community workers, using an integrated approach and considering the characteristics and needs of each and every beneficiary. As such, once the information or the counselling service is delivered, it is possible that the beneficiary will seek a specialised service on their own, without requiring accompaniment or referral. For all cases, monitoring will inform the community workers whether or not they need to provide the next service, while evaluation will indicate whether the services they've delivered, possibly in conjunction with the specialised service the beneficiary resorted to, have yielded the expected results: vulnerability lessened or eliminated.

With the exception of the identification service, which is a one-off service and which determines the package of services to match the vulnerabilities identified, Aurora generates **services from all the other 6 types of services for each vulnerability**.

Figure 10. Maximum number of services included in the minimum package of services and addressing each of the vulnerabilities identified with the aid of Aurora



Source: UNICEF – Aurora

Consequently, in view of its design, the package of services proves relevant in relation to the identified vulnerabilities, covering all these vulnerabilities with a considerable range of interventions which are customised to suit each individual situation.

Except for a limited number of services which are gender-tailored and contingent (such as those for pregnant adolescent girls, for teenage mothers or for pregnant women regardless of age) and those which are age contingent (such as those for school-age children or for children under age 5), most services are neither gender- nor ethnicity-conditional. The model design entails customizing the service upon delivery according to the particulars of each service recipient (e.g. gender, educational attainment, disability, language, where possible etc.). With regard to the service identifying new cases (beyond the list of cases that were already active in 2014), priority was given to newborns and pregnant adolescent girls and women.

3.1.2.3. Model relevance in relation to the needs of the social assistance and health systems

As documented by the situation analyses underlying the National Strategies[52] drafted during 2014–2015, as well as by previous reports and analyses[53], and as also shown by the summative evaluation inception phase findings, the social assistance system and the community health care system are faced with several challenges affecting local social assistance service capacity to meet the needs of the most vulnerable children. The SPAS, responsible with the local implementation of national policies and strategies, struggle with

52 e.g. *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*, *National Strategy on Social Inclusion and Poverty Reduction 2015–2020*, *National Health Strategy 2014–2020* etc.

53 MoLFSPE, 2013. *Studiu conclusiv, bazat pe evaluarea la nivel național a DGASPC, SPAS și a altor instituții și organizații implicate în sistemul de protecție a copilului*. [A conclusive study based on the national assessment of the GDSACPs, public social assistance services (SPAS) and other institutions and organisations involved in the child protection system in Romania]; Comșa, R., Dărăbuș, Șt., Pop, D. and Stegeran, B., 2013. *The Financial Impact of the Public Child Protection System Reform in Romania*; Stănculescu, M. S., Grigoraș, V., Teșliuc, E., Pop, V. (coord.), 2017. *Romania: Children in Public Care*; Federation of NGOs for Children(FONPC), 2012. Protecția Drepturilor Copilului. *Probleme identificate și sugestii pentru îmbunătățirea sistemului.* [Child Rights Protection. Identified problems and suggestions for system improvement]

problems like lack of funding and of qualified staffing, which, in turn, diminishes their capacity to perform their duties. Frequently, the SPAS in rural areas do not have a specialised social worker on their staff, they employ outreach workers or social assistance operatives who sometimes also fulfill other duties within the local public administration. At the same time, the local public administration from poorly-developed rural areas have to deal with budgetary constraints, given that local budgets are primarily formed of local taxes and charges, and transfers from the state budget are proportional to the income tax, corporate tax and VAT collected by the state budget from the respective area/locality. Such transfers can be very small in areas where the employment rate is low and there are no profit and VAT-generating local economic activities (since the main economic activity there is subsistence farming). Under the circumstances, "First Priority: No More 'Invisible' Children!" was relevant in overcoming or reducing these challenges.

To increase the SPAS capacity to deliver social services through outreach work, particularly since these public social assistance services will often (and most of all in rural areas) lack dedicated social work staff, several social/outreach workers were hired as part of the demonstration project[54]. The training sessions organised and the development of standardised working tools for the social workers were relevant project activities designed to address the problems resulting from the fact that most of the resources the SPAS hired were not specialised social workers with a degree in this field.

The project introduction of a community health care component and advocacy towards an integrated approach to social and health service delivery address the need for developing community health care in Romania, an area which is currently underdeveloped, with insufficient community health nurses being hired by the local public administration in Romania. The joint training sessions received by social workers and community health nurses in the project, as well as the common tools designed for their use determined these community workers to start working in an integrated and coordinated manner.

As shown when describing the background to the modelling project, the national legislation includes certain provisions related to the methodological coordination of SPAS that county institutions should ensure. However, these provisions are not accompanied by working methodologies and procedures, which hinder their implementation. The project focus on coordination between SPAS, on the one hand, and the GDSACP and the DPH, on the other, as well as on increasing the capacity of county-level specialised staff to provide adequate support to community workers is relevant in addressing the existing inter-institutional communication problems.

The systematic assessment of children's vulnerabilities, the design and testing of a special service to address child-family separation risks ("priority zero service"), are highly relevant project activities in relation to the child protection system, considering that the child-family separation cases the system deals with are often poorly documented and justified on grounds of poverty or disability, criteria which do not necessarily call for children being separated from their family, but rather for addressing the vulnerability(ies) of the respective family, in the manner proposed by the UNICEF model.

3.1.3. Model relevance in relation to national, regional, european and international child protection policies

To what extent is the modelling project relevant to national policies and programmes (including National Reform Programme and ESF Programme 2014–2020), sectoral and cross-sectoral strategies and to UNICEF's Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) Regional Knowledge and Leadership Agenda (RKLA) Results Areas on a child's right to a supportive and caring family environment, as well as on a young child's right to comprehensive well-being and a child's right to social protection?

54 Social workers or referents are hired part time or have other administrative duties in addition to their social work. This lack of staff is often a result of funding shortage. Local public authorities are bound by the law on social assistance to set up social assistance services in the form of functional departments, with no legal personality. However, salaries for SPAS staff are to be paid from the local budget which, in small and poor communities (with no tax-generating economic activities), is often insufficient to cover wages for all the staff categories that should be hired according to the laws governing administrative activities.

To answer this question, we analyzed each of the elements that render the model relevant in relation to national policies as well as in relation to the UNICEF regional strategic approach.

3.1.3.1. Model relevance in relation to national public policies

In line with the thematic objectives of the Romanian Partnership Agreement for the 2014–2020 Programming Period, during 2013–2014, the Government of Romania approved several National Strategies and Operational Programmes to guide public investment and intervention for children and vulnerable people. On the one hand, some of the strategies were developed using evidence which had been generated by the model under implementation at that time (as explained in section 2.4. Model contribution to national strategic planning processes), while, on the other hand, most of the strategies provided a better defined framework for a wider/national implementation and scaling up of the model.

As the model is as much an intervention test as it is an implementation exercise for a large number of public policy measures, it is especially relevant in relation to the following:

1) the **National Strategy for the Protection and Promotion of Children's Rights 2014–2020** and the **Operational Plan** for implementing it[55], developed by the National Authority for the Protection of Child Rights and Adoption, are the Government of Romania's two main programme documents on child rights, which continue the strategic approach set out in the previous National Strategy in the area of child rights protection and promotion 2008–2013[56]. The Strategy aims to "promote investment in child development and well-being, based on a holistic and integrated approach by all state institutions and authorities, and ensure respect for children's rights, coverage of children's needs, and universal access to services".

Trei dintre obiectivele generale ale strategiei sunt în mod particular relevante pentru abordarea preventivă promovată de modelul evaluat, respectiv:

– Increase children's access to quality services;

– Observe the rights and promote the social inclusion of children in vulnerable circumstances;

– Prevent and combat any form of violence.

The first two general objectives focus on increasing service coverage at the local level, as well as the quality of public services provided to children in all major areas: social, educational, health. Special focus is on children in vulnerable circumstances, i.e. children at risk of social exclusion, children with special needs, Roma children, children with unhealthy or risk behaviours, children with parents gone to work abroad etc. One of the specific measures is aimed at **developing and testing a minimum package of social services for children**.

2) the **National Strategy on Social Inclusion and Poverty Reduction 2015–2020** and its **Strategic Action Plan**[57] includes the following key interventions (towards poverty reduction and promotion of social inclusion) regarding social services, in relation to which our evaluated model is highly relevant:

– Strengthen and enhance social services at the local level by: developing a minimum package of interventions which each local authority is required to provide; financing a national program to ensure that each locality has at least a full-time employee who does social work for people in vulnerable situations and their families; financing a national program to train employees with social work duties and draft methodologies, guidelines and tools to strengthen case management implementation at SPAS level;

– Develop integrated intervention community teams to provide social services (in healthcare, education, etc.) and social facilitation programs at local level, especially in the poor and marginalised areas by: developing clear procedures, protocols and tools for community-based social workers and developing, in

55 Approved via Government Decision 1113/2014 and published in the Official Gazette of Romania no. 33 of 15 January 2015
56 Approved via Government Decision 860/2008 and published in the Official Gazette of Romania no. 646 of 10 September 2008
57 Approved via Government Decision 383/2015 and published in the Official Gazette of Romania no. 463 of 27 May 2015

the marginalised areas, multi-functional community centers to provide integrated services to families in extreme poverty;

– Strengthen child protection services by: increasing community-based prevention capacity and reconsidering the means of providing family support in order to prevent child-family separations.

3) the **National Health Strategy 2014–2020**[58] includes activities that provide the necessary legal and institutional framework for developing functional community-based health services which are integrated with the social services and target priority groups such as the vulnerable population in rural areas, the Roma, patients requiring home care, people with disabilities etc. These provisions are in sync with the healthcare interventions tested in the evaluated modelling project, which makes the project relevant also in relation to the national health policy. The main measures considered in the strategy include reviewing the primary and secondary legislation (carried out in 2017), creating the mechanisms for ensuring cooperation between public and private sectors, redefining the types of community-based health services to highlight their prevention role and enhance linkages with the social services, conducting a needs assessment with regard to increasing service coverage, and ensuring inter-sectorial cooperation.

The National Health Strategy also aims to develop the institutional and technical capacity of community-based service providers, particularly the public sector staff working in these services (whether social, health or educational ones). Here, the main measures set in the Strategy include developing standards, working methodologies and tools for integrated community-based service delivery, as well as providing initial and continuous training, including via e-learning solutions.

4) the **National Strategy on Reducing Early School Leaving**[59] is centred on the principle of providing an integrated response of all relevant services – education, health, social, employment etc., ensuring both horizontal and vertical coordination of public and private stakeholders, an approach which makes it relevant in relation to the model as well as to the present summative evaluation. As such, next to measures that target the educational system per se, the Strategy also includes activities that acknowledge the role played by the family and its direct involvement in programmes on parental education and awareness-raising with regard to the essential nature of early childhood education. Moreover, the involvement of authorities, communities and parents as well as other stakeholders at the local level is regarded as key in stimulating school attendance and preventing school dropout, which is also the general approach taken by "First Priority: No More 'Invisible' Children!", therefore the model is also relevant in relation to the national education policy.

5) the **Government Strategy for the Inclusion of the Romanian Citizens Belonging to the Roma Minority 2015–2020**[60] aims primarily to ensure the social and economic inclusion of Romanian citizens belonging to the Roma minority through integrated policies in areas such as education, employment, health, housing, culture and social infrastructure. The Strategy focus on community-based service integration is in sync with the model promoted by UNICEF.

6) In the area of public administration, the "First Priority: No More 'Invisible' Children!" model is also relevant in relation to the **Strategy for Strengthening the Public Administration 2014–2020**[61], by proposing an implementation solution (focused on children and families) to improve the organisation and capacity of decentralised local services, such as the SPAS. The Strategy provides that line ministries develop or revise the quality and cost standards for public services delivered at local level. It also outlines the need to establish a minimum package of public services to be delivered, as a rule, by every administrative level; with regard to the local level, the social, health and educational services should be included in the minimum package, among other services, and, in this respect, the UNICEF model is highly relevant as it can inform the design of the minimum package of services at the national level.

58 Approved via Government Decision 1028/214 and published in the Official Gazette of Romania no. 891 of 8 December 2014
59 Approved via Government Decision 417/2015 and published in the Official Gazette of Romania no. 439 of 19 June 2015
60 Approved via Government Decision 18/2015 and published in the Official Gazette of Romania no. 49 of 21 January 2015
61 Approved via Government Decision 909/2014 and published in the Official Gazette of Romania no. 834 of 17 November 2014

At the same time, considering the strategic objectives or operational measures that aim to ensure the transition to integrated, community-based, accessible, sustainable, quality and child-centred services at family and community level, the "First Priority: No More 'Invisible' Children!" model is relevant in relation to other strategies as well, such as:

7) the **National Strategy for Preventing and Combating Domestic Violence 2013–2017** and the **Operational Plan for its implementation**[62], two documents which include local capacity-development, staff continuous training, development of specialised services for victims of domestic violence, a unified/integrated response and monitoring mechanism, and awareness-raising campaigns on zero tolerance for domestic violence.

8) **"A Society without Barriers for People with Disabilities", 2015–2020**, the national strategy on protecting and promoting the rights of people with disabilities.

9) the **National Youth Policy Strategy 2015–2020**[63] which also includes elements related to the social protection of adolescents, while emphasizing the importance of addressing today's challenges for adolescents and young people, including with regard to health, equal access to education and prevention of risk behaviours.

3.1.3.2. Model relevance in relation to european policies and to Unicef Regional Knowledge and Leadership Agenda (RKLA) results areas

I. Relevance in relation to european policies

As regards the European strategic documents, the "First Priority: No More 'Invisible' Children!" model is relevant to the following:

1) the **European Commission Communication COM(2011) 60 final – "An EU Agenda for the Rights of the Child"** is the first significant document that addresses the following:

– The need to protect particularly vulnerable children who face greater risks for their lives and well-being due to social, political and economic factors. For instance, Spre exemplu, children growing up in poverty and social exclusion, often accompanied with drug abuse, are less likely to do well in school and enjoy good physical and mental health. Children with disabilities are also more vulnerable to the violation of their rights and they require and deserve special protection.

– Access to early childhood education and care is the foundation for successful lifelong learning, social integration, personal development and later employability.

– The situation of Roma children is particularly worrying, due to a range of factors that may make them especially vulnerable and exposed to poor health, poor housing, poor nutrition, exclusion, discrimination and violence. Social exclusion of Roma children is often linked to lack of birth registration, low participation in early childhood and higher education, high school drop-out rates, trafficking and labour exploitation.

2) the **European Commission Recommendation C(2013) 778 final – "Investing in children: breaking the cycle of disadvantage"** acknowledges that early intervention and prevention are essential for developing more efficient policies, best achieved through integrated strategies that include access to services which are vital to children's well-being, such as quality education, health care, housing and social services. The Recommendation calls for careful consideration of children in particularly vulnerable situations, given the serious impact of the economic and financial crisis on children and families, with a rise in the proportion of those living in poverty and social exclusion.

62 Approved via Government Decision 1156/2012 and published in the Official Gazette of Romania no. 819 of 6 December 2012

63 Approved via Government Decision 24/2015 and published in the Official Gazette of Romania no. 68 of 27 January 2015

Of the three key pillars proposed for the development of integrated strategies, the second pillar is relevant to our evaluation as it refers to affordable quality services for families, namely:

– Support parents in their role as the main educators of their own children during the early years and encourage early childhood education services to work closely with parents and community actors involved in the child's upbringing;

– Develop and implement comprehensive policies to reduce early school leaving which encompass prevention, intervention and compensation measures; ensure that these policies include measures for those at risk of early school leaving;

– Devote special attention to children with disabilities or mental health problems, undocumented or non-registered children, pregnant teenagers and children from families with a history of substance abuse;

– Stop the expansion of institutional care settings for children without parental care; promote quality, community-based care and foster care within family settings instead;

– Provide appropriate support to children left behind when one or both parents migrate to another country to work, as well as to their replacement carers.

The EC Recommendation underlines the need to develop regular and systematic links between policy areas of high relevance to the social inclusion of children, particularly in the fields of education, employment, health, equality and children's rights, and to promote close cooperation and regular dialogue between public authorities at all levels, social partners, local communities and civil society organisations.

3) the **EU Council Conclusions on early childhood education and care: providing all our children with the best start for the world of tomorrow (2011/C 175/03)** set forth measures designed to meet the challenge of providing generalised equitable access to early childhood education and care, including:

– Providing equitable access to high-quality, inclusive early childhood education and care, in particular for children with a socioeconomically disadvantaged, migrant or Roma background, or with special educational needs, including disabilities;

– Promoting cross-sectoral and integrated approaches to care and education services in order to meet all children's needs — cognitive, social, emotional, psychological and physical — in a holistic way, as well as to ensure close collaboration between the home and early childhood education and care and a smooth transition between the different levels of education.

The Council invites Member States, with the support of the EC, to engage in policy cooperation via the open method of coordination with the relevant sectors (such as education, culture, social affairs, employment, health and justice) and involving all relevant stakeholders, with a view to producing reference tools at European level which will support policy development in the field of early childhood education and care at the appropriate local, regional and national level.

II. Relevance in relation to the Unicef regional strategy

The following are the **UNICEF Regional Knowledge and Leadership Agenda (RKLA) Results Areas**[64] considered for the purpose of the present evaluation as framework for strategic actions and plans to influence policies in the CEE: RKLA 1 on the child's right to a supportive and caring family environment, RKLA 7 on the young child's right to comprehensive well-being and RKLA 8 on the child's right to social protection.

1) **RKLA Results Area 1, a child's right to a supportive, caring family environment** stems from the need for reform in the Central and Eastern Europe/Commonwealth of Independent States (CEE/CIS) region, considering that the separation of children from their families is a serious challenge for this region. As of the year 2000, supporting child protection system reform has become a major priority for UNICEF in CEE/

64 Thematic strategies developed by the UNICEF Regional Office for CEE/CIS.

CIS countries. Under RKLA 1, piloting is one of the most important contributions to the reform policy. *The approach promoted by UNICEF through piloting and various forms of support and resources provided to decision-makers is based on case management, with early intervention, evaluation and prevention as its building blocks. The key concept behind the models promoted under RKLA 1 is also promoted by the "First Priority: No More 'Invisible' Children!" pilot project.*

2) **RKLA Results Area 7, a young child's right to comprehensive well-being**, promotes a combined model that provides a certain degree of support to all families, but it primarily targets children with developmental difficulties and/or disabilities who need specialised services such as home visiting and special care. This targeted approach to vulnerable children through qualified health services delivered by community health nurses, or, where these are not available, by specially-trained social/outreach workers is also part of the *"First Priority: No More 'Invisible' Children!"* pilot project. Consequently, the summative evaluation will give special attention to RKLA Results Area 7 in the region as basis for considering the implementation of a similar project in Romania.

3) **RKLA Results Area 8, a child's right to social protection**, includes objectives related to: i) a child's right to an adequate standard of living, health, proper nutrition, lifelong education, adequate support and care as well as protection against marginalization and abuse due to poverty and/or material deprivation, and ii) access for children and their carers to a minimum combination of material benefits and social support services, regardless of gender, age, disability, family circumstances, nationality, residence, ethnicity, language or religion.

Models and demonstration projects are some of the resources provided under RKLA 8 to promote a child's right to social protection, one of the main tools being the package of services for preventing child-family separation. According to RKLA 8, projects such as "First Priority: No More 'Invisible' Children!" contribute to: (1) government and civil society capacity development, (2) child rights monitoring, knowledge generating and horizontal cooperation, (3) policy dialogue and support, (4) advocacy, (5) establishing partnerships and extending available resources for children, (6) ensuring adequate internal control and risk management.

3.1.4. Summary of the answers to the evaluation questions on relevance

The data and information collected for the summative evaluation allow for formulating answers to all the evaluation questions on relevance, as follows:

A. **The model is highly relevant vis-à-vis the overall goal and the achievement of its expected outputs and outcomes in the given period of time**, considering that the model implementation logic is accurately and coherently captured by the Theory of Change at all intervention levels (vulnerable children and their families, the local public administration level and the county public services level), and, consequently, the planned inputs lead to the achievement of the expected outputs and outcomes. However, although highly relevant, the model cannot determine a full achievement of its expected outcomes (i.e. identification of all 'invisible' children, ensuring their access to education and health services and protecting them in situations of risk). Given the complex circumstances on the ground, the objective related to ensuring access to social and community health care services for children is feasible, but aiming for full service coverage is too ambitious.

B. **The model addresses the needs of the most vulnerable children and reduction of inequities for the 'invisible' children to a large extent**, by including a methodology for identifying children's vulnerabilities, based on internationally-accepted indicators and definitions that allow for an objective needs assessment, as well as services to address all the vulnerabilities identified.

C. **The model is highly relevant to national policies and programmes (including the National Reform Programme and ESF Programme 2014–2020), sectoral and cross-sectoral strategies and to UNICEF's Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) Regional Knowledge and Leadership Agenda (RKLA) Results Areas on a child's right to a supportive and caring**

family environment, as well as on a young child's right to comprehensive well-being and a child's right to social protection, bringing evidence to support their development, addressing problems and needs identified in at least 10 national strategies on social, educational, health, youth and public administration issues, and contributing, through its activities and results, to the implementation of these strategies and of various European and regional recommendations (UNICEF strategy, RKL Results Areas 1, 7 and 8)..

3.2. Effectiveness of "First priority: no more 'invisible' children!"

The evaluation of effectiveness aims to determine the extent to which the analysed intervention has reached its objectives, in other words, the extent to which the expected outputs were achieved. When evaluating effectiveness, we will also address the main factors that influence achievement of the planned results.

3.2.1. Dynamics of child vulnerabilities

Evaluation question and specific approach

Did the modelling project contribute to the realisation of child rights (by vulnerabilities)? Does the minimum package of services address all vulnerabilities? Which component was most successful? Is there added value resulting from the integrated approach?

To answer these questions, we analysed the results of the services delivered in the model, based on changes occuring at the level of the assessed vulnerabilities, using the data recorded initially in 2011 and 2012 in comparison to the data recorded in the Aurora in 2014 and upon reassessment in 2015. Comparing results over time allowed us to establish which vulnerabilities had been addressed more effectively and which less effectively. To formulate our findings and draw conclusions with regard to the effectiveness of the model, the changes in the status of the vulnerabilities identified at various moments in time were analysed based on the immediate outcomes for vulnerable children and their families, i.e. the target group of the project inputs, as outlined in the Theory of Change.

In answering the questions, in addition to the minimum package of services, we also considered the contribution of the microgrants, the level of community engagement within the CCS and the integrated approach to the social and the community health care services promoted during the model. The outcomes of the integrated approach were evaluated by comparing the outputs of the services that were delivered by the social/outreach workers and by the community health nurses individually, and the outputs of the services that were delivered by the two categories of community workers as a team.

3.2.1.1. Model effectiveness in identifying vulnerable children and their families

With regard to identifying 'invisible' children and their families, analysis considered two aspects generated by two interdependent operational objectives of the model, as follows:

– the extent of coverage of the identification service, considering the objective to identify and record all 'invisible' children into the model databases;

– the level of data accuracy, considering the objective to provide an accurate and complete assessment of the vulnerabilities affecting the identified 'invisible' children and their families.

Initially, in 2011, the model included conducting a census in 96 communities, which should have provided complete coverage of the identification of 'invisible' children. **Model formative evaluations indicated there were limitations to the model effectiveness until 2012, regarding both the completeness and the accuracy of the data on some of the vulnerabilities**. The second formative evaluation showed that the inaccuracy of the data on the children recorded in the model databases was mainly due to the fact that the tools used in the identification process were not standardised[65]. The definitions used by the social workers who conducted the identification left considerable room for interpretation and bias, both in terms of de-

65 Stănculescu, M. S. (coord.), 2013, pp. 90–91

termining the target group and of the vulnerabilities recorded. The working tool limitations were associated with the lack of training and practical experience on the part of the social/outreach workers, given that many of those hired in the project had no social work background. As such, the training sessions organised for the social workers in 2011 as part of the modelling project had limited impact when considering the complex tasks they were assigned. For instance, they recorded children with vulnerabilities related to poverty and poor housing conditions, without doing the same for those children's siblings who lived in the same household with them, or they ignored various situations of child abuse and neglect.[66]

Following the recommendations of the formative evaluation conducted in 2013 which underlined the need to develop and implement a unitary methodology for all community workers to use in identifying all vulnerabilities, for all children and all household members, as well as the need to integrate this methodology into an online software application, the Aurora working methodology was developed in 2013[67], tested and subsequently implemented starting 2014.

According to the data from the databases that were used during the implementation of the model, as well as the community workers' statements, the number of children identified with vulnerabilities increased once the Aurora began to be used in 2014, even though the identification of new cases was no longer a priority at that point. After 2014, the model focused on providing an accurate and complete assessment of the cases that had already been identified and on delivering social services based on the minimum package of basic services generated by the Aurora for the cases that were identified and assesed.

As for identifying new cases of vulnerable children, other than those already recorded via the 2011 census and the 2012 community data sheets, interviews show that community workers did not use a unitary strategy in identifying new cases of 'invisible' children. Initially, the Aurora database was filled with all the active cases that local professionals had on record, while the identification undertaking involved collecting data on these cases (children and their families). On the other hand, although the systematic identification of new cases was recommended and, in certain situations, even mandatory (i.e. community health nurses had to systematically identify newborns and pregnant women), it was, however, not a unitary practice. Morever, the identification of new cases depends to a large extent on the social worker's knowledge of the community, on their relation with the other local authorities and services, on their determination and on other individuals' or institutions' reports and alerts to SPAS.

As the interviews reveal, *"for identification purposes, any type of information is considered, whether gossip or written report, and house calls are made"*, however this is not always enough to ensure that all vulnerable children are identified. Subsequent to identification, the service delivery methodology provides more clarity, particularly with the introduction of the Aurora. By generating a package of services, Aurora helps community workers perform systematic case management for all the services, be it evaluation, monitoring, information, counselling, accompaniment and support, or referral.

A comparative analysis of the databases shows that no data collection and recording model per se is perfect[68] **and that results may differ depending on the model used. With this in mind, the way in which the Aurora application and database were developed renders their results more reliable compared to other vulnerabilities assessment tools used in the modelling project**, given that:

– Aurora uses a large number of questions, including filters and control questions, and it generates a vulnerabilities assessment using algorythms which are calculated based on the measured indicators. As a result, though the community worker's bias is not entirely excluded, its effect is reduced.

66 According to the formative evaluation report, the lack of data accuracy with regard to the children recorded in the model databases was due to: "(1) the adjustment of the project coverage, (2) the discontinuity of activities and changes of project tools, without a proper training of the social workers, (3) the introduction of new specifications regarding the target groups, (4) the results of the activities carried out in 2011, (5) the insufficient capacity of response at the local level, and (6) the community characteristics".

67 Stănculescu, M. S. (coord.), 2013, p. 71

68 See above, Chapter II. Summative Evaluation Overview, Section 2.2.3. Data collection and analysis

– The interviews for the use of the Aurora questionnaire are conducted by community workers who have good knowledge of the household situation. This way, community workers can perceive when the interviewees are insincere or inaccurate and can insist to be given an answer that matches the family's real circumstances.

The data recorded by the Aurora in 2015 are highly reliable and are confirmed by the survey conducted in 2016, demonstrating the effectiveness of the services for identifying and assessing the 'invisible' children in terms of the vulnerabilities related to:

– access to education and school attendance;

– risk behaviours related to substance abuse;

– poor housing conditions;

– lack of ID papers;

– disabilities;

– risk of child-family separation for children with siblings up to 18 years of age who do not live in the household, including because they are in public care.

Differences of over 3 percentage points, which is the survey margin of error, occur when assessing the vulnerability related to living in a household in extreme poverty; vaccination of children under 5; children from families prone to violence against children and child neglect; teenage mothers or pregnant adolescent girls; children with only one parent at home. A more in-depth analysis of the effectiveness of the assessment used in the model is required for these five categories of vulnerabilities.

With regard to the survey conducted in 2016, in most cases, due to the random sampling procedure, identification of those categories of people whose share in the reference population is relatively small (i.e. pregnant adolescent girls or teenage mothers, limited age categories like children under age 1) is difficult or even impossible. The data presented below should be treated with caution for the categories just mentioned.

Limits of effectiveness in identifying and assessing vulnerabilities of children living in a household in extreme poverty

The survey conducted as part of the summative evaluation recorded a percentage of children living in extreme poverty (8%) higher than the one resulting from the data the Aurora recorded at the most recent vulnerabilities assessment (1%). In both cases, the vulnerability is recorded for girls and boys of all ages, with no significant disparities genderwise, but with higher shares for Roma children versus non-Roma.

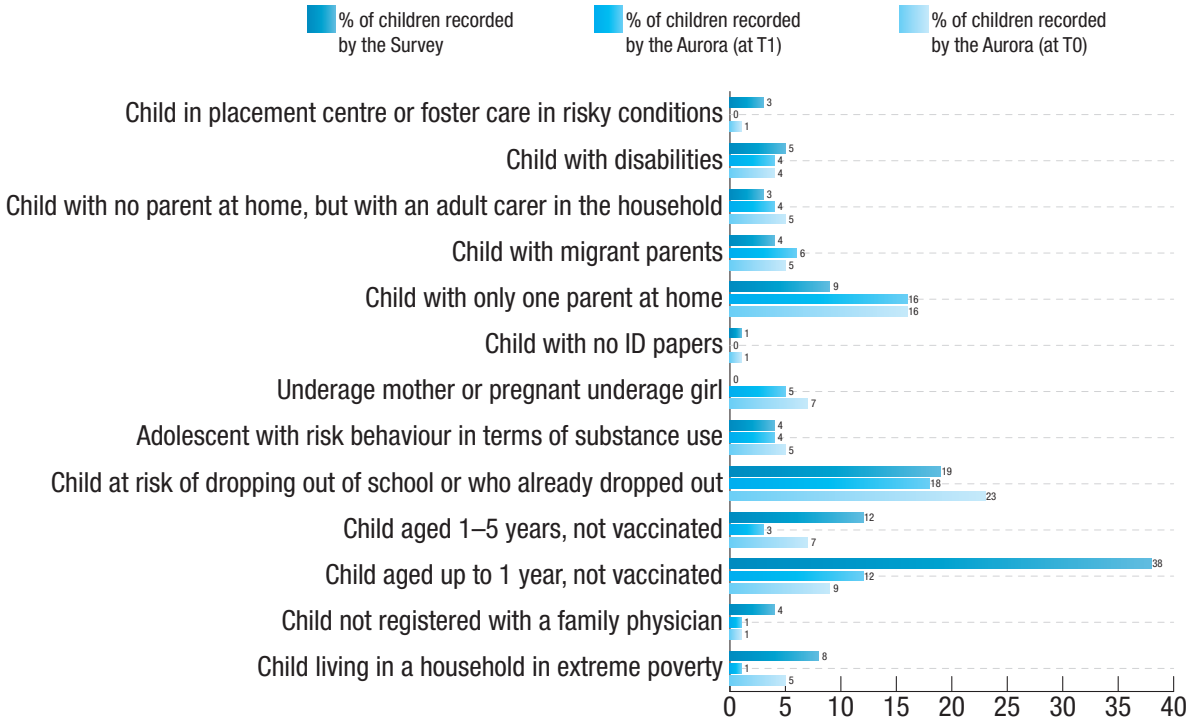
It is worth mentioning that in 2014, the Aurora database recorded 5 times fewer cases of children living in extreme poverty than the 2012 survey. This difference can be acccounted for by the fact that the data are based on the interviewees' statements which may change with time. According to the instructions used with the Aurora and communicated to the interviewers who conducted the 2012 and 2016 surveys, assessment of the situation of poverty is based on the statement made by the household children's main carer with regard to how often they encountered problems in heating the house and in providing food. Such statements can change depending on the season, the interlocutor, and interviewees may behave differently with the local social workers versus the survey interviewers and researchers outside their community.

Limits of effectiveness in identifying and assessing vulnerabilities of children not registered with a family physician and of children under 5 not vaccinated

Data on the vulnerability related to lack of registration with a family physician vary from 2.9 percent of the 'invisible' children (according to the model databases) recorded with this vulnerability in 2012, to 1 percent recorded at the two instances of data collection via Aurora (T0 and T1) and to 4 percent in 2016, according to the survey data. The vulnerability is recorded for girls and boys of all ages, Romanian and Roma, with no significant disparities age or genderwise. The differences between 2012 and 2015 can be

accounted for by the effectiveness of the services delivered in the modelling project, while the 3 percentage points more children not registered with the family physician in 2016 versus 2015 may be due to the reduced number of newborns recorded after the project ended in September 2015, given the reduced field presence of the community workers.

Figure 11. Frequency of vulnerabilities identified for children recorded in the model databases during the identification activity and the assessments conducted



Sources: UNICEF – Aurora and ICE: (a) first use of the Aurora questionnaire (T0) in 2014 (N=5,171), (b) second use of the Aurora questionnaire (T1) in 2015[69] (N=3,485), (c) survey conducted in 2016 for the purposes of the present summative evaluation (N=1,100).

Note: The graph shows only the vulnerabilities that were assessed using the same definition in all the three databases under comparison.

The Aurora data did not register significant differences in terms of vaccination for girls and for boys, nor among children under age 1 of different ethnicity. With regard to vaccination of children aged between 1 and 5 years, in 2015, the percentage of non-vaccinated Roma children was three times higher than that of their Romanian peers. According to the survey conducted in October-December 2016, the incidence of vaccination among children under age 1 (i.e. those born right after the completion of the modelling project) was lower than in 2015. Thus, according to their parents' statements, 8 of the 29 children under 1 identified via the survey were not vaccinated as per the national immunization scheme. Given the small number of cases of non-vaccinated children identified, the reasons for non-vacccination were not analysed for the present evaluation.[70]

In all instances of vulnerabilities assessment in terms of health and access to health services, data accuracy can be affected by the limitations of data collection via survey. It may be that the accurate situation of the household children is not known to the survey respondent who was not always the children's main carer. For the vulnerabilities under analysis here, which can be cross-checked factually with the family physician, in the case of the Aurora-based data collection, the community worker validated the answer they received in

69 Given the methodology developed for the use of Aurora, for most of the children recorded in the database, the first use of Aurora was in 2014, while the second was in 2015. However, any new case recorded by the community workers is shown at T0, which is why not all cases recorded at T0 were identified in 2014, some being recorded in 2015.

70 Nevertheless, overall, there were 29 children under age 1 in the 2016 sample of intervention communes, and the differences in percentages compared to the 2015 assessment may also be due to the measurement limits set for small samples.

the household, while the algorythm used to generate the vulnerability drew on the family physician answer. As such, the data provided by Aurora are more reliable than those collected via survey.

Limits of effectiveness in identifying and assessing vulnerabilities of pregnant adolescent girls and teenage mothers

As regards the situation of pregnant adolescent girls and teenage mothers, the survey did not record any cases, although they are accounted for in the community and were targeted with comprehensive services during the modelling project. This is rather an outcome of the random sampling, representative for the project target group but unable to cover the categories which are poorly represented within the population. To study small population shares in the overall population, one needs separate non-random samples.

Limits of effectiveness in identifying and assessing vulnerabilities of children with only one parent at home

As to recording children with only one parent at home, a vulnerability for which the survey found 9 percent cases versus Aurora's 16 percent, the differences can be accounted for by the fact that, in some of the communities where the model was implemented, there was a rather high mobility among the children's parents who migrate within the country or abroad for seasonal work.

Limits of effectiveness in identifying and assessing vulnerabilities in cases of child violence, abuse and neglect

Identifying cases of child violence, abuse and neglect was one of the biggest project challenges, as shown by all those involved in the project implementation, from UNICEF representatives to implementing partners to local professionals and key community stakeholders.

For community workers, identifying cases of child abuse and neglect was a gradual process whereby:

– they first gained the trust of the beneficiaries who gradually started to reveal the problems they were having. **The least visible vulnerabilities are those related to various forms of violence. Interviews show that these vulnerabilities can be uncovered and addressed only after the community workers build a certain level of trust with the household members**;

– beneficiaries began to grasp the serious nature of certain instances of abuse or neglect which the community sometimes treated as "normal".

"I organised workshops on domestic violence which enabled me to gain the women's trust and have them share with me their situation at home, how they are being beaten and driven away from home together with their children".

Social/outreach worker, Buzău county

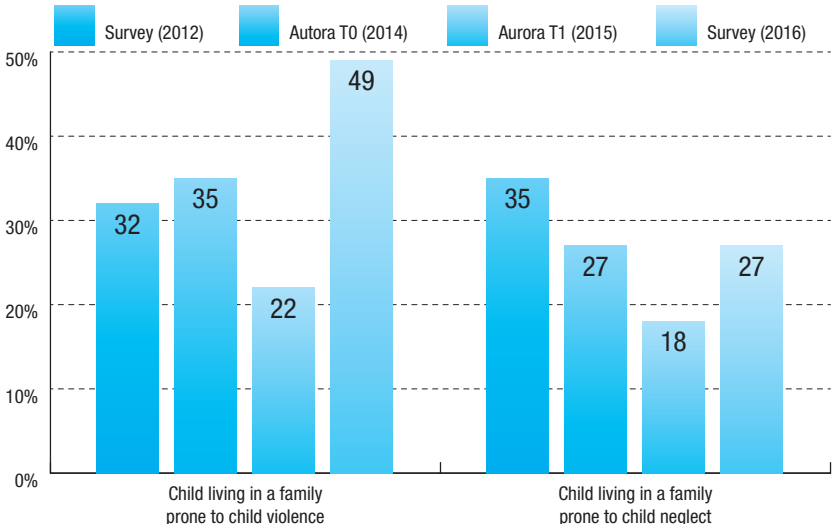
"Naturally, we didn't perceive all the vulnerabilities out there. When we completed data collection and saw the identified vulnerabilities and needs and the services generated to address them, we realised we had missed a lot. I would comment with the CHN: «See, m'am, how smart the Aurora is?». The services generated by the Aurora leave no stone unturned and fit the family's situation. We ourselves would have been more lenient in our assessment".

Social/outreach worker, Buzău county

Community workers reported being able to identify these vulnerabilities better and better as the project progressed, though not very successful in combating them (see the following sections on impact analysis). Even so, between 2014 and 2015, the Aurora data recorded a decrease in the incidence of these vulnerabilities. **As for children living in families prone to child violence, the data recorded by Aurora when first used are similar to those measured via the 2012 survey. On the other hand, there are large disparities between the way community workers assessed this vulnerability on the basis of the Aurora questionnaire they used in 2015 and the results of the 2016 survey conducted on a sample of households**

recorded in the Aurora, and there is also a large variation across all the 4 measurements carried out between 2012 and 2016 with regard to children living in families prone to child neglect.

Figure 12. Frequency of the risk of child violence, abuse or neglect identified for children recorded in the model databases during the identification activity and the assessments conducted



Sources: UNICEF, CERME and ICE: (a) survey conducted in 2012 for the purposes of the second formative evaluation (N=923), (b) first use of the Aurora questionnaire (T0) in 2014 (N=5,171), (c) second use of the Aurora questionnaire (T1) in 2015[71] (N=3,485), (d) survey conducted in 2016 for the purposes of the present summative evaluation (N=1,100).

A better knowledge of the families in the community and of the specific problems children are facing would determine one to believe that the data collected via the use of the Aurora methodology are more accurate. Yet, the incidence of violence and neglect assessed by the community workers is much lower than the one recorded by the household surveys conducted by unfamiliar survey interviewers with whom the respondents have not built a personal trust-based connection. **Hence, the identification and assessment of child abuse and neglect cases continues to present a problem.**

By organising various campaigns against violence, the modelling project helped increase the level of knowledge and understanding of violence among social workers, community health nurses, key community stakeholders and members of the CCS, as well as project beneficiaries.

"During the 'Stop Violence' workshops that were organised, various cases of domestic violence were uncovered, which had not been shared with us when the family assessment was carried out. They all admitted having been assaulted by their husbands. They avoid talking about it out of fear. [...] If at first they denied being battered, later they began to tell us what was going on. Now, when they have problems, they come and see the social worker for advice. They reveal the places they flee to when their husband's rage strikes, the house's attic or other places".

Social/outreach worker, Buzău county

Despite the progress made, the instances of violence, abuse and neglect are still frequent (even the lowest incidence of the phenomenon recorded into Aurora in 2015 is of concern) and providing an accurate assessment of them continues to pose a challenge.

71 Given the methodology developed for the use of Aurora, for most of the children recorded in the database, the first use of Aurora was in 2014, while the second was in 2015. However, any new case recorded by the community workers is shown at T0, which is why not all cases recorded at T0 were identified in 2014, some being recorded in 2015.

3.2.1.2. Delivery of the minimum package of services

The services

While in 2011 the main modelling project activity was identifying the 'invisible' children and assessing their situation in order to determine their vulnerabilities, starting 2012, the identified, assessed and monitored vulnerabilities were also targeted with social services. The vulnerabilities and needs identification, assessment and monitoring carried out using the tools and methodologies developed in the project and, in 2014, the Aurora as well, were key in changing the 'invisible' children into 'visible' ones to the authorities and their community.

At the same time, during 2011–2013, a series of services were designed and later delivered for children, their families and carers with the aim of eliminating or reducing the vulnerabilities affecting them. In the model's initial version, most of the vulnerable children could receive information and counselling services, but not all of their vulnerabilities were addressed through services. A child with multiple vulnerabilities would often receive services for only one of the vulnerabilities, after which he/she was removed from the database. Such cases were not revisited later with further services.[72] As a result, it was clear that the approach regarding the project services needed to be changed and the database required a better surveillance. Following the recommendations of the second formative evaluation, the Aurora working methodology was developed and tested starting 2014, based on the Aurora application and online platform.

An analysis of the Aurora data shows that each of the identified vulnerabilities was correlated with services tailored to the needs of the vulnerable persons. Also, the data show that information on the local and county resources available to the vulnerable person was the service delivered most often for:

– children not registered with a family physician (service offered in 79 percent of cases),

– adolescents and children in situations of risk (service offered in 90 percent of cases),

– children at risk of violence, abuse or neglect (service offered in 93 percent of cases),

– children at risk of separation from their family (service offered in 81 percent of cases).

Referral to the GDSACP was the main service delivered only for children without ID papers (81 percent of the cases), due to the fact that cases related to identification documents are complex situations which can be solved only with the aid of the competent county institutions.

The sets of services delivered for each and every type of vulnerability show that vulnerabilities were targeted with different interventions:

– information (over 79 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– counselling (over 70 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– referral (over 65 percent of the cases affected by any one of the vulnerabilities recorded in the database),

– accompaniment and support (over 60 percent of the cases affected by any one of the vulnerabilities recorded in the database).

At the same, monitoring was carried out in over 70 percent of cases.

The survey conducted in the intervention communities as well as in the control communities shows statistically significant differences between the basic social services delivered in the intervention group and those delivered in the control group with regard to:

– registration with the family physician,

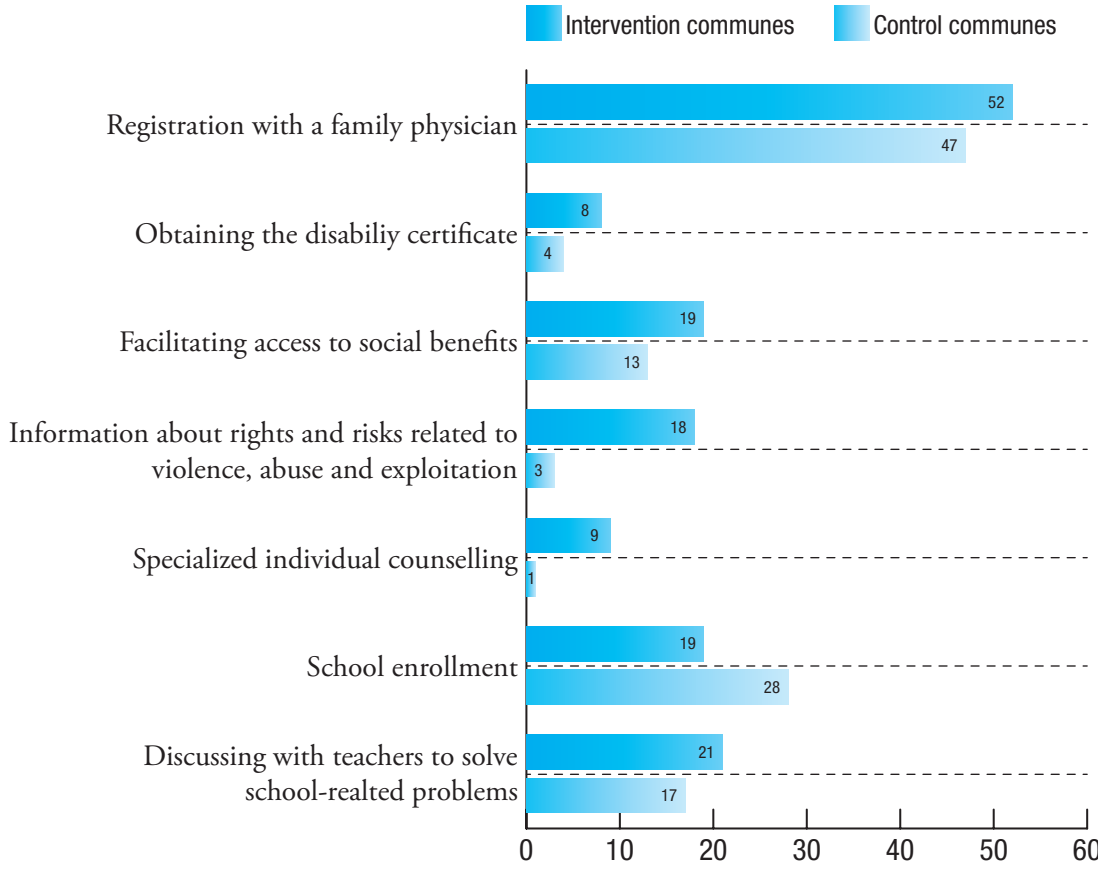
72 Stănculescu, M. S. (coord.), 2013, pp. 60–71

– obtaining the disability certificate,

– information and counselling.

No statistically significant differences were recorded with regard to social workers' support in obtaining identity papers, which can be explained by the fact that this activity is a priority to all the SPAS, given that ID papers are a prerequisite for the administration operations in general, not only social work ones.

Figure 13. Percentage of households with children who received social services during January 2013–September 2015, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S (social & market research company)

N=2,209; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05 for all the indicators presented.

On the one hand, in the communities in which the model was implemented, the services delivered included facilitating access to social benefits, obtaining the disability certificate, registration with the family physician, information about rights and risks related to child violence, abuse or exploitation, even discussing with teachers to solve school-related problems. On the other hand, though, one can notice a negative difference in the intervention sample versus the control sample, with regard to the services for facilitating children's access to education. This indicates the need to enlarge the community team by bringing in a school mediator or school counsellor to focus on the educational issues.

Relative to the total number of people who received services, around 1/5 of the services recommended by the Aurora were not carried out after the first data collection, and around one third were not carried out after the second use of the Aurora.

"The least successful component was accompaniment and support, which did work but only locally, as long as it didn't involve travelling outside the community which required financial resources that neither the local SPAS, nor the beneficiary had available".

Social/outreach worker, Botoșani county

"Aurora generated services fitting the situations identified during fieldwork. However, there were communities that didn't have what it took to deliver some of the services. For instance, Aurora recommended taking a child to a day care centre/creche, or provide vocational training for a young person over 18 who did not attend school. The community lacked the necessary capacity to enable delivery of such services".

Social/outreach worker, Buzău county

There are several causes leading to this situation:

– the second use of the Aurora coincided with the end of the modelling project (case reassessment started in August 2015, 9 months after the first use of the Aurora), and the services that were generated afterwards were no longer delivered during project implementation, which left a large number of services not carried out.

– community workers who used the Aurora reported that the application generated large sets of services in what is supposed to be "minimum packages of services" and they believe there are situations that do not call for all the services recommended by the Aurora. There are other (fewer) cases when there is no time or there are no resources to carry out all the recommended services.

– **while community workers highly valued services such as identification, information, counselling (supported also by the micro-grant-funded activities), monitoring and evaluation, they believed accompaniment and support services were less successful because there were times when they did not manage to identify the material resources required to implement them.**

Table 9. Average number of services delivered/not delivered for each service recipient recorded in the Aurora database after first (T0) and second (T1) use of the Aurora questionnaire

Criteria used in analysing the average number of services delivered/not delivered for each recipient		No. of services generated after first use of Aurora (2014)/service recipient				No. of services generated after second use of Aurora (2015)/service recipient			
		Total open services	Services not delivered	Services delivered	Services impossible to deliver	Total open services	Services not delivered	Services delivered	Services impossible to deliver
Gender	male	25.3	4.6	20.1	0.5	22.6	9.3	13.3	0
	female	32	5.8	25.5	0.7	28.7	10.8	17.7	0.1
Age	under 1	11.1	2.5	8.6	0.1	12.2	5	7.1	0
	1–5 yrs	13.4	2.4	10.8	0.2	13.3	5.4	7.9	0
	6–10 yrs	17.6	3.1	14.1	0.3	15.7	7.1	8.6	0
	11–15 yrs	22.2	4.3	17.4	0.5	17.3	6.7	10.6	0
	16–17 yrs	21.5	3.7	17.4	0.4	17	5.7	11.2	0.1
Ethnicity	Romanian	28	5	22.3	0.7	25.4	10.3	15	0.1
	Roma	32.9	6.3	26.1	0.5	28.7	9.7	19	0
County	Bacău	25.6	6.3	19	0.2	20	10.9	9.1	0
	Botoșani	31.3	0.2	30.9	0.2	23.5	2	21.6	0
	Buzău	31.6	4.4	26.7	0.5	28.4	14.2	14.2	0
	Iași	26.8	5.7	18.4	2.7	30	28.3	1.5	0.2
	Neamț	28.5	1	27.1	0.4	25.8	4.3	21.4	0.1
	Suceava	28.9	18.6	10.3	0	28.7	23.2	5.5	0
	Vaslui	31.9	9.5	22	0.4	30.4	11.6	18.6	0.2
	Vrancea	25.2	1.2	24	0.1	23.4	3.9	19.2	0.2

Source: UNICEF – the Aurora database

These general elements aside, when we look at the number of services not carried out we see that, while there are no significant differences by child's gender, age or ethnicity, there is an important disparity among the 8 counties. One can notice, on the one hand, the positive influence of the county supervisors' proactive attitude, in terms of the large number of services carried out, and on the other hand, the importance of the community social workers' specialised training. Thus, the smallest number of services not carried out is recorded in the county where all the social workers that were hired had specialised training/studies and

where the county supervisors were very active both in identifying and selecting the social workers and in guiding and monitoring them throughout the model intervention.

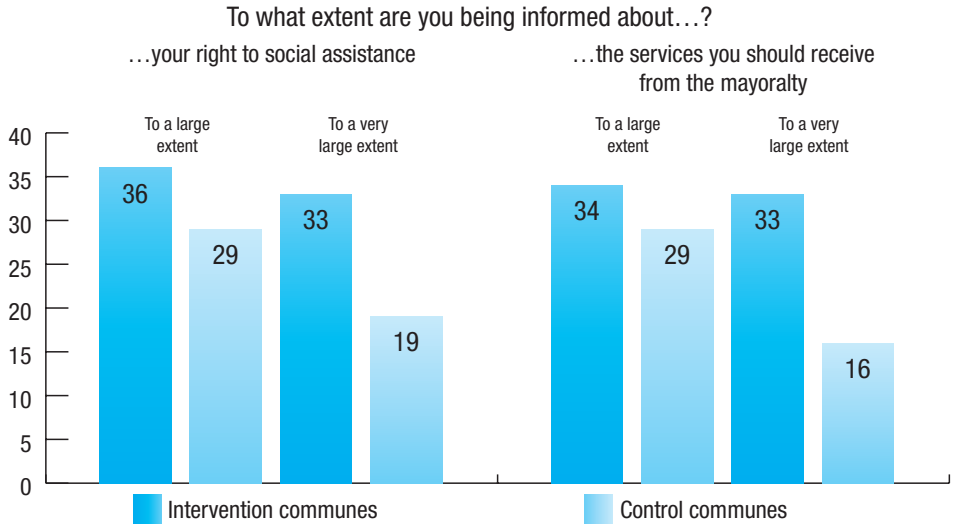
Information about rights and entitlements

Informing children and their families about their rights and entitlements was a service provided both as part of the minimum package of services recommended by the Aurora – given that, as shown previously, information was one of the most frequently delivered services – and as part of the projects funded via micro-grants which developed community centres. In these projects, information was accompanied by counselling for groups of parents, adolescents and children as well as for individuals (fewer cases).

The survey conducted to allow for a counterfactual evaluation (the group of people who received project services versus the group of people who did not benefit from the model intervention, from other communities) shows that **the level of information (about rights and entitlements to social support and mayoralty services) according to the adult respondents from the households with 'invisible' children who received the model intervention is significantly higher than the level of information among the control group.**

Therefore, the outcome of the modelling project, of the information campaigns and of the fieldwork carried out by the community workers hired in the project is an obvious significant increase in the beneficiaries' level of information about their rights to social assistance.

Figure 14. Level of information of the household children's main carer, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=824; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05 for the "To a very large extent" answers.

With regard to the level of information about fundamental child rights other than social ones (e.g. right to education, right to be registered with a family physician, right to vaccination), there are no significant differences between the group of beneficiaries and the group of people who did not benefit from the model services and micro-grants. The fact that not all communities had community health nurses may account for the limited level of information on health rights recorded via the survey.

On the other hand, the interviews with parents showed that, during the project, parents learned a lot of new things from the community workers and are better informed now than they were in 2011–2012. In addition, many parents noticed that, after being visited several times by the community workers, their children also became aware of their rights and started demanding their family observe those rights, showing they even know that they can talk to the social worker if they are abused.

3.2.1.3. Effects of service delivery on situations of vulnerability

Comparing the situations recorded at the first (2014) and, later, the second (2015) use of the Aurora questionnaire, progress can be noticed with regard to both identifying vulnerability cases and addressing them, namely:

– a series of vulnerabilities listed after the first assessment no longer featured at the second assessment, which is an important indicator of the effectiveness and impact of the services delivered as part of the minimum package[73];

– a series of vulnerabilities not listed in the initial assessment became visible at the second use of the Aurora questionnaire, which primarily indicates the dynamics of the cases[74], but also an increase in the effectiveness with which the vulnerabilities were identified.

Table 10. Evolution of the incidence of vulnerability cases assessed based on the Aurora questionnaire

Vulnerability	Number of initial cases (at T0)	% of cases in which the vulnerability is no longer present (listed at T0 only)	% of cases in which the vulnerability persisted (listed at both T0 and T1)
Child living in poverty	1570	79	21
Child not registered with the family physician	38	100	0
Child not enrolled in school, who dropped out of school or is at risk of dropping out	798	51	49
Adolescent/child with risk behaviours	992	65	35
Child living in a family prone to child violence, abuse or neglect	1602	52	48
Child living in precarious housing conditions	2845	23	77
Child with no ID papers	19	84	16
Child with only one or no parent at home	860	23	77
Child separated from their family or at risk of separation	316	60	40

Source: UNICEF – Aurora database

Data refer to children assessed both at T0 (2014) and at T1 (2015). Percentages are calculated relative to N (number of initial cases for which each vulnerability was identified at T0, as shown in the first column) for each and every vulnerability.

The vulnerability cases were addressed through the provision of basic services during the community workers' fieldwork as they delivered the package of services recommended in the project, starting with needs assessment and continuing with information, counselling, accompaniment and support with receiving/referral to primary and specialised services.

Interviews with the community workers show that they spent considerably more time in the field during the project than they did prior to 2011, in the case of those recruited from mayoralties, or than their peers hired by the local authority, in the case of those recruited from sources other than the mayoralties. This finding is direct evidence of the model's effectiveness, given that delivery of prevention services through outreach carried out by social workers was one of the first project objectives. Moreover, a noticeable outcome of the prevention services is the fact that some vulnerabilities have 'disappeared', between 23 percent for children living in precarious housing conditions or children with only one or no parent at home to 100 percent for children not registered with a family physician. Therefore, all children not registered with a family physician at the time of the first vulnerabilities assessment were registered over the following 9 months. Even poverty-related vulnerabilities were addressed in 80 percent of the cases recorded, which proves the effectiveness of the services delivered with the aim of ensuring the realisation of rights, including with regard to the receipt of social benefits.

73 See Chapter III. Evaluation results, section 3.2.1.2. Delivery of the minimum package of services, and Chapter III. Evaluation results, section 3.5.1. Impact on vulnerable children and their families

74 See Chapter III. Evaluation results, section 3.2.1.1. Model effectiveness in identifying vulnerable children and their families

Of equal relevance is the high dynamics of the identified vulnerabilities, as the data confirm the interview statements according to which many of the vulnerabilities the model addressed are recurring ones, they may show again even after the delivery of the services, and can be alleviated sustainably only through a long-term intervention.

The analysis of the children's vulnerability incidence shows no major differences between girls and boys (except for the gender-conditional vulnerabilities which refer only to girls). The biggest gender-related disparities are encountered at the first use of Aurora (in 2014), for preschoolers not enrolled in kindergarten (22 percent girls versus 18 percent boys) and for adolescents with sexual risk behaviours (28 percent boys versus 21 percent girls). These differences do not persist at the second use of the Aurora (in 2015), when the incidence of both vulnerabilities declines for both genders and the disparities no longer exceed two percentage points.

The analysis of the children's vulnerability incidence by ethnicity shows that some of the vulnerabilities register a higher incidence among the Roma children who are more at risk of violence, abuse or neglect.

Table 11. Incidence of the vulnerability related to risk of child violence, abuse or neglect, for girls and boys, Romanians and Roma, according to the data recorded in the Aurora

Assessed vulnerability	Analysis criteria		% of children identified with the vulnerability	
			Aurora (T0)	Aurora (T1)
Risk of child violence, abuse or neglect	gender	male	47	32
		female	42	29
	ethnicity	Romanian	43	29
		Roma	52	34
	Total		**44**	**30**
Child living in a family prone to child violence	gender	male	38	25
		female	32	20
	ethnicity	Romanian	33	20
		Roma	43	29
	Total		**35**	**22**
Child living in a family prone to child neglect	gender	male	28	17
		female	26	18
	ethnicity	Romanian	24	16
		Roma	36	23
	Total		**27**	**18**

Source: UNICEF – Aurora database. N for T0 (2014)=5,171, N for T1 (2015[75])=3,485. For the data recorded in the table, the sample size varies as follows: in 2014, total number of children N=5,178, of whom boys N=2,682, girls N=2,496, Romanians N=3,857, Roma N=1,268; in 2015, total number of children N=3,485, of whom boys N=1,818, girls N=1,667, Romanians N=2,621, Roma N=863.

The school dropout incidence is three times higher for Roma children compared to their Romanian peers (21 percent in 2014 and 15 percent in 2015 among the Roma, versus 6 percent in 2014 and 5 percent in 2015 among Romanian children), while the percentage of Roma children at risk of dropping out was two times higher in 2014 (22 percent versus 10 percent) and 1.5 times higher in 2015 (15 percent versus 10 percent) than that of their Romanian peers.

With reference to children being administered vitamin D and iron, when first used, the Aurora questionnaire recorded a ten percentage points higher incidence among the Romanian children (between 44 percent and 40 percent) versus Roma children (between 34 percent and 29 percent). The difference drops below 5 percentage points and the administration rate for vitamin D and iron increases in all cases to over 50 percent.

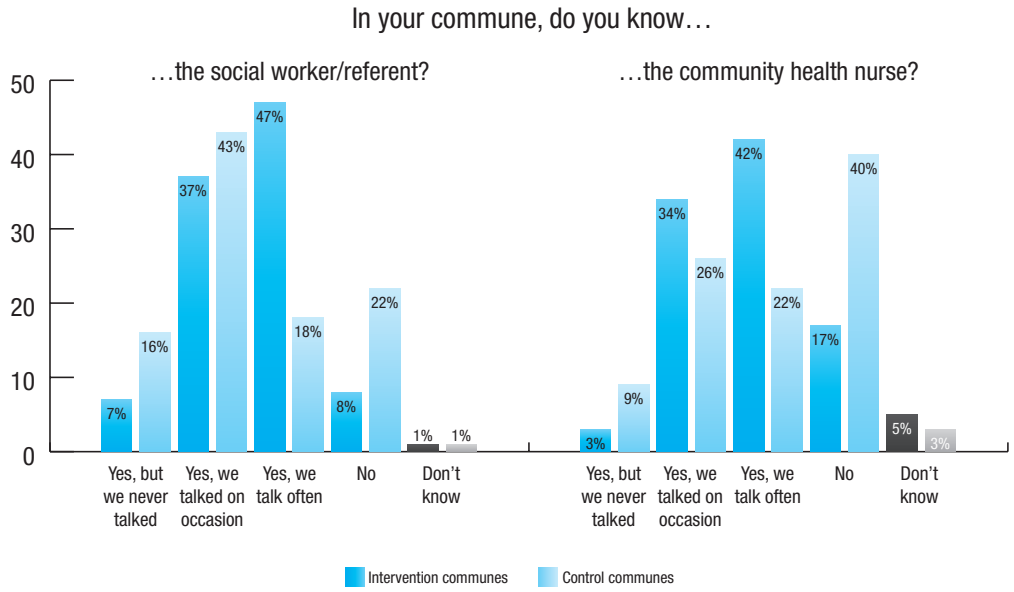
75 Given the methodology developed for the use of Aurora, for most of the children recorded in the database, the first use of Aurora was in 2014, while the second was in 2015. However, any new case recorded by the community workers is shown at T0, which is why not all cases recorded at T0 were identified in 2014, some being recorded in 2015.

The full table (shown in Annex 9) and the differences indicated above show that, even though there are a series of vulnerabilities in relation to which gender and ethnicity are relevant characteristics, they are relatively few. In addition, the differences recorded between the two uses of the Aurora questionnaire show progress was made and, even if some disparities still occur, they tend to grow smaller in the course of the intervention.

3.2.1.4. Service delivery capacity

An effective addressing of the identified vulnerabilities requires delivery of basic social and community health care services, which, in turn, requires the field presence of community workers. Their work should primarily consist of visits to their beneficiaries, and their capacity to interact with these and tailor the services recommended by the Aurora methodology to each beneficiary's particulars so as to reach the intended outcomes is one of the main features that lends the modelling project its overall effectiveness.

Figure 15. Level of knowledge of and interaction with the community workers, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=825; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05 for the "Yes, but we never talked", "Yes, we talk often", "No" answers.

Confirming the community workers' assessment, the survey conducted in the intervention communities in which the model was implemented until 2015 and in the control communities in which the model was implemented only in 2011 shows significant differences in terms of the community workers' presence in the field, visiting the vulnerable families, and their willingness to talk to the beneficiaries to find a solution to their problems.

Table 12. Community workers' fieldwork intensity, measured as frequency of visits to vulnerable households, in the intervention vs. the control communes

How often was your family visited by …		Intervention communes %	Control communes %
…the social/ outreach worker	Once a week	2	1
	A few times a month	28*	4
	Once a month	18*	8
	Less than once a month	31	28
	Never	21	60*

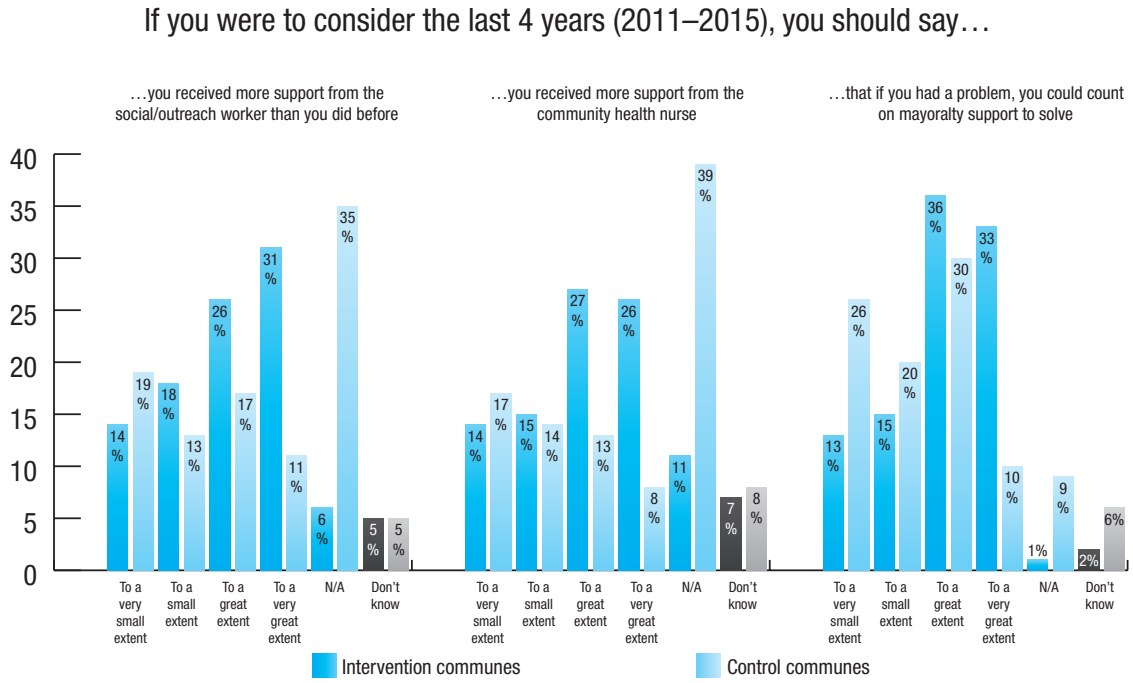
…the community health nurse	Once a week	2*	0
	A few times a month	24*	4
	Once a month	14*	7
	Less than once a month	28	26
	Never	31	64*

Source: Survey conducted in 2016, ICE and C|C|S|A|S

*N=766; data were weighted by age, ethnicity and educational attainment, *statistically significant differences for p=0.05*

The interview statements support the survey results according to which the social service recipients from the intervention communes received the support of community workers and rated it as useful two to three times more than those of the control communes.

Figure 16. Community workers' contribution to addressing the problems of vulnerable households, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=717; data were weighted by age, ethnicity and educational attainment

The interviewed parents specified the type of support they received from the community workers. They assessed the care and drive shown by the social/outreach workers and the CHNs, the effort put into addressing each case and the support they provided to children first and foremost. The information and counselling sessions organised in the projects that were developed with micro-grant funding are what the interviewed parents mentioned most often, but so were the cases in which they were provided with referral, support to access specialised services and even accompaniment to those services.

"We have a very good relationship with the social worker. He is a person you can talk to about any problem you have, he listens to our problems and is there for us whenever we need help, he helps us when we need a document, advice. Apart from the material aid we received, he stood by us, helped out in an instant. [...] He helped us get the emergency aid after our home burnt down. He helped us with the paperwork, came with us to Buzău to file it with the AJPIS [County Agency for Payments and Social Inspection]. He came with us because we didn't know where we were supposed to go. Advised us to take our problems to the county institutions for resolution. For instance, he accompanied us to AJPIS Buzău to draw up the papers for the emergency aid, we had problems with the certificates/attestations in the file, but with his help, we took care of it".

Interviewed parent, Buzău county

Nevertheless, the experience gained in implementing the modelling project shows one-time service delivery is not enough, considering that the intervention is aimed at cases with complex vulnerabilities and addressing some of these vulnerabilities rests on the success of other interventions. For instance, information and counselling determine immediate behaviour changes only in few cases, but a persistent approach may generate change. At the same time, some of the services that provide guidance and support or referral to specialised services (such as the recovery services for people with disabilities) should be recurrent because specialised services require continued accessing.

"Early and repeated intervention in problem families is a need. For instance, there is this family with 8 children, the parents are alcohol users, into which a great deal of resources were invested to avoid child-family separation. Several organisations and institutions got involved, but the family itself did nothing to contribute, it just expected to receive help. If the intervention occurs early, the situation will not escalate. To get good results, the intervention needs to be repeated".

Social/outreach worker, Bacău county

With regard to how effective the services are: *"To a certain extent, because people stick to the same habits no matter how hard you try to explain otherwise, to inform them; if they are more flexible, then yes. There are few of them for which one can say problems were solved, say 30 percent, even less".*

Social/outreach worker, Botoșani county

Given the characteristics of the beneficiaries and of the communities in which the model was implemented, and that service delivery should occur over a period of time that exceeds the timespan of a particular model intervention, future similar interventions will have to consider the available time and the need to use field multidisciplinary teams of community workers, including a social worker, community health nurse, school mediator or counsellor,[76] and, in certain cases, a health mediator, to carry out prevention activities and ensure early intervention, especially in cases of complex vulnerabilities.

3.2.1.5. Community counselling and support centres for children and parents

Community centres providing counselling and support to children and parents were set up in all 32 communes in which the model was implemented until 2015, as a direct output of the projects funded via micro-grants.

The centres carried out information, counselling, non-formal learning activities for children and parents as well as recreational activities for children. A limited number of project beneficiaries received psychological counselling, family planning and other specialised services delivered by qualified staff. The activities developed in the micro-grant-funded projects were very well received by the community and were considered highly useful by the community workers who benefited from direct specialised support in their everyday work, but also by the county supervisors. In 2014, the activities focused on preventing and combating violence against children and domestic violence, while in 2015, the activities primarily targeted adolescents, with the aim of eliminating or mitigating risk behaviours.

"I believe they [the micro-grants] *are the highest reward for professionals and beneficiaries, they cause change, they stimulate the beneficiaries, they involve the community via volunteers, increasing the beneficiaries' motivation for change and facilitating work with important/professional people".*

Social/outreach worker, Suceava county

"This project component [the micro-grants] was a success at every level: for the community, for the families with social problems, but also for me personally, I learned to write a project proposal. The greatest advantage is that they [the micro-grants] enabled activities with specialists who had not been available before in the commune, whose occupations the beneficiaries didn't even know the meaning of – like the psychologist, for instance".

Asistent/lucrător social, județul Bacău

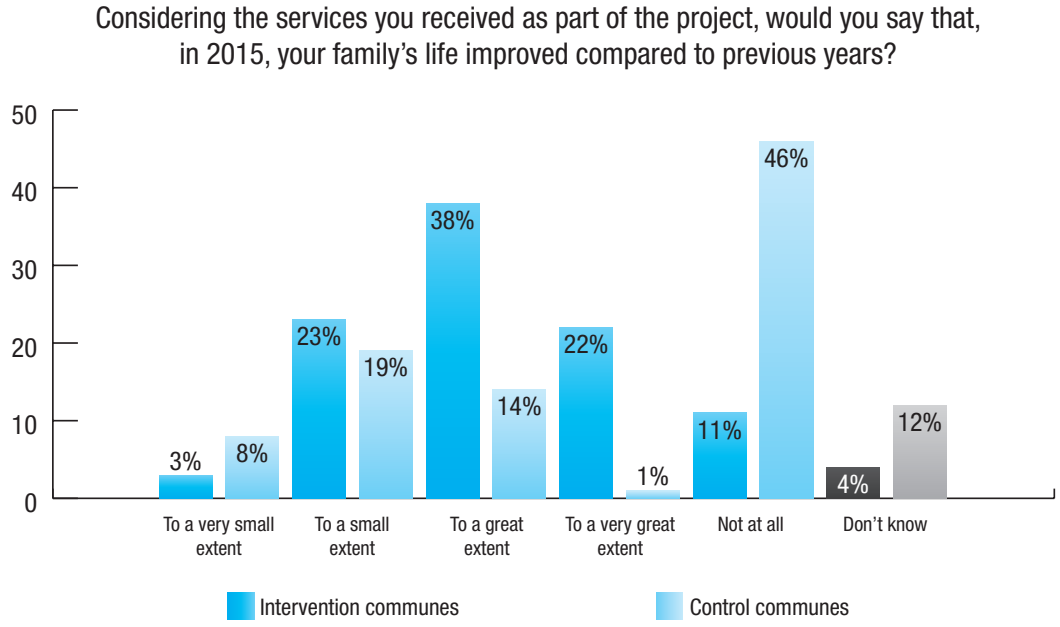
76 See Chapter III Evaluation results, section 3.2.1.2. Delivery of the minimum package of services, and section 3.2.1.7. The integrated approach

"Micro-grants were a real succes. They were a genuine exercise in acquiring skills like writing and implementing a project. The activities that were carried out via the micro-grant were based on the community's needs and had a positive impact on their beneficiaries. The micro-grant implementation increased the mayoralties' capacity to implement projects and the professionals' capacity to work in keeping with certain donor rules".

Social/outreach worker, Neamț county

According to the survey we conducted, over 60 percent of the respondents from the intervention communes took part in the activities organised by the Community Centre, invited by one of the community workers. 50 percent of all the respondents from the intervention communes, including those who participated in the activities of the Community Centre, said their family's life improved to a great or very great extent as a result of the project, which proves the project effectiveness and impact due to this component. In addition, the assessment regarding family life improvement rated significantly higher in the intervention communes than in the control group.

Figure 17. Impact of social services on beneficiaries' life, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=431; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05 for the "To a great extent", "To a very great extent", "Not at all" and "Don't know" answers.

The workshops attended by children showed that community workers are people involved in the children's life, though the children are not always able to provide details as to the exact nature of these people's work, beyond the activities they carry out as part of the micro-grants. The children feel at ease in their presence, however, there are few communities in which children are used to being asked their opinion or used to expressing their options and preferences. According to the children's accounts, the two specialists came to each child's home and invited them to take part in activities such as those aimed at combating violence, including information and counselling about their rights, about the attitude and behaviour they should have relative to physical or verbal violence, but also to workshops where "together they painted t-shirts with messages like «Stop violence» or «Violence hurts»". Children and adolescents also took part in information and counselling activities on topics of personal hygiene, pill treatment, the importance of vaccination. In the communes where the CHNs were present as well, the activities were conducted by the social worker and the CHN as a team, while, in some cases, professionals from town were brought on board to deliver specialised services and conduct workshops for children and adolescents. The micro-grants also helped develop introductory leaflets which participants to the information and counselling activities received afterwards for further reading. Thanks to the group information and counselling activities which facilitated

group discussions, brainstorming and sharing of ideas, children and especially adolescents were able to understand their problems better and identify potential solutions to them. As such, children and adolescents felt they could count on the community workers' support to solve not only the problems that the grown-ups had identified, but their own as well, by listening to them and working with them towards resolution.

On the other hand, even though the micro-grant project development experience was highly regarded by the community workers, the lead on developing new projects stayed with the county authorities, since, so far, there haven't been any other projects initiated at the local level by mayoralties to continue the UNICEF model. In fact, a review of the projects that were awarded the micro-grants and of the related reports reveals that both community workers and county supervisors need further project management training to enable an assessment of the effectiveness of this component based on the data recorded at the time of implementation.

3.2.1.6. Community engagement

During the implementation of the modelling project, the intervention communes, unlike the control ones, registered an important progress with regard to the community intervention approach based on the activity of the community workers, through:

– community cooperation within the Community Consultative Structures;

– inter-institutional cooperation and engagement of specialists (e.g. psychologists) within the community centres (micro-grant projects);

– systematic use of an electronic tool for case identification and management (Aurora);

– consistent and constructive cooperation with the GDSACP and the DPH.

Starting 2013, the micro-grant projects were implemented in all communities, as were the Aurora and the cooperation with the GDSACP and the DPH, but the Community Consultative Structures did not work the same everywhere.

"The micro-grant determined the local communities to get involved, while emulating the people involved in the micro-grant project activities generated added value for those communities. The community itself changed its outlook on social service delivery, it realised it was possible to carry out activities for children and their families using minimal financial resources, and their beneficiaries want these activities to go on beyond the projects. Partnerships were also concluded with the County Centre for Prevention, Assessment and Counselling, and the joint activities can continue in the future as well".

Social/outreach worker, Neamț county

As shown by the interviews with community workers, in some communes the CCS meets at least once a month, while in other communes, their meetings are half-yearly or quarterly. Even so, almost all the community workers we interviewed said they worked well with the CCS and its members and that, when necessary, each relevant stakeholder is ready to participate in solving one social problem or another.

"The CCS members did not meet according to a particular schedule, only on a need basis. I worked with each of them, I communicated with the family physician and kept in touch with the policeman. The involvement of the priest was also important as he took part in the meetings organised with the parents. We went over the risks generated by the tablet computer and over what his own records showed".

Social/outreach worker, Vaslui county

"The CCS provided support, convened whenever necessary and it represents a successful component, given that its members bring to the table their knowledge of the community and the authority they hold within the community".

Social/outreach worker, Suceava county

Moreover, in Bacău county, where the UNICEF intervention is ongoing, there is an increased level of engagement and cooperation between the CCS and the community workers.

3.2.1.7. The integrated approach

According to the survey, the recipients of social services are satisfied and highly satisfied with the individual work of the social worker and of the community health nurse, as well as with their work as a team, where available. There are no notable differences in the assessment of the two community workers' individual activity and their teamwork as a whole. The differences become significant when comparing the intervention communes versus the control ones, in that the people from the control group are much less satisfied with the services they received.

Table 13. Household children's main carers' personal assessment of community workers' services, in the intervention vs. the control communes

How would you rate the services provided by …		% of the intervention sample	% of the control sample
…the social/outreach worker	Very poor	4	6
	Poor	4	4
	Good	36	42
	Very good	47*	15
	Don't know/Won't answer	10	33*
…the community health nurse	Very poor	2	4
	Poor	5	3
	Good	26	30
	Very good	45*	18
	Don't know/Won't answer	21	44*
…the two of them (SW and CHN) together as a team	Very poor	2	4
	Poor	2	5
	Good	26	29
	Very good	44*	12
	Don't know/Won't answer	27	51*

Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=787; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05.

As the qualitative research shows, community workers rated their teamwork highly and even when there were disagreements, they managed to put them aside as the need to solve the cases prevailed. Many of the community workers particularly appreciated the fact that teamwork provided them with a chance to exchange views and to look at a case and approach service delivery from different professional perspectives.

"I teamed with a CHN, a secretary, a policeman, we were 4 people out on fieldwork. Teamwork is extremely beneficial, most welcome, you have several people with different perceptions, more ideas, we exercise more authority".

Social/outreach worker, Botoșani county

"It's one thing to have one person go in the field to address a complex case and another to have two specialists from different areas of expertise, with different outlooks and experiences who will manage the situation differently and complement each other's efforts. If the model is replicated, the CCS should be given a higher profile, it should be given a more prominent and visible role".

DPH supervisor, Botoșani county

"With the arrival of the community health nurse, my work improved and the burden became lighter, in that we are both alert as to the community's problems, we get information, we jointly set a course of action and engage the

CCS members as needed. For instance, if the CHN identifies a pregnant adolescent girl, she lets me know and together we decide our intervention, our approach to solving the problems we identify".

Social/outreach worker, Buzău county

The integrated approach was particularly useful in ensuring access to and information on the available health services.

"What was most important in achieving this increase [in the access to health services] was the teamwork carried out by the social worker and the community health nurse, in the sense that they could help each other: the social worker would identify a child who had not been vaccinated and they would alert the community health nurse who, in turn, would know what had to be done to solve the vaccination problem and got it done; the social worker would contribute to mobilising the community members during the vaccination campaign, an opportunity to educate the mothers at home and provide them with easy to understand information and basic recommendations on preventing pregnancies and family planning, and on maintaining good hygiene. Perhaps the interventions were rather minor at the individual level, however, at the community level, this approach was able to change habits, mentalities, it actually increased access to health services".

Community health nurse, Suceava county

Integrating the activities of the community workers was possible due to the design/concept of the working tools used in the project. Aurora was used both by the social workers and by the CHNs, consisting of questions that covered all relevant areas, including the health of children and pregnant women, and generating services in all relevant fields. In the communes in which a CHN was available within the SPAS, delivery of various health services fell to them, while in the communes without a CHN, those services were delivered by the social/outreach workers, within their competence, with the guidance and support of the DPH supervisor.

Interviews conducted in the communes where there was no CHN showed that the absence of a CHN translated into a higher workload for the social worker, affecting quality of work and the extent to which they could provide certain services that were part of the CHN portfolio. On the other hand, due to the various meetings organised for them during the model implementation (training sessions, experience exchange), the workers/specialists hired and involved in the project were able to build a cross-cutting network which helped to further the exchange of solutions to similar problems they encountered as well as to make up for the absence of the CHN in certain communities.

3.2.2. Increasing the capacity of the Public Social Assistance Services (SPAS) and of other responsible institutions

Evaluation question and specific approach

Did the modelling project help develop local authority capacity to deliver the minimum package of integrated social services (compared to the 32 communities where the model interventions occurred only in 2011)?

In terms of immediate outcomes for communities, the SPAS and county institutions, the Theory of Change for the "First Priority: No More 'Invisible' Children!" modelling project focused on:

– Increasing social workers' and community health nurses' capacity to identify vulnerable children and their families;

– Effective delivery of the minimum package of services;

– Increasing the GDSACP and DPH capacity to provide methodological support to local authorities.

Each of these objectives will be analysed further based on the available data, particularly those resulting from the research interviews and focus groups conducted at county level.

3.2.2.1. SPAS Capacity

As the demonstration project documentation shows, both in the intervention communes and in the control ones (in 2011), most of the social/outreach workers were recruited from sources other than the mayoralty and integrated in the SPAS to carry out project-specific activities, primarily through outreach/fieldwork, and to complement the work of the social/outreach workers who were already tasked to manage the social benefits files. Where it was not possible to identify potential employees from outside the administrative apparatus, the project recruited one of the mayoralty employees who was paid for the extra work assigned in the project. As such, the recruiting of social/outreach workers for the modelling project increased the SPAS capacity as the activities carried out by the community workers (outreach prevention services) were additional and complementary to what the SPAS undertook prior to project implementation.

The community health workers, on the other hand, were always mayoralty employees. After first testing the intervention of the social/outreach workers, starting 2013, the project was expanded to include the community health care component. This component was developed and tested in partnership with the CPSS, based on the experience and expertise of the specialists involved in the project. Thus, the CHNs were integrated in the team delivering the minimum package of services. Where no community health nurses were available, the local authorities together with the county DPH made the necessary efforts to identify and recruit them. Still, the process undertaken to identify community health nurses proved even more challenging than the one for the social workers, and CHNs were hired for the duration of the project only in 25 out of the 32 target communities.

According to the interviews conducted with social workers and community health nurses, during project implementation, in addition to the identification service carried out using the Aurora questionnaire, **a social worker provided a wide range of services and interventions which involved several home visits, activities and meetings required to address 5 to 15 cases per month**, not counting other mayoralty tasks (i.e. handling the social benefits files).

On the other hand, in large communes with many scattered villages, a single social worker has limited capacity to visit households and deliver services, particularly if their transportation is not covered. Under the circumstances, activities need careful planning and their implementation requires additional resources.

"One week might involve being present in court, 2 days would be spent with micro-grant activities, accompanying the counsellor for sessions, fieldwork, assessments, take the vaccination programme for instance. The main travel mode was on foot, to each village in the commune".

Social/outreach worker, Bacău county

"Unless a social worker is hired to see to these activities separately from those related to the social benefits, there won't be continuity. It would be good to have separate funds to pay the social worker and cover the expense account for the model activities, funds not from the local budget resources which can't even cover the local infrastructure projects or the mayoralty employees' salaries. Not least, the mayors should be motivated, incentivised to become willing to hire these specialists".

Social/outreach worker, Suceava county

On the other hand, the interviews showed that the **community health nurses' work can entail over 100 cases in a month or even more, covering all categories of beneficiaries of community health care services, regardless of age or vulnerability**. As such, the authors of the present report believe that one could conceive a method to organise an integrated service delivery that would also accommodate the community workers' duties to other categories of beneficiaries as well as the resulting workload. Such an approach would be likely to improve the two community professionals' joint case management of vulnerable children. The community workers' capacity to deliver services for over 4,500 cases of children and families with vulnerabilities is deemed low. As the findings of the second formative evaluation also show, in 2012, 64 social/outreach workers in the 64 project communes were delivering services, on average, for 97 children per

community, an workload considered "rather large"[77]. By comparison, data from the Aurora (2015) show an average of 140 cases per community or 72 cases per community worker. All these data point to an workload that is more than community workers can cover, according to their statements.

3.2.2.2. Community worker skills/competencies required in delivering the minimum package of services

Professionals involved in the modelling project, both at local and county level, received training which focused less on the initial training per specific profession and more on developing the skills/competencies required to undertake the project tasks and use the integrated approach and new working methodologies, as shown in the table below.

Table 14. Training of professionals during the "First Priority: No More 'Invisible' Children!" modelling project

Year	Training topic	# hours of training	Target group
2011	Developing the capacity of local stakeholders in rural areas to deliver effective and efficient community-based services	20	Social workers and supervisors
	Planning supervisory activities in working meetings	16	GDSACP supervisors
2012	Organising and planning local activities in meetings organised by the county resource centres (by the supervisors)	6	Social workers
	Planning supervisory activities in working meetings	16	GDSACP supervisors
2013	Organising and planning local activities in meetings organised by the county resource centres (by the supervisors) – including developing and implementing micro-grant projects	6	Social workers and community health nurses
	Planning supervisory activities in working meetings	16	GDSACP and DPH supervisors
	ToT on preventing and combating violence against children	10	GDSACP and DPH supervisors
2014	Training session on preventing and combating violence against children	10	Social workers and community health nurses; GDSACP and DPH supervisors
	Training session on using the Aurora working methodology	10	social workers and community health nurses; GDSACP and DPH supervisors
	Organising and planning local activities in meetings organised by the county resource centres (by the supervisors) – including developing and implementing local campaigns to prevent violence against children	6	Social workers and community health nurses
	Planning supervisory activities in working meetings	16	GDSACP and DPH supervisors
	ToT on adolescent problems and risk behaviours	10	GDSACP and DPH supervisors
2015	Training session on working with adolescents and delivering services that address risk behaviours	10	Social workers and community health nurses; GDSACP and DPH supervisors
	Organising and planning local activities in meetings organised by the county resource centres (by the supervisors) – including developing and implementing interventions for adolescents with risk behaviours	6	Social workers and community health nurses
	Planning supervisory activities in working meetings	16	GDSACP and DPH supervisors

Source: UNICEF

Social/outreach workers from both the intervention communes and the control communes took part in one training session organised in 2011. Later on, further experience/know-how exchanges and training

77 Stănculescu, M. S. (coord.), 2013, p. 77

events were organised in the intervention communities on topics such as preventing and combating violence against children and domestic violence, and adolescent development. The training approach involved organising ToT sessions for county supervisors who, in turn, facilitated training sessions, working and planning meetings for the community workers in their respective county.

An important stage in the training of community workers was teaching them to use the Aurora tool. Here, we must point out that the model included not only training of the human resources (which are mobile and potentially volatile), but also providing the SPAS with valuable working methodology and tools which enables them to continue to ensure increased intervention, as opposed to a community which never received this kind of methodological support. In terms of personal assessment, social workers from both the intervention and the control communes believe that their capacity to help children and their families increased after the training received in 2011. County supervisors also believe that community workers' capacity and the quality of their work has increased as a result of the exposure to the training sessions organised during the project.

"Quantitatively, I think they've improved their activity, they've broadened their horizons, in terms of community information, and since they are community-oriented, I think they've improved their social work service a great deal".

DPH supervisor, Botoșani county

As regards the initial training of the community workers, the following are to be noted:

– of the total number of social/outreach workers, 18 have specialised education and are social workers per se, which shows there are differences in the level of knowledge and skills each of them started out with at the beginning of the implementation. Although the need for specialised training was not assessed during the present evaluation, we can say that the professionals' level of knowledge and their intervention practices could be enhanced and updated through continuing education programmes;

– on the other hand, in the community health care field, the local professionals' need for initial training was assessed by UNICEF in partnership with the CPSS and addressed in the project through thematic meetings. Specialised continuing education for this professional category too should remain a recurrent objective on the local authorities' agenda as well as on that of the county specialists, particularly in light of the new regulations governing community health care, of the disparities in the CHN competency level (as noticed in the evaluation), and of the need for new working methodologies which will also require specific training.

3.2.2.3. SPAS capacity-building via the use of Aurora

An important project output was the development and testing of the Aurora working methodology used by the community workers, which enables: a comprehensive assessment of children and their families' situation, involving unitary data collection on all household members, the identification of their vulnerabilities and the automatic listing of services to address those vulnerabilities, to be delivered in the form of a minimum package of services. The social/outreach worker cannot alter the list of vulnerabilities as it is automatically generated once they fill in the answers to the questions assessing the situation.

"Aurora was refined based on the feedback received from the field and the county level or resulting from the sessions we attended. The changes triggered by the Aurora: it helps with the reporting process, it provides a record of the cases. For the community workers, the change is that they have a new modern tool and being connected to the Internet, you have access to information anywhere in the field".

DPH supervisor, Botoșani county

"If all communes had the Aurora tool and that would be connected to the CMTIS, we would have quite a different picture. Identification was the most successful service, next to Needs assessment, because once these two are completed, half the problem is basically solved".

GDSACP supervisor, Botoșani county

"The Aurora platform and application aid the local community workers, eliminate bias (e.g. in one community, the worker may assess a pregnant underage girl as being vulnerable, while in another community, the worker may assess her as not vulnerable), and generate precisely the type of services that need to be delivered".

Social/outreach worker, Neamț county

The accuracy of the data on the identified 'invisible' children's vulnerabilities also varied a great deal between 2011 and 2015. The issues reported by the formative evaluations with regard to the coverage of the identification activities are also the cause of an uneven assessment of children's vulnerabilities. According to the community workers, these deficiencies were solved by the Aurora.

"Let me give you some examples: in 2012, we drew up a kind of leaflet – about the invisible child, to disseminate in the community, and we made hundreds of them, starting with the definition of the invisible child; in 2011, it was about rights and obligations, also a kind of information sheets we distributed to parents. The invisible children were identified in 2011, we started out with 48 children with multiple vulnerabilities – at the time, in 2011, there were only 8 vulnerabilities, whereas now the Aurora application lists 14–15 vulnerabilities and 40 sub-vulnerabilities. That means that right from the start, the identification of the risks faced by children and their families is much better now and you can deliver specific services in each field: health, education, social services. Before that, the services were not structured so well, nor were the vulnerabilities well defined. We're done with 2011, we observed a few vulnerabilities, what I did in the community was to conduct a training course for the carers of children with disabilities, also a course on parental education, all of these carried out with volunteers' aid. I organised a school counselling and guidance session as well because I saw that these young people ceased to attend high school classes. I did not know the cause of this school dropout, I couldn't figure it out. With time, I began to identify the causes. In 2012, I thought it was the parents who were not all that well-intentioned, then I found out about the parents' level of education, I saw the available infrastructure and how difficult it was for children from certain villages to get to school".

Social/outreach worker, Vaslui county

The package of basic services also includes recommendations for other necessary primary and specialised services (through accompaniment or referral).

"Once we learned what a centralised data system is all about, we could get a feel of the commune and its problems. Aurora is the best project proposal if you're looking for funding in the social field of interest, it is a source of statistics as well as a mapping of the community. It gives the social worker and the CHN the opportunity to work together without fear of overlapping".

GDSACP supervisor, Botoșani county

Aurora received unanimous recognition, as social workers, community health nurses, county supervisors and national stakeholders alike who used it or were familiar with it consider it a highly useful and accurate tool in identifying and assessing vulnerabilities. Even though, at first, the tool was perceived as cumbersome and time-consuming, the interviews we conducted showed that Aurora contributed significantly to increasing the quality of the activities/services carried out for the identification of the 'invisible' children, needs assessment, monitoring and vulnerability reassessment. Over time, all community workers came to value the tool for its usefulness and especially for the information it provides.

"Initially, the Aurora application and platform was a nightmare, but later on, it proved most useful. It wasn't easy to find yourself in a household holding a tablet computer while that family was struggling with poverty. It took a long while until we explained to those families what purpose the tablet served, the process of providing information about the Aurora application took a lot of time, around 30 min. per household. Another useful thing about the Aurora was that it generated services".

Social/outreach worker, Neamț county

The change in the identification strategy, from the comprehensive household census in 2011 to the use of the Aurora for cases with previously available information on existing vulnerabilities, as well as cases where vulnerabilities were identified by the community workers, directly or with the aid of other people, leads to a decrease in the extent of systematic and full vulnerability identification. Even so, in the communities in which it is used, the Aurora ensures increased identification of vulnerable children, compared to communities with no form of fieldwork/outreach-based identification.

On the other hand, the Aurora could sustain certain enhancements, particularly with regard to its integration with the community workers' other activities and reporting duties which could use the data collected with the help of the Aurora.

"The indicators generated by the Aurora do help, but in the community workers' [the community health nurses'] reporting on their routine activity, the tool does not provide sufficient support".

DPH supervisor, Botoșani county

The issues highlighted most often during the interviews were those related, on the one hand, to the possibility of using the information recorded via Aurora in preparing the necessary documentation for granting various types of child and family social benefits, and, on the other hand, to using the application to generate summaries and reports requested by other public authorities regarding various aspects of the social workers' activity (e.g. services and social benefits they provide) or required to undertake a sustainable and informed development of social services that meet the needs of each local community.

3.2.2.4. County supervisors' input

Training the GDSACP and DPH supervisors and setting up resource centers within these county-level deconcentrated public institutions helped lay the groundwork for using the resources to support other communes than those included in the UNICEF model. Obviously, the intervention communes covered in the modelling project benefited from a series of additional key support features, including specialists' field visits.

During the interviews conducted for the purposes of the present summative evaluation, the cooperation aspect rated high and the supervisors' support in increasing the social/outreach workers' capacity proved to be substantial, particularly since some of the workers were beginners or had no specialised knowledge in the field of social assistance.

"I worked very well with the supervisor and their co-workers, both during the project and afterwards. The type of support received was a little bit of everything – coordination, supervision, intervention, case resolution. The GDSACP support forte was in matters of legislation".

Social/outreach worker, Botoșani county

"Aurora was like a "sunbeam" because the county supervisor had a clear real-time picture of the field worker's activity, the assessment is carried out accurately, in real time, focusing on objectivity and urgency. The fact that the application generates graph charts, performs assessments, issues a service plan is all very useful because there are social workers without higher education".

GDSACP supervisor, Iași county

In fact, the GDSACP supervisors too received training and went on study tours during the project, and considered that capacity-building together with the Aurora enabled them to have a very good knowledge of the field and provide an accurate monitoring of the community workers' activity, both the application and the related database receiving unanimous positive feedback at the county level.

3.2.3. Reducing the pressure on the child care system

Did the modelling project contribute to reducing the pressure on the child care system? And on the health care system?

To answer this evaluation question, we requested and analysed the GDSACP data on children who had been separated from their families and placed in public care and on children with a successful reintegration into the family, in the counties in which the model was implemented. These data were then compared to the Aurora data in order to validate the assumptions underlying the definition of the child-family separation risk and to formulate recommendations for an improved definition of this risk. In addition, data was also requested from DPH Botoșani, as the county had the largest CHN coverage.

At the same time, we used information obtained from the interviews to determine whether or not the county professionals perceived a decrease in the pressure on the child care system or on the health system.

3.2.3.1. Child-family separation risk definition and the "Priority Zero Service"

In the absence of an established definition available in the specialised literature, in the legislation or accepted by international organisations with regard to the risk of child-family separation, the demonstration project used a "working definition" which was not evidence-based, but rather the result of a consultation process among relevant specialists community workers and GDSACP supervisors[78]. According to the working definition, a child at risk of separation from his/her family is a child with 7 or more vulnerabilities accumulated.

"Priority zero service" was designed to address this risk and was generated in all the cases in which a child accumulated 7 or more vulnerabilities. The service aimed to provide a roadmap of the main actions for the cooperation between community workers, community consultative structures and county structures (the GDSACP and the DPH), as well as of the necessary steps for delivering the service, planning and prioritizing the services included in the minimum package of services, and undertaking monitoring and case reassessment. "Priority zero service" entails contacting the GDSACP and working together with the community stakeholders and the GDSACP to address the vulnerabilities, seeking to avoid child-family separation, to the extent possible. This service was generated rarely, as there were few cases in which children accumulated more than 7 vulnerabilities. Moreover, at the beginning, right after the service was introduced, the social workers did not fully understand it and would often mistake it, in part, for the emergency procedures defined in the legislation (Order 177/2003, Law 217/2003 etc.), judging it was not applicable unless they were dealing with serious exceptional circumstances.

"This component needs to be backed by the professional's judgement, because when we used it in our commune, Aurora flagged priority 0 for a family whose situation was not highly serious, but it did not flag it for a family in a much more difficult situation".

Social/outreach worker, Bacău county

For the record, this service is designed to prevent serious situations which require urgent intervention and removing the child from their family to preserve their best interest. As such, in terms of prevention, "priority zero service" aims to keep the child with their family. Delivery of this service is given priority (hence its name "priority zero") over other services, as it addresses a situation of multiple vulnerabilities, it involves communication with the GDSACP and a potential prioritization of the service package that the Aurora recommends and which, for multiple vulnerabilities, may consist of a large number of services. The GDSACP emergency procedure can be enforced even when only one vulnerability is present but child-family separation still needs to be undertaken swiftly in order to protect the child's rights.

78 From the outset, the model aimed to use the experience accrued during the implementation to help add to/adjust the definition, depending on its results at community level and on the recommendations of the summative evaluation.

3.2.3.2. Entries into and exits from the child care system

According to the data collected by GDSACP at the request of UNCEF, the overall number of children in public care as a result of child-family separation was, in 2013, 2014 and 2015, one third higher in the intervention communes than in the control ones (absolute figure). A decrease in the difference between the two groups of communities occurs in 2015, but the number of children separated from their families in the intervention communes remains higher than those from the comparison group. The differences persist even when focusing only on the cases of child-family separation on grounds of abuse and neglect.

To validate the hypothesis according to which the modelling project reduces pressure on the child care system, we analysed data regarding the entries into the public care system and the instances of reintegration into the family, in relation to the overall number of inhabitants (provided by the NIS). The table below shows the results of this analysis according to which there are no differences between the intervention and the control communes. The analysis is therefore inconclusive as to the hypothesis that the model reduces pressure on the public child care system.

Table 15. Total number of entries into and exits from the child care system during 2013–2014, in the 8 counties in which the model was implemented

	Intervention communes					Control communes				
	2013	2014	2015	TOTAL CASES	Share in the overall population‰ (n=145,957)	2013	2014	2015	TOTAL CASES	Share in the overall population‰ (n=112,418)
Children separated from their family	90	109	82	281	1.93‰	64	56	75	195	1.73‰
Children separated from their family on grounds of abuse and neglect	53	63	50	166	1.14‰	38	39	47	124	1.10‰
Children reintegrated into their family	13	15	16	44	0.30‰	19	14	2	35	0.31‰

Source: Data made available by the GDSACP in each of the 8 counties

Even so, when it comes to children's reintegration into their family, the absolute value for reintegration in the intervention communes is higher than the one recorded in the control communes (44 vs. 35). This can be accounted for by the fact that reintegration is possible only when the family is ready for it and when the community has the necessary services to support the family and enable it to ensure an environment that fosters child development.

On the other hand, the qualitative research shows that an increase in the number of entries into the system recorded in the intervention communes, and therefore **an increase rather than a decrease in the pressure on the child care system, is an outcome of the modelling project and a result of the community workers' efforts and focus in identifying vulnerabilities as well as their use of the Aurora working methodology**.

The GDSACP supervisors and part of the social workers we interviewed believed the pressure on the child care system decreases as project implementation advances, however, this decrease in pressure is neither mechanical, nor quantitative in nature, but rather qualitative. The children are recorded by the GDSACP and, if the situation calls for it, they are taken into the child care system, but due to the activity undertaken locally and to the Aurora data entries, **the work of the GDSACP is eased a great deal**.

"This model reduces the pressure on the child care system. There are cases that get solved in our commune and there is no need for the GDSACP intervention. For instance, we had a case, 3 children who were left without a mother and a father and no relative that we could identify to care for them. We eventually identified a member of the community, a pensioner, who was willing to be their guardian. The three children are well cared for, they stayed in the community, and their placement in a centre or with a professional foster carer was avoided".

Social/outreach worker, Buzău county

"This community intervention definitely reduces pressure on the GDSACP, case in point: a family from Corbasca, with many children and multiple vulnerabilities identified, the work to support this family was undertaken at the community level, and even if, later on, the GDSACP was involved, it was to mobilise additional resources which the community did not have".

GDSACP supervisor, Bacău county

Experience drawn from the model implementation shows that pressure on the child care system will decrease once prevention service delivery is systematic and long-term. The modelling project proposes effective mechanisms for vulnerability identification/assessment, such as the Aurora and the "priority zero service".

"A reduced pressure on the system was indeed expected. At first, the pressure increased because the problems were being identified, they became known and the resources to address them were not available at the local level. […] Now we have increased knowledge of how to approach the problems identified in the community/the vulnerable families and of who is supposed to carry out the intervention, though initially, the practice was to refer the identified cases to the county level. I think that, in the long run, the number of those referred to the GDSACP will drop because they have learnt to find solutions to their problems locally".

GDSACP supervisor, Buzău county

Therefore, if the Aurora is used in the community for systematic identification and assessment of existing needs and vulnerabilities (and not only to document cases already identified as being highly vulnerable), and services aimed at preventing child-family separation are delivered early and long enough to improve parental behaviours and attitudes, the child will not be separated from their family.

3.2.3.3. Vulnerabilities of children in public care

I. Identified vulnerabilities

For an evidence-based definition of the risk of child-family separation, we analysed the data that GDSACP supervisors in each county collected from the files of children placed in public care, using a database-type structure proposed by UNICEF. In our analysis, we took into consideration the fact that, as shown in the 2016 study conducted by UNICEF, NAPCRA and the World Bank[79], the GDSACP recording of children's vulnerabilities is often incomplete and, at times, innacurate, and the data on the vulnerabilities of children who entered public care are to be treated with caution.

According to the GDSACP files, of the children from the intervention communes who were separated from their families, none have more than 7 vulnerabilities on record, and only 5 of the 54 children in public care were recorded with 7 vulnerabilities. 45 of the 54 were recorded as "children living in poverty", 41 were identified as "children living in families prone to child violence, abuse or neglect", while 36 were "children living in precarious housing conditions". In 36 out of 53 cases, two vulnerabilities apply most frequently to the children who were separated from their families: "children living in poverty" and "children living in families prone to child violence, abuse or neglect". All children for whom the GDSACP ordered the emergency placement were found with a combination of the three vulnerabilities most frequently encountered in connection with child-family separation.

Table 16. Most frequent vulnerabilities of children who were separated from their families, as recorded in the GDSACP files

Vulnerability	Frequency	Percentage of overall no. of children separated from their family, according to the GDSACP
Child living in poverty	45	83%
Child living in a family prone to child violence, abuse or neglect	41	76%
Child living in precarious housing conditions	36	67%

79 Stănculescu, M. S., Grigoraș, V., Teșliuc, E., Pop, V. (coord.), 2017, *Romania: Children in Public Care*, p. 32, p. 47 et. al.

Vulnerability	Frequency	Percentage of overall no. of children separated from their family, according to the GDSACP
Child with only one or no parent at home	22	41%
Child aged 1 to 5 years, in a situation of risk	14	26%
Child aged up to 1 year, in a situation of risk	11	20%
Child not enrolled in school, who dropped out of school or is at risk of dropping out	10	19%
Child not registered with the family physician	6	11%
Adolescent/child with risk behaviours	5	9%
Child with no ID papers (with no Personal Numerical Code)	5	9%
Child with chronic disease or living in a household whose members have chronic diseases	4	7%
Child with disabilities	4	7%

Source: Data made available by the GDSACP in each of the 8 counties. GDSACP vulnerability coding.

On the other hand, of the 54 children recorded with the GDSACP in the communes in which the UNICEF model was implemented and for whom there was available data on their vulnerabilities, only 25 were listed in the Aurora database. The Aurora did not record any cases of children at risk of separation at T0 (time of first data collection) and in placement 9 months later at T1 (time of second data collection). None of the children on record with the GDSACP showed in the Aurora with more than 7 vulnerabilities, and "priority zero service" was not activated. Consequently, the definition proposed by the Aurora for assessing the risk of child-family separation on the basis of a number of accumulated vulnerabilities has no confirmation in practice.

Of the 25 children listed in the Aurora database who entered public care, only 3 were flagged as being at risk of separation due to the fact that they had other siblings in the system. 20 of the 25 separated children listed in the Aurora lived in families prone to child violence, abuse or neglect, while 17 lived in precarious housing conditions. 15 children were affected by these two most frequent vulnerabilities and were also listed as children or adolescents with risk behaviour. The next vulnerability ranked in terms of frequency (and which occurs in combination with the others in 9 out of 25 cases) is poverty.

Table 17. Most frequent vulnerabilities of children who were separated from their families, as recorded in the Aurora

Vulnerability	Frequency	Percentage of overall no. of children separated from their family, according to the GDSACP
Child living in a family prone to child violence, abuse or neglect	20	80%
Child living in precarious housing conditions	17	68%
Adolescent/child with risk behaviours	15	60%
Child living in poverty	9	36%
Child not enrolled in school, who dropped out of school or is at risk of dropping out	9	36%
Child with only one or no parent at home	6	24%
Child aged 1 to 5 years, in a situation of risk	3	12%
Child aged up to 1 year, in a situation of risk	2	8%
Child with disabilities	2	8%
Child with chronic disease or living in a household whose members have chronic diseases	1	4%

Source: UNICEF – the Aurora database

II. Proposed definitions of the child-family separation risk indicator

An analysis of the Aurora data reveals the most frequent combinations of vulnerabilities affecting children placed in public care. As the tables show, none of the combinations of vulnerabilities cover all the cases, while a combination of all the 4 vulnerabilities occurs in less than 20% of the cases.

Table 18. Most frequent combinations of vulnerabilities for children separated from their family

Combination of vulnerabilities	Frequency – absolute figures	Frequency – percentages
Child living in a family prone to child violence, abuse or neglect & Child living in precarious housing conditions	17	68%
Adolescent/child with risk behaviours & Child living in a family prone to child violence, abuse or neglect	16	64%
Adolescent/child with risk behaviours & Child living in precarious housing conditions	15	60%
Adolescent/child with risk behaviours & Child living in a family prone to child violence, abuse or neglect & Child living in precarious housing conditions	15	60%
Child living in poverty & Adolescent/child with risk behaviours	10	40%
Child living in poverty & Child living in a family prone to child violence, abuse or neglect	10	40%
Child living in poverty & Adolescent/child with risk behaviours & Child living in a family prone to child violence, abuse or neglect & Child living in precarious housing conditions	9	36%
Child living in poverty & Adolescent/child with risk behaviours & Child living in precarious housing conditions	9	36%

Source: UNICEF – Aurora database

Overall, the number of recorded cases is too small to enable the formulation of a recommendation to UNICEF on how to define the risk of child-family separation. Nevertheless, we can put forth a few working hypotheses that could be tested in other projects and verified against a larger database, namely:

(**Working hypothesis 1**) The child-family separation risk is accurately assessed in 68 percent of the cases based on the presence of 2 vulnerabilities: "Child living in a family prone to child violence, abuse or neglect" and "Child living in precarious housing conditions". The risk of child-family separation could be defined as the situation whereby these two vulnerabilities occur concurrently. However, chances are a large number of children will fall into this category, which will determine an increase in the pressure on the public care system generated only by the interaction with the community workers and the casefile analysis. Since the model is aimed at preventing child-family separation, it would not be wise to artificially increase the separation risk incidence by using this definition, therefore working hypothesis 1 should be rejected.

(**Working hypothesis 2**) The child-family separation risk is accurately assessed in 60 percent of the cases based on the presence of 3 vulnerabilities: "Adolescent/child with risk behaviours", "Child living in a family prone to child violence, abuse or neglect" and "Child living in precarious housing conditions". The risk of child-family separation could be defined as the situation whereby these three vulnerabilities occur concurrently. Here too, there is a relatively high chance that a large number of children which do not require the GDSACP analysis will come to the attention of this institution.

(**Working hypothesis 3**) To the proposed definition of the child-family separation risk based on the concurrent presence of the three vulnerabilities mentioned above, we shall add another vulnerability and require that the presence of four vulnerabilities be a condition for activating the "priority zero service". In 36 percent of the cases, the fourth vulnerability encountered is poverty. On the other hand, the presence of all three vulnerabilities mentioned under working hypothesis 2 can also generate a health risk for the children.

As such, the risk of child-family separation could be defined as the concurrent presence of 4 vulnerabilities: (1) "Adolescent/child with risk behaviours", (2) "Child living in a family prone to child violence, abuse or neglect", (3) "Child living in precarious housing conditions" and (4) one of the vulnerabilities selected from among the most frequent vulnerabilities affecting separated children, likely to be connected with the other three. This connection could also consider health-related vulnerabilities, given that the findings of the study on children in public care show that the child care system includes many children for whom placement in the system is the easiest way to ensure access to specialised health services and to education[80]. **Considering the limitations of the present analysis, the available data cannot support this working hypothesis either**.

If new hypotheses are to be developed, they should be tested in projects which carefully observe and document all child-family separation cases, and the GDSACP in several counties should accurately record, for each entry into the public care system, all the vulnerabilities outlined in the Aurora methodology. Subsequently, using the comprehensive database thus built, these hypotheses should be verified and validated, or different ones should be developed based on representative data regarding the problems and needs of children in public care.

The authors of the present report also recommend introducing additional indicators to measure the severity/ intensity of certain vulnerabilities or situations of risk. Defining such indicators would require searching similar countries and contexts for theories, models and evidence that could be adapted to the national model.

III. Need for additional data

The available data are not sufficient to enable a proposed functional definition of the child-family separation risk nor an assessment, be it even a partial one, of the pressure which the active community-based intervention places on the child health care system. In its own database, the DPH records cases of children and pregnant women with chronic diseases or health risks, as well as the number of individuals not registered with a family physician, but not data on other vulnerabilities affecting these people (especially children). Moreover, even the Aurora allows a recording of the pressure on the health care system only to a certain extent. Given the goal of the modelling project and its activity focus on children and their families, the Aurora provides the necessary data on children and women, including with regard to vulnerabilities and services, as well as general data on all household members, in connection with their health status (registration with the family physician, routine checkups, chronic diseases, disabilities, etc.), even though, for the time being, the Aurora does not generate a diagnostic and a list of services for other age categories.

The hypothesis underlying the model according to which local prevention-focused intervention can reduce pressure on the child protection and the health care systems was translated into the types of services that were delivered in the modelling project. Thus, looking at how the identified vulnerabilities were addressed through delivery of services from the minimum package of services (i.e. information and counselling services on healthy lifestyle, personal and home hygiene, vaccination, accompaniment and support to access medical services etc.), we may assume that these services could help reduce the pressure on the health care system. According to the Aurora data, the number of unvaccinated children decreased between 2014 and 2015 (even if the vaccination rate dropped in 2016 also due to the national vaccine crisis). The interviews also show that the model was effective in informing its beneficiaries (children and their families) on matters related to personal and home hygiene. Therefore, we believe the pressure on the health care system may well have been reduced, but in the absence of systematically-collected data by the DPH, we are unable to assess the outcome of project implementation on the health care system.

80 Stănculescu, M. S., Grigoraş, V., Teşliuc, E., Pop, V. (coord.), 2017, *Romania: Children in Public Care*, p. 31, pp. 81–83, pp. 127–135 et. al.

3.2.4. Model contribution to national strategic planning processes

Did the modelling project contribute to strengthening national strategies and focus on prevention of child-family separation and of violence against children?

The answer to this evaluation question is based on desk reviews and interviews with representatives of public central institutions involved in public policy-making, conducted to determine how the model influenced national policies.

3.2.4.1. Unicef cooperation with public central institutions involved in public policy-making

As shown above, in the answer to the third evaluation question, the modelling project is relevant in relation to a large number of national policies and strategies developed during 2013–2015.

The interviews we conducted revealed a significant model contribution to three national strategies tackling the prevention services developed and tested in the project. Thus, UNICEF worked closely with the NAPCRA, informing the development of the **National Strategy for the Protection and Promotion of Children's Rights 2014–2020** and of the **Operational Plan** for the implementation of the strategy. The formulation of these documents was based on a wide consultation process undertaken with UNICEF technical assistance and support, through cooperation with the line ministries involved in promoting child rights, with relevant NGOs as well as with child organisations. The UNICEF accrued experience and evidence together with the recommendations of the project formative evaluations were translated into the national policy.[81]

In addition, the evidence generated during the demonstration project, the prevention-based intervention approach of the model and the cooperation between the GDSACP and the SPAS served to input the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and the Working Methodology for GDSACP-SPAS collaboration, both approved via Government Decision 691/2015. The substantiation report for this GD[82] includes clear references to the UNICEF work on preventing child-family separation and assessing children's multiple vulnerabilities. Not least, it is worth mentioning that one of the Annexes to this GD is a risk identification form (regarding the situation of families with children living in Romania) which drew on the interview guide developed in the modelling project to a considerable extent, though not on the entire methodology for the diagnosis of vulnerabilities and for generating the minimum package of services.

The National Strategy on Social Inclusion and Poverty Reduction 2015–2020 and its **Strategic Action Plan** clearly support the delivery of a minimum intervention package, necessary and mandatory in every rural and urban community, and mention that UNICEF in Romania has developed and tested such a package via its "Helping the 'Invisible' Children" modelling project later called "First Priority: No More 'Invisible' Children!". The minimum intervention package is similar to the minimum package of social services set out in Law 292/2011 on Social Assistance, as well as to the minimum package of public services to be delivered by public local government authorities outlined in Government Decision 1/2013 and the Strategy for Strengthening the Public Administration 2014–2020. Moreover, in line with the definition used in the "First Priority: No More 'Invisible' Children!" modelling project, the Strategy on Social Inclusion and Poverty Reduction lists the following interventions that should form the minimum package: outreach activities for identifying potential beneficiaries and for early intervention services, needs assessments for communities, households, and vulnerable people, planning of needed services based on a family- and person-centered approach, information and counselling services, support, referral and monitoring activities.[83]

81 See Chapter III Evaluation results, section 3.1.3.1. Model relevance in relation to national public policies

82 Document available online in Romanian at: http://gov.ro/ro/guvernul/procesul-legislativ/note-de-fundamentare/nota-de-fundamentare-hg-nr-691–19–08–2015&page=27 (last accessed on 16.01.2017).

83 See Chapter III Evaluation results, section 3.1.3.1. Model relevance in relation to national public policies

Furthermore, according to the Ministry of Health representative, the model represented the necessary drive for developing the community health care legislation (GEO 18/2017). In fact, the recital of this GEO[84] states the UNICEF experience with implementing the model.

The UNICEF input is also considered in the **Government Strategy for the Inclusion of the Romanian Citizens Belonging to the Roma Minority 2015–2020**, in its „Plan of sectorial measures", with regard to ensuring methodological support for integrated community services and developing community health services.

In 2014, UNICEF also worked with the Ministry of Youth and Sports to develop the **National Youth Policy Strategy 2015–2020**. The Strategy includes aspects related to the prevention of adolescent risk behaviours, but the UNICEF model experience with identifying vulnerabilities and developing the minimum package of services was not used in this Strategy. At the same time, though UNICEF was part of the strategic planning process for the development of **"A Society without Barriers for People with Disabilities"**, the document does not contain information based on which one could infer that the modelling project for 'invisible' children contributed to this national strategy on protecting and promoting the rights of people with disabilities.

3.2.5. Summary of the answers to the evaluation questions on effectiveness

The data and information collected for the summative evaluation allow for formulating answers to almost all the evaluation questions on effectiveness, as follows:

A. **The modelling project contributed considerably to child rights realisation**, ensuring first of all the "visibility" of the vulnerabilities, by using a unitary and effective methodology for assessing the needs of children and their families.

   The minimum package of services addresses all vulnerabilities, which makes the model effective in terms of child rights realisation. Certain vulnerabilities could be tackled in a relatively short period of time, particularly the administrative ones related to obtaining ID papers or other official documents (such as the disability certificates) and ensuring access to social benefits, but also, in part, those related to poverty and housing and ensuring access to primary health care services. Vulnerabilities related to behaviours and attitudes, however, need to be addressed through long-term interventions in order to reach the intended outcome. The model was less effective in ensuring children's access and participation to education, despite the fact that it included services for preventing or combating school dropout, which means future similar projects will have to have a stronger component on education services.

B. **The information and counselling activities, including the group ones carried out in the micro-grant projects, proved most successful of all**, including due to the fact that both the community workers and the service recipients were able to benefit from the expertise of specialists (counsellors, psychologists) engaged in the community activities.

C. The accompaniment and support services and part of the referral services could not be delivered because specialised services were innaccessible or not available. These deficiencies of the social assistance system at national level affected the effectiveness of the intervention at local level. On the other hand, an analysis of the needs that were assessed and the services that cannot be provided would help determine the need for service development.

D. **The community-based integrated approach to social assistance and community health care proved highly effective**, particularly because it encouraged community workers to support each other. The integration of working methodologies and tools, such as the Aurora, allowed for an effective implementation of this approach.

84 Document available online in Romanian at: http://www.ces.ro/newlib/PDF/proiecte/Lege-asistenta-comunitara-2016.pdf (last accessed on 16.01.2017).

E. **The modelling project helped develop local authority capacity to deliver the minimum package of integrated social services (compared to the 32 communities where the model interventions occurred only in 2011)**, as it encouraged the hiring of community workers for outreach/fieldwork, vulnerabilities and needs assessment and delivery of the minimum package of services, enabling their training through training sessions and providing them with the necessary tools and methodologies to carry out their fieldwork.

F. **The model contributed to reducing the pressure on the child care system**, as it entailed a considerably better approach and documentation of cases at the local level, which, in turn, facilitated the GDSACP county professionals' work.

   Data collected from the GDSACP show that this output is not directly reflected by a decrease in the number of children from the project communes who went into public care, merely by a better documentation of cases at the local level.

   To increase the model effectiveness in reducing pressure on the child care system, the definition of child-family separation risk needs changing, for instance by testing various working hypotheses regarding this definition in large intervention models and/or on large databases.

G. **There is no available data to enable an assessment as to whether and how much the modelling project contributed to reducing pressure on the health care system**. This would require the development and systematic collection, both at local and at the DPH level, of certain indicators on the vulnerabilities of children who receive specialised medical services and the number of hospitalizations or interventions required on the part of the health system.

H. **The modelling project contributed to strengthening national strategies and focus on prevention of child-family separation and of violence against children**, an outcome supported by the fact that the substantiation reports prepared for most of the public policy documents (strategies, laws) on child protection mention the fact that the experience gathered in implementing the modelling project was used to inform decisions regarding public policy options and that tools developed in the project were integrated into regulations as is, i.e. the Aurora interview guide.

3.3. Efficiency of "First priority: no more 'invisible' children!"

The evaluation of efficiency focuses on the relation between the actual outputs and the resources used to achieve them. To formulate our findings with regard to efficiency, the present summative evaluation used both an analysis of resource consumption as well as a benchmarking of the resources used in the modelling project against other similar activities implemented with similar outputs.

3.3.1. Efficiency of resourse use

Did the modelling project use resources in the most economical/efficient manner to achieve expected results? What are the benefits of the integrated approach from a financial point of view? and How do project costs compare to those of other similar programmes or standards?

In this section, the evaluation is based to a large extent on the findings and conclusions of the "Financial impact analysis for scaling up a model of community based services at national level"[85], conducted in 2015 by PricewaterhouseCoopers (PwC) for UNICEF in Romania, using the financial data resulting from the implementation of the demonstration project until 2014. Benchmarking against local budgets and costs of other similar interventions served to provide a clear picture of the model efficiency. It is worth mentioning that all costs related to developing new functionalities as well as to maintaining the Aurora were not part of the PwC analysis.

85 Pop, V. (coord.), 2016. *Financial impact analysis for scaling up a model of community based services at national level*, UNICEF and PricewaterhouseCoopers

3.3.1.1. Analysis of model implementation costs

I. Types of expenses and costs

The costs budgeted for the model implementation were split into six categories:

1) salaries for the community workers (the social workers – SWs and, starting 2013, the community health nurses as well – CHNs) and salaries for the county supervisors from the GDSACP and the DPH,

2) training for the community workers and the county supervisors – training sessions and experience exchanges,

3) equipment for the community workers and the county supervisors – tablet computers for the use of Aurora as well as medical kits,

4) costs for the community centres (developed via the micro-grant projects),

5) costs for the resource centres at county level (the GDSACP),

6) transportation for the county supervisors.

With few exceptions, the planned and the actual costs for the 6 categories did not register a perfect match. A summary of the budgeted costs and the actual costs incurred in the modelling project is provided in the table below, with the amounts indicated in lei.

The modelling project did not include overhead costs, whether for the local or for the county level. Based on the partnership agreements UNICEF concluded with the local and county institutions, the overhead costs were covered by the local institutions which employed the community workers and the county supervisors.

Given the savings generated by the project, as shown in the table below, the actual costs amounted to 67.75 percent of the budgeted costs, which, in absolute terms, points to the simple conclusion that the model was efficient. The average costs per community covered in 2014 amounted to 35,681,25 lei actually spent versus 56,256,25 lei initially budgeted.

Table 19. Model implementation budgeted and actual costs

Year	Expense category	Level	Unit cost (lei)	No. of communes	No. of months budgeted	Total budgeted costs	No. of actual months	Total actual costs (Lei)
2011	Salaries	SWs	750	96	12	864,000	8	576,000
		GDSACP supervisors	800	8	12	76,800	10	64,000
	Training	SWs	1,400	96	1	134,400	1	134,400
		GDSACP supervisors	1,000	8	2	16,000	2	16,000
	Community centres	-	-	-	-	-	-	
	Resource centres	-	-	-	-	-	-	
	Transportation	GDSACP supervisors	350	8	12	33,600	8	22,400
	TOTAL/YEAR 2011					**1,124,800**		**812,800**
2012	Salaries	SWs	1,000	64	12	768,000	10	640,000
		GDSACP supervisors	850	8	12	81,600	11	74,800
	Training	SWs	500	8	4	16,000	2	8,000
		GDSACP supervisors	1,000	8	2	16,000	2	16,000
	Community centres		10,000	24	1	240,000	1	240,000
	Resource centres		1,000	8	4	32,000	4	32,000
	Transportation	Supervizori DGASCP	300	8	12	28,800	11	26,400
	TOTAL/YEAR 2012					**1,182,400**		**1,037,200**

Year	Expense category	Level	Unit cost (lei)	No. of communes	No. of months budgeted	Total budgeted costs	No. of actual months	Total actual costs (Lei)
2013	Salaries	SWs	1,000	32	12	384,000	9	288,000
		CHNs	1,500	32	12	576,000	0	0
		GDSACP supervisors	850	8	12	81,600	10	68,000
		DPH supervisors	850	8	12	81,600	10	68,000
	Training	SWs	-	-	-	-	-	-
		CHNs	-	-	-	-	-	-
		GDSACP supervisors	1,000	8	2	16,000	2	16,000
		DPH supervisors	1,000	8	2	16,000	2	16,000
	Community centres		10,000	32	1	320,000	1	320,000
	Resource centres		1,000	8	4	32,000	4	32,000
	Transportation	GDSACP supervisors	300	8	12	28,800	10	24,000
		DPH supervisors	-	-	-	-	-	-
	TOTAL/YEAR 2013					**1,536,000**		**832,000**
2014	Salaries	SWs	1,000	32	12	384,000	10	320,000
		CHNs	1,500	32	12	576,000	0	0
		GDSACP supervisors	850	8	12	81,600	11	74,800
		DPH supervisors	850	8	12	81,600	11	74,800
	Training	SWs	1,000	32	2	64,000	2	64,000
		CHNs	1,000	25	2	50,000	2	50,000
		GDSACP supervisors	1,000	8	5	40,000	5	40,000
		DPH supervisors	1,000	8	5	40,000	5	40,000
	Equipment	SWs	1,400	32		44,800		44,800
		CHNs	1,400	25		35,000		35,000
		GDSACP supervisors	1,400	8		11,200		11,200
		DPH supervisors	1,400	8		11,200		11,200
	Community centres		10,000	32	1	320,000	1	320,000
	Resource centres		1,000	8	4	32,000	4	32,000
	Transportation	GDSACP supervisors	300	8	12	28,800	10	24,000
		DPH supervisors	-	-	-	-	-	-
	TOTAL/YEAR 2014					**1,536,000**		**832,000**
OVERALL TOTAL						**5,643,400**		**3,823,800**
TOTAL/health care component						**1,467,400**		**327,000**

Source: UNICEF and PwC

If the budget review is extended to 2015, we see the expenses did not exceed 4.5 million lei. If the review considers the costs for 2014 only (the biggest in the project as they covered equipment and training) and the overall number of children recorded in the Aurora database (5,178), we find that, **on average, about 350 lei/child beneficiary were budgeted and a little over 220 lei/child were spent per year.** However, the model was not just about identifying the children and providing them with services. Hence, in 2014, at the first data collection, the overall number of people recorded into the Aurora was 10,677, which means that the budgeted average cost per beneficiary decreases to below 169 lei/person per year, and the actual average cost to below 107 lei/person per year.

Calculating the exact number of beneficiaries of the micro-grant projects so as to be able to assess these projects' efficiency separately is a difficult task. This difficulty is first due to the fact that the reporting for the micro-grant projects was not undertaken in a unitary manner, given that most of the reports developed by the social workers and the county supervisors either covered the indicators which Aurora also measured (number of children and number of households recorded into the database each year) or they included indicators such as the number of participants or beneficiaries measured only for part of the activities carried out. Moreover, in addition to the participants to the activities organised, one has to take into account that there is an estimated larger number of beneficiaries who were indirectly informed as an outcome of the micro-grant activities. Still, a review of the reports submitted by the supervisors and the community workers enables us to determine that at least 100 persons/community were direct beneficiaries of the pro-

ject information, counselling, training and support activities each year, which means an estimated 100 lei/beneficiary/year.

To model a sustainable intervention in those communities in which the project was implemented and replicate it in similar communities, the model operating costs were deliberately maintained low, so as to match the local budget capacity. As such, the community workers that were hired in the project were paid at the same level as the SPAS employees, while the activity of the Community Consultative Structures was not factored into the model budget. At the same time, travel costs for the community workers were not considered, even though some of the communes in the project consisted of a large number of villages spread some km apart.

II. Costs for health care and integrated approach

One can notice that the project proved to be highly efficient when analysed in relation to the estimated budget. Then again, a number of costs no longer needed covering. For instance, besides the CHNs already employed with the local authorities, no other professionals were hired and paid as part of the modelling project which was eventually implemented based exclusively on the input of those already present in the field[86]. In addition, where the CHNs were hired during project implementation, they were hired according to the law in force and their salaries were covered by the Ministry of Health which transferred the necessary funds from its budget to that of the local public authorities who employed the CHNs. A similar situation occurred with regard to the medical kits for the community health nurses, estimated at 950 lei/piece. Given that the project did not hire new community health nurses, and instead it involved those already employed with the mayoralty, they continued to use the medical equipment they had. Also, no transportation costs were included for the DPH supervisors who covered the health services component, as it was assumed that they would visit the community together with the GDSACP supervisors.

Thus, the health care component planned budget was initially around 40 percent of the overall modelling project budget in 2013 and 2014, **but the actual costs with the salaries, training of and equipment for the CHNs and the county supervisors amounted to no more than 14 percent in 2013 and 18.5 percent in 2014. As a share of the overall actual project costs, the community health care costs accounted for 8.55 percent.**

On the other hand, some of the costs for the services included in the minimum package and for the community counselling and support centres were shared by the social assistance and the health care components. In this respect, the integrated approach to community-based social and health care services was highly efficient. All the costs for the identification activities, a good deal of the vulnerabilities assessment costs, some of the information and counselling costs, and many of the supervision costs were shared by the two components, and the integrated approach prevented their overlapping.

3.3.1.2. Benchmarking model implementation costs against other initiatives

As the PwC showed in their analysis of the model's financial impact, **the amount budgeted for the community centres (the micro-grant projects) was defined based on benchmarking against similar initiatives implemented by NGOs** (such as World Vision etc.) and/or supported through previous funding mechanisms like Phare projects etc.[87], and therefore, we can talk about comparable costs.

When compared to ESF-funded initatives, the model costs are very low. Thus, a review of projects with a strong social assistance component, targeting particularly the Roma community, funded through the

86 According to the PwC analysis regarding the salaries of community health nurses, "The budget was based on the assumption that one community health nurse would be employed in each community, and their salary was estimated based on the average salary paid by the mayoralty for this position, namely 1,500 lei/person/month. However, the necessary human resources were available in only 25 out of the 32 communities included in the project at that time, i.e. where community health nurses were already hired by the mayoralty. Given the specific context, in the end, the costs incurred through the UNICEF budget was zero, as the funds for the community health nurses' salaries were allocated from the budget of the Directorate for Public Health (DPH)". Pop, V. (coord.), 2016, p. 28

87 Pop, V. (coord.), 2016, p. 20

Human Resources Development Sectoral Operational Programme (HRD SOP), reveals that for Major Intervention Area 6.2. *Improving the access and participation of vulnerable groups on the labour market*, the costs considered in the programme for each beneficiary amounted, on average, to 1,350 euros, while in the projects with a large number of Roma beneficiaries, the average unit cost amounted to 2,625 euros for each participant in the project. If we consider projects with a maximum 3 year span, **the average cost per beneficiary per year in HRD SOP projects could be estimated at between 450 and 875 euros (2,025–3,937,5 lei) for each target group individual**[88]. **This cost is at least 10 times higher than the costs recorded in the modelling project for the micro-grant project beneficiaries.**

When benchmarked against the provisions of GD 978/2015 regarding the approval of the minimum cost standards for social services, the modelling project costs prove highly efficient once again. The minimum cost standard for the counselling centres and other day care services set out in this government decision is 2,600 lei per year, with reference to child beneficiaries exclusively. This amount is over 10 times higher than the average costs calculated per year for each modelling project beneficiary recorded in the Aurora database (220 lei) in 2014.

Moreover, the estimated costs for prevention services are considerably lower than the cost standards for reactive services. Thus, according to GD 978/2015, the cost standard per child per year varies as follows: 8,075 lei for foster parents with 3 children in foster care; 12,025 lei for foster parents with 2 children in foster care; 21,456 lei for foster parents with 1 child in foster care; between 24,602 lei and 28,847 lei for residential services. As such, the cost of 220 lei/child/year, considering adult beneficiaries as well, is at least 12 times lower than the cost paid to a foster parent for each child in their care and 75 times lower than the standard cost set for the reception centres and the recovery centres for victims of domestic violence (16,570 lei).

3.3.2. Costs of implementing the approach based on the minimum package of services at national level

What are the costs of scaling up the model at national level? What are the implications of such a scale-up?

Here too, the evaluation is based on the analysis conducted by UNICEF and PwC[89]. To estimate the costs associated with scaling up the model, using the existing data resulting from the project implementation, as well as the related legal provisions in force and statistics, PwC proposed a compound indicator for determining the required coverage of the intervention for children and their families, consisting of primary and secondary indicators such as: number of children in the community and their share in the total population of the community, population density, unemployment rate, the potential number of 'invisible' children in each community, recipients of the minimum guaranteed income (calculated as a rate), number of necessary social workers in relation to the number of beneficiaries, type of community (rural/urban).

3.3.2.1. Model scaling-up scenarios

Considering UNICEF's experience with implementing the "First Priority: No More 'Invisible' Children!" modelling project and the evidence generated by this model intervention, but also the complexity of the issue at national level and the need for an integrated approach, the authors of the "Financial impact analysis for scaling up a model of community based services at national level"[90] proposed six scenarios for scaling up the model, based on the type of communities (rural/urban) and the complexity of the services to be

88 Ministry of European Funds, 2015. A doua evaluare intermediară a POSDRU 2007–2013 [Second intermediate evaluation of 2007–2013 Human Resources Development Sectoral Operational Programme (HRD SOP) – ESF], available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.1.pdf (last accessed on 18.05.2017), pp. 287–289; Evaluare ad-hoc a intervenției POSDRU privind tinerii [Ad-hoc evaluation of the HRD SOP intervention on youth], available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.2.pdf (last accessed on 18.05.2017), pp. 51–66; Evaluare ad-hoc a intervenției POSDRU privind populația Roma [Ad-hoc evaluation of the HRD SOP intervention on Roma population], available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.3.pdf (last accessed on 18.05.2017), pp. 77–83

89 Pop, V. (coord.), 2016

90 Ibid.

delivered (including an education/school counselling component in the optimal version of the minimum package of services). The costing model used various statistics regarding the economic development of the communities and the number of children in each community, classifying the communities into risk categories in order to enable a planning of the model scaling up.

Thus, the proposed scenarios[91] are as follows:

1. **Basic rural scenario**: Implementation of the minimum package of services, basic version (social assistance/social worker component) in rural communities.
2. **Basic urban scenario**: Implementation of the minimum package of services, basic version (social assistance/social worker component) in urban communities.
3. **Extended rural scenario**: Implementation of the minimum package of services, extended version (social assistance/social worker and health care/community health nurse components) in rural communities.
4. **Extended urban scenario**: Implementation of the minimum package of services, extended version (social assistance/social worker and health care/community health nurse components) in urban communities.
5. **Optimal rural scenario**: Implementation of the minimum package of services, optimal version (social assistance/social worker, health care/community health nurse, and education/school counsellor components) in rural communities.
6. **Optimal urban scenario**: Implementation of the minimum package of services, optimal version (optimal version (social assistance/social worker, health care/community health nurse, and education/school counsellor components) in urban communities.

Given that the salaries of the social workers and the CHNs represent the main cost component of the modelling project, estimating the number of community workers required to replicate and scale up the model was the main focus of the costing model.[92]

For all the six scenarios, the costing model was based on a series of hypotheses/assumptions verified against the literature review and international databases, as well as the national law in force at the time of the analysis. Thus, according to the analysis estimates, replicating and scaling up the project would require hiring a social worker for every 200 vulnerable children, while communities with less than 50 vulnerable children would only require a part time social worker. Another assumption supported by the implementation of UNICEF models in various counties of the North-Est region was that approximately 10 percent of a community's child population are vulnerable (or 'invisible', to use the UNICEF term). Therefore, according to the initial estimation, a social worker would be required to cover every group of 2,000 children in a community (for communities with over 500 children) and a part time social worker woud be required for communities with 500 children or less. In addition, the PwC costing model also included a series of coefficients designed to increase the number of social workers in certain situations versus the initial calculated standard, namely:

– in rural communities, given that according to the literature review, the risk of social exclusion is three times higher in rural areas versus urban areas;
– in communities with a high share of children in the total population of the community, an indicator of families with many children, often in greater need of social services;
– in communities with low population density, hence very scattered, with a larger geographical area that needs to be covered through fieldwork;
– in communities with a high share of MGI recipients, given that the poverty addressed via the mini-

91 Ibid., p. 34
92 Ibid., pp. 35–41

mum guaranteed income is one of the vulnerabilities considered when defining the 'invisible' children;

– in communities with a high unemployment rate, as this vulnerability can be linked to many of the vulnerabilities addresed in the modelling project.

Using the coefficients established, all communities in Romania, both rural and urban, were analysed based on the available NIS data and divided into three risk categories. For communities with low risk, the number of social workers was reduced to half of the theoretical number (1 social worker for every 2,000 children), with the exception of those communities requiring a part time or one full time social worker, which remained unchanged; for communities with medium risk, the number of social workers remained unchanged (i.e. equal to the theoretical number), while for communities with high risk, the number of social workers was doubled compared to the theoretical number.

The salary costs for community workers whose number was estimated using the costing model described above were calculated by PwC based on the coefficients set out in Law 284/2010 regarding a unitary wage system for staff paid from public funds (the provisions in force in 2015). The costing model factored in travel costs for the social workers within the community, training costs and overhead costs, especially since the separate funding of the community centres is not considered (according to the UNICEF model design), while the equipment and the consumables purchased in the micro-grant projects were offset with funds estimated from the budget. In addition, for the scenarios involving health services, the costing model estimated the costs for medical consumables for the community health nurses. The calculations also considered salary, travel, training and equipment costs for the county supervisors as well as overheads to support their work.

Considering the budgetary constraints, the PwC analysis proposes a phased approach to the implementation of the first scenario, leading to full service coverage of rural communities in three years' time[93], as follows:

i. In **the first year** of implementation, the scope of the intervention could cover communities with high risk, determined based on a risk coefficient developed and calculated by PwC;

ii. In **the second year**, the scope could be increased to include communities with medium risk

iii. In **the third year**, the scope would be extended to cover all rural communities.

A phased approach was not also proposed for scaling up the model in urban areas and for the versions which include community health care and educational/school counselling components, though such an approach could be extended to these versions as well. A progressive phased scaling up is necessary not only cost-wise, but primarily because one needs to establish all the specific details of managing the model implementation at national level[94], whether the decision is to implement only in rural areas or in both rural and urban areas.

On the other hand, the extended scenarios that include a community health care component require increasing the budget for replicating the intervention nationwide by one third compared to the costs of implementing the basic scenario, both in rural and in urban areas. Given the added value of the integrated approach and the need to have a specialist delivering the community health care services, these costs could be assimilated to the costs required to implement the national policy for developing the community health care field, which the successive governments in Romania over the last 3 years committed to.

3.3.2.2. Budgetary implications of model scaling up

The constraints identified in 2014 by the authors of the financial impact analysis with regard to scaling up the modelling project included:

– Fund availability and management at the local level;

– Legislation constraints related to the hiring freeze in the public sector;

93 Ibid., p. 34

94 See Chapter III. Evaluation results, section 3.4.3. Potential for model replication

– Limited availability of human resources – the small number of social workers and community health nurses available to work in vulnerable or isolated rural communities located far away from town;

Between 2014 and 2017, the legislative constraints ceased to be an issue and, as shown previously in the present evaluation, the national strategic and legal context is now auspicious for scaling up the model. However, one still needs to consider the limitations related to the lack of human resources and the budget planning and execution deficiencies affecting the availability of budget funds. As such, in terms of delivering the minimum package of services as an integrated approach to community-based social and health care services, the budget planning and execution regulated by the law on public local finances does not foster inter-institutional cooperation with the specialised services at county level, intersectorial initiatives and monitoring of budget indicators in relation to service delivery targets. Still, as set out in the Strategy for Strengthening the Public Administration, the Government aims to develop, by 2020, the quality and cost standards for public decentralised services, including social assistance and community health care services, therefore, in the medium term, the legislative and budgetary framework related to public local finances may enable scaling up the model that focuses on delivering a minimum package of services.

Implementing the model nationwide can also generate budget savings by reducing the pressure on the residential care side of the protection system once prevention of a large number of child-family separation cases is ensured. The analysis shows that "the separation of children from their families – children exposed to abandonment or at risk of child abandonment, was prevented in 58 out of 70 cases. This was ensured with a cost per child (and his/her family) of 250 lei/year. By comparison, the cost standard established in the child protection system varies between 11,000 and 21,000 lei/child/year (as per Government Decision 23/2010 on the approval of the cost standards for social services)"[95].

Moreover, the UNICEF and PwC analysis also identifies funding alternatives to the consolidated state budget[96]:

– European Social Fund/Administrative Capacity Development Operational Programme (POCA) – which could be used for the social assistance component of the Minimum Package of Services, to cover training activities and equipment (i.e. for improving the social assistance services);

– European Social Fund/Human Capital Operational Programme (POCU) – for the social assistance and health components of the Minimum Package of Services, to cover training activities and material expenses (i.e. for improving access to social assistance and healthcare services);

– Regional Operational Programme (POR) – for all components of the Minimum Package of Services (i.e. for improving access to social assistance, education and healthcare services);

– National Rural Development Programme (PNDR) – to finance the training activities for all the package components implemented in rural communities, as well as material expenses for the social assistance component implemented in rural communities (i.e. education and training for rural economy employees and improvement of access to social assistance services);

– World Bank Loan – Health Sector Reform (reimbursable funds) – for financing the health component of the Minimum Package of Services;

– Norway Grants, EEA Grants and Swiss Grants – for all components of the Minimum Package of Services.

However, these funding sources do not fully cover the required investments/expenses. Thus, considering how the operational programmes were approved:

– the Administrative Capacity Development Operational Programme (POCA) has three specific objectives for which local government authorities are eligible: development of standards, increasing public

95 Pop, V. (coord.), 2016, p. 54. Cost standard per child per year varies as follows: 11,014 lei for foster parents with 3 children in foster care; 13,931 lei for foster parents with 2 children in foster care; 20,896 lei for foster parents with 1 child in foster care; 20,653 lei for residential centres. The PwC study refers to GD 23/2010, in force at the time of the authors' analysis on cost standards.

96 Pop, V. (coord.), 2016, pp. 67

administration transparency, and ensuring a transparent judiciary. Therefore, increasing the administrative capacity to deliver social assistance services is not one of the elements that can be funded through POCA. The programme can finance the development and implementation of quality and standard systems for all activities, including social assistance ones, but it cannot be used exclusively for this component;

– the Regional Operational Programme (POR) can only finance the development of health and social service infrastructures (multifunctional centres providing integrated services at local level);

– the National Rural Development Programme (PNDR) can only provide local public authorities with funds for small infrastructure for local transportation and utilities (e.g. water and sewerage) and educational infrastructure such as nurseries, kindergartens and vocational high schools and high schools with agricultural and environmental protection profiles.

The Human Capital Operational Programme (POCU), the World Bank and Norway Grants, EEA Grants and Swiss Grants remain viable funding sources. However, none of these funding sources can fully cover the national scaling up of the model, they can only bring more pilot project evidence to support a national mainstreaming in the years to come.

Considering all the elements included in the costing model, the costs for full implementation of the first scenario (in all rural communities) amount to 180 million lei at the local level (communes' budgets) and 5.5 million at county level (county budgets). Implementing the model consisting of only one package of social services in all towns of Romania would entail a cost of 26.6 million lei at local level and 1.3 million lei at county level.

If the community health care component is factored in, the costs of scaling up the model would amount to 232 million lei at local level and 11 million lei at county level if implemented in the rural areas, and 54.2 million lei at local level and 2.5 million lei at county level if implemented in the urban areas.

Still, the costs for scaling up the model could be higher, as the main cost component is the human resources one and, between the time PwC developed its costing model and the beginning of 2017, there have been several decisions regarding the salaries of staff paid from public funds, including in the social assistance sector and at the level of the public local administration. Also, the estimated number of social workers and community health nurses required for the scaling up considers population density only to a small extent, with only two thresholds envisaged (over and below 60 inhabitants/km^2).

The costs of scaling up the model at national level were calculated by UNICEF and presented to public policy makers ever since 2015. We would like to underline once more that the overall budget should also include costs for maintenance and developing functionalities related to the use of the Aurora methodology. Full scale up at national level can only be ensured with support from the overall consolidated budget, both in terms of the size of the required budget and in terms of the established objectives. Technically, in public finances, this support consists of VAT and income tax deducted amounts collected at central level and transferred to the local budgets. While in 2016, the budget of the Ministry of Labour amounted to over 33.17 billion lei, **the budgetary impact of scaling up the model at full capacity by implementing the extended scenario in both rural and urban areas would amount to nearly 300 million lei, less than 1 percent of the Ministry budget**, therefore extremely low compared to the documented benefits of the prevention-focused intervention based on a minimum package of services.

The analysis of the model effectiveness shows that some of the services in the minimum package of services generated by the Aurora require the availability of specialists to enable accompaniment and referral activities. This leads to a need for setting up resource centres and multidiscipinary teams of specialists at county level that SPAS community workers could resort to, both for advice and support and for direct involvement in the management of complex, challenging cases. In light of this need, the estimated cost of scaling up the model at national level according to the 2016 UNICEF and PwC analysis may be underrated.

However, a realistic cost can be obtained only by piloting the model in more counties and communities using several formulas to be able to determine the added value (in terms of effectiveness and addressing the beneficiaries' vulnerabilities) relative to the public investment/expense, such as:

– hiring one versus hiring more community workers,
– extending the model to include a school counselling component,
– increasing counselling activities and workshops conducted by community centres,
– developing a dedicated infrastructure (well-furnished community centres and day centres),
– increasing the development of the resource centres at county level and hiring specialists (e.g. psychologists) to carry out activities that specifically target supporting the SPAS,
– providing detailed standards for costs and activities using the Aurora or minimum standards and a large degree of leeway for community workers to adapt to special cases.

3.3.3. Efficiency of the minimum package of social services

How efficient was the model in terms of results for the recipients of the minimum package of services and of social benefits compared to individuals who received only social benefits?

For the answer to this evaluation question, the results achieved among the child recipients of preventive social services should have been analysed in relation to the contribution of the social benefits to improving children's lives. However, the evaluation managed to answer the question only by analysing the community workers' and county supervisors' perception and experience in this respect. The limitation of the answer to the evaluation question on the basis of data regarding the vulnerability indicators was due to the fact that these data did not allow for isolating cases of children who received only social benefits and cases, similar in terms of the vulnerabilities involved, of children who received only the preventive services delivered via the minimum package of services. At the same time, there were no national studies on the impact of the social benefits granted in Romania that the gains achieved for children and their families through the modelling project could be benchmarked against.

3.3.3.1. Recipients of both services and social benefits versus recipients of social benefits only

Community workers showed that, in their opinion, for outcomes that influence the actual situation of the target group, service delivery is more efficient than granting social benefits, as **social benefits sometimes enable the perpetuation of risks and vulnerabilities.**

"Resources were used efficiently in the modelling project. I worked together with the CHN to address various problems, helped some of the beneficiaries to increase their income, but not all of them managed to solve their problems. Project costs were lower, but results were greater. With social benefits, the costs are higher and results are smaller, people come to rely on this source of income. They settle for things being this way and see no other way out. As a result of applying the model, they achieve a different outcome, they are better informed, they take action to solve their problems. Granting social benefits leads to dependence, to recipients settling for it. As opposed to the services delivered via the model which help recipients solve their problems".

Social/outreach worker, Buzău county

"We are more efficient when delivering social services than when granting social benefits. By providing social services through the project, I'd say we offered these people more than they stood to gain from the social benefits (a lot of them use the benefits to pay the debts they accrue with purchasing alcohol and tobacco)".

Social/outreach worker, Neamț county

Along the same lines, section 4 – "The policy framework – challenges" of the National Strategy for the Protection and Promotion of Children's Rights mentions that, although social benefits based on means-testing are well targeted and account for a significant share of the poor household budgets, field research shows there are sizeable groups of vulnerable children who either benefit too little from these social benefits or whose situation does not improve considerably over time as a result of this financial aid[97].

However, most of the community workers regard services and social benefits as being complementary, addresing different but interdependent vulnerabilities, such as the lack of information on poor hygiene-related health risks, on the one hand, and unsanitary housing, on the other.

"The project has provided a lot of information, but social benefits are very useful too. Results would be great if both social services and social benefits were offered. Both social services and social benefits impact recipients positively. Services delivered via this project helped decrease school dropout, prevent child-family separation, while social benefits provide the family with a minimal financial resource".

Social/outreach worker, Neamț county

Not least, the lack of material resources to enable accessing of certain social services (particularly those available only in towns) made it impossible to deliver some of the basic package services and the specialised services to which people should have been referred. As such, the complementarity of services and social benefits is obvious.

3.3.4. Summary of the answers to the evaluation questions on efficiency

The data and information collected for the summative evaluation allow for formulating answers to all the evaluation questions on efficiency, as follows:

A. **The modelling project used resources in an efficient manner to achieve expected results, while the integrated approach proved highly efficient from a financial point of view**, given that it entailed expenses for needs identification and vulnerabilities assessment, for community counselling and support centres and for supervising community workers, and that project beneficiaries received both social services and community health care services.

B. **In relation to other similar programmes or standards, project costs were very low**, the costs per beneficiary per year being at least 12 times lower in this preventive services-based model than in the case of reactive social service delivery (e.g. compared to the standard costs for payment of foster carers or child care residential centres).

C. **The costs of scaling up the model at national level amount to less than 300 million lei/year**, if we sum up the costs calculated for scaling up the model in rural and urban areas, integrating the social assistance and community health care components, and consider the impact on both local and county budgets. These costs were calculated by UNICEF based on a costing model ever since 2015 and have already been presented to the Government.

D. The costs of scaling up the model at national level amount to less than 1 percent of the Ministry of Labour budget for 2016, which means the scale up is economically feasible. Also, several funding alternatives to the state budget were identified, though none of them could support a national scaling up of the model, only the piloting of various implementation and management versions in view of scaling up.

E. **The model is efficient in terms of results for the recipients of the minimum package of services and of social benefits, compared to individuals who receive only social benefits**, as, unlike social benefits, preventive services address child vulnerabilities and needs related to information and preven-

97 *National Strategy for the Protection and Promotion of Children's Rights 2014–2020*, approved based on Government Decision 1113/2014, p. 11

tion of risk behaviours, even though to improve children's situation, the material aid is also deemed necessary, in conjunction with the services. However, the present evaluation was unable to isolate certain cases for an accurate comparison between the outcomes of the service package and those of the social benefits.

3.4. Sustainability of "First priority: no more 'invisible' children!"

The evaluation of sustainability aims to determine whether the benefits generated by the model are likely to last once the UNICEF support is withdrawn, and it explores both the possibilities of continuing the activities, including the local context and the motivation of the stakeholders involved in those activities, and the extent to which the model outcomes can be maintained in the absence of the support received until 2015.

For this evaluation, an important document of reference was the Exit strategy developed within the project. This strategic document was developed by UNICEF with input from partners at all levels, to enable planning and preparation in view of continuing the project in the communities in which it was initially implemented as well as developing and scaling up the model.

3.4.1. Chances of continuing the model implementation

To what extent is the current context more or less favourable to continuing such approaches in the near future?

The answer to this question entails an analysis of the context and of the local community capacity to continue implementing the model, using their own resources or receiving support from other levels. The answer to this question is based on a reassessment of the indicators analysed for the answer to the evaluation question on model effectiveness in increasing SPAS capacity.

The Exit strategy included an inventory of the project achievements, on the one hand, as well as of the barriers and bottlenecks identified as having the greatest impact on the project sustainability and scaling up, on the other hand. Some of these obstacles were also identified during the summative evaluation and their analysis considers both the strategy provisions and the evaluators' findings.

3.4.1.1. Assessment of the local environment at end of model implementation

According to the interviews conducted in communities, it seems that barring a few exceptions – in which there was a limited involvement on the part of the local administrative stakeholders and particularly of the mayor, while support for the model was form, not substance even at the time of project implementation – the local environment is favourable to continuing the project implementation, as there is a high motivation to continue and an enabling legal and public policy framework.

"The mayoralty capacity increased, especially as a result of the UNICEF model intervention which was very important in shacking things up, I mean in making people realise or see for themselves that it's possible to provide social services too".

Social/outreach worker, Botoșani county

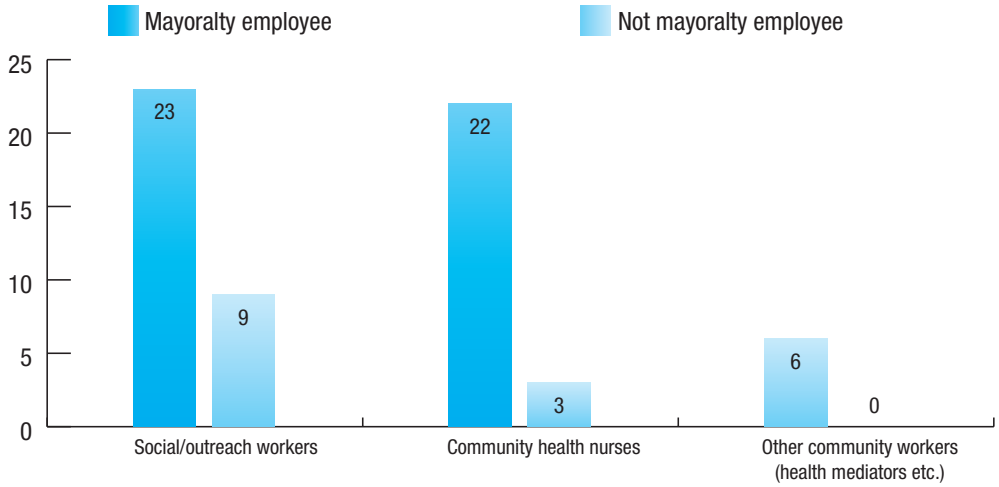
According to the data collected by UNICEF in Romania for the month of September 2015 when the model implementation was completed, two thirds of the social workers having undertaken project activities were mayoralty employees, while a third remained outside the mayoralty system and once the model implementation was over in September 2015, they too ceased their social work and, thus, their contribution to the SPAS capacity to provide quality social services. For five of them, available information indicates they were hired based on an agreement between the mayoralty and UNICEF or that suitable positions within the mayoralty were advertised and they applied.

As regards the community health nurses, with few exceptions, they continued to work in the communes in which they had carried out their activity and, in 2016, CHNs were hired in another 2 communes. Of the

25 community health nurses employed (in the overall 32 intervention communes), two retired in 2015 and the continuity of the work in the commune was limited to a transfer of the know-how they accumulated in implementing the model, including with regard to using the Aurora, and which they were kind to share with the new employees.

Existing data show there was no period of handover between the retired persons or the community workers who went on child care leave and the persons hired to take their place, so as to ensure a transfer of knowledge and competencies accrued and developed during project implementation.

Figure 18. Community workers' employment status within the mayoralties in 2015



Source: UNICEF

The community workers' employment status within the entities officially assigned social work and community health care duties, in the mayoralty, to be more precise, shows there are grounds for a moderate increase of the SPAS capacity.

"The main requirement for project continuity is to have the financial resource and the possibility to hire a person to deal only with social services. Currently, the specialised service in the mayoralty has 4 employees who spend most of their working time on the social benefits files. The social services component is tackled only as an emergency by a referent [Romanian term for specialist/counsellor/adviser]".

Social/outreach worker, Vrancea county

In most cases, local authorities are open to hiring community workers, but in almost one third of the intervention communes, the human resources needed to ensure the continuity of activities were not secured by the end of the model implementation. The interviews and the focus groups we conducted show there are two main reasons for questioning the chances of continuing the model implementation: (1) where positions are open, qualified, trained and willing candidates are not identified, (2) in small communes with no economic activity and, therefore, with a limited available budget, there are no openings for social workers assigned with fieldwork/outreach duties complementing the social benefits management work. In fact, the Exit strategy identified the local hiring of community professionals as being a major barrier, even though the model involved developing and disseminating a material which included an inventory of the regulations in force in 2015, procedures and practices for hiring community professionals – social workers and community health nurses. The same document also formulated recommendations for local authorities with regard to addressing the human resources shortage, in accordance with the laws in force at the time.

The training provided in the project was valuable, however, if the social workers and the community health nurses cease to be hired, this professional capacity-building does not also determine an administrative capacity increase. Moreover, although several training sessions and exchanges of experience took place and were considered very useful, they need to be continued and even increased, including for social workers with higher education and more so for those lacking specialised studies, given the wide disparities that

still exist in community workers' professional competencies. The need for staffing and for training remains high and consistent, particularly considering the rather limited availability of professionals who deliver preventive services in disadvantaged areas. Identified in the Exit strategy as another barrier in ensuring the continuity and the sustainability of the modelling project, professionals' lack of motivation to work in disadvantaged and isolated areas, in the absence of incentives and/or compensation mechanisms, also leads to widening the gaps and prevents the increase of quality of local social services. Consequently, policy advocacy efforts should also consider the development of policies that stimulate human resources allocation and distribution, with special focus on disadvantaged areas.

"First, at the LPA level, you need the relevant human resources (social workers and community health nurses), hired as well as regularly trained, and then you need to coordinate these people; the LPAs need to develop their integrated community-based services and sustainable development strategies. The LPA staff needs regular training".

GDSACP supervisor, Bacău county

According to the analysis of the model costs in 2014, **the average cost per community was 26,000 lei**. As the section on model efficiency showed, the payment of the social workers involved in the UNICEF project was set at the same level as the one regulated for the SPAS staff, while the CHNs were paid by the mayoralty, therefore there may well be a problem of staff motivation, given the statements about small and unattractive salaries for a high workload and demanding fieldwork. **In terms of the communes' overall budget, that would account for between 1 and 0.25 percent of their budgets**. Thus, with a proper financial management, the SPAS could have the capacity to go on supporting the implementation of the model, despite both mayors' and social workers' view that there are no funds available to ensure continuity of the model.

Therefore, available funds for social assistance activities are generally identifiable, but the administrative structure used the model in a limited manner in order to ensure a sustainable increase of its capacity to deliver services. Some of the community workers believe that despite encouraging statements, not all mayoralties and communities have the motivation required not only to accept the piloting and continued implementation of the model, but also to make investments from the local budget and actively engage all community decision-makers. This lack of motivation to continue with the model can also be accounted for by the fact that, at present, the process whereby local public administrations are consulted on and involved in policies on human resources (as well as other areas) is only occasionally supported, as the Exit strategy findings also show. Given that the local authority can and should contribute with solutions that are adequate and affordable for the local communities, stimulating the participation of the LPA representatives should be encouraged and strengthened.

3.4.1.2. Capacity to continue service delivery

The capacity to deliver social services at the local level, in addition to the employment of specialised staff, is greatly supported by the Aurora which remained available for community workers, social workers as well as community health nurses – all still municipality employees.

We need to mention that the reassessment of the active cases identified as of 2014 using the Aurora methodology was scheduled for August 2015. The modelling project ended in September 2015, but the reassessments continued to be carried out and the services included in the minimum package of services continued to be delivered, even though at a slower pace in some communities. In a few cases, the Aurora was still used even in 2016, both to reassess existing cases and to identify new ones.

"Of course, because new cases are being identified. We've identified about 40 cases per year, at the moment the Aurora lists 297 children and 6 mothers with vulnerable pregnancies, and in September 2015 when we closed the project it listed 206 children. This year we have a bigger increase, we've identified in one year 90 children because I had the help of the community health nurse and she took care of the pregnant women and the children aged 0–1 year whom I might missed to identify with Aurora".

Social/outreach worker, Vaslui county

"We keep delivering the services, but we no longer provide certain extras (e.g. meeting refreshments, gifts for children). Currently, there are no obstacles preventing the continuation of this model in our community. Some changes to the legislation would be necessary because we may identify a need but we lack the local resources to address it. We have the service delivery infrastructure in place, more than just the tablet computer, but there are no legal means to enable cooperation with or hiring a psychologist. It's not necessarily that the legal framework forbids it, but it is an obstacle nevertheless. It should be in the law to have a minimum package of services to be delivered at the local level and budgeted for separately".

Social/outreach worker, Neamț county

Therefore, the tool for assessing vulnerabilities, planning the services and undertaking case management exists and so does the motivation to use this tool. However, given the complexity of the Aurora and the time it takes to apply its questionnaire, not all community workers continued using this opportunity to improve their work, as both the interviews with community workers and with county supervisors revealed. In some cases, waiving the use of the tool was a decision of the local public authority, while in other cases, the community workers gave up using the Aurora for reasons of convenience, not because of pressure exerted by the mayor.

"Once the project ended, the Aurora application ceased to be used with the same intensity. You need the local authority's decision to use it. They have tablet computers with the Aurora platform, but not all of them still use them".

GDSACP supervisor, Buzău county

"I still do my work the way I did in the project. I no longer use the tablet computer, I mean, I no longer enter new cases, but we still do case reassessment and determine what services are needed."

Community health nurse, Buzău county

We must point out, though, that, in most cases, **the community workers still in the mayoralty continued to use the Aurora even after the demonstration project was over**.

Moreover, the project created an enabling environment for community engagement and participation. The CCSs discussed the problem and emergency cases and provided community workers with real support in almost all the communities in which the intervention took place. Once communication is established/connection is built with the community responsabile persons, through activities which proved their usefulness in various fields, it will usually persist.

"I had a very good, exemplary even, work relationship with the psychologist with whom I also worked in the microgrant project. I've cooperated with the psychologist both before and during the project. I also worked very well with the constable who always helped when I came to him on cases of relinquished children whose parents were alcoholic and used verbal and physical violence, we would go together to solve those cases. It means a lot to have the support of a police officer. With the physician I worked well on topics related to drug use and sexual education. I also worked well with the CHN with whom I teamed up for fieldwork".

Social/outreach worker, Botoșani county

CCS participation in the management of "priority zero" cases (even though these were few in relation to the number of children in each community) and in the planning of microgrant project activities increased community capacity to address social problems, thus ensuring an enabling environment for continuing to implement similar interventions.

3.4.2. Sustainability of model outcomes for children, families and public social assistance services

Are modelled interventions and impact on the most vulnerable children likely to continue when external support is withdrawn?

The evaluation focused on all stakeholders' motivation to continue the interventions, including to actively search for alternative funding sources, given the sustainability conditions described previously.

3.4.2.1. Assessing the motivation to continue implementing the project

As shown when analysing the model effectiveness, the necessary steps include providing long-term implementation of the model measures, implementing an early intervention-based approach, continuing with the vulnerability assessment and ensuring sustained basic social service delivery, in light of the model beneficiaries' multiple and complex vulnerabilities. Consistent and long-term counselling and support are required in order to bring lasting changes to these beneficiaries' situation, while services that offer support, guidance and referral to specialised services need to be delivered repeatedly in order to significantly reduce the identified vulnerabilities. Given that not all the social workers are specialists in this field, **their motivation alone to continue the activities, without sustained support and supervision on the part of the communities and the county institutions, cannot ensure the model sustainability**.

As the local interviews and focus groups show, **the overwhelming majority of the community workers said they thought the implementation of the modelling project was beneficial, the key community stakeholders (mayor and mayoralty staff, teachers, police, family physician, where available, priest) were eventually** (with more or less effort) **mobilised to address social cases and, as such, model implementation can continue as it is supported by the community. In addition, mayoralty decision-makers have come to see the value of fieldwork**.

"Enabling factors include the local authority in the commune who wants to see the project/model continue, has witnessed the benefits of interacting with the beneficiaries and believes that social services are a must if vulnerabilities are to be reduced".

Social/outreach worker, Neamț county

"In our community, the mayor won't sign off on the social surveys unless there's fieldwork involved".

Social/outreach worker, Vaslui county

However, **the evaluation did not find that communities showed any real intentions to seek alternative funding sources to continue the implementation of the UNICEF model**. Continuing the implementation requires hiring community professionals and using the Aurora methodology. With regard to budget requirements, covering the salary of a social/outreach worker in each commune would require a minimum amount of 21,500 lei, if the social workers are paid the minimum salary set for 2017. As for the community health care component, the framework law regarding a unitary wage system for staff paid from public funds (Law 153/2017) stipulates an increase of health staff salaries, however, due to the regulations regarding decentralisation, to pay the CHNs, funds have to be transferred from the state budget to the local budgets.

On the other hand, the social workers who are hired need to be encouraged and allowed to undertake fieldwork, and should not be burdened with deskwork related to managing the social benefits files. Our field research indicated that many community workers feel discouraged now that the UNICEF intervention has come to an end, as they would have wished it to continue. Hence, though essentially there is motivation, with few exceptions (such as the county supervisors with duties in the GDSACP strategies and programmes departments), there was no strong initiative or drive towards continuing the implementation of the model and ensuring the continuity of its outcomes.

It is also true that there were a few initiatives to replicate the demonstration model at county level, referred to in the Exit strategy as "Lever 1.0 and 2.0"[98]. Although not all the counties involved succeeded in this endeavour, there are those like Neamț county[99] which obtained additional funding (1,176,788 lei for 14 months, under the "Synergies for the Future – Children at Risk" CORAI call for project proposals) to scale up/continue the demonstration project after the initial funding was over in September 2015[100].

As such, a continuation of the implementation depends on hiring the community workers involved in implementing the UNICEF model at SPAS level and/or increasing the number of SPAS employees, so as to ensure the capacity required to continue the fieldwork/outreach activities. Such action cannot be undertaken unless the mayoralties commit to continuing the community workers' fieldwork and the delivery of the minimum package of social services, a commitment which is apparent in only about half of the communes in which the model was implemented.

3.4.3. Potential for model replication

Is the modelling project replicable? As a whole or only certain components? At local, county or national level? What are the prerequisites for replication? Are any model adjustments required to enable replication?

As mentioned in Chapter 1.1 at the section dealing with the regulatory and institutional framework and the policy environment, using the experience accrued in implementing this intervention model as well as other interventions at the local level supported by UNICEF, a new modelling project was developed and launched in 2014 in Bacău county: "Social inclusion through the provision of integrated social services at community level". The findings of the present evaluation will be used to complete the advocacy plan for progressively scaling up the model of integrated community-based services, by end of 2017.

Our evaluation hereby is exclusively concerned with the "First Priority: No More 'Invisible' Children!" demonstration project and focuses on the environment in place in communes other than those of intervention and on the capacity of the local communities in the control group to implement the model. We also analysed the motivation of all stakeholders in order to determine the requirements for replication, the level of replication and what model components can be replicated.

3.4.3.1. Replication level

A logical analysis of the model indicates it can be scaled up nationwide. **The Aurora methodology which enables the creation of a database of children and their families and generates an individual minimum package of services is a complex tool that can be used to generate customised minimum packages of services for all children and their families in all communities** to address the vulnerabilities identified.

At the same time, the **national stakeholders** we interviewed who were familiar with the project **judged the model as being replicable** and its nationwide replication as desirable. On the other hand, according to the "Financial impact analysis for scaling up a model of community based services at national level", **the financial impact of extending the model nationwide could be covered from the general consolidated**

98 In light of the resource mobilisation strategies for progressive investments targeting county level replication and scaling up, key to ensuring nationwide coverage, a short-term plan was formulated including the provision of technical assistance to county and local authorities for the preparation and submission of project proposal(s) to access EEA and Norwegian Grant funding under Programme RO10 "Children and Youth at Risk and Local and Regional Initiatives to Reduce National Inequalities and Promote Social Inclusion".

99 Capitalizing on the experience gained in the demonstration project, GDSACP Neamț applied for (in partnership with the mayoralties of three of the county communities) and received funding for a project called "Area Centre for Local Resource Mobilisation in Support of Integrated Services for Children in Need". The three participating communities, two of them rural (Răucești and Pipirig) and one urban (Tîrgu Neamț), set up centres to deliver community-based services for vulnerable children and their families, while Târgu Neamț established an Area Centre for Local Resource Mobilisation in Support of Integrated Services which involves the supervision and technical and methodological support of an area coordinator. Once the project is completed, the local public authority and the participant communes, as well as GDSACP Neamț will take over the activity.

100 Project funding information is available on the CORAI programme website: http://www.granturi-corai.ro/documents/100367/108859/Liste+proiecte+SITE+SINERGII+copii_1.pdf/326f0737-16e2-45de-8b2a-7039e3a1246f

budget and a limited scale up (pilot extension) **can be carried out with minimal budgetary impact by using external funding sources** (ESF, the World Bank etc.).

With regard to the control communes, **interviews with the social workers indicated a high level of openness to implement the model**, even though their experience with the project was limited to 2011 only.

A plausible scaling up scenario is based on **strengthening the cooperation between UNICEF and the MoLSJ and/or the NAPCRA** with the aim of developing a **larger scale pilot project** involving full rural coverage in a few pilot counties. Such a project could be funded by ESF/POCU and/or the World Bank and/or Norway and EEA Grants. **National coverage would then become possible once this larger scale pilot project is implemented and a sense of ownership for the initiative is built within the Ministry of Labour**.

Still, any real chances of replicating the model directly depend on its effectiveness and demonstrated impact, as these are the elements that the Ministry of Labour and Social Justice can bring to the table to persuade its potential funding partners.

On the other hand, through small scale projects based on local initiatives and using ESF/POCU funds (priority axes 4 and 5), the model can be extended to all the communes that have the interest and capacity to develop a quality project eligible to receive funding.

3.4.3.2. Replication environment

Any plan to replicate a model will work only after overcoming the structural problems of the social assistance system and the persisting challenges identified by all partners at the time of the Exit strategy development. Thus, as indicated by the interviews conducted with representatives of UNICEF, ministries and national NGOs, these challenges include barriers and bottlenecks which need to be removed through combined policy advocacy strategies developed in partnership with the relevant national and local stakeholders, and they concern:

– The intersectorial approach to intervention planning and programming, including to budget design.

– Regulating the funding of decentralised social assistance services, observing the framework law on decentralisation and undertaking transfers from the state budget to the local budgets, based on cost standards and on the model used to regulate the financing of community health care in 2017 (via GEO 18/2017 on community health care) and considering the number of vulnerable children in the communities and the other elements that can affect the actual cost of services. The current experience with the modelling project is already a source of data for standardising costs based on the number of vulnerable children, urban/rural area, share of children in the total population, population density and other established indicators on social exclusion in the communities of interest. Moreover, the systematic identification enabled by the Aurora working methodology can generate an accurate county or national level quantification of the number of vulnerable children.

– Local public administration engagement and participation in the development of national policies.

– Developing a medium to long term human resources strategy for the SPAS and CHN, including:

  – hiring community professionals at the local level;

  – training the current social assistance operatives;

  – establishing partnerships between the local public administration, the national authorities and the faculties of social assistance in the country for the purpose of developing special and free of charge programmes (long-distance courses and especially modular training programmes tailored to the needs and availability of the social assistance operatives already working in the SPAS), for SPAS staff training and specialisation;

  –securing community worker availability by developing a strategy to ensure support for social workers and community health nurses who move or commute to rural areas, to ensure participation of competent candidates to the job openings.

- Establishing a national intervention strategy that includes the phased approach to scaling up the model, e.g. MoLSJ piloting the model in a few counties with full coverage of rural areas at least, so as to be able to determine which are the best funding and human resource allocation formulas, as well as the time and staffing required to ensure county and national management of an intervention that covers all the communities of one or more counties.
- Increasing the capacity of the social assistance and child care system at county level by setting up departments whose staff is adequate and specialised in ensuring monitoring, supervision and methodological support for the SPAS activity (within the GDSACP, the County Council or the Prefecture, the latter two coordinating the work of GDSACP, DPH, CSI, the County Agency for Payments and Social Inspection), so as to ensure solid support to community workers in their fieldwork duties.
- Developing a culture and practice of monitoring and evaluation of public policies at national and local level and of interventions planned at the local level.
- The need for long term interventions, considering that, in some cases, the goal is to change mentalities and social norms.
- Considering the limitations of evaluations and evidence to date and taking a flexible approach to and testing elements which are as yet unsupported by reliable relevant data.

In fact, the interviews with community workers and their county supervisors also show they regard the continuation, replication and scaling up of the model as a national level coordinated process, with a greater involvement of the central authorities including the MoLSJ, the MoH (for the community health care component), the NAPCRA, the National Agency for Payments and Social Inspection etc.

"To replicate the model in all the communities of our region, I think things are now different, they involve a top-down approach, so the power of the model can be replicated top-down, based on practical arguments and as a source of relevant indicators for model continuation and replication".

DPH supervisor, Botoşani county

"Legislation should make it mandatory for the SPAS to hire a social worker and a community health nurse. We keep talking about inclusion, there's all kinds of slogans on this topic, but concretely, unless there are professionals at the local level, there can't be any talk about inclusion. There should be a legislated budget for the provision of a minimum package of social services relative to the number of inhabitants. For instance, if a community has 100 elders with special needs, social services for this category of beneficiaries should be developed as a mandatory requirement".

GDSACP supervisor, Neamț county

"Unless action is taken now through measures designed to legislate this model and unless the interventions continue, it will all be history, a nice account of the past. It would be useful to have an intervention from the ministry level, a minister's order perhaps or a government decision stipulating that this is a model with such and such costs, benefits, methodologies".

GDSACP supervisor, Suceava county

The professionals from both local and county level involved in the modelling project, therefore, underline the need to proceed with a scaling up or replication of the model while the approach developed and tested by UNICEF still generates interest and enthusiasm to capitalise on.

3.4.4. Summary of the answers to the evaluation questions on sustainability

The data and information collected for the summative evaluation allow for formulating answers to all the evaluation questions on sustainability, as follows:

A. The current context is favourable to continuing the approach promoted by the modelling project, given that most of the communes in which the model was implemented have retained the community workers involved in the project who received the Aurora methodology and the necessary equipment, as well as relevant training. The activity could also continue in the communities in which social workers were not hired/retained within the mayoralty after the model implementation ended, since the tablet computer for the use of Aurora remained with the SPAS. Still, when it comes to these communes, the model has smaller chances of being continued, as stakehoders are in doubt as to the existing willingness/availability to take over the fieldwork duties involved in delivering social services for children.

B. If the interventions are not continued, the positive outcomes generated by the model are unlikely to last long, as the vulnerabilities of most of the model beneficiaries are complex and the interventions that can address them most effectivelly are early and long-term ones.

   On the other hand, **local stakeholders, including mayors and professionals at local level, have the drive and motivation to continue with identifying vulnerabilities**, delivering services and using the tablet computer for the Aurora methodology, but the capacity of the local workers still needs building to enable model implementation in the absence of the UNICEF support, and since the local authorities are not proactive in identifying solutions, projects and funding sources for this capacity increase, a continuation of the model without the necessary support remains limited and challenging.

C. **The model is replicable, both as a whole and as separate components**, just the social assistance services, just the community health care services or both, but one should consider that the most efficient approach is the integrated one which the demonstration project focused on all along. On the other hand, the Aurora can be replicated, both the methodology and the working tool, as special modules can be added to it.

D. **The model is replicable at local, county or national level**, however nationwide replication can only be achieved if thecentral authorities, MoLSJ and MoH, commits to it as a public policy.

E. **Even though no adjustments are required to replicate the model at the local level, but** replication at county or national level require strengthening the UNICEF-MoLSJ cooperation and **testing various intervention options to address several social assistance and protection, as well as health systems deficiencies** related to the reduced availability and capacity of qualified human resources, the lack of comprehensive methodologies and the underfunding of the child care system, particularly at the local level.

3.5. Impact of "First priority: no more 'invisible' children!"

The evaluation of the model impact focuses on identifying the positive or negative changes generated by the implementation of the project, whether directly or indirectly, as well as the main outputs and outcomes and their main beneficiaries. The main findings on the impact of the model were formulated based on a comparative analysis of the data collected throughout the model implementation and a comparison between the situation of the communes in which the intervention was undertaken until September 2015 and that of other similar communes in which the intervention was withdrawn at the end of 2012.

3.5.1. Impact on vulnerable children and their families

What change did the modelling project determine or influence for beneficiaries (children and their families), communities, professionals, public government – at local, county and/or national level?

To answer this question, we compared model outcome indicators for communes which received the intervention all throughout 2011–2015 and communes from the control group in which only the identification of vulnerable children was carried out in 2011, using data from the Aurora database and data provided by the household survey conducted for 843 households in both intervention and control communes.

In terms of medium-term outcomes for vulnerable children and their families (the group generally targeted by the UNICEF activities), the following were considered by the Theory of Change for the "First Priority: No More 'Invisible' Children!" modelling project:

- All children are **'visible'** to their communities and to health, education and social assistance systems;
- All children have **access to health care**;
- All children have **access to education**;
- All children are **protected against separation from their family**;
- All children are **protected against all forms of violence (including neglect, abuse and exploitation)**;
- All adolescents are **informed about risk behaviours**.

3.5.1.1. Children are 'visible' to the community

The first set of interconnected model objectives included identifying children with multiple vulnerabilities, accurately assessing these vulnerabilities which until then had been 'invisible', and raising community awareness of their existence and complexity. Given the issues related to the accuracy of data collected in 2011 and 2012 by the social/outreach workers from 96 and, later, 64 communities, this outcome was only partially achieved until 2013. Once the Aurora was introduced and used to assess the vulnerabilities, the assessment and monitoring of risk and vulnerability situations improved considerably and the children that were identified with the help of this application became 'visible' to their community (despite the limitations still present in assessing the risk of child abuse, violence or neglect).

An extreme case of "invisibility" of children and their carers is the lack of ID papers, an issue that local professionals helped address to a large extent. In 2011, this vulnerability affected 6 percent of the 'invisible' children (girls and boys, Romanians and Roma, especially in Iași and Neamț counties), while in 2015, at the closing of the project, it was recorded for less than 0.5 percent of the children. The Aurora data show that, in 2015, only 3 persons who had been identified as lacking ID papers 9 months before, at the first use of the Aurora questionnaire, still had this vulnerability (and even so, the registration procedure may well have been in progress).

"In 2011, in our commune, we identified 94 cases of people who lacked a valid ID card. We took steps together with the local police, we brought in clerks from the population records office in Buzău, helped them prepare the necessary documentation and provided them with ID cards. I told them at the time that because they didn't have valid ID cards, it was as if they didn't exist for the rest of the world. This way they understood it was very important to address this issue. Since then, we no longer have in our community any cases of people without civil registration documents".

Social/outreach worker, Buzău county

The survey conducted in 2016 shows statistically significant differences between the number of people without ID papers in the communes in which the model implementation included the Aurora methodology and tool, the service package delivery and the micro-grant projects and the number of people without ID papers in the communes in which the intervention entailed only the identification of vulnerabilities in

2011. Also, the number of people with disabilities and with a disability certificate is significantly higher in the intervention communes than in the control group.

Table 20. Percentage of people who have the necessary papers to access social benefits and services, in the intervention vs. the control communes

	% in the intervention communes	% in the control communes
Person with ID papers	99	94*
Person with a disability certificate	84*	56

Source: Survey conducted in 2016, ICE and C|C|S|A|S

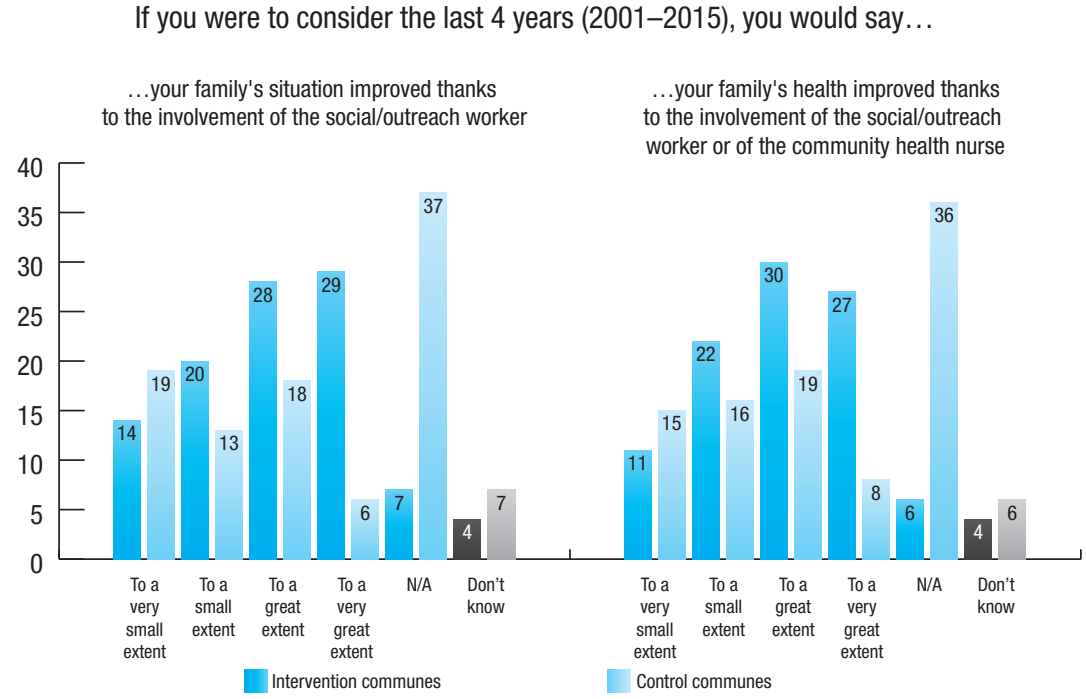
*N=2,209; data were weighted by age, ethnicity and educational attainment, *statistically significant differences for p=0.05.*

The provision of assistance with administrative tasks such as those required to obtain ID papers or certification of disability degree and type as well as to receive the social benefits that children and their families are entitled to is evidence of a clear and verifiable outcome of the "First Priority: No More 'Invisible' Children!" model

3.5.1.2. Increasing access to health care

According to the survey conducted for the purposes of the summative evaluation, the modelling project beneficiaries believed their life and health improved as a result of the community workers' input. Compared to the statements of the control group respondents who did not receive the sustained assistance of the community workers, the differences of perception are big and statistically significant.

Figure 19. Beneficiaries' perception of the impact of social workers' input on their family situation and health, in the intervention vs. the control communes



Source: Survey conducted in 2016, ICE and C|C|S|A|S

N=717; data were weighted by age, ethnicity and educational attainment, statistically significant differences for p=0.05 for the "To a great extent", "To a very great extent", and "Not applicable" answers.

Nevertheless, the survey did not enable the measurement of significantly statistic differences between the intervention and the control group regarding child vaccination and periodic medical checkups.

Leaving aside the differences found when comparing the survey results to the Aurora data with regard to registration with a family physician and child vaccination, given that the Aurora database is more reliable (see why in the section on model effectiveness which elaborates on the differences between the survey data and the Aurora data), a close look at the evolution of the vulnerabilities assessed by the community workers starting 2014 will reveal a successful intervention. First of all, we need to emphasise that **none of the children identified in 2014 as not registered with a family physician stayed that way**. This is confirmed by the community workers.

"Following the inventory undertaken using the Aurora, all the children identified as not registered with a family physician, and they were lots, I'll tell you that, were registered and received services. Still, where health counselling was concerned, parents from families in need were the first to give up attending the meetings organised by the social worker".

Community health nurse, Bacău county

However, 20 new situations of vulnerability were identified (newborns not registered with the family physician or children left without a family physician) that needed to be addressed after the case reassessment at T0, which started in August 2015 and should have been carried out after completion of the model implementation.

At the same time, except for vaccination of children under age 1, the other situations of health risks for children aged up to 5 improved following the implementation of the model, as shown by the Aurora data.

Table 21. Percentage of children recorded with health-related vulnerabilities following the use of the Aurora questionnaire

Assessed vulnerability	% of children identified with the vulnerability	
	Aurora (T0)	Aurora (T1)
Child aged up to 1 year, in a situation of risk	61	42
Child aged up to 1 year not vaccinated	4	7
Child aged 1 to 5 years, in a situation of risk	7	5
Child aged 1 to 5 years not vaccinated	63	45

Source: UNICEF – Aurora database. Data refer to children assessed at T0 (2014) and at T1 (2015). The sample size varies as follows: in 2014, children aged up to 1 year N=322, children aged 1 to 5 years N=1,030; in 2015, children aged up to 1 year N=156, children aged 1 to 5 years N=706.

On the other hand, though not recorded in the databases as such, the community workers highlighted a perceived increase in the quality of life for children with disabilities.

"When it comes to children with disabilities, it is not only the quality of care that increased, but also their quality of life. For instance, there was this child who received a hearing aid and, clearly, the child was integrated in school and in the community. There were children who received wheelchairs, walking frames. Increasing quality of care for children with disabilities was an undertaking initiated as part of the project, but developed with NGO support".

Community health nurse, Neamț county

Children with disabilities received psychological support as well as aids and equipment, thanks to the linkages with other public or NGO-provided specialised services the project facilitated.

3.5.1.3. Increasing access to education

Project impact on increasing access to education for vulnerable children was limited, as shown by the Aurora database entries, the survey conducted in the intervention and control communes and the quality research. The risk of dropping out of school and actual dropout are vulnerabilities which were reduced

especially among the Roma children where they were high, but the proportion of school age children not enrolled in school did not decrease as well.

Table 22. Percentage of children recorded with education-related vulnerabilities following the use of the Aurora questionnaire

Vulnerability	Assessment criteria		% of children recorded with the vulnerability	
				Aurora (T1)
Preschooler not enrolled in kindergarten	gender	male	18	17
		female	22	15
	ethnicity	Romanian	13	8
		Roma	36	34
	Total		**20**	**16**
Child aged 6 to 15 not enrolled in school	gender	male	1	1
		female	1	1
	ethnicity	Romanian	0	1
		Roma	2	2
	Total		**1**	**1**
Child at risk of dropping out of school	gender	male	15	13
		female	11	8
	ethnicity	Romanian	10	10
		Roma	22	15
	Total		**13**	**11**
Child who dropped out of school	gender	male	9	7
		female	11	8
	ethnicity	Romanian	6	5
		Roma	21	15
	Total		**10**	**8**

Source: UNICEF – Aurora database. Data refer to children assessed at T0 (2014) and at T1 (2015). The sample size varies as follows: in 2014, (a) preschoolers total N=1,316, of whom boys N=690, girls N=629, Romanians N=917, Roma N=387, (b) children aged 6 to 15 (school age) total N=3,047, of whom boys N=1,579, girls N=1,468, Romanians N=2,316, Roma N=698; in 2015, (a) preschoolers total N=897, of whom boys N=482, girls N=415, Romanians N=608, Roma N=289, (b) children aged 6 to 15 (school age) total N=2,075, of whom boys N=1,091, girls N=984, Romanians N=1,621, Roma N=454;

According to the interviewed community professionals, they carried out several activities to advocate for and encourage school attendance, but their efforts had limited results. Of the children initially identified as school dropouts, who said they did not attend school and did not intend to go back there, 39 percent (116 children out of 294) resumed education, including via the "Second Chance" national programme, and were no longer listed with this vulnerability at the second use of the Aurora questionnaire.

"Children were advised to access the "Second Chance" Programme, and as such, their access to education increased. There are children who resumed classes they had abandoned a couple of years back".

Social/outreach worker, Neamț county

However, 2.5 percent of the children who were recorded as attending school when first assessed (69 of 2,753 not recorded as dropouts initially), dropped out of school between 2014 and 2015 when the Aurora reassessments took place. Of them, nearly 40 percent (27 children) were recorded at T0 at risk of dropping out.

Table 23. Evolution of education-related vulnerabilities in children, based on Auroras

Vulnerability	Number of initial cases (at T0)	% of cases in which the vulnerability was no longer present (listed at T0 only)	% cases in which the vulnerability persisted (listed at both T0 and T1)
Child not enrolled in school, who dropped out of school or is at risk of dropping out	798	51	49
Child at risk of dropping out	299	59	41
Child who dropped out of school	201	58	42

Source: UNICEF – Aurora database. Data refer to children assessed both at T0 (2014) and at T1 (2015). Percentages are calculated relative to N (number of initial cases shown in the first column).

At the same time, the increased share of children enrolled in kindergarten is credited by community workers to the implementation of "Every Child in Kindergarten" programme more than of the UNICEF model, while school participation is connected to the "Croissant and Milk" programme. Community workers believe one of the main methods of promoting participation to education is to have the granting of social benefits conditional on the certificates issued by schools, while focus groups reveal that representatives of the local institutions forming the CCSs view material aid as still being the main motivator behind school attendance.

"Children come and ask for these items [croissant and milk], to them it's a meal – some of them ask for an extra portion for their kid sibling at home. School, not the social worker, is considered responsible for ensuring participation to education. They tried motivators like trips for children, but unless you work with the parents, you get no results".

CCS member, focus grup participant, Bacău county

With regard to school attendance, the survey does not record statistically significant differences between the intervention and the control communes. The risk of dropping out is higher in the intervention communes where the repetition rate is 10 percent versus 6 percent in the control communes, a statistically significant difference.

Nevertheless, due to a series of noteworthy exceptions pointed out by the community workers and the parents, we find the modelling project has had a positive impact on school attendance, even though not to a considerable one.

"We had a girl whose mother died and her father lacked the means to support her through high school in Pătârlagele. She was a very good girl. Everyone came together to lend a hand, the community structure, the father, we brought in two business entities who promised to help her by covering her transportation subscription until her father got back on his feet. Later, she became an 'olympic' contestant in Romani language international competitions and was awarded a scholarship all through high school. The President of Romania himself congratulated her on her achievements and she received a 4,000 lei reward. Thanks to the project intervention, she could complete her high school studies. She calls me often to thank me".

Social/outreach worker, Buzău county

Thus, the project impact on school attendance is still limited to a series of exceptional situations in which the professionals at community level were providing support for children to be enrolled and to continue their education. On the other hand, in the absence of an education-targeted component and the project involvement of school counsellors, one cannot talk about a statistically noticeable impact on school attendance in the intervention communes.

3.5.1.4. Protecting children against child-family separation

The risk of child-family separation was one of the most important vulnerabilities addressed by the model which included a special dedicated service for it – "priority 0 service". The interviews we conducted re-

vealed that once the service was well understood by the community workers, it proved useful in approaching the identified cases and ensuring effective risk prevention.

"We had one priority 0 case; we initially panicked when we saw that the Aurora generated 0. Naturally, we need to act right away, according to the procedure. The GDSACP stepped in and helped solve the case. I for one thought that such priority 0 situations occur in extreme circumstances. But when I entered the data into the tablet and saw that it displayed priority 0, even though we were working on this case, it drove us more, it compelled us to take action".

Social/outreach worker, Buzău county

However, this vulnerability persists among the community child population, both because of the still low community-based capacity of the social assistance system and because of the serious cases of abuse, violence and neglect that can be found in some families.

The Aurora data show that, although the case incidence of children separated from their family, placed in residential centres or in foster care, decreased from 1 percent to 0.3 percent, the vulnerabilities which generate the risk of child-family separation – children whose mothers have underage children not living in the household – persist at a consistent level and there are no relevant differences of risk between Romanian and Roma children, girls and boys or determined by age.

Table 24. Percentage of children recorded at risk of separation from their family following the use of the Aurora questionnaire

Vulnerability	Assessment criteria		% of children recorded with the vulnerability	
				Aurora (T1)
Child separated from his/her family or at risk of being separated from their family	gender	male	8	8
		female	9	10
	ethnicity	Romanian	8	8
		Roma	9	13
	Total		**8**	**9**
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care	gender	male	5	6
		female	7	8
	ethnicity	Romanian	6	6
		Roma	6	10
	Total		**6**	**7**
Child at risk of being separated from his/her family – whose mother has underage children in public care	gender	male	1	1
		female	1	1
	ethnicity	Romanian	1	1
		Roma	1	2
	Total		**1**	**1**

Source: UNICEF – Aurora database. Data refer to children assessed at T0 (2014) and at T1 (2015). The sample size varies as follows: in 2014, total number of children N=5,178, of whom boys N=2,682, girls N=2,496, Romanians N=3,857, Roma N=1,268; in 2015, total number of children N=3,485, of whom boys N=1,818, girls N=1,667, Romanians N=2,621, Roma N=863.

Among the few vulnerabilities whose incidence differs according to the children's ethnicity, the risk of child-family separation stands out, the children having underage siblings not living in the household with their parents but not in public care either. Thus, 6 percent of the Romanian children are at risk of separation from their family, living in households where underage siblings are not living with their parents, versus 10 percent of the Roma children in this situation. Overall, considering other risk elements as well (besides children not living in the household with their mother), 13 percent of the Roma children are separated or at risk of separation from their family versus 8 percent of the Romanian children. Although the differences are not big, we recommend delivering services tailored according to ethnicity, so as to ensure service delivery that better meets the needs of vulnerable children and adapts to their environment.

When analysing the evolution of the vulnerability among the same children in the Aurora database, we find a high dynamics of the risk of child-family separation. In 60 percent of the 316 cases initially recorded at risk of separation or already separated from the family, the separation appears to have been addressed at the second data collection, 9 months later.

Table 25. Evolution of case incidence of children at risk of separation from their family assessed based on the Aurora questionnaire

Vulnerability	Number of initial cases (at T0)	% of cases in which the vulnerability was no longer present (listed at T0 only)	% of cases in which the vulnerability persisted (listed at both T0 and T1)
Child separated from his/her family or at risk of being separated from their family	316	60	40
Child in placement centre or foster care in risky conditions	20	70	30
Child at risk of being separated from his/her family – care cumulează 7 sau mai multe vulnerabilități	25	96	4
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care	230	67	33
Child at risk of being separated from his/her family – whose mother has underage children in public care	45	47	53

Source: UNICEF – Aurora database. Data refer to children assessed both at T0 (2014) and at T1 (2015). Percentages are calculated relative to N (number of initial cases shown in the first column).

This dynamics, with regard to both vulnerabilities related to child-family separation and vulnerabilities related to parents' presence in the household, demonstrates that there is a need for ongoing intervention in order to address child-family separation effectively and with impact. Such intervention should help improve the effectiveness of the identification of children at risk of separation from their family[101] and of the measures designed to prevent this risk, all of which form the "priority zero service".

3.5.1.5. Protecting children against all forms of violence, abuse or neglect

As the evaluation of the model in terms of its effectiveness also shows, despite the fact that community workers recorded via the Aurora a decrease of the vulnerabilities linked to violence, abuse and neglect, for all categories of children, this evolution is not supported by the survey conducted in 2016.

Table 26. Percentage of children recorded at risk of violence, abuse or neglect following the use of the Aurora questionnaire

Vulnerability	Assessment criteria		% of children recorded with the vulnerability	
			Aurora (T0)	Aurora (T1)
Child living in a family prone to child violence, abuse or neglect	gender	male	47	32
		female	42	29
	ethnicity	Romanian	43	29
		Roma	52	34
	Total		**44**	**30**
Child living in a family prone to child violence	gender	male	38	25
		female	32	20
	ethnicity	Romanian	33	20
		Roma	43	29
	Total		**35**	**22**

101 See Chapter III. Evaluation results, section 3.2.3. Reducing the pressure on the child care system

Vulnerability	Assessment criteria		% of children recorded with the vulnerability	
			Aurora (T0)	Aurora (T1)
Child living in a family prone to child neglect	gender	male	28	17
		female	26	18
	ethnicity	Romanian	24	16
		Roma	36	23
	Total		**27**	**18**

Source: UNICEF – Aurora database. Data refer to children assessed at T0 (2014) and at T1 (2015). The sample size varies as follows: in 2014, total number of children N=5178, of whom boys N=2,682, girls N=2,496, Romanians N=3,857, Roma N=1,268; in 2015, total number of children N=3,485, of whom boys N=1,818, girls N=1,667, Romanians N=2,621, Roma N=863.

According to the survey, 73 percent of the children in the intervention group are sometimes left home with no adult present, in a situation of neglect. 49 percent of the children in the intervention group are disciplined through use of abusive methods: physical violence (3 percent), verbal violence (16 percent), emotional violence – threats (7 percent) or privation (23 percent). Comparison with the control group reveals no significant differences.

Community workers, CCS members and parents mentioned that the workshops organised for the purpose of informing and counseling parents were useful as they provided parents with helpful advice on how to relate to their children, thus preventing potential situations of violence, abuse and neglect.

Even so, the risk of violence, abuse or neglect is not only difficult to identify, but once identified it is also very hard to address, as indicated by the nterviewed community workers, despite the progress they've recorded in the Aurora..

"Mentality is a serious challenge, because violence is regarded as normal, as no big deal. Families which are known for their alcohol consumption are a source of violence as well as antisocial behaviours which are passed on to their children".

Mayor, CCS member, focus group participant, Bacău county

"Following case identification and assessment, we identified situations of domestic violence. We tried to talk to the offender but the outcomes aren't always what we expect. For instance, I had a family where the husband was very violent, I talked to him, I explained he could lose his wife if he continued to harm her and he would be left with the kids. Although he assured me he understood and would stop harming her, he didn't stop".

Social/outreach worker, Buzău county

Considering the complexity of this dimension, as well as the limited time of intervention, the model impact is limited to a small number of cases in which the household environment enabled the intervention.

All data collected via qualitative research methods, including workshops with children, show that the risk of child violence, abuse and neglect cannot be tackled independently of vulnerabilities such as alcohol consumption, which enables and accompanies the most serious cases, or the lack of jobs (unemployment) which often leads to situations of neglect. Also, given the high level of social tolerance towards violence and neglect, as indicated in all interviews and focus groups, the measures aimed to decrease these vulnerabilities need to be systemic and long-term, targeting not only children and parents, but the whole community as well.

Furthermore, certain vulnerabilities affecting children are triggered by their parents' problems and vulnerabilities, some of which can best be addressed through specialised services such as counselling, addiction treatment and employment, services which are not available at the local level and not accessible/affordable to vulnerable people, as shown by all the interviews we conducted. Only a structural reform to bring these services closer to those who need them and continued information and counselling activities to prevent risks will eventually effectively curb the instances of child abuse, violence and neglect.

3.5.1.6. Informing adolescens about risk behaviours

The survey does not reveal any significant differences between the intervention and the control groups with regard to the incidence of risk behaviours related to alcohol or tobacco consumption. Thus, in relation to a control group, the samples included in the survey did not demonstrate that the model had a positive impact in combatting risk behaviours through information, nor that there was a direct connection between the perception of the level of information and the incidence of risk behaviours. This can be explained by the need for long-term interventions to significantly change risk behaviours.

However, the situation is paradoxical as the **community workers and key local stakeholders perceive the results of the model and especially of the micro-grant projects as successful and the Aurora data show a decrease in the percentage of adolescents with risk behaviours**.

Table 27. Evolution of case incidence of children with risk behaviour vulnerabilities assessed based on the Aurora questionnaire

Vulnerability	Number of initial cases (at T0)	% of cases in which the vulnerability was no longer present (listed at T0 only)	% of cases in which the vulnerability persisted (listed at both T0 and T1)
Adolescent with risk behaviour in terms of healthy lifestyle (nutrition and physical activity)	3	100	0
Adolescent with risk behaviour in terms of sexual activity	372	78	22
Adolescent with risk behaviour in terms of substance use	77	75	25

Source: UNICEF – Aurora database. Data refer to children assessed both at T0 (2014) and at T1 (2015). Percentages are calculated relative to N (number of initial cases shown in the first column).

On the other hand, the Aurora recorded data show a high case dynamics for adolescents with risk behaviours. This dynamics is an indicator that long-term intervention is required, as pointed out by all community workers.

"I couldn't say, I don't think the risk of pregnancy among adolescents was reduced, in some communities it's a matter of tradition, custom. The project did not last long enough for that, information and counselling services should last years if they are to change mentalities, behaviours".

Social/outreach worker, Neamț county

Consequently, the information activities were highly welcomed by the community, but their impact in terms of behaviour change is still a limited one, and all stakeholders believe a long-term intervention focused on prevention is necessary to effectively increase adolescents' information and awareness level and reduce risk behaviours. As such, as our data on the model effectiveness and sustainability also show, for all risk behaviours (including violence), changes in attitudes as well as behaviour occur as a result of long-lasting actions that focus on prevention and individual information and counselling. At the same time, risk behaviour change is boosted by an increased social pressure and this pressure is generated via public information campaigns targeted at the overall community.

3.5.2. Impact on public social assistance services and other responsible institutions

To what extent did the modelling project increase institutional capacities to ensure that the most vulnerable benefit from the minimum package of services in a way which contributes to prevention of child-family separation and of violence against children?

The answer to this evaluation question was formulated based on the results of the interviews we conducted and, where possible, we compared the model outcome indicators in the intervention and the control communes.

At community level, according to the Theory of Change, the following outcomes of the model implementation were envisaged:

- increased community capacity to deliver social services and community health care services (in 32 communes);
- around 150.000 people in rural areas better informed about child rights as well as family rights and responsibilities;
- 32 community counselling and support centres for children and parents in place;
- 32 functional community consultative structures operating for the worst-off on the basis of local action plans.

3.5.2.1. Building SPAS capacity

Given the participation of the social workers and community health nurses to the training sessions organised by UNICEF and the introduction of a tool (the Aurora) which standardises the identification and assessment work and automatically generates recommendations for services to be delivered, we can say that **the capacity to deliver social services has increased** and so has the capacity to deliver community health services. Also, the SPAS capacity has increased as a result of the exposure to working with clear indicators and definitions for the various vulnerabilities, which enabled community workers to become aware of issues they might otherwise have overlooked, and of the community engagement to support the community workers in the most difficult cases. More details in this respect are available in the section dealing with the answer to the evaluation question on the effectiveness of the model at community level.

"The model proposed through the project, particularly the Aurora application, first came to the aid of the specialists who learned what to tell the beneficiaries in order to help them. For the specialists, the programme was an opportunity for professional growth, for a change of attitude and outlook on the family assessment. The model helps specialists provide correct and objective solutions. The community health nurse was able to provide much more information than he/she would have in the absence of the Aurora questionnaires. They could also mobilise the Mayoralty and the School for more support in carrying out their information activities. I believe this model provides the services that vulnerable people need, it's just that more staff should be involved".

Community health nurse, Suceava county

"The project helped increase beneficiaries' access to social services due to the fact that, by using the Aurora, [the community worker] was exposed to more situations whereby families, parents and children, needed support and were guided to the relevant services, but also due to the fact that specialists changed their approach to the assessment activity, perceiving problems they didn't use to regard as such (e.g. early sexual activity among the 13–14 year olds, pregnant Roma adolescent girls)."

CCS member, focus group participant, Suceava county

As of 2013, when the health component was added to the project, the community health nurses who were mayoralty employees were integrated in the team charged with delivering the minimum package of services. Where community health nurses were not available, the local authorities together with the county Directorates for Public Health made every effort to identify and recruit them. Nevertheless, in the end, community health nurses were available in only 25 out of the 32 intervention communities. As such, **the capacity to deliver community health care services increased in only 25 communes and was absent in the other 7 communes included in the model**.

On the other hand, we have to note that, in some of the communes, **the capacity of local public authorities to deliver social services remained low**, these communes being in the same situation as the control communities, as shown by the analysis of the model sustainability. Capacity remained low as long as the social/outreach workers trained in the UNICEF model were not SPAS employees, and the know-how regarding the use of the Aurora, together with the tablet computer hosting it were not passed on to the SPAS. Nevertheless, there are cases in which the transfer of skills and equipment to the SPAS social workers did occur, even if there was no continuity in the employment of the social workers, and the Aurora was still in use, which is why we can state that the project has determined an increase in the capacity of the SPAS, but

the strength of the outcomes differs according to the enabling factors at the local level: staff continuity, local public authority support, SPAS employee teamwork.

3.5.2.2. Model impact through community-based actions

Community Counselling and Support Centres for children and parents were functional in the 32 intervention communes, funded via the UNICEF microgrant projects, and their activity benefited the local recipients greatly due to the involvement of specialists such as psychologists who provided information and counselling and complemented the capacity of the social workers in the commune. The centres were **a good lesson of cooperation and increasing strength and quality of services provided at local level, but their sustainability depends on availability of funding**, whether from the budget or from a donor (NGO, European funds, etc.).

The **Community Consultative Structures** work well or very very well in all the 32 communes, even if the regularity of their meetings varies from monthly to half-yearly. In almost all the communes, the community workers we interviewed said that, **whenever necessary, key commune stakeholders, members of the CCSs, step in and support the community workers' activity. This is important for increasing the SPAS capacity to deliver social services, as long as the institution can count on community support.** It is worth mentioning here that good cooperation with other institutions in the community was also mentioned by the social workers in the control communes, while working on the basis of local action plans is not a priority for the CCS in the intervention communes either.

3.5.2.3. Informing the target audience

Our survey shows that, in the intervention communes, 66 percent of the most vulnerable persons heard about the modelling project and over 60 percent of the survey respondents took part in the micro-grant projects and received the services provided by the community centres, while 50 percent of them believe their life and that of their family's improved to a large or very large extent. According to the community workers, the main benefit of the information activities was that the targeted recipients became aware of their problems, they learned where to go for help and their level of confidence in the community workers increased, which, in turn, led to more frequent requests for support.

Beneficiaries *"understood that when they have a problem, they need to ask for help, and that asking for help is nothing to be ashamed of, nor is it undignified. The first step in identifying a solution is to acknowledge you have a problem".*

Social/outreach worker, Neamț county

"Due to the project intervention, people, "problem families", no longer regard the social assistance service as a "Boogeyman", but as a friend, and they resort to it whenever they need advice or help".

Social/outreach worker, Bacău county

Nevertheless, the level of information about child rights and risk behaviours does not appear to be significantly higher in the intervention communes versus the control ones, except for information about the mayoralty services available to vulnerable persons and the right to social aid. There are no significant differences between the intervention and the control groups with regard to the level of information about fundamental children's rights to access health care and education, while respondents from the control group reported more often to have been better informed about risk behaviours, compared to respondents from the intervention group.

Table 28. Level of information among recipients of social services, in the intervention vs. the control communes

To what extent are you informed about... ?		Intervention communes %	Control communes %
your right to social aid	To a very small extent	14	26*
	To a small extent	17	17
	To a large extent	36	29
	To a very large extent	33*	19
	Don't know	1	9*
your right to health care	To a very small extent	8	10
	To a small extent	16	14
	To a large extent	40	39
	To a very large extent	35	30
	Don't know	0	6*
the mayoralty services you should receive	To a very small extent	14	23*
	To a small extent	19	25
	To a large extent	34	29
	To a very large extent	33*	16
	Don't know	1	7*
the vaccines your children need	To a very small extent	6	9
	To a small extent	15	11
	To a large extent	40	35
	To a very large extent	39	43
	Don't know	0	3
your children's right to education	To a very small extent	7	9
	To a small extent	11	9
	To a large extent	42	40
	To a very large extent	39	36
	Don't know	1	5*

Source: Survey conducted in 2016, ICE and C|C|S|A|S

*N=824; data were weighted by age, ethnicity and educational attainment, *statistically significant differences for p=0.05.*

As can be seen, the level of information assessed for the model is good and very good (information to a large and a very large extent), between 60 and 80 percent for various topics. Consequently, in relation to the overall population of the intervention communes, an estimated 100.000 people at most were informed about children's rights, particularly social and mayoralty-related ones, as well as about their carers' rights and duties, which means the model had a considerable impact even if it did not reach the intended level set in the Theory of Change.

3.5.3. Increasing the impact of national social assistance and child protection policies

To what extent has the modelling project increased the impact of social protection policies for the poor and most vulnerable children?

The answer to this evaluation question is based on desk reviews and interviews with representatives of public central institutions involved in public policy-making, conducted to determine how the model influenced national policies.

3.5.3.1. Research-generated data

According to the data resulting from the interviews conducted at all levels (national, county and local levels), the "First Priority: No More 'Invisible' Children!" model is highly relevant in closing the gaps which occur at the local level in the implementation of national policies targeting children and their families. Thus, the project was implemented in a national environment in which:

- Social surveys/investigations are conducted in an inconsistent manner, and in some places, they are not conducted almost at all, this deficiency being linked to the next problem,
- There is a lack of social assistance professionals, especially in rural areas,
- The local social assistance system is underfunded, interventions having to rely on the local budgets which are often insufficient,
- Social/outreach workers employed within the SPAS are often overburdened with desk work related to the granting of social benefits and, as a result, they rarely (or never) go out in the field,
- Community health care is still poorly developed,
- Social service regulations are still limited,
- Prejudice persists, even among the social assistance staff, and that affects service delivery negatively,
- The methodological guidance received by the SPAS from the GDSACP and DPH is limited for social and community health care services,
- Both social assistance and community health care services are affected by systematic challenges at the level of the public government in Romania, such as lacking or poor communication among the various public institutions and the absence of a shared use of databases[102] (sometimes because of the technical incompatibility of some of the databases).

The model has offset these deficiencies, as shown by our analysis of the project effectiveness and impact at community and SPAS level, thus increasing the local impact of the existing national policies.

At county level, the model encouraged cooperation between the GDSACP, DPH and the SPAS, which was much stronger than prior to 2011. The GDSACP and DPH acquired competencies and received tools they can use in their supervision of and methodological guidance to all local social assistance services in the county, thus helping increase the impact of national policies.

"The experience gained in this project, the cooperation with UNICEF and other large organisations involved, as well as with specialists from other counties have had a major impact on me as a professional. I have grown professionally as the project progressed and today my outlook on the social system, on community development and social policies is much broader and complex than before. I have worked with highly competent people, I had the opportunity to cross paths with professionals at different levels or working in related areas, we learned from one another, we thought and felt alike. The cooperation with other county supervisors was also very useful and interesting, we made a great team and connected outside the project as well, whenever in need of an idea, a piece of advice or a solution in our daily work. We still stay in touch because we still act like a team. As a professional, I was designated to participate in various working groups, at both county and national level. The social worker dealing with children/families that I started out as is now a social worker dealing with social policies, consulted on decisions related to "building" the system. Of course, the social assistant in the first category is also very very important, but what I meant to say is how this project changed me as a professional".

GDSACP supervisor, Neamț county

At national level, the "First Priority: No More 'Invisible' Children!" model influenced a considerable number of strategies and laws passed in 2015, 2016 and in the first half of 2017, including:

- The National Strategy for the Protection and Promotion of Children's Rights 2014–2020 and the

102 For instance, using shared databases could eliminate the risk of having a newborn initially recorded in the maternity not registered later with the population records office for the purpose of being issued a Personal Numerical Code and birth certificate.

Operational Plan for its implementation,

- Government Decision 691/2015 for approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and of the Working Methodology for GDSACP-SPAS collaboration and of the standard model for the documents developed by these two institutions,
- The National Strategy on Social Inclusion and Poverty Reduction 2015–2020 and its Strategic Action Plan,
- Government Emergency Ordinance 18/2017 on community health care,
- The Government Strategy for the Inclusion of the Romanian Citizens Belonging to the Roma Minority 2015–2020
- The National Youth Policy Strategy 2015–2020,
- "A Society without Barriers for People with Disabilities" strategic document.

However, these policies and laws have not been in force long enough to enable an assessment of the project outcome in terms of increasing the impact of public child protection policies.

The new regulatory document on community health care provides a partial solution to the funding problem, through enforcement of the framework law on decentralisation and regulation of the transfers of funds from the state budget to the local budget. This way, the community health nurse work and profession will undergo development in the coming years.

The vulnerability assessment model described in GD 691/2015 is largely built on the Aurora system, but it is not used in the field via a digital tool, like a tablet computer, instead it requires filling in detailed forms which then have to be centralised back in the office, entailing an additional administrative burden. Moreover, enforcement of this government decision does not occur yet within all the SPAS because of their limited staff busy with desk work who rarely have time to do fieldwork. In any case, the GD is an example of national policy which was strongly influenced by the UNICEF model from which it used the working tool for the vulnerabilities assessment. However, since it did not also use the tablet computer method of work, model replication is only partial. In fact, as the assessment tool is used on paper, a customised basic package of services cannot be generated, nor is case management made easier.

No legislation was passed to specifically regulate and provide systematic and long-term solutions to the problems regarding the necessary human resources – training, hiring and organising the activity of the social workers so as to ensure their professional development and a correct time management of their desk and field work. Also, except for the form proposed via GD 691/2015, no other national tools were designed to provide a standardised, unified and coherent modus operandi for the social assistance work carried out by the SPAS.

With regard to budgeting for the social services and community health care services delivered at the local level, it is important that, following the activities carried out by UNICEF, the Human Capital Operational Programme include a series of specific objectives under priority axis 4 on Promoting Social inclusion and Combating Poverty to fund activities similar to the ones organised in the "First Priority: No More 'Invisible' Children!" modelling project.

3.5.4. Summary of the answers to the evaluation questions on impact

The data and information collected for the summative evaluation allow for formulating answers to all the evaluation questions on impact, as follows:

A. **Compared to the control group, the model clearly increased children's and their families' access to social services**, including specialised services for children with disabilities, and to community health care services.

B. **Compared to what the situation was like prior to project implementation, the model increased children's and their families' access to primary health care (particularly vaccination), and contributed to reducing risky behaviours and situations of abuse, violence or neglect**. However, the intervention needs to be implemented on the long term in order to produce changes in behaviours.

C. **The model contributed to raising awareness and engaging communities** to address children's vulnerabilties.

D. **The model increased the capacity of child protection professionals and institutions**, through training, developing the Aurora methodology and providing the necessary equipment to use this methodology, but the social workers and CHNs need to continue using the Aurora in their everyday work in order to ensure continuity of outcomes.

E. **The model increased institutional capacity to ensure that the most vulnerable children benefit from the minimum package of services in a way which contributes to prevention of child-family separation and of violence against children**, both by ensuring accurate identification of children's needs and vulnerabilities, and by having the minimum package of services address these vulnerabilities in several ways and with priority. Even so, the identification of vulnerable children and the information and counselling activities need to continue over a long period of time, as it is the only way to ensure, on the one hand, that all vulnerable children receive the services they need and, on the other hand, that risk attitudes and behaviours are changed through basic services.

F. **The model influenced a large number of public social protection policies for the most poor and vulnerable children, including programming of European funds for model scaling-up**, and the impact of these policies on improving these children's life is expected to be considerable, **but the time between the passing of these public policy measures and laws to the present summative evaluation has been too short to enable an assessment of the specific (on the ground) impact of these decisions**.

4. CONCLUSIONS AND LESSONS LEARNED

4.1. Lessons learned and unexpected outcomes

What are the lessons learned at each level of intervention that should be taken into account for further modelling projects and action related to scaling up and mainstreaming the minimum package of prevention services at national level?

4.1.1. Lessons learned

4.1.1.1. Lessons learned from the intervention on 'invisible' children and their families

I. Lessons learned in the identification process

As early as 2011, the model underlined the importance and value of identifying vulnerabilities, assessing the situation of vulnerable children and their families and monitoring them. Community workers and county supervisors unanimously agreed that it was necessary to continue using the Aurora, which nevertheless requires strengthening by ensuring the relevant human resources at local level.

"The mandatory requirement for local communities to provide this prevention-focused minimum package of services should be legislated. If these aspects were legislated, all vulnerabilities would have to be known. The SPAS should hire a person to focus exclusively on using the Aurora, and the team should meet regularly (at least once a week) to address the community problems/needs".

Social/outreach worker, Vrancea county

"All the SPAS should have the Aurora application, it is vital, saves time, it is efficient and it generates a service plan. … Every community should conduct a mapping of the social needs, followed by a local strategy to address social issues so that mayors become aware and understand the social challenges in their community and allocate the necessary resources effectively (human resources/social workers, money, transportation). If the application is in place and is efficient, it should be used in all communities".

GDSACP supervisor, Iași county

The process undergone by the model design, from its inception in 2011 up until the formula that included the use of the Aurora as of 2014, shows that the stage whereby children's situation is assessed and their vulnerabilities identified is fundamental in generating a basic social services package which is tailored and adequately meets the needs of its recipients. **Given the rather large workload of the community workers, both these and their county supervisors indicated the need to have the data recorded using the Aurora exported into the forms required by the social assistance legislation (assessment data sheets, social investigations), as well as the possibility to generate case reports to ease the work on filling in the official documentation**. In some cases, the data is available in the Aurora database, but the law also requires filling in additional documents. In other cases, the Aurora methodology needs to be developed in order to allow for covering all the legal requirements.

"It would be useful to be able to export some of the data (e.g. the social investigation, a MGI form), as the Aurora should not be regarded merely as a data collection tool, independent of the other working tools used by the social worker".

GDSACP supervisor, Botoșani county

Aware that their communities have other cases of 'invisible' children they have not yet identified or that new cases emerge with time, several community workers recommended that periodic community censuses be carried out at the beginning of the intervention, using the Aurora, to enable an accurate selection of the group of beneficiaries. On the other hand, all the interviewees underlined that such an action would require mobilising a considerable amount of human resources/staff.

II. Lessons learned from case management and service delivery

Our evaluation shows that the model effectiveness in identifying situations of child abuse, violence or neglect was limited and that addressing these situations did not generate a substantial impact on the target group. Moreover, the model did not register a relevant impact on the adolescents' level of information about risk behaviours and on reducing the incidence of these behaviours.

In all these cases, lessons learned indicate the following: :

- The importance of carrying out prevention interventions and information and counselling services before the vulnerabilities become serious and the risks high;
- Reducing the vulnerabilities involves changing the target group's risk behaviours, with results achieved only through long-term intervention;
- Where vulnerabilities are chronic or where there are multiple vulnerabilities, it is necessary to be able to access specialised counselling or recovery services which are often unavailable, unknown or inaccessible to the target group or to the community workers themselves.

As such, the community workers we interviewed underlined the following three elements which need to be ensured:

a) continuity, to maintain the results achieved in preventing certain vulnerabilities and risk behaviours,

b) continuous training and experience exchange among specialists,

c) development of a "map" of the specialised social, health etc. services available in every county, to ensure effective delivery of accompaniment, support and referral services..

Sustainable impact on vulnerable children's and their families' lives can be achieved by using the Aurora, securing the necessary well-trained human resources (social workers and community health nurses), applying an approach based on preventing risk behaviours and situations of violence and abuse, and ensuring access to specialised services where needed.

Moreover, **our analysis shows that the model should include a component on education**, for a stronger impact on the school attendance of children who also receive other types of social and health services.

4.1.1.2. Lessons learned from the intervention at community and county level

The model showed the value of the close relationship between the SPAS community workers and the county professionals in the GDSACP and DPH. One of the main lessons learned in this respect was the need to continue this cooperation and to ensure methodological supervision.

"It's important to have someone to discuss with when you have ethical dilemmas and you don't know if you did the right thing or not, because sometimes the parents and the specialists can have a different perception of the right thing".

Social/outreach worker, Botoşani county

For all the local stakeholders, their cooperation was a lesson learned during the implementation of the model, and its benefits became visible in time.

"A higher degree of involvement at the local level is necessary (a lot of problems can be solved at this level), there has to be communication (people should know each other, they should constantly share their problems so as to be able to find solutions to them), and this can be achieved through meetings, acting towards common objectives, using shared working tools that standardise and provide a common ground".

CCS member, focus group participant, Bacău county

The interviewed community workers admitted the project activities helped them overcome certain prejudice which proves the importance of training the SPAS staff to ensure a professional social service delivery.

"I've learned that every child matters and that you need to visit any child in the community because you can't know what goes on behind closed doors or gates, you can't know whether the parent can or cannot manage health or parenting situations".

Social/outreach worker, Neamț county

Another lesson learned for all those involved in the intervention was that achievement of the outcomes related to the social protection of vulnerable persons is possible with few resources, by engaging all those who have relevant duties and access to information in addressing a specific problem or case.

Not least, the model underlined the need for qualified or trained human resources to carry out social assistance activities and, especially, to deliver services. To ensure a sustainable increase of the SPAS capacity to deliver social services, an outcome not achieved in every case, social or outreach workers need to be recruited in the mayoralty SPAS at the onset of the model implementation and continuity of their work needs to be ensured. Also, as some communes were more demanding of the community workers than others, the number of community workers should be tailored to the size and characteristics of the communities (the number of vulnerable children) in which the model is implemented so as to ensure equal access to services for all beneficiaries.

"More human resources should be involved in the actions of a model such as the one promoted by UNICEF. For the social worker, even with the periodic involvement of other CCS members, it was a lot of work. The large population size of the commune and the large number of vulnerable persons overloaded the social worker".

Social/outreach worker, Bacău county

It is also clear that the salaries and resources made available to the social workers need to be compatible with the work they carry out on the ground and in delivering the minimum package of services. In this respect, the budget for the minimum package of services should be able to cover expenses related to the community workers' travel within the communes, from one village to another, as well as expenses related to the transportation required to access various specialised services.

The evaluation revealed the need to document the model in all its complexity, including a presentation of the Theory of Change and of the intervention logic, of the tools used in the implementation of the model (starting with the Aurora), but also of the actions and activities carried out to increase the capacity of all the involved stakeholders (social workers, community health nurses, county supervisors, CCS members etc.), the development of standard formats for the projects funded via microgrants and the formulation of unitary strategies for the identification of the most vulnerable children and for communication in the community, so as to have a model that can be replicated in other communities by people other than those who were directly involved in its implementation.

4.1.1.3. Lessons learned in delivering community health care

In terms of ensuring access to health services, the model had limited effectiveness and impact. This is also due to the fact that recruitment of CHNs in the communes lacking community health care did not succeed. Given the adoption of the GEO on community health care, UNICEF could play an important role in **promoting this profession and piloting projects with a wider coverage than the one planned for the "First Priority: No More 'Invisible' Children!", which provide community health nurses with functional working tools, such as the Aurora, lead to community health care development and impact the lives of vulnerable children and their families**.

4.1.1.4. Other necessary services

The minimum package of basic services was developed to facilitate and ensure access to primary and specialised services. This package covers all the needs of the vulnerable children only in conjunction with the basic and the specialised services provided by the related legislation. As such, the effectiveness of some of the guidance services proved limited because specialised services were either not available or not easy to ac-

cess. Community workers and their supervisors believe the minimum package of services is complete and covers all the vulnerabilities identified in the communities, but they also admit that delivering some of its services depends on the existence of providers of specialised services at local and county level.

"The social services offered definitely contribute to addressing and reducing the vulnerabilities as long as there are services that can be accessed locally. It is one thing to identify a need and another to be able to access the proper services. For instance, if a social worker identifies the need for a child to go through a programme of speech therapy, the case will not be solved as long as the child's family lacks the means to access those services, often located at great distances from the community of residence. Speech therapists or psychologists working in the education system cannot cover these needs".

Social/outreach worker, Neamț county

"The minimum package of services is complete. For referral services, a map of the county social services should be available, to help determine what providers of social services could support children and their families to eliminate/reduce the vulnerabilities".

Social/outreach worker, Neamț county

"The most important resources needed and currently absent in the commune are the psychologist and the school mediator".

CCS member, focus group participant, Bacău county

When it comes to the needs identified in the case of the 'invisible' children and their families, the demonstration project was able to cover the basic services, however, when considering the multiple vulnerabilities affecting a large part of the beneficiaries, many cases require access to **specialised services (i.e. psychological counselling, vocational guidance and training, addiction treatment)**. Some of these services were delivered for a relatively small number of recipients as part of the micro-grant projects, depending on the project target groups' needs identified by the community workers. The identification of vulnerabilities through fieldwork revealed the need for services which the stakeholders involved in the model implementation (community workers, CCS members etc.) considered as potentially highly relevant, such as active employment and vocational training measures or specialised home care for children with disabilities or special educational needs.

The reason why these services cannot be provided on a large scale is the lack of specialists in the community, a problem which we have tackled in the section dealing with project effectiveness on community-based social assistance and child support services.

The research undertaken shows that where the local budget allowed for providing material aid, this was in the form of emergency aid.

"The problems that could not be addressed through the project were related to the need for material support... Identifying the problems is useless unless you can offer concrete aid... Advice alone won't be of much help".

Social/outreach worker, Bacău county

"Information and guidance services are being delivered, but there are problems with services/benefits which are not available, though they should be – for instance, information about the emergency aid service. A large number of families are eligible for it, but if they are informed they are entitled to receive this service, they will address themselves to the mayoralty for it and the mayoralty doesn't have the budget for something like this. The only cases in which the emergency aid was granted were those with severe medical problems and it was approved via AJPIS [County Agency for Payments and Social Inspection]".

Social/outreach worker, Bacău county

In the opinion of some of the community workers, the absence of a component that provides material support to the beneficiaries can be a problem, on the one hand, because poverty is often the cause of some of the vulnerabilities (e.g. by limiting access to health care or education, even if the families have the re-

quired information), and on the other hand, because, in the absence of a financial motivation, part of the vulnerable children' carers (families) refused to participate in the project activities and, therefore, to receive information, counselling and guidance.

4.1.2. Unexpected outcomes

Are there any unexpected outcomes worth considering for reducing capacity gaps and/or addressing remaining bottlenecks?

The evaluation has identified few unexpected outcomes. At first, **the model increases the pressure on the child care system, instead of decreasing it**, as it increases the number of children recorded with vulnerabilities who then enter public care, an aspect which needs to be considered if the model is to be extended on a larger scale, in more communities or counties, or even nationwide.

The great cooperation among the child protection and the community health care specialists, at local and county level, translated into an **initiative to continue the activities** in an organised setting.

"All 8 of us supervisors have worked as a team, we supported one another, we communicated constantly also on other GDSACP-related topics (service accreditation/licensing, regulations, staff employment methods etc.), we became friends. Also, together with the UNICEF coordinators, we discussed forming an association (like a social service professionals' guild)".

GDSACP supervisor

Given that the project underwent two formative evaluations and a series of changes to the intervention logic and the working methodologies, the unexpected outcomes surfaced at the beginning, but by the end of the project they became key model elements. **Aurora was an initial unexpected outcome of the model**. The need to introduce a unitary, standardised electronic tool for the identification and assessment of the vulnerabilities, as well as for shaping the tailored service packages was initially an unexpected outcome. Moreover, the considerable success of the methodology, despite the fact that at first the interview guide seemed cumbersome, requiring a long time to process, is regarded as a positive outcome. The worth of the tool was acknowledged by all those who used it as it allows for an accurate assessment of the vulnerabilities and it generates the package of services, facilitating case management and integrated approaches. Many of the social assistance and community health care professionals we interviewed recommended the model be extended not only geographically, but also to other categories of vulnerable persons, including elders or unemployed adults.

4.2. Main evaluation conclusions

Throughout the present evaluation, we have summarised the answers to the evaluation questions at the end of each section dealing with each evaluation criteria. The following is a brief overview of these answers as well as of several other evaluation conclusions leading to the formulation of recommendations for both UNICEF and the administrative entities in Romania involved in child protection.

I. Relevance

Model relevance in relation to the Theory of Change

The project logical framework proved coherent and therefore its design enables achievement of its objective, increasing the impact of social assistance and child protection measures. During 2011–2012, as focus was set high on the identification activities and relatively low on service delivery, the connection between the model inputs and all the estimated long-term outcomes seemed somewhat too optimistic. With the introduction of the Aurora, of the minimum package of services and of the micro-grant projects, implementation of project activities became considerably more likely to yield outputs and outcomes which

improved children's situation. Hence, the model is highly relevant in relation to the overall goal and to the achievement of the expected results.

However, both in 2011 and after the Aurora was added to the model, as a result of the working methodology used to assess the situation of children and their families and identify their vulnerabilities, as well as of the normal limits that define the effectiveness of any social assistance work, the far-reaching outcomes envisaged for all children came out as too ambitious.

At local and county level, the model is highly relevant as its design and activities allowed for successfully addressing the local public administration structural gaps in ensuring social assistance, child protection and community health care, by providing staff training and tools to facilitate supervision and methodological support.

Model relevance in relation to the needs of vulnerable children and their families

The model underwent a rather long phase of fine-tuning before defining a clear set of vulnerabilities assessed for children and families in the target communities, but once the Aurora methodology was ready, all the problems identified with the target group were reflected in a diagnosis of vulnerabilities. Our qualitative research did not reveal any major target group problems or needs that the Aurora working methodology failed to consider when establishing the main categories and subcategories of vulnerabilities. Most of the vulnerabilities (except for the risk of child-family separation) are assessed using nationally and internationally accepted standardised definitions based on which institutions at all levels design intervention models.

Furthermore, both the experience accrued by the social assistance, child care and community health care professionals and the lessons learned from the first years of model implementation (2011–2012) and from the formative evaluations of the project show the vulnerabilities assessment phase is highly relevant, key in the planning adequate services for children. In the absence of the vulnerabilities assessment, social assistance, child care and community health care services cannot be adequately targeted and delivered, nor can their effectiveness and impact be measured later on.

Also, all identified vulnerabilities are considered in the design of the minimum package of basic services that Aurora automatically generates. The model is thus created to guide the community workers in addressing all the identified vulnerabilities, which makes the model highly relevant in relation to the needs of the 'invisible' children and of their families.

All vulnerabilities are targeted with services from different categories, following the stages of case management, starting with information, counselling, support and accompaniment, referral, and ending with monitoring and re-evaluation in order to assess the progress and validate the services provided for each of the vulnerabilities. In terms of community-based preventive services delivered by SPAS social workers and by community health nurses, the minimum package of basic services developed and tested within the model is complete and relevant for all the identified vulnerable children. Given the design of its interventions, the model is highly relevant in addressing the needs of (i) adolescents and children with risk behaviour, (ii) children living in families prone to child violence, abuse or neglect, (iii) children with only one or no parent at home, (iv) children with disabilities, categories for whom it provides many different services.

The model is highly relevant for children who were separated from their family or at risk of separation. Not only is there a reasonably large set of services designed to address this vulnerability, but the model also included a special priority service for children in this situation. "Priority zero service" was developed specifically for preventing child-family separation wherever this risk occurs.

Model relevance in relation to the needs of the social assistance and health systems

The SPAS capacity was mainly increased through employment of social workers that were trained and provided with adequate instruments in order to conduct mainly outreach work and to provide basic prevention services for 'invisible' children and their families. In addition, by introducing a health component

and promoting an integrated approach of social and health services, the model responds to the needs of community health services in Romania.

As part of the modelling project, the trainings that involved both the social workers and community health nurses, as well as the instruments professionals at local level shared enabled the integrated approach. Community workers gradually started to work in an integrated manner and coordinate their activity.

Due to the Aurora methodology which enables a systematic assessment of vulnerabilities and helps develop customised service plans, thus supporting the work of the social/outreach workers and community health nurses, regardless of their initial training or previous experience, and due to its focus on prevention and intervention at the community level, the model addresses a systemic problem of the child social assistance system, namely the low availability of professionals, especially in rural areas.

Model relevance in relation to national policies and European and regional public policy documents

The model provided evidence and informed a large number of strategies and regulatory documents and is in line with the provisions of several national strategic documents as well as with various European and regional approaches in the area of child rights protection and promotion. As such, the "First Priority: No More 'Invisible' Children!" model is highly relevant for the public policy framework in Romania and in the region, which is essential in view of its subsequent scaling up and adopting by the Government as a public project with budgetary funds.

II. Effectiveness

Effectiveness in identifying children's and their families' vulnerabilities

The model proved effective to a large extent, as indicated by the Aurora database as well as by the survey conducted against a control group, and by the interviews, focus groups and workshops organised for the purpose of the present evaluation. The number of cases tackled by the model increased over time, while the vulnerabilities identification and assessment was carried out accurately and reliably with the help of the Aurora methodology.

With regard to the effectiveness of the vulnerabilities identification, the data recorded by the Aurora in 2015 and confirmed by the survey in 2016 provide a high degree of reliability, particularly for the following vulnerabilities: access to education and school attendance, risk behaviours in terms of substance use, living in precarious housing conditions, lack of ID papers, children with disabilities, risk of child-family separation where the child has siblings not living in the household including because they are in public care.

As regards the risk of child violence, abuse or neglect, the vulnerability was not always assessed accurately (the children were recorded in the database, but they were not listed with this vulnerability).

Since the introduction of the Aurora was not followed by a new community census to use the questionnaire for all children (as the model focus shifted on service delivery and the minimum package of services), the vulnerability identification and assessment service coverage did not achieve maximum effectiveness and the deficiencies indicated by the second formative evaluation with regard to target group coverage were not fully addressed, even though the social workers did enter into the Aurora database all the newborns and other new cases, whenever reported or identified. Thus, the child-family separation risk was not subject to a full vulnerability identification and assessment process (not all cases of vulnerable children in the community were identified), given that, in the intervention communities, there were children who were separated from their family and who are listed in the GDSACP database, but not in the Aurora database as well.

Effectiveness of minimum service package delivery

According to the Aurora data, in the implementation period, the model proved its effectiveness particularly in addressing administrative issues and certain vulnerabilities, through activities such as obtaining ID papers, disability certificates, social benefits, and ensuring access to primary health care services.

The minimum package of services covers all vulnerabilities, while the net number of people having received services is much larger in the intervention communities compared to people from the control communes. Beneficiaries in the first category expressed their satisfaction with the services received and rated them great and very great. The survey conducted in the intervention and the control communities shows statistically significant differences between the basic social services provided in the communes which implemented the model and those delivered in the control communes, particularly with regard to services such as registration with the family physician, obtaining the disability certificate, information and counselling, including about rights and risks related to child violence, abuse or exploitation.

On the other hand, there is a negative difference between the intervention and the control sample with regard to services designed to facilitate children's access to education, despite several services being delivered to this end. This proves the need to extend the model to include a component that specifically tackles education and involves hiring school counsellors.

The model enabled better knowledge and understanding of child violence, abuse and neglect, while the use of Aurora significantly reduced SPAS staff assessment bias. Despite this progress, issues of violence, abuse and neglect remain frequent (even the lowest incidence rates recorded in the Aurora in 2015 are cause for concern).

With few exceptions, there are no significant differences in the vulnerabilities encountered among girls versus boys, Romanian versus Roma children. Furthermore, the differences recorded between the two uses of the Aurora questionnaire indicate progress was made and, even though some differences persisted, the intervention helped reduce not increase them.

The model was effective in informing the target group (vulnerable children and their families) about their rights to social assistance. On the other hand, no significant differences were noted between the recipient group and the group not covered with services or micro-grant projects in terms of information about other fundamental child rights, such as the right to education, to health care or vaccination. The limited coverage with community health nurses in some of the communities may account for the limited extent of information about health rights indicated by the survey.

Relative to the total number of service recipients, around one fifth of the services recommended by the Aurora were not delivered after the first use of the questionnaire and one third, after the second use. This is due, on the one hand, to the design of the Aurora which will recommend the full range of necessary services to address a case and sometimes the vulnerabilities are eliminated after delivery of a smaller set of services, and, on the other hand, to the fact that some of the specialised services to which the Aurora recommended referral or accompaniment were not available or accessible. Thus, the information and counselling services were more effective than the referral, accompaniment and support services. At the same time, most of the social workers we interviewed as well as their county GDSACP supervisors underlined the need for development of the specialised social services, to complement the model.

It is also true that the more comprehensive counselling services provided by the community counselling and support centres for parents and children within the micro-grant projects were well regarded by all community workers and by all the children and parents we interviewed. Nevertheless, it is still difficult to accurately determine the effectiveness of this activity separately from that of the service package delivered outside the micro-grant project activities, due to the uneven planning and reporting and a poor recording of the targeted and performance indicators.

There are, however, significant differences among the counties which implemented the model in terms of the number of services not delivered. Where the number of services delivered was high, we have observed the positive influence of the county supervisors' proactive approach, on the one hand, and the importance of having community social workers with specialised training/studies. Thus, the smallest number of undelivered services was recorded where the hired social workers had specialised background and the county supervisors were highly active both in identifying and selecting the social workers and in providing them with the necessary guidance and monitoring all throughout the intervention.

Therefore, overall, the model is effective in ensuring the delivery of basic social services via community workers' fieldwork. In the communes in which the model was implemented, the social/outreach worker and the CHN are known to the vulnerable persons to a greater extent and their work is well regarded. Three times more people in the intervention communes versus the control group believe they can count on the community workers' support and three times more families received their help in the intervention communes versus the control ones. As such, early and long-lasting intervention is most effective in addressing the community problems. Moreover, several vulnerabilities are recurrent, which only emphasises the need for repeated and long-term intervention targeting vulnerable families.

Effectiveness of the integrated approach to service delivery

Project service recipients were satisfied and very satisfied with the individual work of the social/outreach worker and of the community health nurse, as well as with their teamwork, where the team was complete. Differences between the intervention and the control groups are significant, in that a much lower share of the respondents from the control group were satisfied with the services they received. Therefore, the integrated approach to the delivery of social and community health care services is perceived as added value for the service recipients. In fact, all the relevant professionals highlight the interdependence between health and social vulnerabilities and the interdependence between social and community health care service effectiveness. Consequently, the integrated approach proved effective and its implementation was supported in all communities in which a CHN was hired but also where the CHN was absent (though to a lesser extent) due to the fact that the Aurora recommended both social and health services and the DPH supervisors provided support to social workers as well.

Building community institutional and consultative structure capacity to help reduce the vulnerabilities of children and their families

Engaging the community via the Community Consultative Structures contributed a great deal to addressing the most complex vulnerabilities, in all communities, even if the CCS activity was uneven (more intense and better organised, with regular meetings and a proactive approach in some communities, with less frequent meetings and a rather reactive approach in other communities).

Our research shows that, during 2011–2015, the model was effective in increasing the capacity of the SPAS, GDSACP and DPH. Hiring social workers to conduct mainly outreach work and training them contributed to increasing the SPAS capacity to deliver social services. Afterwards, a more comprehensive approach of vulnerabilities was tested through the project, by adding the community health component and promoting the integrated approach. In connection with the model effectiveness in increasing the SPAS capacity to deliver social services throughout the implementation period, four aspects need mentioning first:

- capacity building for community workers through training sessions which provided them with skills and competencies to carry out social assistance work, in an integrated manner, and also subjects as: violence against children and at risk behaviours;
- systematic use of the Aurora, a modern standardised electronic system for identifying vulnerabilities and conducting case management;
- establishment of community centres which enabled service delivery as well as helped increase community worker capacity through experience exchanges with professionals providing specialised services (psychologists, counsellors);
- enhanced cooperation at community level and among county-level institutions.

The county supervisors' input was well regarded by the community workers. Nevertheless, for both local level and national level (UNICEF model coordinators), there were large differences of approach in the way the supervisors related to the SPAS and community workers activity, leading to different outcomes both in terms of service delivery and of SPAS capacity building.

Preventing child-family separation

Judging from the GDSACP data for the 8 counties selected for the intervention and from the findings of the analysis carried out based on the Aurora data, the risk of child-family separation vulnerability which generates the "priority zero service" requires redefining. Existing information can support working hypotheses which need testing in other modelling projects.

At first sight, the UNICEF model appears to increase rather than reduce the pressure on the system, since the increased focus on identifying and addressing vulnerable cases has made these 'visible'. However, case files are much better prepared and communication between the SPAS and the county deconcentrated and decentralised services is very good, which is why even if a larger number of children enter public care, the GDSACP workload related to cases from the intervention communities will be somewhat smaller.

Strengthening national strategies and their focus on preventing child-family separation and combating violence against children

The substantiation reports underlying relevant regulatory documents as well as the interviews we conducted with representatives of the central government authorities with duties related to child protection, social assistance, community health care and youth show that the "First Priority: No More 'Invisible' Children!" model informed and influenced national policies significantly. Even if a model scaling up is not yet envisaged as such, model good practices were nevertheless included in the strategic planning for promoting child rights, social inclusion and poverty reduction, health, reducing early school leaving, and inclusion of the Romanian citizens belonging to the Roma minority. The strategies that were adopted plan for building the SPAS capacity and developing social services focusing on identifying vulnerabilities and on prevention (as opposed to last minute intervention and cash benefits). Also, as a result of the model implementation, combating violence against children was given higher priority, relevant strategic documents included the concept of "minimum package of social services" and the integrated approach, and the work of the community health nurses was promoted, in conjunction with that of the social workers involved in service delivery.

Already there are several regulatory documents which take into account the experience accrued in the model, such as Government Decision 691/2015 for approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and of the Working Methodology for GDSACP-SPAS collaboration and of the standard model for the documents developed by these two institutions, and the Draft Law on community health care.

III. Efficiency

Our analysis shows that project use of material resources was economical/efficient, with actual costs of less than 220 lei/child per year. The community health care component used many of the resources allocated to the social assistance component, which resulted in a highly efficient integrated approach. Compared to the cost standards for social services set out in GD 978/2015 and to the ESF projects funded in Romania, the model approach based on delivery of a minimum package of services and on micro-grant projects implemented by the SPAS community workers proved very efficient, as the costs per beneficiary per year were at least 12 times lower in the preventive model than for reactive social services (for instance, versus the standard costs set for payment of professional foster carers or of residential care centres).

Given that the model was designed efficiently from the start and did not include costs which local public authorities could not include in their budgets, the costs of scaling up the model at national level can be covered by the state budget. Should the model be extended nationwide, the impact on the general consolidated budget would be nearly 300 million lei for implementation in both rural and urban areas of both social and community health care components. A limited part of these funds could be ensured from external sources such as the European Social Fund (via POCU), the World Bank, Norway and EEA Grants etc., in an initial scale up phase covering only communities rated at high social risk. However, a full nationwide scale up can only be supported from the general consolidated budget, but such support is less than 1 percent of the current MoLSJ budget.

A simple comparison between the model average cost/beneficiary and all types of social benefits shows a lower cost for the basic services included in the minimum package versus the social benefits. Nevertheless, in the absence of conclusive statistical data enabling a comparison not only of the costs but also of the worth of social benefits relative to that of the preventive services, our interviews show that the minimum package of services is efficient. This package, while not designed to replace material aid, is essential to increasing the effectiveness and efficacy of social benefits with minimal added costs.

IV. Sustainability

As the analysis of the model efficiency also shows, the costs associated with implementing the model in each commune are quite low, which allows for continuing the implementation. Community engagement, use of a standardised case management tool (Aurora) and teamwork created an enabling environment for continuing the intervention.

According to the interviewees at local, county and national level, the positive outcomes reducing children's vulnerabilities are unlikely to continue once the minimum package of services ceases to be delivered, given that multiple and complex vulnerabilities can be effectively addressed only through long-term interventions, and the preventive service delivery carried out for 4 years (2012–2015), with more planning and intensity during 2014–2015 thanks to the Aurora working methodology, does not suffice. As such, sustainability of results depends on activity continuity. Both project staff and key community stakeholders show motivation to continue delivery of the minimum package of services, while service beneficiaries are responsive. Still, the extent of initiative among the social workers is small and only two thirds of the mayoralties in the intervention communes show convincing commitment to support continuation of the model activities, hiring social workers and actively fostering their fieldwork.

From an administrative perspective, SPAS staff capacity still needs building, additional social workers need to be hired and all community workers need to be trained to ensure optimal model implementation.

Model scaling up is feasible at all levels (local, county and national), however, for a viable nationwide model, the current model still requires piloting on a larger scale first to test county and national management of the intervention. On the other hand, such piloting is already in progress, in Bacău county, also with UNICEF support. A successful scale up strategy requires enhanced cooperation between UNICEF and the MoLSJ and piloting of the model in various formulas for comparison purposes, while considering different intervention options that would address several social assistance and child care system gaps.

V. Impact

"First Priority: No More 'Invisible' Children!" generated considerable impact on its target group in terms of ensuring vulnerability identification, access to social services, including specialised services for children with disabilities, and access to community health care.

The model proved having had impact regarding access to primary health care (particularly vaccination) and reduced risk behaviours and situations of child abuse, violence or neglect only relative to data recorded previously in the communities it covered, but not when compared to the control group. On the other hand, the model had some impact on protecting children from being separated from their family.

The intervention of the social/outreach worker and of the community health nurse, where available, helped vulnerable families to a considerable extent. Even where some vulnerabilities still persist, the moral support received by children and individuals who otherwise felt lonely and insecure was a factor that improved quality of life and could have long-term impact.

All these cases revealed a need for long-term interventions, early preventive actions and linkages between the basic services delivered via the model and specialised services available and accessible to vulnerable children and persons living in rural areas, sometimes tens of kilometers away from the county capital towns.

The model generated the planned impact, building capacity to deliver social services, increasing the community level of information about child rights, supporting the most vulnerable children and their families, determining an increase of the interinstitutional cooperation in support of social services and a moderate increase of the population information level about children's rights and their families' rights and obligations.

However, two limitations are to be noted: (1) the identified impact is not sustainable in all cases, as not all the social workers hired by UNICEF remained with the SPAS, while the community counselling and support centres are dependent on funding, as they did not generate any sustainable voluntary structures, and (2) few of the communities lacking a community health care component managed to recruit the necessary CHNs, and therefore the capacity to deliver community health care services remained limited.

The model generated impact also by offsetting certain national policy gaps and by driving institutional cooperation otherwise very limited prior to 2011. At national level, though the UNICEF actions were highly effective in promoting the inclusion of model tested tools in public policies and in ensuring funding for scaling up the model in a limited number of communities, with ESF/POCU support, their implementation has not occurred yet. The findings of the present summative evaluation can serve to anticipate the increase of the national policy impact should the model be replicated or at least the elements currently included in the national strategies and regulatory documents implemented.

5. Recommendations and responsible stakeholders

What recommendations could be made to UNICEF and to the Government of Romania with regard to replicating and scaling up such a model?

5.1. Recommendations pentru UNICEF

To replicate or scale up the model in more communities or counties, UNICEF in Romania should consider the following:

1. Keep the Theory of Change. To promote model scale up at national level or its replication by other organisations, UNICEF in Romania can use the Theory of Change developed within the model, adding to it an education service delivery component. However, for institutions and organisations interested in replicating the model to be able to use all the model good practices, the integrated approach needs to be extended to include a school mediator or school counsellor, while aspects such as the working methodologies used, the approach, the implementation timetable, the need for coordination staff etc. should be well documented and described.

2. Promote the Aurora methodology at national level, for both the identification of vulnerabilities and the management of the minimum package of services, since this methodology is a modern tool enabling identification of children's needs, including the less visible ones (i.e. situations of violence, abuse and neglect or risk behaviours among children and adolescents), as well as planning of the necessary services for those children, a tool accessible to all community professionals within the SPAS.

3. In advocating for scale up, use model relevance in relation to national, European and regional strategic documents and evidence to its effectiveness, efficacy and impact. Emphasis should be put on the fact that the model contributes to practical translation of international recommendations as well as national strategic objectives.

4. Continue the UNICEF advocacy efforts so as to ensure that national public policies cover not only the needs identification activity (currently reflected in part by the tools outlined in the annexes to GD 691/2015), but also the standardised assessment of vulnerabilities and the minimum package of services.

5. Strengthen UNICEF, MoLSJ/NAPCRA and MoH cooperation and pilot the model in various formulas for comparison purposes, while considering different intervention options that would address several social assistance and child care system gaps.

6. Identify all vulnerable/'invisible' children in the communities by carrying out a comprehensive needs identification activity, ensuring that the social/outreach worker and the community health nurse with fieldwork duties (delivering social and community health care services) know all households and all children in the community and identify those households with vulnerable children in need of an in-depth needs assessment. The specific organisation and implementation of this activity should be chosen based on the experience accrued in implementing the "First Priority: No More 'Invisible' Children!" model as well as other similar projects. Possible approaches include:

    a. community workers apply the Aurora to all households in the community (conduct a census using the Aurora methodology). Pros: it provides the benefit of a comprehensive analysis. Cons: requires a lot of time and resources. Moreover, in an average community, a comprehensive use of the Aurora by 1-2 people may take more than a year, during which time there would be no social service delivery capacity and the data first collected could become obsolete;

    b. community workers initially use a screening questionnaire for all community households, possibly integrated into the Aurora, such as the Observation Data Sheet set out in GD 691/2015 (conduct a community census using a simplified tool). This would allow for identifying the households that will require a full use of the Aurora methodology for in-depth needs assessment and service package generation. Unlike applying the full Aurora methodology to all households, use of a simplified tool would cover a shorter period of time;

c. initial use of the Aurora or of a simplified tool for all households in the community – in other words, conducting a community census – with the help of field interviewers hired specifically for this purpose. Pros: allows for a relatively fast implementation. Cons: does not enable community workers to get to know the local households or build on the trust-based relationship they can establish with their beneficiaries (children and their families).

7. Revise the Aurora so as to enable flagging of the recommended minimum package services whose delivery was not carried out, indicating the specific reasons why that occurred – service was no longer required/was not available/was inaccessible – to allow for a more clear assessment of the basic or specialised services needed in every community as well as at county level. For best case management results, the platform should also enable flagging of services whose repeated delivery is recommended.

8. To significantly increase the level of information of vulnerable children and adolescents and their families, information and counselling activities need to be repeated, replicated nationwide, both via information campaigns and via information and counselling activities conducted by social workers in the field, for a longer period of time, given that such activities are designed to eliminate stereotyping and change attitudes.

9. Address the need for training community workers and county supervisors on project management issues, via a 3 to 5 day basic course, and the development of forms (or a reporting platform) that would help collect, centralise and archive data on the outcome of micro-grant project activities.

10. Develop a new Aurora module to provide a platform for reporting on the micro-grant project activities.

11. Develop working methodologies for county supervisors to standardise their work.

12. The working hypotheses for defining the risk of child-family separation need verifying against databases larger than the ones available in the modelling project. Also, they need testing in another model, to generate a definition of the risk of child-family separation that would serve to promote "priority zero service" at national level as a standard service in the SPAS portfolio to ensure prevention of the actual separation and of the child entering public care.

13. Provide a mapping of the specialised services available in each county, in a digital format that can be updated according to service availability, to help social workers stay informed and allow for monitoring the availability of specialised services and developing them where they are needed. This "map" of specialised services could be included in the Aurora as a source of information for social workers and community health nurses who deal with referral and accompaniment services.

5.2. Recomandări pentru alți actori relevanți

5.2.1. Recomandări pentru Guvernul României

To address the problems of the child care system that we identified and increase its effectiveness in addressing children's vulnerabilities, the Government of Romania, particularly the MoLSJ and the MoH, should consider the following recommendations related to using or adapting the good practices proposed by UNICEF:

1. Develop national tools for identifying and assessing vulnerabilities which are standardised, integrated in electronic systems based on online applications and which enable using the collected information in conducting case management and in generating useful statistics[103]. This recommendation can be implemented by taking ownership of the Aurora methodology at national level.

103 At present, GD 691/2015 aims to ensure prevention of child-family separation and includes an observation data sheet and a risk identification data sheet. According to the provisions of this GD, these data sheets are intended to inform the social worker in their preparation of the service plan. For the time being, although necessary, there is no clear procedure for determining the risks and the required services to address those risks based on the answers to the data sheet questions, and as a result, similar situations are assessed differently and are covered with different service plans, depending on the social worker's experience, training or beliefs. For this reason, aside from the identification data sheets, the current methodology should be completed with new tools.

2. Develop the national regulatory framework with respect to operationalising the concept of minimum package of basic services for children and families, including by developing documents, procedures and working methodologies to be made available to all the SPAS. These working methodologies can be based on replication/scaling up of the Aurora methodology (which fulfils all the necessary conditions and has proved effective).

3. Improve assessment of the risks of child violence, abuse and neglect, including in implementing the provisions of GD 691/2015, with special focus on training the social/outreach workers to recognise these situations.

4. Develop free of charge training programmes (average duration distance learning programmes) for social assistance operatives who lack specialised higher education.

5. Analyse, within the MoLSJ and MoH, the possibility to develop an incentive system that would determine social workers with specialised studies and community health nurses to take up residence in rural areas.

6. Any model scaling up initative should include activities planned for the long-term, given the complexity of the vulnerabilities that need to be addressed and the slow progress in sustainably improving children's situation.

7. Develop working tools for ensuring an integrated delivery of social and community health care services. To this end, we recommend an integrated government budget planning of the minimum package of basic services for children and even the development of common working procedures for GDSACP and DPH at county level and for social workers and community health nurses at local level.

8. Develop modules enabling queries across databases and data exportation from the Aurora to complete files required in the child care and the community health care systems, to facilitate the work of professionals at all levels as well as to enable continued monitoring and evaluation of the activities and development of reports requested by various county or local level authorities. To this end, we recommend looking into interconnecting the CMTIS, SAFIR and the databases resulting from the CHN reporting to enable an accurate assessment of the vulnerabilities of children in public care.

9. For the purpose of funding the model scale up, relevant central authorities should consider the possibility of reviewing and/or adapting the guidelines and evaluation grids for projects (ESF and other national or international funding sources) involving the development of community-based services so as to enable the type of activities proposed by the model for delivery of the minimum package of services, granting thus real priority to preventive social services which demonstrated their efficiency over that of the reactive services.

10. Integrate CCS capacity-building activities into national programmes designed to target rural areas on an ongoing and systematic basis to help increase proactivity and improve management of complex vulnerabilities.

11. Taking into account the recommendations already formulated, to scale up the model and accurately calculate its budgetary impact, the model should be piloted in more counties and in more formulas to allow for determining its added value (in terms of effectiveness and addressing beneficiaries' vulnerabilities) relative to the public investment/expense, such as: hiring one versus hiring more community workers to carry out fieldwork for vulnerable families; extending the model to include a school counselling component; increasing counselling activities and workshops conducted by community centres; developing a dedicated infrastructure (well-furnished community centres and day centres); increasing the development of resource centres at county level and hiring specialists (e.g. psychologists) to carry out activities that specifically target supporting the SPAS; providing detailed standards for costs and activities using the Aurora or minimum standards and a large degree of leeway for community workers to adapt to special cases.

5.2.2. Recommendations for mayoralties

In the communes in which the model was implemented, we recommend continuing activities as follows:

1. Continue using the Aurora and carry out the identification of vulnerabilities on a regular basis, according to the methodology.
2. Continue delivering the services included in the minimum package of services and recommended by the Aurora.
3. Hire a social worker to carry out fieldwork in every commune and, where the social worker involved in the UNICEF model was not ensured continuity of employment, ensure transfer of know-how from that social worker and from the SPAS staff involved in the model.
4. Hire a community health nurse in every commune.
5. Continue setting up community counselling and support centres for children and parents and organising group activities designed to facilitate access of vulnerable children and their families to specialised counselling services. Such activities can continue with minimal financial resources from the local budget and with engaging communities to support the activities, as was already done in most of the model communes.
6. Continue the CCS work. Social/outreach workers should continue being involved in the activity of these structures, while mayoralties should also support the actions of other persons who can drive the CCS activity, both by facilitating communication among the CCS members and by supporting the CCS decisions for children in the community.
7. Organise field trips/exchanges of good practices not only for community workers but for all CCS members as well. CCS member participation in information as well as team-building activities would help increase their understanding of child rights, reduce their tolerance for abuse and addictive behaviours, while increasing this group's cohesion and intervention capacity.

On the other hand, the SPAS all over the country should be able to hire social workers for fieldwork in addition to the SPAS employee(s) in charge with managing the social benefits case files, as well as CHNs in all communes nationwide. The number of social workers employed to carry out fieldwork should be sufficient to cover a community's needs. The UNICEF and PwC study of the costs involved in implementing and scaling up the model proposes an algorithm for calculating the minimum number of social workers required in a community based on a series of indicators such as the number of vulnerable children, type of community (urban vs rural), share of children in total population, population density, number of MGI recipients, and average unemployment rate. Using this algorithm allows for determining the minimum number of social workers who need to be hired in each SPAS in order to meet children's needs through delivery of the minimum package of services.

5.2.3. Recommendations for the gdsacp and other county structures

For the GDSACP and DPH, the following should be considered:

1. Create departments whose staff is adequate and specialised in ensuring monitoring, supervision and methodological support for the GDSACP-governed SPAS activity and the DPH-governed CHN activity.
2. Organise further education and training courses for county supervisors to enhance their specialised skills in the area of community-based social and health services. In addition, if the model is scaled up at county or national level, the number of GDSACP and DPH specialised supervisors required to provide guidance to social workers and CHNs in delivering basic community services needs to be increased.
3. Strengthen capacity to develop county-level multidisciplinary teams of specialists (starting from the

provisions of GD 49/2011) available to support and counsel SPAS community workers and to step in for direct input in the management of complex challenging cases.

4. Ensure analysis of the Aurora data on all children who ended up being separated from their family and were recorded in the model as well as those to be recorded in future model replication/scaling up projects, to help develop case management.

Annexes

Annex 1 – Theory of change for the "First priority: no more 'invisible' children!" Modelling project

Initial		Activities	Expected outputs	Expected outcomes	Impact
Poor children and their families are 'invisible' and/or accumulate vulnerabilities and are thus at increasing risk of social exclusion	'Invisible' children and their families	– Children's and their families' vulnerabilities are assessed and addressed through individual service plans; – Vulnerable children and their families are informed about their rights and entitlements and are assisted to access relevant services.	– 'Invisible' children (and their families) are identified and receive a minimum package of services; – Children and their families have more information about their rights and entitlements as well as increased access to basic social services.	Even in disadvantaged rural communities: – all children are visible to their families and communities and to the health, education and social protection systems; – all children have access to primary health care services; – all school age children are enrolled in school; – all children are protected against separation from their family; – all children are protected against all forms of violence (including neglect, abuse and exploitation); – all adolescents are informed about risk behaviours.	Increased impact of social protection policies for poor and socially excluded/invisible children aged 0–17 years and their families
	Community level	32 social workers hired and trained to: – carry out mainly outreach activities and deliver the minimum package of services; – mobilise professionals within the Community Consultative Structures; – support the development of project proposals and micro-grant implementation; – organise experience exchange field trips. Facilitate coordination and integration of social workers' and community health nurses' activities.	– Increased capacity of social workers and community health nurses to identify vulnerable children and their families; – Effective delivery of the minimum package of services; – 32 community counselling and support centres for children and parents are set up; – 32 Community Consultative Structures are active.	– Improved community capacity to deliver social services and community health care services (in 32 rural communities); – Approximately 150,000 persons from rural areas are better informed about child rights, as well as family rights and responsibilities; – 32 community centres for children and parents; – 32 functional Community Consultative Structures acting for the worst-off based on local action plans.	
	County level	– County supervisors from both social and health fields trained and provided with tools for monitoring and ensuring methodological guidance at local level; – Organise experience exchanges.	Increased capacity of the GDSACP and DPH to provide methodological support to local authorities	– Reduced pressure on the child special protection system and on the specialised health services system (in 8 counties); – Improved capacity of the GDSACP and DPH to provide methodological support to local authorities via the resource centres for communities set up at county level.	
	National/Central level	Mapping policies and strategies on preventive and community-based services and identifying bottlenecks and barriers to implementation.	Evidence based justification for effective and efficient models of preventive services developed at community level.	Strengthening the national strategy on preventing child-family separation and combating violence against children, through efficient and adequate budgeting.	

Insertions in dark blue contain adjustments/refinements and/or changes in definitions of concepts implemented and/or modifications resulted due to geographical area targeted between 2013–2015.

Insertions in blue cyan contain additions to the initial modelling project, mainly due to the component on community health care and integrated services.

Annex 2 – List of communities included in the modelling project

County	Commune	Phase 1 (control communes)	Phase 2	Phase 3 (intervention communes)	County	Commune	Phase 1 (control communes)	Phase 2	Phase 3 (intervention communes)
Bacău	Berzunți	1	1		Botoșani	Albești	1	1	1
	Blăgești	1	1			Bălușeni	1		
	Colonești	1	1	1		Călărași	1	1	
	Corbasca	1	1	1		Copălău	1	1	1
	Dealu Morii	1				Coțușca	1		
	Găiceana	1				Călărași	1		
	Gura Văii	1	1	1		Hlipiceni	1	1	
	Parava	1				Ibănești	1		
	Parincea	1				Răuseni	1	1	
	Răchitoasa	1	1	1		Șendriceni	1		
	Sănduleni	1				Todireni	1	1	
	Stănișești	1	1			Tudora	1	1	1
	Ungureni	1	1			Vorona	1	1	1
Buzău	Bisoca	1	1	1	Iași	Aroneanu	1	1	
	Brădeanu	1	1			Ceplenița	1	1	1
	Calvini	1	1	1		Coarnele Caprei	1	1	
	Cătina	1	1			Cozmești	1	1	
	Costești	1	1			Dolhești	1	1	1
	Merei	1	1			Focuri	1	1	
	Pietroasele	1				Lespezi	1		
	Scorțoasa	1				Mironeasa	1	1	1
	Vadu Pașii	1	1	1		Țibănești	1		
	Vernești	1				Trifești	1		
	Viperești	1	1	1		Vânători	1	1	1
Neamț	Bahna	1	1	1	Suceava	Bogdănești	1	1	1
	Bîra	1	1			Brodina	1	1	
	Boghicea	1	1	1		Capu Câmpului	1		
	Brusturi	1				Dornești	1	1	1
	Dragomirești	1	1			Izvoarele Sucevei	1	1	1
	Oniceni	1	1			Moldova Suliță	1		
	Războieni	1				Pătrăuți	1	1	
	Români	1	1	1		Râșca	1	1	
	Săbăoani	1	1	1		Ulma	1		
	Tămășeni	1	1			Valea Moldovei	1	1	1
	Valea Ursului	1				Vultorești	1	1	

County	Commune	Phase 1 (control communes)	Phase 2	Phase 3 (intervention communes)	County	Commune	Phase 1 (control communes)	Phase 2	Phase 3 (intervention communes)
Vaslui	Băcești	1	1		**Vrancea**	Cîrligele	1	1	
	Coroiești	1	1	1		Dumbrăveni	1		
	Cozmești	1	1			Gugești	1	1	
	Dimitrie Cantemir	1				Jariștea	1	1	
	Dragomirești	1	1	1		Milcovul	1		
	Ferești	1				Movilița	1	1	
	Ghergheşti	1				Popești	1	1	1
	Grivița	1	1	1		Rugineşti	1		
	Ivănești	1	1			Sihlea	1	1	1
	Puiești	1	1			Slobozia Bradului	1	1	1
	Pungești	1				Tătăranu	1		
	Rebricea	1				Timboești	1		
	Tăcuta	1	1	1		Vîrteşcoiu	1	1	1

Total: Phase 1: 96; Phase 2: 64, Phase 3: 32

Annex 3 – Terms of reference

Summative evaluation of "First Priority: No More 'Invisible' Children[104]!" modelling project in Romania, 2011–2015

1. Context

In the context of the economic crisis, across the European Union, fiscal consolidation measures have had a strong impact on social service accessibility and quality, especially for vulnerable groups [105]. In Romania, children were in one of the most affected groups, as one-third of them lived in poverty. Moreover, the crisis hit rural and Roma children the hardest: whereas in urban areas the absolute poverty rate was only 3.5%, in rural areas it reached 12.4%; for Roma children, the absolute poverty rate is extremely high: in urban areas, 2% of Romanian children compared to 27.3% of Roma children, and 10.6% versus 41.1% in rural communities[106]. Under the circumstances, while evidence shows that children who grow up in poor households face a higher risk of poverty in the future, breaking the intergenerational cycle of poverty makes it essential for the government to adopt social protection policies, including social services that can tackle both child and adult poverty in the same household simultaneously.

Additionally, as a consequence of an impoverished population and the limited budget for family-based services, in 2011, for the first time in 15 years, the number of institutionalised children increased[107]. According to the data collected by the National Authority for the Protection of Child Rights and Adoption (NAPCRA), the main causes for children being separated from their family and entering into public care were linked to poverty (declining though from 44.10% in 2010 to around 42% in 2013), abuse and neglect (increasing from 22.23% in 2010 to 26.82 in 2013%) and disability (around 10%). Furthermore, reported cases of violence including neglect, emotional abuse, physical abuse, sexual abuse, child labour, exploitation for the purpose of committing crimes increased (+11%) from 11,232 cases in 2010 to 12,542 cases in 2014. In light of this and in the absence of adequate social services, children's social inclusion and their right to develop to their full potential were at risk.

In 2013, the European Commission (EC) recommended[108] to all member states to develop and implement policies to address child poverty and social exclusion, promoting children's well-being through multidimensional strategies that go beyond ensuring children's material security and promote equal opportunities so that all children can realise their full potential. As part of their successive partnership agreements (2010–12, 2013–17), the Government of Romania and UNICEF demonstrated commitment to reviewing and adjusting policies promoting children's and their families' well-being, with special focus on children without or at risk of being deprived of parental care, including through the priority objectives set in the 2014–2020 National Strategy for the Protection and Promotion of Children's Rights[109]. These opportunities facilitated the alignment of the National Strategy with EC and UN Committee on the Rights of the Child Recommendations, ensuring synergies and coherence between various national strategies and between various levels of implementation as well. It also designs an appropriate balance between universal strategies of intervention, aimed at promoting the well-being of all children, and targeted approaches, aimed at supporting the most disadvantaged, ensuring a focus on children who face an increased risk due to multiple disadvantages such as Roma children, children with special needs or disabilities, children in alter-

104 'Invisible' children are those who are "disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children" (SOWC 2006, UNICEF, p. 35)

105 EC, 2011. *The social impact of the economic crisis and ongoing fiscal consolidation*. Third report of the Social Protection Committee, available at: http://goo.gl/ZiHjM8

106 Preda, M. (coord.), 2011. *Situation Analysis of Children in Romania*. UNICEF Report. HBS data, NIS. Bucharest.

107 2011 data according to the Ministry of Labour, Family and Social Protection, General Directorate for Child Protection. The number of children in residential care was 23,240 in 2011 versus 23,103 in 2010.

108 EC Recommendation, 2013. "Investing in children: breaking the cycle of disadvantage", http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013H0112&from=EN

109 Approved via Government Decision 1113/2014. The National Strategy for the Protection and Promotion of Children's Rights 2014–2020 acknowledges taht early and preventive intervention enables reduction of child poverty and social exclusion and, as such, helps children achieve their full potential and realise their rights.

native care, and children living in low income households. Briefly, the priority objectives of the 2014–2020 National Strategy include:

General Objectives	Specific Objectives
1. Increase children's access to quality services	Increase service coverage at the local level
	Increase the quality of services provided to children
	Increase beneficiaries' capacity to access and use child and family services
	Build the capacity to monitor and evaluate children's rights and social circumstances
2. Observe the rights and promote the social inclusion of children in vulnerable circumstances	Secure a minimum level of resources for children by way of a national anti-poverty programme that places special emphasis on children
	Reduce existing gaps between outcomes for rural and urban children
	Remove attitude and environmental barriers to the rehabilitation and social reintegration of children with disabilities
	Reduce the opportunity gap between Roma and non-Roma children
	Continue the transition from institutional child care to community-based care
	Curb the street child phenomenon
	Foster the social and family reintegration of children who are in conflict with the law and prevent their re-offending
	Reduce the influence of risk factors and increase the influence of protective factors regarding children's use of drugs or other harmful substances
	Offer adequate support to children whose parents work abroad and to their caregivers
	Promote a healthy lifestyle among adolescents
3. Prevent and combat any form of violence	Promote non-violence and raise awareness of all forms of violence
	Reduce violence among children
4. Encourage children's participation in relevant decision-making	Develop mechanisms to ensure children participate in the decisions that directly affect them

As outlined in the National Strategy, 2 of the 4 general objectives target strengthening social services for children:

– Objective #1 – Increase children's access to quality services: sets out priorities for developing and strengthening the capacity of community-based prevention and support services – one of the main responsibilities of public local authorities – while also aiming to avoid separating children from their families and thus preventing new entries into the public care system.

– Objective #2 – Observe the rights and promote the social inclusion of children in vulnerable circumstances: includes a special focus on children deprived of parental care and protected in the public care system as well as on children living in poverty, Roma children, children with disabilities, and other children in need.

These objectives and related activities were drawn based also on a series of assessments[110] conducted since 2010 which showed that over one-third of local public administrations in rural areas had not set up Public Social Assistance Services (SPAS), which are responsible for putting social assistance policies and strategies into operation and for delivering social services at community level[111]. The SPAS are severely understaffed in rural areas where there are only one or two staff members with social assistance duties. Most of them focus on the identification of poor families who receive cash benefits, and very few professional social workers respond to the needs of a population who is usually spread over several villages.

UNICEF's assistance in this particular area was ensured through various strategies such as technical assistance and advocacy for the development of new social policies, generating evidence and child rights moni-

110 The capacity of local government decision makers to develop Public Social Assistance Services (SPAS) has been hindered by a lack of financial resources at the local level, by the hiring freeze and wage cut-off in the public sector (as part of the austerity policies implemented during 2008–2010), by the limited use of flexible forms of employment (such as part-time work) in the public sector, and by a lack of effective training for staff. Almost 45% of local public administrations in rural areas had not set up the relevant services; only 29% of all SPAS were accredited as social service providers, with 70 percent falling short of the standards needed for accreditation. MoLFSPE and SERA Romania, 2012

111 Provision of Inputs for the Preparation of a Draft National Strategy and Action Plan on Social Inclusion and Poverty Reduction (2014–2020), *Social Assistance Services at Community Level*, World Bank, 2014.

toring, convening partnerships and modelling innovative services. The piloting or modelling approach[112] has been a key strategy to demonstrate results on a small scale with a view to generate evidence to influence national policies and programmes and to leverage state budget and local funding for scaling up[113]. UNICEF, in close partnership with central, county and local authorities, as well as civil society, has modelled social services developed at community level, aiming for progressive implementation to reach national scale and respectively all children, with special focus on the most vulnerable children.

2. Object of evaluation

The object of this summative evaluation covers the modelling project implemented between April 2011 and September 2015, first entitled "Helping the invisible children" and then "First Priority: No More 'Invisible' Children!". During the period of implementation, a Theory of Change was developed (in 2012) and adjusted for the period 2013–2015 based on intermediate formative evaluations. The budget allocated for this modelling project was approximately 250,000 USD/year.

2.1. Brief history of the modelling project

Taking into account the underdevelopment of social assistance services at community level in Romania, the modelling theory considers that children's welfare in Romania will improve only if and when children, especially the most vulnerable ones, will have enhanced access to basic social services (education, health, and social assistance services). In light of this, in rural areas (particularly in the poorest communities), the capacity of local authorities needed to be developed and/or strengthened, including through the hiring and training of community workers to carry out mainly outreach activities and to provide a minimum package of services[114] to the most vulnerable children and their families, including needs assessment, information and counselling, and monitoring. The modelling project initiated in 2011 as an equity innovation and funded by specific allocation of thematic funding, is presented below rather in chronological sequences to better reflect changes occurred and adjustments made, along with recurrent activities at various levels.

The goal of the model[115] was to contribute to an increased impact of social protection policies on the poorest and vulnerable children and families in Romania, through the modelling of a minimum package of services focused on prevention. The new approach and working methodology at local level would increase access of most vulnerable children and their families to social services and would contribute to a paradigm shift – from a reactive and protection approach to a proactive and prevention strategy – within the child/social protection system, particularly in rural disadvantaged areas. The model's aim and objectives were in line with the provisions of the UNICEF Child Protection Strategy[116] according to which successful child protection begins with prevention, and focused on children who are 'disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children' (State of the World's Children Report 2006, UNICEF, p. 35).

The modelling project was designed and implemented in partnership with:

– at the national level: the Ministry of Labour, Family, Social Protection and the Elderly (MoLFSPE) and the General Directorate for Child Protection (which became in 2014 the National Authority for the Protection of Child Rights and Adoption – NAPCRA). They contributed to the design of the modelling intervention at county level, to the development of methodological support for county authorities, and to the analysis of accumulated evidence. The purpose was for them to adjust primary and secondary legisla-

112 Pilot or modelling projects are activities designed to test the feasibility and/or effectiveness of an intervention. They are a specific type of 'demonstration project' with explicit attention to documenting and measuring progress and results. PPPeM, UNICEF

113 Scaling up is replicating and expanding pilot approaches, while at the same time transferring longer-term ownership to Government counterparts, to ultimately bring positive results for a greater number of children and women. PPPeM, UNICEF

114 Within the context of advancing child-sensitive social protection and adequately investing in child wellbeing, UNICEF advocates for a Minimum Package of Services as a universal mandatory social service package delivered through outreach field work by public local authorities at community level to fulfil every child's right to development, to combat poverty, to prevent the risk of social exclusion and to support vulnerable families with children.

115 The modelling project was launched in 2011 under the title "Helping the invisible children".

116 UNICEF Child Protection Strategy, http://www.unicef.org/protection/files/CP_Strategy_English.pdf

tion and develop strategic programmes and policies, including the National Strategies on Child Rights, the Social Inclusion and Poverty Reduction Strategy and the 2014–2020 EU Operational Programmes under the 2014–2020 EU Multiannual Financial Framework;

– at county level: County General Directorates for Social Assistance and Child Protection (GDSACP) and the Prefectures in 8 counties. Their role was to provide technical and methodological support to social workers and other local professionals trying to find solutions for the most vulnerable children and their families at local level; to contribute to the documentation of progress; to participate in the evaluations and provide feedback on key recommendations, including key adjustments of the modelling project;

– at local level: Public Local Authorities from 96 disadvantaged communes (in the selected 8 counties). Their partnership was essential to the implementation of activities at local level mainly through social workers, but also with the support of other professionals, as part of the Community Consultative Structures (CCS)[117].

To this end, in 2011, after a selection of the most vulnerable rural communes[118] in eight counties (Bacău, Botoşani, Buzău, Iaşi, Neamţ, Suceava, Vaslui, and Vrancea), social workers were hired and employed by municipalities with UNICEF financial support in 96 communes. Their job description focused on outreach work and identification of vulnerable children and their families. After a brief training organised by UNICEF, they conducted a community census to identify these vulnerable children. Social workers' interventions included mobilization of other community professionals (such as community nurses, family doctors, teachers, police workers, priests, etc.) and leaders gathered under the CCSs. Under the supervision of the GDSACP, they provided basic social services for some 3,000 'invisible' children[119] identified during the first year of implementation (2011), who represent some 2.7% of all children in the targeted communes, addressing key bottlenecks for an equitable child friendly social protection system.

After a first formative evaluation in 2012[120], several adjustments such as geographical coverage and definition of the minimum package of services were incorporated within the modelling project as the focus of social workers' interventions shifted from community census to delivery of basic social services. Adjustments also took into account: i) the objectives and expected outcomes of the Cooperation Programme implemented by UNICEF with the Romanian Government and the strategic decisions made to outline key benchmarks for social policy development and modelling[121]; ii) feedback from project partners and supervisors from each GDSACP; and iii) budgetary allocations for implementing the activities at local level.

As a consequence, in 2012 the project covered 64 communes and the remaining 32 were considered counterfactual for the future evaluations. A minimum package of services which was community-based, relying on community resources and with a preventive role[122], started to be modelled and delivered to some 5,700 'invisible' children and their families until end of 2012.

In 2013, the modelling project aimed at developing basic social services at community level was renamed "First Priority: No More 'Invisible' Children!".

117 Each partner's specific role and input are outlined in the Convention of Collaboration signed on a yearly basis, which can be made available to the evaluation team.

118 The selection methodology and list of communes are available in Stănculescu, M. S. (coord.), 2012, *Helping the invisible children – Evaluation Report*. pp. 125–129, https://www.unicef.org/romania/Raport_HIC_engleza.pdf. The most vulnerable communities were selected from eight counties of Romania's poorest region – North-East.

119 'Invisible' children are those who are "disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children" (SOWC 2006, UNICEF, p. 35)

120 Stănculescu, M. S., 2013. *Helping the 'invisible' children. Second Evaluation Report*

121 A special focus was on the improved access for children and families to integrated basic social services, through defining and developing the minimum package of services.

122 To this end, the minimum package of services consisted of seven categories of basic social services, namely identification, needs assessment, information and education, counselling, accompaniment and support, referral and monitoring and evaluation (Minimum Package of Basic Social Services, UNICEF in Romania, April 2012)

A second formative evaluation[123] **in 2013** produced overwhelming proof that the issue of 'invisible' children is highly relevant for the rural communities from Romania and it represents a serious problem that needs an urgent and determined policy response. Quality evidence and lessons learned contributed to more adjustments to the modelling project such as: i) geographical concentration in only 32 communes; ii) modelling of integrated services by adding a community health care/CHN component[124] to the social assistance provided by social workers; iii) micro-grants awarded to all 32 communes. It also strengthened advocacy for addressing the bottlenecks and increasing impact of social protection and health policies for poor and most vulnerable children and families

The modifications brought within the modelling project, also sustained through the **UNICEF management response plan**[125], considered the main objectives of the 2011–2013 National Reform Programme[126], published in April 2011, and related national implementation report from 2012[127] regarding social assistance, poverty reduction, and social inclusion, as well as the 2014 National Reform Programme[128]. At the same time, the project's adjustments were also aiming to ensure compliance with the provisions of the National Strategies, including (approved in chronological order): on Public Administration Reform (August 2014), on Health and Health Services (September 2014), on the Protection and Promotion of Children's Rights (November 2014), and on Social Inclusion and Poverty Reduction (July 2015).

In this context, in 2013, 2014 and 2015 until September, the modelling project was implemented in 32 communes of the 8 counties. Adjusted theory of change[129], objectives and specific activities were consolidated after several consultation processes at national, county, and local level. Main amendments within the modelling project were linked to: i) the new methodology for identification[130] and diagnosis of vulnerabilities[131] (data validation, training, data base construction, monitoring and evaluation); ii) revised minimum package of services[132] and case management facility to be used by community workers in an integrated manner; and iii) new interventions addressing improved knowledge, attitudes and practices that impact the development and protection of children and adolescents, with a focus on reducing all forms of violence against children within family and community.

The formative evaluations informed the development of a new model for integrated social services in the county of Bacău, which was built on the experience accumulated during the "First Priority: No More 'Invisible' Children!" modelling project and another model focusing on improving access to and quality of

123 Stănculescu, M. S., 2013. *Helping the 'invisible' children. Second Evaluation Report*, https://www.unicef.org/romania/HIC.eng.web.pdf

124 In 2012, in parallel with the modelling project, another initiative was launched to help increase access to community-based medical care, focusing rather on policy advocacy and refining legal and regulatory frameworks for community health care. Starting 2013, this initiative also included a modelling component in the "First Priority: No More 'Invisible' Children!" project.

125 The UNICEF management response plan will be made available to the evaluation team.

126 National Reform Programme, April 2011, https://ec.europa.eu/info/publications/2011-european-semester-national-plans-romania_en

127 National Reform Programme 2011–2013: Implementation Report, March 2012, https://ec.europa.eu/info/publications/2012-european-semester-national-plans-romania_en

128 National Reform Programme, April 2014, https://ec.europa.eu/info/publications/2014-european-semester-national-plans-romania_en

129 The initial Theory of Change can be found in the second formative evaluation report, Stănculescu M. S. (coord.), 2013, pp. 23–25.

130 Aurora – an intelligent online application was developed as a tool for ensuring a unitary methodology for the identification of all children's vulnerabilities by all community professionals and across all communities and facilitating the generation of an integrated service plan for children and their families to be provided by the community professionals. At the same time, Aurora provides real time monitoring of the fieldwork as well as data aggregation at various levels (community, county, project level) at any moment, enabling evidence-based adjustments of policies and various interventions in a timely manner.

131 The Aurora methodology includes a revised list of vulnerabilities and indicators for their measurement, in 6 dimensions: poverty, health, education, risky behaviours, housing, family and social status. More details will be made available to the evaluation team.

132 The revised Minimum Package of Services includes understanding key sources of vulnerability based on comprehensive household assessment and matching needs with service provision based on individual assessment and plan of services. It contributes to strengthening the capacity of families to care for their children and mitigates the effects of shocks, exclusion and poverty on families, recognizing that families raising children need support to ensure equal opportunity. The revised Minimum Package has a stronger multi-sector approach identifying and maximizing linkages between social protection and sector outcomes (e.g. health, education, nutrition, early childhood development and care, child protection).

education. Several components of the modelling project implemented by 2014 that were validated by the evaluations (such as the concepts of the minimum package of services, Community Consultative Structures, micro-grants) are incorporated into the new model, which is expected to take place from the end of 2014 to the end of 2018.

Last but not least, the Exist Strategy[133], developed in early 2015 in consultation with major stakeholders, is intended as a planning tool that outlines the achievements until end of 2014 and interventions until end of 2015, as well as a strategic road map for continuing advocacy for mainstreaming the evidence generated by the model into national policies and practices, funded by state and/or local budgets and European funding. Moreover, the exercise of developing the Exit strategy also highlighted barriers and bottlenecks identified in the determinants analysis performed for the child protection intermediate results[134] of the 2013–2017 Romania Country Programme. Those results were only partially addressed through the modelling project, but have a significant influence especially on sustainability and on the scale-up objective incorporated into the Mid-Term Review process and report adjusting the Cooperation Programme for 2016 and 2017 and beyond.

2.2. Reconstructing the Theory of Change[135]

The Theory of Change (ToC) was developed in 2012, in a format which provides a clear picture on how results would be achieved in the modelling project. It focuses on the expected increased impact of social protection policies on vulnerable children and their families in Romania. The ToC includes activities, outputs and outcomes to be achieved especially in the social protection area, considering mainly social assistance services developed at community level with special focus on prevention.

As mentioned in the previous section, starting 2013, as a result of the second formative evaluation recommendations and interventions aiming to increase access to community health care through community health nurses, the modelling project incorporated a new focus on the integrated approach in the design and delivery of services at community level. The modelling project also included, in a more consistent manner, a series of activities addressing social norms linked to violence against children, with special focus on disciplinary practices, and independent life skills and healthy behaviours of adolescents. All of the model's adjustments resulting from the translation of the second formative evaluation recommendations led to a diversified and more complex model, as well as to the concentration of the implementation in only 32 rural communes in 8 counties.

Taking into account the most significant adjustments to the modelling project, the ToC[136] required consecutive fine-tuning and amendments which were performed by end of 2013 (see Annex Theory of Change for the "First Priority: No More 'Invisible' Children!" modelling project, 2013–2015). The most important changes reflected in the ToC below include:

– Concentration of modelling intervention at local level in 32 rural communes in 8 counties (with consecutive changes in number of partners and actors active at local level);

– Promotion of the integrated approach in i) service design and delivery at local level; ii) planning and methodological support at county level; and iii) the development of strategies and policies at national level;

133 The Exit Strategy for the "First Priority: No More 'Invisible' Children!" modelling project, 2013–2015, will be made available to the evaluation team.

134 National integrated social protection system and other stakeholders provide effective quality continuum of services, and support protective norms and behaviours for children and families, with special focus on protection from and prevention of any form of violence, especially child separation.

135 As per UNICEF PPP manual: A Theory of Change (ToC) provides a blueprint of the building blocks needed to achieve long-term goals of a social change initiative. It can be viewed as a representation of how results will be achieved in a development undertaking and the markers that will permit measurement of whether or not it remains on track. At its core, a ToC identifies: a) the results a development effort seeks to achieve; b) the actions necessary to produce the results – in terms of outputs, outcomes or impact of that effort; c) the events and conditions likely to affect the achievement of results; d) any assumptions about cause and effect linkages, and e) an understanding of the broader context in which the programme operates.

136 The ToC for the "First Priority: No More 'Invisible' Children!" modelling project, 2013–2015, is available as Annex to the present ToR.

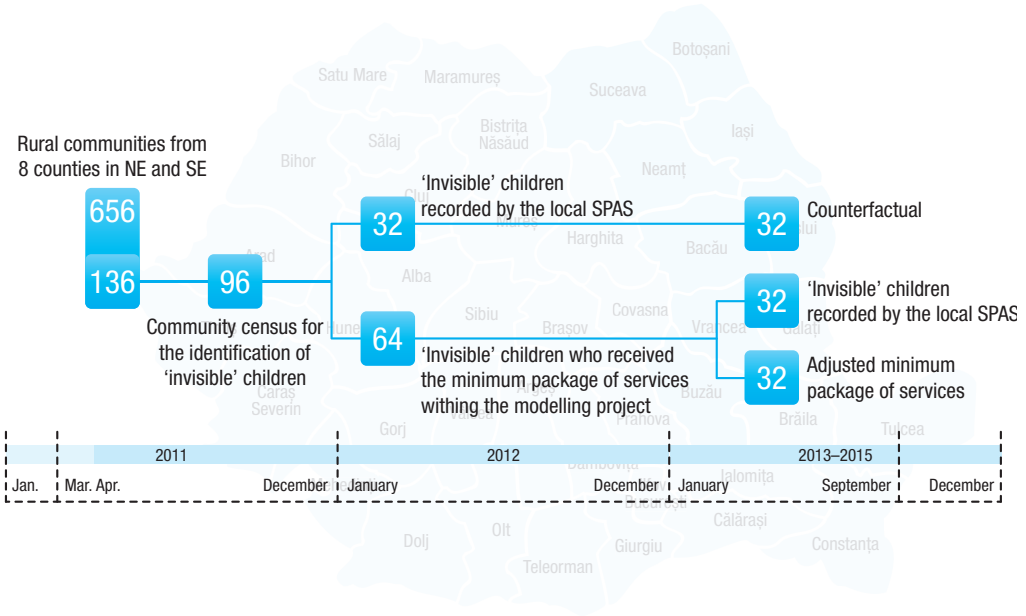
– New definitions of vulnerabilities of children, mechanisms and tools for the identification of vulnerabilities, invisible children, revised minimum package of services and case management.

The ToC in the current format may be limitative with regard to additional information explaining, for example, the relevance of integrated services and the understanding that besides the initial outcomes, additional ones were generated reflecting the model changes in time, as well as possible impact[137]. Nevertheless, a wealth of external evidence[138] is available, as well as from the modelling project itself which explains "how high quality, integrated and personalised services are important to achieve the best possible social outcomes, developing people's skills and capabilities, enhancing people's opportunities and confronting the risks and transitions in the life course as well as possible"[139]. More information on UNICEF contribution and roles at every implementation level and/or sector area are available in the first two formative evaluations and programme documents that together with the ToC will serve as a basis for the development of the evaluation framework.

3. Rationale for the summative evaluation

The modelling project started in 2011 was subject to two formative evaluations completed in 2012 and 2013. As highlighted above, both evaluation reports, including evidence and lessons learned, contributed to the adjustment of the modelling project, but also to strengthening advocacy for addressing bottlenecks and increasing impact of social protection policies for poor and most vulnerable children and families.

A summary of the implementation phases is reflected below:



137 Integrated social service delivery can improve both the effectiveness and efficiency of social services, while also ensuring increased take-up and coverage. Integrated services are likely to promote continuous care, avoid duplication and gaps in the delivery and reduce waiting times. They also facilitate information and knowledge sharing between professionals and thus a better and quicker identification of the needs and of the adequate responses. Moreover, integrated service delivery is likely to reduce the service costs by limiting multiple interlocutors and repeated interventions. Finally, structural integration could also lead to savings due to the mutualisation of some costs. Call for proposals for social policy innovations supporting reforms in social services, European Commission, DG Employment, Social Affairs and Inclusion (VP/2015/011).

138 Scharle, Ágota (2015), *Literature review and identification of best practices on integrated social service delivery* (http://ec.europa.eu/social/main.jsp?catId=1169&langId=en). On service integration, see also *Council of Europe (2007): Integrated social services in Europe*

139 Social Protection Committee, *A Voluntary European Quality Framework for Social Services* (SPC/2010/10/8 final). See http://ec.europa.eu/social/main.jsp?pager.offset=10&advSearchKey=voluntary&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0

At the end of the modelling project (September 2015), as mentioned in the 2015 Exit Strategy, a summative evaluation was planned in order to determine to what extent the model made an impact on vulnerable children and their families, whether it was done in an efficient and effective manner, and whether the results are sustainable and replicable. The summative evaluation is also considered as an opportunity for all key stakeholders and partners involved at all levels of implementation, to evaluate positive and negative, primary and secondary, medium and long-term effects produced, directly or indirectly, intended or unintended.

The summative evaluation is expected to provide quality evidence to inform key stakeholders at national and county level and make adjustments to the new modelling project "Social inclusion through the provision of integrated social services at community level" currently implemented in Bacau county[140], as well as to support advocacy for the transition towards accessible, sustainable, quality and child rights centred, integrated services at family and community level.

Additionally, it will shed light on remaining barriers and bottlenecks that have a significant influence especially on sustainability and replicability. Many of these were identified in the determinants analysis performed for the child protection output results of the 2013–2017 Country Programme[141], but were however addressed only partially through the modelling project. MoLFSPE and NAPCRA, and the Ministry of Health (MoH) together with UNICEF may reshape the remaining two years of the current Cooperation Programme and prioritise interventions addressing the remaining bottlenecks and barriers as highlighted by the evaluation.

Last but not least, the summative evaluation is expected to contribute to national and regional knowledge regarding the child's right to grow up in a family environment, prevention and community based care and components strategic to the adjustment of social protection policies (one of the eight Regional Knowledge and Leadership Agenda Results Areas in the region). Romania Country Office, working closely with the UNICEF Regional Office for Central and Eastern Europe and Commonwealth of Independent States (CEE/CIS) and the Government of Romania, is expected to use the evaluation as a knowledge management tool, as well as an area for future horizontal cooperation in the region and beyond.

4. Evaluation objectives

The exercise will independently evaluate:

– the impact of the modelling project and to what extent the modelling intervention and all its components have contributed to improving children's welfare through enhanced access to basic social services (education, health, and social assistance services) of children and their families, particularly in the selected rural disadvantaged areas;

– whether the model's interventions were relevant to address the main bottlenecks;

– how results and evidence generated by the model contributed to improving the impact of social protection policies on the poorest and most vulnerable children and families in Romania;

– the lessons learned, key bottlenecks and good practices;

– how efficient the model was in developing new services and improving the life of children and their families;

– how effective the model was in producing the expected results;

140 The modelling project "Social inclusion through the provision of integrated social services at community level", currently implemented in Bacău county, includes a component of modelling a revised minimum package of services which, along with the social worker and community health nurse, also

141 National integrated social protection system and other stakeholders provide effective quality continuum of services, and support protective norms and behaviours for children and families, with special focus on protection from and prevention of any form of violence, especially child separation.

– to what extent the model could be replicated at national level through revision and/or development of the normative framework, standards, methodologies, budgets etc.

– how sustainable the model is at the local, county and national levels.

Finally, the evaluation is expected to make recommendations for further action related to the sustainability, scaling up and mainstreaming of the minimum package of services at national level.

5. Scope and focus

The overall scope of the evaluation is to assess the impact of the "First Priority: No More 'Invisible' Children!" modelling project, addressing the challenges faced by children and families from rural disadvantaged areas in accessing basic services.

The summative evaluation will cover the entire implementation period of the modelling project (April 2011–September 2015) based on an initial and an adjusted Theory of Change (2012 and 2013–2015). Reference will also be made to the formative evaluations completed in 2012 and 2013, including, whenever possible, comparisons with their key findings, and an analysis as to what extent the management response considering previous key recommendations was implemented.

The focus will be on the 32 rural communes in the 8 counties (Bacău, Botoşani, Buzău, Iaşi, Neamţ, Suceava, Vaslui, and Vrancea), which were active throughout the entire period of the implementation of the modelling project, along with the counterfactuals – the 32 communes in which intervention was implemented only in 2011, the community census providing the baseline for 'invisible' children as described above.

This evaluation will consider all **stakeholders** involved and who contributed to current results and will include: children and their families, local stakeholders – community workers, professionals in the CCS and members of the community, public local authorities, NGOs; county stakeholders – supervisors and other professionals from the GDSACP and the Directorate for Public Health (DPH), the County Council and Prefecture; and national stakeholders – MoLFSPE and NAPCRA, MoH. Other stakeholders should be involved as well, such as: other Ministries – Regional Development and Public Administration, Public Finance, European Funding; the World Bank, relevant NGOs, academia, mass media, donors, etc.

Potential limitations and risks may be linked to the availability of data, such as updated information about the 'invisible' children who may have moved or migrated, and the participation of key informants from the 32 communes to be considered counterfactual for this summative evaluation. Other risks may refer to the political changes in the Government that may interfere with the implementation of data collection and consultations. As both local and national elections are scheduled the next year, political changes in the local and national administration may happen; however, technical staff is not expected to be changed.

5.1. Evaluation questions

Considering the OECD-DAC[142], the evaluation will specifically address the following categories of question which are expected to provide accurate insights related to the objective of the evaluation, scope and focus. The questions below should complemented by specific ones taken into account specific threats, obstacles and bottlenecks if this is considered of strategic importance regarding objectives of the summative evaluation.

Relevance:

– To what extent does the modelling project address the needs of the most vulnerable children and reduction of inequities (with reference to the 'invisible' children)?

142 http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

– To what extent is the model relevant vis-à-vis the overall goal and the achievement of its expected outputs and outcomes in the given period of time?

– To what extent is the modelling project relevant to national policies, programmes (including the National Reform Programme[143] and 2014–2020 ESF Programme[144]), sectoral and cross-sectoral strategies[145] and to UNICEF's Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) Regional Knowledge and Leadership Agenda (RKLA) Results Areas on a child's right to a supportive and caring family environment, as well as on a young child's right to comprehensive well-being and a child's right to social protection[146]?

Effectiveness: does the modelling project contribute to:

– Does the modelling project contribute to the realisation of child rights (by vulnerabilities)? Does the minimum package of services address all vulnerabilities? Which component was most successful[147]? Is there added value resulting from the integrated approach?

– Does the modelling project help develop local authority capacity to deliver the minimum package of integrated services (compared to the 32 communities where model interventions occurred only in 2011)?

– Does the modelling project contribute to reducing the pressure on the child care system? And on the health care system[148]?

– Does the modelling project help strengthen national strategies and focus on prevention of child-family separation? And on prevention of violence against children?

Efficiency:

– Does the modelling project use resources in the most economical/efficient manner to achieve expected results? What are the benefits of the integrated approach from a financial point of view?

– How do project costs compare to those of other similar programmes or standards[149]?

– How efficient was the model in terms of results for the recipients of the minimum package of services and of social benefits compared to individuals who received only social benefits?

– What are the cost implications of scaling up? What are the implications in terms of national mainstreaming[150]?

Sustainability:

– To what extent is the current context more or less favourable to continuing such approaches in the near future?

---

143 2015 National Reform Programme, https://ec.europa.eu/info/publications/2015-european-semester-national-plans-romania_en

144 Partnership Agreement with Romania 2014–2020, http://ec.europa.eu/contracts_grants/agreements/index_en.htm, and Operational Programmes, http://www.fonduri-ue.ro/

145 National Strategies on Public Administration Reform, on Health and Health Services, on the Protection and Promotion of Child Rights, on Social Inclusion and Poverty Reduction etc.

146 CEE/CIS RKLA Results Area 1 (a child's right to a supportive, caring family environment), Results Area 7 (a young child's right to comprehensive well-being) and Results Area 8 (a child's right to social protection) – concept notes to be made available to the evaluation team.

147 The minimum package of integrated services includes the following components: social worker and community health nurse, plus other actors – i.e. CCSs, plus micro-grants/community centres.

148 Pressure on the health care system may include indicators such as number of days of hospitalization, but others may be suitable as well.

149 Such as those defined by Government Decision 23/6 January 2010 regarding the approval of the cost standards for social services.

150 Based on the *Financial impact analysis for scaling up a model of community based services at national level*, 2015 draft report, PricewaterhouseCoopers and UNICEF.

– Are modelled interventions and impact on the most vulnerable children likely to continue when external support is withdrawn?

– Is the modelling project replicable? As a whole or only certain components? At local, county or national level? What are the prerequisites for replication? Are any model adjustments required to enable replication?

Impact:

– What change did the modelling project determine or influence for beneficiaries (children and their families), communities, professionals, public government – at local, county and/or national level?

– To what extent did the modelling project increase institutional capacities to ensure that the most vulnerable benefit from the minimum package of services in a way which contributes to prevention of child-family separation and prevention of violence against children?

– To what extent has the modelling project increased the impact of social protection policies for the poor and most vulnerable children?

Lessons learned and unexpected outcomes:

– What are the lessons learned at each level of intervention that should be taken into account for further modelling projects and action related to scaling up and mainstreaming the minimum package of prevention-centred services at national level?

– Are there any unexpected outcomes worth considering for reducing capacity gaps and/or addressing remaining bottlenecks?

6. Methodology

The approach followed from the outset of the evaluation will be as participatory as possible. In the development of the current Terms of Reference, stakeholders at local, county and national level were consulted. The list of evaluation questions was finalised within a working group that included county supervisors from both GDSACP and DPH. Stakeholders at all levels, including children and their families, will participate in the evaluation through discussions, consultations, provision of comments on draft deliverables and some will reply to the recommendations made by the evaluation in the management response. In gathering data and views from stakeholders, the evaluation team will ensure that it considers a cross-section of stakeholders with potentially diverse views to ensure the evaluation findings are as impartial and as representative as possible.

The evaluation will apply the UNEG norms and standards[151], including evaluation criteria of relevance, efficiency, effectiveness, impact, and sustainability, and the UNEG ethical guidelines[152], including the UNICEF Procedure for Ethical Standards in Research, Evaluation, and Data Collection and Analysis (effective as of 1st April 2015), in order to ensure quality of evaluation process. Moreover, the evaluation should mainstream gender and human rights considerations throughout. Concerning gender, the evaluation will carefully analyse aspects related to the place and role of girls in Roma communities where specific typologies of risks occur. Aspects related to violence against children and/or women will also be acknowledged. The report should use gender-sensitive, child-sensitive and human rights-based language throughout, and whenever possible, disaggregation of data by gender, age, ethnicity and income, should be made.

The evaluation team will propose the methodology design which should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (e.g. stakeholder groups, including beneficiaries, etc.) and using a mixed methodological approach (e.g. quantitative, qualitative, participatory) to ensure triangulation of information through a variety of means.

151 UNEG Norms for Evaluation in the UN System, 2005, http://www.uneval.org/document/download/562
152 UNEG Ethical Guidelines for Evaluation, 2008, http://www.uneval.org/document/download/548

As concerns evaluability, the theory of change and available data allow for assessment of progress achieved and evaluation of project results. In this context, the evaluation will consider the baselines and counterfactual[153] established and used in the 2012 and 2013 formative evaluations, which are considered reliable. The evaluation will also use relevant available data collected through monitoring and evaluation, such as data management tools (Aurora[154] and other dabases, forms, fiches, social inquiries etc.); reporting materials from community workers and supervisors; monitoring reports, including UNICEF monitoring field trips and experience exchanges. All these data sources are assessed as highly reliable, including data collected through Aurora that are disaggregated by age, gender, ethnicity and other criteria, given that control mechanisms have been in place at all data collection levels (community, county, and at model level), while the online application allows for aggregation of data at different levels.

The evaluation will use mixed methods and could integrate:

– Primary quantitative data, collected through survey among service users, staff working in services and/or communities. The evaluation will seek to collect disaggregated data based on the following criteria: geographical – county and community levels (all communities are in rural areas); gender – boys/girls, male/female; ethnicity; age groups. If possible, other criteria will be considered, such as: grade for children in school, family educational stock (mother/ father), etc. Nevertheless, when considering quantitative data collection for comparison with counterfactual, we recommend the use of Aurora as main tool.

– Secondary data analysis of: i) trends referring to reduced pressure on the child care and health care systems available through existing administrative data; ii) existing reports on costs and financing of services from both UNICEF and other sources.

– Qualitative data, obtained through interviews and focus groups with key informants in the government, public authorities at county and local levels, partner organisations (civil society and intergovernmental organisations), service users, staff working in services and/or communities and with different stakeholders in the evaluation.

The existing sources of information, such as reports, studies and evaluations already referred to have been assessed as reliable and web links to each are provided. Additionally, together with the data sources, a contact list of all relevant stakeholders, project implementing partners and consultants will be made available to the evaluation team once a contractual agreement has been made.

– Financial impact analysis for scaling up a model of community based services at national level, 2015 draft report, PricewaterhouseCoopers and UNICEF in Romania.

– Research Report, Community involvement in reducing violence against children project, Violence against children living in rural communities, Population Services International (PSI), July 2015.

– UNICEF programme materials such as country programme documents, strategies, project proposals and reports to donors.

– Modelling project documents such as monthly and annual reports of community workers and supervisors, reports on the micro-grant implementation by the respective public local authority, etc.

The quality assurance process will consist of the following steps: review of research tools prior to collecting the data, review of all deliverables and corrective actions recommended. All the tools and deliverables will be reviewed by the UNICEF Child Protection Specialist and Child Rights Systems Monitoring (M&E) Specialist.

153 Counterfactual data for previous evaluation and suggested also for the current one, are represented by any type of information from the 32 communities involved in the modelling project only in 2011 and where baseline data related to 'invisible children' was collected through community social census.

154 Aurora – an intelligent on-line application was developed as a tool i) ensuring a unitary methodology for identification of vulnerabilities for all children by all community professionals and across all communities; ii) facilitating the generation of an integrated servics plan for children and their families to be provided by the community professionals; iii) providing real time monitoring of the fieldwork as well as data aggregation at various levels (community, county, project level) at any moment, enabling evidence-based adjustments of policies and various interventions in a timely manner.

7. Work plan and tentative time frame

The evaluation process will include an **inception phase** during which a detailed evaluation framework and an inception report will be prepared. The evaluation framework will build on the revised Theory of Change. It will provide details on how to respond to the evaluation questions, which indicators to use, sources of verification.

This phase may include and/or be developed in parallel with the **comprehensive analysis of available information** – desk review, including of national laws, policies, action plans etc., county and local strategies, reporting materials from community workers and supervisors; monitoring reports, including UNICEF monitoring field trips and experience exchanges. This phase may also include initial interviews with key stakeholders at national level (i.e. MoLFSPE, NAPCRA, MoH) and possibly at county level (supervisors and directors from the GDSACP and DPH).

It is expected that data collection will start after submission and approval of the inception report, including proposed methodology and tools. While acknowledging that quantitative data and information may be collected through a variety of instruments, we particularly recommend the use of the UNICEF-developed Aurora tool for easy accessibility and comparability.

By end of data analysis, a draft evaluation report is to be submitted according to UNICEF standards and Global Evaluation Report Oversight System (GEROS) template[155]. After submission of comments from UNICEF and key stakeholders, a final evaluation report, including an executive summary[156] and a bibliography annex, are to be submitted for review.

In this context, phases and tentative time frame are proposed in the table below:

Phases and time frames		**Expected activities**
Inception phase	mid-February 2016	Inception meeting
	end of March 2016	Submission of the inception report
	mid-April 2016	Comments to the inception report
	mid-May 2016	Approval of the inception report
Data collection	mid-June 2016	Submission of data collection tools
	end of June 2016	Comments on proposed tools
	mid-July 2016	Finalisation of tools and pre-testing
	end of August 2016	Field data collection
Reporting	end of October 2016	Submission of 1st draft report
	end of November 2016	A PowerPoint presentation of preliminary findings for the meeting with major stakeholders to be organised by UNICEF to present findings and preliminary conclusions, discuss and finalise the recommendations
	end of January 2017	Submission of final evaluation report
Dissemination	end of February 2017	Development of communication materials and dissemination, including brief advocacy note (around 3,000 words) summarising key findings of evaluation, relevant policy issues and recommendations and a PowerPoint presentation of key findings and recommendations
	mid-March 2017	Launch of the evaluation report
Post-evaluation	end of March 2017	Development of management response

8. Deliverables

All deliverables should be in English:

– Inception report including the evaluation methodology approved by mid-May 2016;

– Evaluation instruments finalised and pre-tested by mid-July 2016;

– Field data collection completed by the end of August 2016;

155 http://www.unicef.org/evaluation/files/UNEG_UNICEF_Eval_Report_Standards.pdf

156 Recommendations for 'Writing a Good Executive Summary' are attached as Annex to the present ToR.

– Draft Evaluation Report according to UNICEF standards and GEROS by end of October 2016;

– A PowerPoint presentation of the preliminary findings by end of November 2016;

– Final Evaluation Report (including an executive summary and a bibliography annex), complying with UNICEF Evaluation Report Standards and GEROS by end of January 2017;

– A brief advocacy note (around 3,000 words) summarizing key findings of evaluation, relevant policy issues and recommendations by end of February 2017.

The evaluation team will participate in the meeting with major stakeholders to present findings and preliminary conclusions, discuss and finalise the recommendations, and at the launch of the final evaluation report.

9. Evaluation team, required experience and credentials

The independent evaluation team, institution/organization and/or consortium should be built of national experts and may include one or more team members with an international profile. The team should be led by an experienced evaluator to be supported by at least one or two experts on social/child protection. To strengthen their capacity for performing the task, applicants may establish cross-sector forms of association, such as between experts and/or organisations/institutions in various fields of practice. The evaluation team will have to comply with the UNEG Code of Conduct for Evaluation in the UN System (UNEG/FN/CoC[2008])[157] and the UNEG Ethical Guidelines.

Competencies required by the team to carry out the evaluation are a combination of a number of years of experience in the subject area and of evaluation methods as per below:

– Advanced university degree in social sciences, law, political sciences or public policy;

– Comparative knowledge of child rights, child/social protection and health systems and of reforms and policy debates in these areas;

– Familiarity with rights-based approaches and with principles of gender mainstreaming;

– Good knowledge and expertise in designing and conducting evaluations, knowledge management and research;

– Proven experience in conducting data collection for various research, including participatory approaches and methods; proven ability to conduct interviews and focus group discussions, and to write reports for publication; proven experience in conducting desk reviews and field visits;

– Strong analytical and conceptual thinking;

– Excellent oral and written English language skills, demonstrable with samples of publications (evaluation reports, relevant research, etc.); ability to synthesise complex information into key messages;

– Ability to work in a multi-disciplinary team and establish harmonious and effective working relationships;

– Familiarity with the work of the United Nations is an asset;

– Availability to work within the proposed time frame;

– Ability to communicate and expertise in cooperation with different stakeholders, professionals, communities, families and children.

Successful applicants will provide samples of evaluations conducted; those should include, but not be limited to, programme & policy evaluations.

157 UNEG Code of Conduct for Evaluation in the UN System (UNEG/FN/CoC[2008]), http://www.unevaluation.org/document/detail/100

10. Roles and responsibilities of stakeholders in the evaluation

In order to provide adequate support for performing the summative evaluation, the following roles and responsibilities of stakeholders are suggested below:

External stakeholders

– At local level: children and their families, community workers, professionals in the CCSs and members of the community, public local authorities, NGOs, are already informed about the process of evaluation and are expected to contribute during the data collection process and some to provide feedback on draft report.

– At county level: supervisors and other professionals from the GDSACP and DPH, County Council and Prefecture, as well as national stakeholders (MoLFSPE and NAPCRA, MoH and others), were already involved in the development of the Terms of Reference for the summative evaluation and will participate in the evaluation through discussions, consultations, provision of comments on draft documents, while some will reply to the recommendations made by the evaluation in the management response.

UNICEF Country Office

– The UNICEF focal point for the evaluation is the Child Rights Systems Monitoring Specialist (M&E) who ensures that the evaluation process is carried out as per UNICEF policies and provides technical support to the evaluation throughout the process.

– The Child Protection Specialist is the key informant throughout the evaluation process: prepares the TORs for the evaluation exercise in consultation with the Child Rights Systems Monitoring Specialist (M&E) and suggests the best proposal for the evaluation; liaises with the evaluation team and provides initial briefing to evaluators on the framework and expectations of the evaluation; provides feedback on evaluation design and research tools and all reports and deliverables; facilitates contact with county and local stakeholders included in the evaluation exercise; facilitates access to complementary background documents to be included in the desk review and to all necessary documents throughout the evaluation process.

Evaluation team

– Has overall responsibility for the successful completion of all phases of the summative evaluation including inception, evaluation tools and methodology, data collection and reporting;

– Manages and carries out all consultations, meetings, focus groups and interviews with key informants, including logistics related to travel, financial and other arrangements associated with the implementation of the evaluation;

– Submits deliverables and invoices (if applicable) in a timely manner.

11. Evaluation budget and funding sources

A detailed budget for the evaluation will be part of the financial proposal the evaluation teams will submit when expressing their interest for the evaluation.

The estimated budget for the summative evaluation is around 80,000 USD and the source of funding is SC 309, funding from UK NatCom/Wella. This amount does not include the organisation of consultation meetings with stakeholders and launch of the report which will be covered by UNICEF separately.

12. General conditions

Reporting. The contractors will report to the UNICEF Child Rights Systems Monitoring (M&E) Specialist and will also work closely with the UNICEF Child Protection Specialist.

Payment calendar. Taking into account the tasks and time frames mentioned above, fees will be paid in three instalments after submission of deliverables and upon approval by supervisor, as follows:

– 30% of the contract total will be released upon acceptance by UNICEF of the inception report;

– 30% of the contract total will be paid after approval by UNICEF of the draft report;

– 40% of the contract will be paid after submission to and approval by UNICEF of the final evaluation report and all requested deliverables.

Ownership. UNICEF will have sole ownership of all final deliverables; no parts of the methodology will be reproduced without UNICEF permission.

13. Annexes

Annex 1. Theory of Change for the 'First Priority: No More 'Invisible' Children!' modelling project, 2013–2015

Annex 2. Writing a Good Executive Summary.

Developed by Voica Pop, Child Protection Specialist

Approved by Eduard Petrescu, Policy and Knowledge Coordinator

Annex 4 – References

Statistics

Eurostat, The European Union Statistics on Income and Living Conditions (EU-SILC)

Ministry of Labour, Family and Social Protection, General Directorate for Child Protection (statistics)

UNICEF Innocenti Research Centre, CEE/CIS TransMonEE database

Evaluations and Studies

***European Centre for Disease Prevention and Control. *Annual Epidemiological Reports on Communicable Diseases in Europe 2007–2011*.

***European Commission, 2011. *The social impact of the economic crisis and ongoing fiscal consolidation*. Third Report of the Social Protection Committee. Available at: http://goo.gl/ZiHjM8

***Federation of NGOs for Children (FONPC), 2012. *Protecția Drepturilor Copilului. Probleme identificate și sugestii pentru îmbunătățirea sistemului*. [Child Rights Protection. Identified problems and suggestions for system improvement]. Bucharest.

***Ministry of European Funds, 2015. *A doua evaluare intermediară a POSDRU 2007–2013* [Second intermediate evaluation of 2007–2013 Human Resources Development Sectoral Operational Programme (HRD SOP) – ESF]. Available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.1.pdf (last accessed on 18.05.2017)

***Ministry of European Funds, 2015. *Evaluare ad-hoc a interventiei POSDRU privind tinerii*. [Ad-hoc evaluation of the HRD SOP intervention on youth]. Available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.2.pdf

***Ministry of European Funds, 2015. *Evaluare ad-hoc a intervenției POSDRU privind populația roma*. [Ad-hoc evaluation of the HRD SOP intervention on Roma population]. Available at: http://old.fonduri-ue.ro/posdru/images/downdocs/raport.lot.3.pdf

***Ministry of Labour, Family, Social Protection and the Elderly, 2013. *Studiu concluziv, bazat pe evaluarea la nivel național a DGASPC, SPAS și a altor instituții și organizații implicate în sistemul de protecție a copilului*. [A conclusive study based on the national assessment of the GDSACPs, public social assistance services (SPAS) and other institutions and organisations involved in the child protection system in Romania]. Bucharest.

***Save the Children Romania and the Ministry of Labour, Family, Social Protection and the Elderly/Directorate for Child Protection, 2013. *Child Abuse and Neglect: National sociologic study*.

***World Health Organization, Regional Office for Europe, 2012. *Survey of Adverse Childhood Experiences among Romanian University Students*.

Comșa, R., Dărăbuș, Șt., Pop, D. and Stegeran, B., 2013. *The Financial Impact of the Public Child Protection System Reform in Romania*. HHC Romania.

Preda, M. (coord.), 2011. *Situation Analysis of Children in Romania*. UNICEF Report. HBS data, NIS. Vanemonde Publishing House, Bucharest.

Pop, V. (coord.), 2016. *Financial impact analysis for scaling up a model of community based services at national level*. UNICEF and PricewaterhouseCoopers. Alpha MDN Publishing House, Bucharest.

Stănculescu, M. S. (coord.), 2012, *Helping the invisible children. Evaluation Report 2011*. UNICEF. Vanemonde Publishing House, Bucharest. Available at: https://www.unicef.org/romania/Raport_HIC_engleza.pdf

Stănculescu, M. S. (coord.), 2013, *Helping the 'invisible' children. Second Evaluation Report*. UNICEF. Vanemonde Publishing House, Bucharest. Available at: https://www.unicef.org/romania/HIC.eng.web.pdf

Stănculescu, M. S., Grigoraș, V., Teșliuc, E., Pop, V. (coord.), 2017. *Romania: Children in Public Care.* Alpha MDN Publishing House, Bucharest.

Stănculescu, M., S., Marin, M., 2011. *Impacts of the International Economic Crisis in Romania 2009–2010*. UNICEF Report. Vanemonde Publishing House, Bucharest.

Strategic documents

European Commision Communication COM(2011) 60 final – "An EU Agenda for the Rights of the Child"

European Commision Recommendation C(2013) 778 final – "Investing in children: breaking the cycle of disadvantage"

EU Council Conclusions on early childhood education and care: providing all our children with the best start for the world of tomorrow (2011/C 175/03)

National Strategy on Child Rights Protection and Promotion 2008–2013, approved via Government Decision 860/2008

National Strategy for Preventing and Combating Domestic Violence 2013–2017, approved via Government Decision 1156/2012

Strategy for Strengthening the Public Administration 2014–2020, approved via Government Decision 909/2014

National Health Strategy 2014–2020, approved via Government Decision 1028/2014

National Strategy for the Protection and Promotion of Children's Rights 2014–2020, approved via Government Decision 1113/2014

Government Strategy for the Inclusion of the Romanian Citizens Belonging to the Roma Minority 2015–2020, approved via Government Decision 18/2015

National Youth Policy Strategy 2015–2020, approved via Government Decision 24/2015

National Strategy on Social Inclusion and Poverty Reduction 2015–2020, approved via Government Decision 383/2015

National Strategy on Reducing Early School Leaving, approved via Government Decision 417/2015

UNICEF, 2008. *UNICEF Child Protection Strategy*, available at: http:/www.unicef.org/protection/files/CP_Strategy_English.pdf

UNICEF Regional Knowledge and Leadership Agenda (RKLA) Results Area 1 – a child's right to a supportive, caring family environment

UNICEF RKLA Results Area 7 – a young child's right to comprehensive well-being

UNICEF RKLA Results Area 8 – a child's right to social protection

Legislation

Law 272/2004 on the Protection and Promotion of Child Rights, as subsequently amended and supplemented

Law 466/2004 regarding the Status of the Social Worker, as subsequently amended and supplemented

Law 448/2006 on Protecting and Promoting the Rights of People with Disabilities, as subsequently amended and supplemented

Law 292/2011 on Social Assistance

Government Decision 691/2015 for approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and of the Working Methodology for GDSACP-SPAS collaboration and of the standard model for the documents developed by these two institutions

Substantiation Report for GD 691/2015

GEO 18/2017 on Community Health Care

Recital of GEO 18/2017

Standards

UNEG Norms for Evaluation in the UN System, 2005. http://www.uneval.org/document/download/562

UNEG Ethical Guidelines for Evaluation, 2008. http://www.uneval.org/document/download/548

Annex 5 – Evaluation matrix

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
Relevance	1. To what extent does the modelling project address the needs of the most vulnerable children and reduction of inequities (ref. invisible children)?	'Invisible' children and families	1. Number/proportion in total (children') population of: A. Additional indications from the Community Fiche (2012) – children at risk of neglect or abuse – children with suspicion of severe diseases – relinquished or at risk of child relinquishment/ separated According to the methodology used by the TOR) – children out-of-school and children at risk of school dropout – teenage mothers who left school and/or are at risk of relinquishing the new-born child – other cases of vulnerable children (vulnerabilities to be determined on the database or based on interviews) B. Indicators of vulnerability on AURORA (2014): – children in poverty – children not registered to or not accessing family medical doctors – under 1 year old children at health risk – 1–5 years old children at health risk – children with chronic disease – pregnant woman at risk – children out-of-school and children at risk of school dropout – including day nursery – adolescent/children with risk behaviour – children of violence, abuse and/or neglect – children living in living in precarious conditions – children lacking ID papers – children with migrant or absent parents – children with disabilities – relinquished or at risk of child relinquishment	Quantitative approach: – Results of the initial census – Community Fiche – AURORA Qualitative approach: – Interviews at local level – 32 interviews with social workers and community nurses (2 per county for each) – Focus groups – 8 focus groups (1 in each country) with CCSs members and local NGOs – Workshops with children/adolescents and field visits – 8 workshops (1 in each country)
Relevance	2. To what extent is the model relevant vis-à-vis the overall goal and the achievement of its expected outputs and outcomes in the given period of time?	'Invisible' children and families Community County (județ) National	2. Evaluation of possible outputs and outcomes of each of the services provided – they will be listed as result of qualitative methods applied: interviews, focus groups etc. and as a result of expert evaluation and experience 3. Indicators of the output – invisible children identified – number of social workers with increased capacity to deliver services (din 2012) (not defined in the ToC, subjective evaluation/to be operationalized) – number of community health nurses with increased capacity to deliver services (din 2013) – number of community centres of support and counselling for children and parents – number of resources centres at county level – functional community consultative structures – organising the minimum numbers of meetings – level of capacity of GDSACP and DPH (subjective evaluation) to provide methodological support to local authorities – evidence measuring effectiveness and efficiency of the model(s) developed	Qualitative approach – Interviews at local level – 32 interviews with social workers and community nurses (2 per county for each) (same as above) – Focus groups – 8 focus groups (1 in each country) with CCSs members and local NGOs (same as above)

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
			4. Indicators of outcome – no./proportion of children visible in their families and in their communities for the health, education and social protection systems: – level of access to primary health services – level of enrolment in school of children of school age – level of protection protected against separation from family – level of protected against all forms of violence (including neglect, abuse and exploitation) (from 2014) – level of information of adolescents regarding risk behaviour (in 2015) – community capacity to deliver social services and community health services (not defined in the ToC, subjective evaluation) – level of information of children and families (not defined in the ToC, subjective evaluation) – functioning of the county support centres for communities – 1 supervisor – qualitative evaluation – level of pressure on child special protection and specialized health services systems (not defined in the ToC) – revisions of national strategies (based on evidence produced by the model/project).	
	3. To what extent is the modelling project relevant to national policies, programmes (including National Reform Programmes and EUSF programme 2014–2020), sectoral and cross sectoral strategies and to the Central and Eastern Europe and Commonwealth of Independent States (CEE/CIS) Regional Knowledge Leadership Area (RKLA) on the right to grow up in a protective family environment, as well as the RKLAs on young child well-being and right to social protection?	National	National strategies on: • Child protection • Social inclusion • Health • Education • Social inclusion of disabled people • Against domestic violence • Youth • Public Administration RKLA of UNICEF	- Desk research on national and regional strategies and RKLA - Interviews at national level (11 interviews with key stakeholders)
Effectiveness	4. Does the modelling project contribute to realization of child rights (by vulnerabilities)? Does the minimum package of services address all vulnerabilities? Which component is most successful? Is there a value added of the integrated approach?	'Invisible' children and families	1. Number/proportion in total (children') population of: A. Indications from the Community Fiche (2012) – children at risk of neglect or abuse – children with suspicion of severe diseases – relinquished or at risk of child relinquishment/separation (according to the terms used by the TOR) – children out-of-school and children at risk of school dropout – teenage mothers who left school and/or are at risk of relinquishing the new-born child – other cases of vulnerable children (vulnerabilities to be determined on the database or based on interviews)	Quantitative approach - Community Fiche - AURORA - Survey on 800 households

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
			B. Indicators of vulnerability on AURORA (2014) – children in poverty – children not registered to or not accessing family medical doctors – under 1 year old children at health risk – 1–5 years old children at health risk – children with chronic disease – pregnant woman at risk – children out-of-school and children at risk of school dropout – including day nursery – adolescent/children with risk behaviour – children at risk of violence, abuse and/or neglect – children living in precarious conditions – children lacking ID papers – children with migrant or absent parents – children with disabilities – relinquished or at risk of child relinquishment 2. Indicators of the output: – invisible children identified – level of information of children and families about rights and entitlements – increased access to basic social services. 3. Micro grants context presentation, expected results, realized indicators	Qualitative approach - Interviews at local level – 32 interviews with social workers and community nurses in targeted communities (2 per county for each) – Interviews with parents in 8 communities (3 parents of benefiting children will be interviewed in each community) – 16 interviews with the social workers/persons responsible for social work in control communities - Focus groups – 8 focus groups (1 in each country) with CCSs members and local NGOs - Workshops with children/adolescents and field visits – 8 workshops (1 in each country) Desk research Analysis of the micro-grants in order to determine the cost/child within micro-grants.
	5. Does the modelling project contribute to the capacity development of the local authorities to deliver the minimum package of integrated services (compared to the 32 communities with interventions only in 2011)?	Community	– No. of SWs employed (internal or external) – No. of community nurses – Specific training of SWs and community nurses (separately and as a team) – No. of social workers with increased capacity to deliver services (from 2012) (not defined in the ToC, subjective evaluation/to be operationalized by evaluation instruments) – No. of community health nurses with increased capacity to deliver services (from 2013) (not defined in the ToC, subjective evaluation/to be operationalized by evaluation instruments) – Continuity of employment of SWs and community nurses – Existence and number of procedures used for social work – Average time spent for service provision (identified in interviews by social workers and community workers) – No. of grants applications for projects with social or health related components targeting children and families, submitted by the communes (municipalities) – No. of projects with social or health education components targeting children and families, implemented by the communes (municipalities) – No. of community centres of support and counselling for children and parents – No. of functional community consultative structures – organising the minimum numbers of meetings – Frequency of meetings and quality of the community consultative structures work (subjective evaluation) – No. of resources centres at county level – quality of support from the county supervisors (GDSACP) for the social workers (subjective evaluation) – Level of capacity of GDSACP and DPH (subjective evaluation) to provide methodological support to local authorities	- Survey at the level of mayoralties Qualitative approach - Interviews at local level – 32 interviews with social workers and community nurses in targeted communities (2 per county for each) – 16 interviews with the social workers/social responsible in control communities – 8 interviews with GDSACP and 8 interviews with DPH - Focus groups – 8 focus groups (1 in each country) with CCSs members and local NGOs

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
	6. Does the modelling project contribute to reducing the pressure on the child care system? And on the health care system?	County (județ)	1.Pressure on GDSACP – number of children at risk of separation (within the project) registered by the system – GDSACP / (and out of those, # of children separated from the family) – (within the model timeframe, until the first evaluation of the risk of separation) – comparison between the vulnerability and risk indicators used by GDSACP and respectively by UNICEF model (AURORA). Other models (HC, SERA etc. will be considered) – services provided to children at risk of separation and their result (separation or not from the family) by GDSACP and respectively by UNICEF model 2.Pressure on the health care system / hospitalization – number of children identified with vulnerabilities in the health dimension (to be selected) compared to number of children hospitalized more than seven days (out of the above) – services provided to children at health risk and their result. 3. total number of cases registered by GDSACP in the intervention counties before and after the intervention. Total number of cases registered by GDSACP in the intervention communities before and after the intervention.	– Desk research – Secondary data usage (quantitative analysis of the existing administrative data available at the level of DGASPC and DJSP on trends referring to reduced pressure on the child and care systems) – Case studies (1 community will be selected from each county to assess: pressure on the system, prevention vs. social benefits, sustainability and impact) – Interviews at county level – 8 interviews with GDSACP and 8 interviews with DPH – 32 interviews with social workers and community nurses in targeted communities (2 per county for each)
	7. Does(the modelling project contribute to strengthening national strategies and focus on prevention of separation of children from their families? And of violence against children?	National	– Evidence based inputs provided and mainstreamed into the relevant national strategies (with special focus on areas addressing prevention of separation of children from their families and of violence against children)	– Desk research on national and regional strategies and RKLA – Interviews at national level
Efficiency	8. Does the modelling project use resources in the most economical/efficient manner to achieve expected results? What are benefits of the integrated approach from financial point of view? How does project costs compare to other similar programmes or standards?	Community County (județ)	Indicators of the cost of the project: – Total budget versus total no. of beneficiaries – Budget (of modelling project)/beneficiary – Budget/minimum package (as a whole) – Costs of project (funded by micro grants)/beneficiaries – etc. Standard costs for child protection/care services and health care services (i.e. average cost/day of hospitalization) (when applicable)	– Desk research of project documents (reports – including report delivered by Pricewaterhouse) – Interviews at local, county and national levels

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
	9. How efficient was the model in terms of results for the beneficiaries of the minimum package of services and social benefits compared to individuals who received only social benefits?	'Invisible' children and families	1. Vulnerability indicators before and after the project implementation – results of assessment and answer to question 4 under effectiveness criteria. 2. Indicators on the social benefits received by the children and their families. - receiving or not social benefits - type of social benefits received	Quantitative approach - Community Fiche - AURORA - Survey on 800 households - Secondary data-quantitative analysis on social benefits from the 32 mayoralties in the intervention group and 32 communities in the control group. Qualitative approach – Interviews at local level – 32 interviews with social workers and community nurses in targeted communities (2 per county for each) – Interviews with parents in 8 communities (3 parents/community of benefiting children will be interviewed) – 16 interviews with the social workers/social responsible in control communities – Focus groups – 8 focus groups (1 in each country) with CCSs members and local NGOs – Case studies
	10. What are the cost implications of scaling up? What are the implications for national mainstreaming?	National	Existing reports – including report delivered by Pricewaterhouse	– Desk research of project documents (reports – including report delivered by Pricewaterhouse) – Secondary data usage (local budgets) – Interviews at national level
Sustainability	11. To what extent is the current context more or less favourable to continue such approaches in the near future?	Community	Capacity indicators of local administration/community – results of assessment and answer to question 4 under effectiveness criteria.	- Survey at the level of mayoralties Qualitative approach - Interviews at local level – 32 interviews with social workers and community nurses in targeted communities (2 per county for each) - Focus groups – 8 focus groups (1 in each country) with CCSs members and local
	12. Are the interventions modelled and impact on the most vulnerable children likely to continue when external support is withdrawn?	'Invisible' children and families Community County (județ)	- Motivation of all actors to continue the interventions - Opportunities (existence of… / identification of…) for continuing interventions through other funding - Attitudes of all actors vis-à-vis the continuation of the intervention >Commitment of members of the community consultative structures and of GDSACP to continue the work without UNICEF presence.	- Interviews at local (32 with social workers and community nurses) and county level - Focus groups

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
	13. Is the modelling project replicable? As a whole or only certain components? At local, county or national level? What are prerequisites for replication? Are any adjustments of the model needed for replication?	Community County (județ) National	1. Indicators of capacity of 32 communes in the control group: – No. of SWs employed (internal or external) – No. of community nurses – if existent – Specific training of SWs and community nurses (separately and as a team) – Continuity of employment of SWs (and community nurses) – Existence and number of procedures used for social work – Average time spent for service provision (identified in interviews by social workers and community workers) – No. of grants applications for projects with social or health related components targeting children and families, submitted by the communes (municipalities) – No. of projects with social or health education components targeting children and families, implemented by the communes (municipalities) – No. of community centres of support and counselling for children and parents – Quality of support from the county level (GDSACP) for the social workers – No. of functional community consultative structures – organising the minimum numbers of meetings – Level of capacity of GDSACP and DPH (subjective evaluation) to provide methodological support to local authorities 2. Results of answers to question 8 and 9 under efficiency 3. Indicators of motivation of 32 communes in the control group - Motivation of all actors to continue the interventions - Opportunities (existence of… / identification of…) for interventions through other funding - Attitudes of all actors vis-à-vis the continuation of the interventions	- Desk research - Survey at the level of mayoralties Qualitative approach - Interviews at local level – 16 interviews with the social workers/social responsible in control communities - Focus groups – 8 focus groups (1 in each country) in control communities - Interviews at county level
	14. What recommendations could be made to UNICEF and to the Government of Romania to replicate and scale up such a model?	National County Community		- Interviews at local, county and national level - Desk research
Impact	15. What change did the modelling project determined or influenced at the level of beneficiaries (children and their families), communities, professionals, public administration – at local, county and/or national level?	'Invisible' children and families	Indicators of outcome – no./proportion of children visible in their families and in their communities for the health, education and social protection systems: – level of access to primary health services – level of enrolment in school of children of school age – level of protection protected against separation from family – level of protected against all forms of violence (including neglect, abuse and exploitation) – level of information of adolescents regarding risk behaviour – level of information of children and families	- Survey on 800 households - Interviews at local and county level - Focus groups - Workshops with children and field visits - Case study

Evaluation criteria	Evaluation question	Level of intervention from ToC	Evaluation indicators	Source of verification
	16. To what extent did the modelling project increased institutional capacities to ensure that most vulnerable benefit from minimum package of services in a way which contributes to prevention of separation of children from their families and prevention of violence against children?	Community County (judet)	Indicators of outcome – community capacity to deliver social services and community health services (undefined in the ToC, subjective evaluation) – functioning of the county support centres for communities – level of pressure on child special protection and specialized health services systems	- Interviews at local and county levels - Desk research of project documents - Focus groups - Survey at the level of mayoralties
	17. To what extent has the modelling project increased the impact of the social protection policies for the poor and most vulnerable children?	National	N/A	- Interviews at national level - Desk research
Lessons learned and unexpected outcomes	18. What are the lessons learned at each level of intervention that should be taken into account for further modelling projects and action related to scale up and mainstreaming of minimum package of prevention at national level?	County (judet) National	N/A	- Interviews at all levels - Desk research - Focus groups - Workshops and field visits - results from quantitative methods used
	19. Are there any unexpected outcomes worth considering for filling in capacity gaps and/ or addressing remaining bottlenecks?	Community County (judet)	N/A	

Annex 6 – Evaluation results framework

Findings	Conclusions	Recommendations	Level
1. RELEVANCE			
1.1. Model relevance in relation to increasing the impact of social protection measures on vulnerable children and their families			
1.1.1. Model coherence at the level of 'invisible' children and their families	1) The project logical framework proved coherent and therefore its design enables achievement of its objective, increasing the impact of social assistance measures. During 2011–2012, as focus was set high on the identification activities and relatively low on service delivery, the connection between the model inputs and all the estimated long-term outcomes seemed somewhat too optimistic. **With the introduction of the Aurora, of the minimum package of services and the micro-grant projects, the correct implementation of project activities became considerably more likely to yield outputs and outcomes which improved children's situation, thereby increasing the impact of the social assistance measures in the communes included in the model. Hence, the model is highly relevant in relation to the overall goal and to the achievement of the expected results.**	1. Keep the Theory of Change. To promote model scale up at national level or its replication by other organisations, UNICEF in Romania can use the Theory of Change developed within the model, adding to it an education service delivery component. However, as indicated by the lessons learned during the project, for institutions and organisations interested in replicating the model to be able to use all the model good practices, descriptive documentation on the working methodologies used, the approach and implementation timetable, the need for coordination staff etc. should also be provided.	Central – UNICEF
	2) However, both in 2011 and after the Aurora was added to the model, as a result of the working methodology used to assess the situation of children and their families and identify their vulnerabilities, as well as of the normal limits that define the effectiveness of any social assistance work, **the far-reaching outcomes envisaged for all children came out as too ambitious**.		
1.1.2. Model coherence at community and county level	3) **At local and county level, the model is highly relevant as its design and activities allowed for successfully addressing the local public administration structural gaps in ensuring social assistance, child protection and community health care**, by hiring and training staff and providing it with the necessary working tools, especially the Aurora application and database and the tablet computers enabling their use.	2. The SPAS all over the country should be able to hire social workers for fieldwork in addition to the SPAS employee(s) in charge with managing the social benefits case files, as well as CHNs in all communes nationwide. The number of social workers employed to carry out fieldwork should be sufficient to cover a community's needs. The UNICEF and PwC study of the costs involved in implementing and scaling up the model proposes an algorithm for calculating the minimum number of social workers required in a community based on the number of vulnerable children, type of community (urban vs rural), share of children in total population, population density, number of MGI recipients, and average unemployment rate. Using this algorithm allows for determining the minimum number of social workers who need to be hired in each SPAS in order to meet children's needs through delivery of the minimum package of services.	Local – Mayoralties
1.2. Model relevance in relation to the needs of vulnerable children			
1.2.1. Identification of vulnerabilities	4) The model underwent a rather long phase of fine-tuning before defining a clear set of vulnerabilities for children and families in the target communities, but once the Aurora application and database were ready, **all the problems identified with the target group were reflected in a diagnosis of vulnerabilities**. Our qualitative research **did not reveal any major target group problems or needs not considered by the Aurora working methodology** when establishing the main categories and subcategories of vulnerabilities and not addressed later through the minimum package of services. Most of the vulnerabilities (except for the risk of child-family separation) are assessed using nationally and internationally accepted standardised definitions based on which institutions at all levels design intervention models.	3. Continue the UNICEF advocacy efforts so as to ensure that national public policies cover not only the identification activity (currently reflected in part by the tools outlined in the annexes to GD 691/2015), but also the standardised assessment of vulnerabilities and the minimum package of services. Moreover, advocacy efforts should also focus on achieving digital versions of the observation and risk identification data sheets set out in GD 691/2015, to enable automatic analysis of data collected and, therefore, an accurate diagnosis of children's vulnerabilities and generation of the recommended services.	Central – UNICEF
	5) Furthermore, both the experience accrued by the social assistance, child care and health care professionals and the lessons learned from the first years of model implementation (2011–2012) and from the formative evaluations of the project show the child vulnerabilities assessment phase is highly relevant, key in the planning of effective services for children. In the absence of the vulnerabilities assessment, social assistance, child care and community health care services are delivered "blindly", they cannot be adequately targeted and delivered, nor can their effectiveness and impact be measured later on.	4. Develop national standardised identification and assessment tools and working methodologies, given that accurate identification of vulnerabilities and needs assessment are key in protecting children's rights and ensuring the services they need. At present, GD 691/2015 aims to ensure prevention of child-family separation and includes an observation data sheet and a risk identification data sheet. According to the provisions of this GD, these data sheets are intended to inform the social worker in their preparation of the service plan. For the time being, although necessary, there is no clear procedure for determining the risks and the required services to address those risks based on the answers to the data sheet questions, and as a result, similar situations are assessed differently and are covered with different service plans, depending on the social worker's experience, training or beliefs. For this reason, aside from the identification data sheets, the current methodology should be completed with new tools.	Central – MoLSJ
	6) Also, all identified vulnerabilities are considered in the design of the minimum package of basic services that Aurora automatically generates. **The model is thus created to guide community workers in addressing all the identified vulnerabilities, which makes the model highly relevant in relation to the needs of the 'invisible' children**.		

Findings	Conclusions	Recommendations	Level
1.2.2. Relevance of model services in relation to the identified needs	7) All vulnerabilities are targeted with services from different categories (information, counselling, support and accompaniment, referral) and for all vulnerabilities the services delivered are accompanied by monitoring and reassessment. In terms of community-based preventive services which can be delivered by SPAS social workers and by community health nurses working in the communes, the minimum package of basic services developed and used in the model is complete and relevant for all the identified vulnerable children. 8) Given the design of its interventions, the model is highly relevant in addressing the needs of (i) adolescents and children with risk behaviour, (ii) children living in families prone to child violence, abuse or neglect, (iii) children with only one or no parent at home, (iv) children with disabilities, categories for whom it provides many different services. 9) The model is highly relevant for children who were separated from their family or at risk of separation. Not only is there a significant set of services designed to address this vulnerability, but the model also included a special priority service for children in this situation. "Priority zero service" was developed specifically for preventing child-family separation wherever this risk occurs.	5. To ensure all children's and their families' vulnerabilities are addressed, develop the national regulatory framework with respect to operationalising the concept of minimum package of basic social services for children and families, including by developing documents, procedures and working methodologies to be made available to all the SPAS. These should include steps to identifying vulnerabilities and assessing needs, based on nationally and internationally accepted criteria and indicators, creating service plans by selecting and prioritising the services included in the minimum package of services, delivering services, monitoring and evaluating service effectiveness. These working methodologies can be based on replication/scaling up of the Aurora methodology (which fulfils all the necessary conditions and has proved effective) or on new tools developed at the NAPCRA/MoLSJ level.	Central – MoLSJ
1.2.3. Model relevance in relation to the needs of the social assistance and health systems	10) Due to the Aurora methodology which enables a systematic assessment of vulnerabilities and helps develop customised service plans, assisting social workers with or without specialised training/studies, and due to its focus on community-based prevention and intervention services, the model addresses a systemic problem of the child social assistance system, namely the low availability of professionals, especially in rural areas.		
1.3. Model relevance in relation to national, regional, European and international child protection policies			
1.3.1. Model relevance in relation to national public policies	11) The model is in line with the provisions of most related national strategic documents as well as with several European and regional approaches in the area of child rights protection and promotion. As such, the model is highly relevant for the public policy framework in Romania and in the region, which is essential in view of its subsequent scaling up and adopting by the Government as a public project.	6. In advocating for model scale up, use model relevance in relation to national, European and regional strategic documents as well as evidence to its effectiveness, efficacy and impact. Emphasis should be placed on the fact that, by implementing its tested working hypothesis, the model contributes to practical translation of international recommendations and national strategic objectives, and thus, in Romania, it does not require legislation or system changes that would involve experimenting with untested hypotheses. In this respect, the model is a relatively simple tool which addresses a series of complex issues at both social and administrative level.	Central – UNICEF
1.3.2. Model relevance in relation to UNICEF RKLA Results Areas		7. Model relevance in relation to international and regional documents, together with the effectiveness, impact and efficiency of its approach based on identification and on integrated delivery of a minimum package of basic community-based preventive services for children and their families, allow for promoting the model to other countries in the region as well.	

Findings	Conclusions	Recommendations	Level
2. EFFECTIVENESS			
2.1. Dynamics of child vulnerabilities			
2.1.1. Identifying vulnerable children and their families	12) The model proved effective to a large extent, as indicated by the Aurora database as well as by the survey conducted against a control group, and by the interviews, focus groups and workshops organised for the purpose of the present evaluation. The number of cases tackled by the model increased over time, while the vulnerabilities identification and assessment were carried out accurately and reliably with the help of the Aurora methodology. 13) The data recorded by the Aurora in 2015 and confirmed by the survey conducted in 2016 are highly reliable, demonstrating the effectiveness of the services for identifying and assessing the 'invisible' children, particularly in terms of vulnerabilities related to: – access to education and school attendance; – risk behaviours related to substance abuse; – poor housing conditions; – lack of ID papers; – disabilities; – risk of child-family separation for children with siblings up to 18 years of age who do not live in the household, including because they are in public care.	8. The vulnerabilities identification and needs assessment component of Aurora as well as the minimum package of services generated using the Aurora methodology should be promoted at national level as modern tools enabling identification of children's problems and needs, including those less visible to the community (i.e. situations of violence, abuse and neglect or risk behaviours among children and adolescents), as well as planning of the necessary services for those children, tools accessible to both social workers and outreach workers/social referents within the SPAS.	Central – UNICEF
		9. Existing tools for the identification of vulnerabilities and for needs analysis, such as those set out in GD 691/2015 or those used by the CHNs to report data to the DPH, should be integrated in electronic reporting systems based on online applications and which enable using the collected information in conducting case management and in generating useful statistics for defining community and county-level interventions as well as related national policies. Aurora is a highly reliable tool that can be used further for any initiative resembling the UNICEF model and can be made part of every SPAS 'toolkit'. Thus, at national level, this methodology should be used or a similar methodology and tool developed to ensure: a. the identification of children's vulnerabilities, to learn about children's needs; b. electronic centralisation of collected data, to enable their processing and the systematic planning of services to be delivered.	Central – MoLSJ
		10. Continue using the Aurora and carry out the identification of vulnerabilities on a regular basis, according to the methodology.	Local – Mayoralty
	14) The model enabled better knowledge and understanding of child violence, abuse and neglect, while the use of Aurora eliminated a significant part of the SPAS staff assessment bias. Despite this progress, issues of violence, abuse and neglect remain frequent (even the lowest incidence rates recorded in the Aurora in 2015 are cause for concern), and their accurate assessment continues to be a challenge, as the survey conducted in 2016 recorded twice as many children at risk of violence compared to the Aurora	11. Improve assessment of the risks of child violence, abuse and neglect, including in implementing the provisions of GD 691/2015, with special focus on training the social/outreach workers to recognise these situations and see beyond the statements of the children's main carer who responds to the Aurora questionnaire. Such training should cover practical notions of psychology as well as new techniques that enable use of the vulnerabilities identification tool separately for each household member to determine the severity of sensitive vulnerabilities such as violence, abuse and neglect or risk behaviours. 12. Since some of the social workers reported an increased capacity to identify various situations of abuse and neglect or risk behaviours as a result of having undertaken a series of counselling sessions (within the micro-grant projects), this type of activities should be standardised, based on experience, targeting specific groups (mothers, adolescents, children) and extended to all communities, including by using external financing sources available to the Government of Romania. Organising such targeted activities at community level in conjunction with nationwide systematic information and awareness-raising campaigns is likely to contribute to a sustainable change in the public attitudes and mentalities relative to these situations.	Central – MoLSJ

Findings	Conclusions	Recommendations	Level
	15) Since the introduction of the Aurora was not followed by a new community census to use the questionnaire for all children (as the model focus shifted on minimum package service delivery), the vulnerability identification and assessment service coverage did not achieve maximum effectiveness and the deficiencies indicated by the second formative evaluation with regard to target group coverage were not fully addressed, even though the social workers did enter into the Aurora database all the newborns and other new cases, whenever reported or identified.	13. Identify all vulnerable/'invisible' children in the communities by carrying out a comprehensive needs identification activity, ensuring that the social worker with fieldwork duties (social service delivery) knows all households and all children in the community and identifies those households with vulnerable children in need of an in-depth needs assessment. The specific organisation and implementation of this activity should be chosen based on the experience accrued in implementing the "First Priority: No More 'Invisible' Children!" model as well as other similar projects. Possible approaches include: a. social workers apply the Aurora to all households in the community (conduct a census using the Aurora methodology). Pros: it provides the benefit of a comprehensive analysis. Cons: requires a great deal of time and resources. Moreover, in an average community, a comprehensive use of the Aurora by 1–2 people may take more than a year, during which time there would be no social service delivery capacity and the data initially collected might become obsolete; b. social workers initially use a screening questionnaire for all community households, possibly integrated into the Aurora, such as the Observation Data Sheet set out in GD 691/2015 (conduct a community census using a simplified tool). This would allow for identifying the households that will require a full use of the Aurora methodology for in-depth needs assessment and service package generation. Unlike applying the full Aurora methodology to all households, use of a simplified tool would cover a shorter period of time; c. initial use of the Aurora or of a simplified tool for all households in the community – in other words, conducting a community census – with the help of field interviewers hired specifically for this purpose. Pros: allows for a relatively fast implementation. Cons: does not enable social workers to get to know the local households or build on the trust-based relationship they can establish with their beneficiaries (children and their families).	Central – UNICEF
Most vulnerable children	16) With few exceptions, there are no significant differences in the vulnerabilities encountered among girls versus boys, Romanian versus Roma children. Furthermore, the differences recorded between the two uses of the Aurora questionnaire indicate progress was made and, even though some differences persisted, the intervention helped reduce not increase them.	n.a.	
2.1.2. Delivering the minimum package of services	17) The survey conducted in the intervention communities as well as in the control communities shows statistically significant differences between the basic social services delivered in the intervention group and those delivered in the control group (where the minimum package of services was not used) with regard to: – registration with a family physician; – obtaining the disability certificate; – information and counselling, including about rights and risks related to child violence, abuse or exploitation.	14. To facilitate the work of professionals at all levels, develop modules enabling queries across databases and data exportation from the Aurora to help complete files required in the child protection and health care systems, as well as develop reports requested by various county or local authorities.	Central – MMJS
	18) On the other hand, one can notice a negative difference in the intervention sample versus the control sample, with regard to the services for facilitating children's access to education.	15. Continue delivering the services included in the minimum package of services and recommended by the Aurora.	Local – Mayoralties

Findings	Conclusions	Recommendations	Level
	19) Relative to the total number of service recipients, around 1/5 of the services recommended by the Aurora were not delivered after the first use of the questionnaire and about one third, after the second use. This is due, on the one hand, to the design of the Aurora which will recommend the full range of necessary services to address a case and sometimes vulnerabilities can be eliminated after delivery of a smaller set of services, and, on the other hand, to the fact that some of the specialised services to which the Aurora recommended referral or accompaniment were not available or accessible.	16. To increase the capacity to accurately determine service package delivery effectiveness, revise the Aurora so as to enable flagging of the recommended minimum package services whose delivery was not carried out, indicating the specific reasons why that occurred – service was no longer required/was not available/was inaccessible – to enable a more clear assessment of the basic or specialised services needed in every community as well as at county level. For best case management results, the platform should also enable flagging of services whose repeated delivery is recommended.	Central – UNICEF
	20) As a result, the information and counselling services were more effective than the referral, accompaniment and support services. At the same time, most of the social workers we interviewed as well as their county GDSACP supervisors underlined the need for development of the specialised social services, to complement the model. 21) There are, however, significant differences among the counties which implemented the model in terms of the number of services not delivered. Where the number of services delivered was high, we have observed the positive influence of the county supervisors' proactive approach, on the one hand, and the importance of having community social workers with specialised training/studies. Thus, the smallest number of undelivered services was recorded in Botoşani county where all the hired social workers had specialised background and the county supervisors were highly active both in identifying and selecting the social workers and in providing them with the necessary guidance and monitoring throughout the intervention.	17. Increase the capacity of the social assistance and child care systems at county level by setting up departments whose staff is adequate and specialised in ensuring monitoring, supervision and methodological support for the SPAS activity.	County – GDSACP / DPH
2.1.3. Information about rights and available benefits	22) The model was effective in informing the target group (vulnerable children and their families) about their rights to social assistance. On the other hand, no significant differences were noted between the recipient group and the group not covered with services or micro-grant projects in terms of information about other fundamental child rights, such as the right to education, to health care or vaccination. The absence of community health nurses in some of the communities may account for the limited extent of information about health rights indicated by the survey.	18. To significantly increase the level of information of vulnerable children and adolescents and their families, information and counselling activities need to be repeated, replicated nationwide, both via information campaigns and via information and counselling activities conducted by social workers in the field, for a longer period of time, given that such activities are designed to eliminate stereotyping and change attitudes	Central – UNICEF
2.1.4. Addressing vulnerability cases	23) The model is effective in ensuring the delivery of basic social services via community workers' fieldwork. In the communes in which the model was implemented, the social worker and the CHN are known to vulnerable persons to a greater extent and their work is well regarded. Three times more people in the intervention communes versus the control group believe they can count on the community workers' support and three times more families received their help in the intervention communes versus the control ones. As such, according to the interviewees, early and long-lasting intervention is most effective in addressing the community problems. Moreover, several vulnerabilities are recurrent, which only emphasises the need for repeated and long-term intervention targeting vulnerable families.	19. Continue with and ensure national regulation of the approach involving fieldwork-based service delivery, and plan for model replication or scale-up interventions taking into consideration that progress in improving children's situation is slow, given the complexity of the vulnerabilities being targeted, therefore interventions need to be planned for the long term.	Central – MoLSJ
2.1.5 . Effectiveness of the integrated approach	24) According to our survey, service recipients were satisfied and very satisfied with the individual work of the social worker and of the community health nurse, as well as with their teamwork, where applicable. No relevant differences were noted between the assessment of the two community workers' individual work and the assessment of the team as a whole. However, differences between the intervention and the control groups are significant, in that a much lower share of the respondents from the control group were satisfied with the services they received. Therefore, the integrated approach to the delivery of social and community health care services is perceived as added value for the service recipients. In fact, all the relevant professionals highlight the interdependence between health and social vulnerabilities and the interdependence between social and community health care service effectiveness. The integrated approach proved effective and its implementation was supported in all communities in which a CHN was hired but also where the CHN was absent (though to a lesser extent) due to the fact that the Aurora recommended both social and health services and the DPH supervisors provided support to social workers as well.	20. To increase model effectiveness in the educational area as well, the integrated approach needs to be extended to include a school mediator or school counsellor with education-focused duties.	Central – UNICEF
		21. Hire CHNs in all communities, given the high added value of the integrated approach and the fact that such an approach yields better results in communities which have CHNs.	Local – Mayoralties

Findings	Conclusions	Recommendations	Level
2.1.6. Community counselling and support centres for children and parents	25) The more comprehensive counselling services provided by the community counselling and support centres for parents and children within the micro-grant projects were well regarded by all community workers and by all the children and parents we interviewed. 26) Nevertheless, it is still difficult to accurately determine the effectiveness of this activity separately from that of the service package delivered outside the micro-grant project activities, due to the uneven planning and reporting and a poor recording of the targeted and performance indicators.	22. Address the need for training community workers and county supervisors (who provide support) on project management issues, via a 3 to 5 day basic course, and the development of forms (or a reporting platform) that would help collect, centralise and archive data on the outcome of micro-grant project activities. 23. Develop a platform for reporting on the micro-grant project activities, using Aurora. Developing this new reporting platform as a new module to the Aurora application facilitates the work of its users and their supervisors who will thus interact with a single application, while training on the use of the new module can be integrated in the initial training plan.	Central – UNICEF
		24. Continue setting up counselling and support centres for children and parents and organising group activities designed to facilitate vulnerable children's and their families' access to specialised counselling services. Such activities can continue with minimal financial resources from the local budget if communities are successfully engaged in supporting the activities, as already accomplished in most of the intervention communes.	Local – Mayoralties
2.1.7. Community engagement	27) Engaging the community via the Community Consultative Structures contributed a great deal to addressing the most complex vulnerabilities, in all communities, even if the CCS activity was uneven (more intense and better organised, with regular meetings and a proactive approach in some communities / with less frequent meetings and a rather reactive approach in other communities).	25. Integrate CCS capacity-building activities into national programmes designed to target rural areas on an ongoing and systematic basis to help increase proactivity and improve management of complex vulnerabilities. Identifying the person best suited to mobilise the CCS and supporting that person through programmes aimed to improve and structure such skills (e.g. social engagement techniques, methods of involving disadvantaged groups in problem-analysis and decision-making process etc.) can also help increase community cohesion and solidarity in addressing the vulnerabilities of its members.	Central – MoLSJ
		26. Continue the CCS work. Social workers should continue being involved in the activity of these structures, while mayoralties should also support the actions of other persons who can drive the CCS activity, both by facilitating communication among the CCS members and by supporting the CCS decisions for children in the community. To increase the level of community engagement and its effectiveness in all communities, it would be useful to organise field trips/exchanges of good practices not only for community workers but for all CCS members as well. CCS member participation in information as well as team-building activities would help increase their understanding of child rights, reduce tolerance for abuse and addictive behaviours, while increasing this group's cohesion and intervention capacity.	Local – Mayoralties
2.2. Increasing the capacity of Public Social Assistance Services (SPAS) and other responsabile institutions			
2.2.1. Hiring community workers 2.2.2. Service delivery capacity 2.2.3. SPAS capacity-building via the use of Aurora	28) Hiring social workers charged with fieldwork duties and training them contributed to increasing SPAS capacity to deliver social services. Our research shows that, during 2011–2015, the model was effective in increasing the capacity of the SPAS, GDSACP and DPH. In connection with the model effectiveness in increasing the SPAS capacity to deliver social services throughout the implementation period, four aspects need mentioning first: 1. capacity building for SPAS employees, most of them without specialised studies, through training sessions which provided them with social assistance skills and competencies; 2. systematic use of the Aurora, a modern standardised electronic system for identifying vulnerabilities and conducting case management; 3. establishment of community centres which enabled service delivery as well as helped increase community worker capacity through experience exchanges with professionals providing specialised services (psychologists, counsellors); 4. enhanced cooperation at community level and among county-level institutions.	27. Given the added value of training social workers to ensure effective service delivery, develop free of charge training programmes (average duration distance learning programmes) for social workers/referents who lack specialised higher education, possibly in partnership with a university, distinguishing between the programmes designed for persons with higher education (a postgraduate programme) and those for persons with secondary education (a vocational training programme). 28. To draw social workers to the most vulnerable communities, disadvantaged areas and isolated places (located far away from towns and difficult to access), analyse, within the MoLSJ and MoH, the possibility to develop an incentive system that would determine social workers with specialised studies to take up residence in rural areas.	Central – MoLSJ
		29. Develop working tools for ensuring an integrated delivery of social and community health care services. To this end, we recommend developing common working procedures for GDSACP and DPH at county level and for social workers and community health nurses at local level. 30. Use an integrated government budget planning of the minimum package of basic services for children, despite the fact that the package services pertain to social assistance, health care and educational policies managed by distinct ministries.	
		31. Hire a social worker to carry out fieldwork in every commune and, where the social worker involved in the UNICEF model was not ensured continuity of employment, ensure transfer of know-how from that social worker and from the SPAS staff involved in the model.	Local – Mayoralties

Findings	Conclusions	Recommendations	Level
2.2.4. County supervisors' input	29) The county supervisors' input was well regarded by the community workers. Nevertheless, for both local level and national level (UNICEF model coordinators), there were large differences of approach in the way the supervisors related to the SPAS and CHN activity, leading to different outcomes both in terms of service delivery and of SPAS capacity building.	32. Develop working methodologies for county supervisors to standardise their work and make it more dynamic. The summative evaluation reveals the need to have these methodologies place special focus on the supervisor selection process as well as on specific training, tools and resources to ensure their effective guidance of community workers.	Central – UNICEF
		33. Ensure human resources capacity building, including by organising further education and training courses for county supervisors to enhance their specialised skills in the area of community-based social and health services. In addition, if the model is scaled up at county or national level, the number of GDSACP and DPH specialised supervisors required to provide guidance to social workers and CHNs in delivering basic community services needs to be increased. 34. Strengthen county resource centre capacity to develop county-level multidisciplinary teams of specialists available to support and counsel SPAS community workers and to step in for direct input in the management of complex challenging cases.	County – DGASPC / DSP
2.3. Reducing pressure on the child care system			
2.3.1. Child-family separation risk definition and the "zero priority service" 2.3.3. Vulnerabilities of children in public care Proposed definitions of the child-family separation risk indicator	30) Judging from the GDSACP data for the 8 counties selected for the intervention and from the findings of the analysis carried out based on the Aurora data, the risk of child-family separation vulnerability which generates the "priority zero service" requires redefining. Existing information can support working hypotheses which need testing in other modelling projects.	35. The working hypotheses for defining the risk of child-family separation need verifying against databases larger than the ones available in the modelling project. Also, they need testing in another model, to generate a definition of the risk of child-family separation that would serve to promote "priority zero service" at national level as a standard service in the SPAS portfolio to ensure prevention of the actual separation and of the child entering public care.	Central – UNICEF
2.3.2. Entries into and exits from the child care system	31) The UNICEF model appears to increase rather than reduce the pressure on the system, since the increased focus on identifying and addressing vulnerable cases has made these 'visible'. However, case files are much better prepared and communication between the SPAS and the county deconcentrated and decentralised services is very good, which is why even if a larger number of children enter public care, the GDSACP workload related to cases from the intervention communities is somewhat smaller.	36. Assess the possibility for Aurora to include indicators for pressure on the health care system, such as the number of hospitalizations in the past 9 months (i.e. the period of time between the two uses of the Aurora questionnaire).	Central – UNICEF
		37. To assess the pressure on the child care and health care systems, improve data collection at GDSACP and DPH level. To this end, a tool similar to Aurora could be used for a complete and accurate diagnostic of the vulnerabilities of children in public care and of children at risk of child-family separation, given the effectiveness of Aurora in this respect. Also, we recommend looking into interconnecting the CMTIS, SAFIR and the databases resulting from the CHN reporting to enable an accurate assessment of the vulnerabilities of children in public care.	Central – MoLSJ
		38. Ensure analysis of the Aurora data on all children who ended up being separated from their family and were recorded in the model as well as those to be recorded in future model replication/scaling up projects.	County DGASPC / DSP
2.4. Model contribution to national strategic planning processes			
2.4.1. UNICEF cooperation with public central institutions involved in public policy-making	32) Even if a model scaling up is not yet envisaged as such, model good practices were nevertheless included in the strategic planning for combating poverty, social inclusion of the Roma, promoting child rights and health. The strategies that were adopted plan for building the SPAS capacity and developing social services focusing on identifying vulnerabilities and on prevention (as opposed to last minute intervention and cash benefits). Also, as a result of the model implementation, combating violence against children was given higher priority, relevant strategic documents included the concept of "minimum package of social services", and the work of the community health nurses was promoted, in conjunction with that of the social workers involved in delivering the preventive services designed and provided within the model.	**See recommendations 6, 7 and 8**	

Findings	Conclusions	Recommendations	Level
3. EFFICIENCY			
3.1. Efficiency of resource use			
3.1.1. Analysis of model implementation costs 3.1.2. Benchmarking model implementation costs against other	33) To model a sustainable intervention in those communities in which the project was implemented and replicate it in similar communities, the model operating costs were deliberately maintained low, so as to match the local budget capacity. If we consider the costs for 2014 only (the biggest in the project as they covered equipment and training) and the overall number of children recorded in the Aurora database (5,178), we find that, on average, about 350 lei/child beneficiary were budgeted and a little over 220 lei/child were spent per year. However, the model was not just about identifying the children and providing them with services. Compared to the cost standards for social services set out in GD 978/2015 and to the ESF projects funded in Romania, the model approach based on delivery of a minimum package of services and on micro-grant projects implemented by the SPAS community workers proved highly efficient, as the costs per beneficiary per year were even 100 times lower in the preventive model versus the reactive social services.	**See recommendations 6, 7 and 8**	
3.2. Costs of implementing the approach based on the minimum package of social services at national level			
3.2.1. Model scaling-up scenarios 3.2.2. Budgetary implications of model scaling up	34) Given that the model was designed efficiently from the start and did not involve costs which local public authorities could not include in their budgets, the costs of scaling up the model at national level can be covered by the state budget. Should the model be extended nationwide, the impact on the general consolidated budget would be nearly 300 million lei for implementation in both rural and urban areas of both social and community health care services. A limited part of these funds could be ensured from external sources such as the European Social Fund (via POCU), the World Bank, Norway and EEA Grants etc., in an initial scale up phase covering only communities rated at high social risk. However, a full nationwide scale up can only be supported from the general consolidated budget, but such support is less than 1 percent of the current MoLSJ budget.	39. For the purpose of funding the model scale up, relevant central authorities should consider the possibility of reviewing and/or adapting the guidelines and evaluation grids for projects (ESF and other national or international funding sources) involving the development of community-based services so as to enable the type of activities proposed by the model for delivery of the minimum package of services, granting thus real priority to preventive social services which demonstrated their efficiency over that of the reactive services.	Central – MoLSJ, MoRDPAEF
		40. Taking into account the recommendations already formulated, to scale up the model and accurately calculate its budgetary impact, the model should be piloted in more counties and in more formulas to allow for determining its added value (in terms of effectiveness and addressing beneficiaries' vulnerabilities) relative to the public investment/expense, such as: – hiring one versus hiring more community workers to carry out fieldwork for vulnerable families, – extending the model to include a school counselling component, – increasing counselling activities and workshops conducted by community centres, – developing a dedicated infrastructure (well-furnished community centres and day centres), – increasing the development of resource centres at county level and hiring specialists (e.g. psychologists) to carry out activities that specifically target supporting the SPAS, – providing detailed standards for costs and activities using the Aurora or minimum standards and a large degree of leeway for community workers to adapt to special cases.	Central – MoLSJ
3.3. Efficiency of the minimum package of social services			
3.3.1. Recipients of both services and social benefits versus recipients of social benefits only	35) A simple comparison between the model average cost/beneficiary and all types of social benefits shows a lower cost for the basic services included in the minimum package versus the social benefits. Nevertheless, in the absence of conclusive statistical data enabling a comparison not only of the costs but also of the worth of social benefits relative to that of the preventive services, our interviews show that the minimum package of services is efficient, though not to replace social benefits but increase their effectiveness and efficacy with minimal added costs.	**See recommendation 5**	

Findings	Conclusions	Recommendations	Level
4. SUSTAINABILITY			
4.1. Chances of continuing the model implementation			
4.1.1. Assessment of the local environment at end of model implementation 4.1.2. Capacity to continue service delivery	36) As the model efficiency analysis also shows, the costs associated with implementing the model in each commune are quite low, which allows for continuing the implementation. Community engagement, use of a standardised case management tool (Aurora) and teamwork created an enabling environment for continuing the intervention. 37) However, not all social workers involved in the implementation of the UNICEF model remained with the SPAS, and, as a result, continuity of knowledge and competencies accrued within the model was not ensured. SPAS staff capacity still needs building, by hiring additional social workers to focus on fieldwork and by training all community workers so as to ensure optimal model implementation.	**See recommendations 6, 7, 8 and 40**	
4.2. Sustainability of model outcomes for children, families and public social assistance services			
4.2.1. Assessing the motivation to continue implementing the project	38) According to the local, county and national level interviewees, the positive outcomes reducing children's vulnerabilities are unlikely to continue once the minimum package of services ceases to be delivered, given that multiple and complex vulnerabilities can be effectively addressed only through long-term interventions, and the preventive service delivery carried out for 4 years (2012–2015), with more planning and intensity during 2014–2015 thanks to the Aurora working methodology, will not suffice. 39) In light of this, sustainability of results depends on activity continuity. Both project staff and key community stakeholders show motivation to continue delivery of the minimum package of services, while service beneficiaries are responsive. Still, the extent of initiative among the social workers is small and only around half the mayoralties in the intervention communes show convincing commitment to support continuation of the model activities, hiring social workers and actively fostering their fieldwork.	**See recommendations 2, 10, 15, 21, 24 and 31**	
4.3. Potential for model replication			
4.3.1. Replication level 4.3.2. Replication environment	40) Model scaling up is feasible at all levels (local, county and national), however, for a viable nationwide model, the current model still requires piloting on a larger scale at local and county level. Such extended piloting already in progress, in Bacău county, also undertaken by UNICEF, can serve to provide further input and significantly contribute to practical evidence-base knowledge of the replication environment.	41. A successful scale up strategy requires enhanced cooperation between UNICEF and the MoLSJ/NAPCRA and piloting of the model in various formulas for comparison purposes, while considering different intervention options that would address several social assistance and child care system gaps.	Central – UNICEF
5. IMPACT			
5.1. Impact on vulnerable children and their families			
5.1.1. Children are 'visible' to the community 5.1.2. Increasing access to health care 5.1.3. Increasing access to education 5.1.4. Protecting children against child-family separation 5.1.5. Protecting children against all forms of violence, abuse or neglect 5.1.6. Informing adolescents about risk behaviours	41) "First Priority: No More 'Invisible' Children!" generated considerable impact on its target group in terms of ensuring vulnerability identification, access to social services, including specialised services for children with disabilities, and access to community health care. 42) The model proved having had impact regarding access to primary health care (particularly vaccination) and reduced risk behaviours and situations of child abuse, violence or neglect only relative to data recorded previously in the communities it covered, but not when compared to the control group. At the same time, available data do not allow for assessing impact in terms of protecting children against child-family separation, as the number of cases that required intervention via "priority zero service" and those regarding children listed with the Aurora and having entered public care is insufficient for an impact analysis. Available data confirm the finding that cases of complex and severe vulnerabilities require long-term interventions, early preventive actions and linkages between the basic services delivered via the model and specialised services available and accessible to vulnerable children and persons living in rural areas, sometimes hundreds of kilometers away from the county capital towns. 43) Even where some vulnerabilities persisted, the moral support received by individuals/parents and children who otherwise felt lonely and insecure was a factor that improved quality of life and could have long-term impact.	42. Provide a mapping of the specialised services available in each county, in a digital format that can be updated according to service availability, to help social workers stay informed and allow for monitoring the availability of specialised services and developing them where they are needed. This "map" of specialised services could be included in the Aurora as a source of information for social workers and community health nurses who deal with referral and accompaniment services. Enabling each SPAS to automatically view the services available at county level for each service plan generated, by geographic distance and other criteria, can only increase the Aurora utility. **See also recommendations 11, 13, 16, 18, 19, 20**	Central – UNICEF

Findings	Conclusions	Recommendations	Level
5.2. Impact on SPAS and other responsible institutions			
5.2.1. Building SPAS capacity 5.2.2. Model impact through community-based actions 5.2.3. Informing the target audience	44) The model generated the planned impact, building capacity to deliver social services, determining an increase of the interinstitutional cooperation in support of social services and a moderate increase of the population information level about children's rights and their families' rights and obligations. 45) However, two limitations are to be noted: 1. the identified impact is not sustainable in all cases, as not all the social workers hired by UNICEF remained with the SPAS, while the community support centres are dependent on funding, as they did not generate any sustainable voluntary structures; 2. recruitment of a CHN in communities lacking community health care failed and capacity for community health care service delivery by a specialist was not created.	**See recommendations 9, 12, 14, 17, 25, 27–30, 32–34**	
5.3. Increasing the impact of national social assistance and child protection policies			
5.3.1. Research-generated data	46) The model generated impact also by offsetting certain national policy gaps and by driving institutional cooperation otherwise very limited prior to 2011. At national level, though the UNICEF actions were highly effective in promoting the inclusion of model tested tools in public policies, sufficient information to analyse the effectiveness and impact of these policies was as yet unavailable in the first semester of 2017. The findings of the present summative evaluation can serve to anticipate the increase of the national policy impact should the model be replicated or if at least the elements currently included in the national strategies and regulatory documents would be implemented.	**See recommendations 6, 7 and 40**	

Annex 7 – Sample structure used in the survey conducted in intervention and control communities

Intervention Group Sample				
No.	**County**	**Commune**	**Village**	**Sample**
2	Bacău	Colonești	Colonești	5
5	Bacău	Colonești	Valea Mare	4
7	Bacău	Corbasca	Băcioiu	6
8	Bacău	Corbasca	Corbasca	5
13	Bacău	Gura Văii	Gura Văii	15
16	Bacău	Gura Văii	Temelia	8
17	Bacău	Răchitoasa	Barcana	6
29	Bacău	Răchitoasa	Răchitoasa	8
31	Botoșani	Albești	Albești	7
36	Botoșani	Albești	Tudor Vladimirescu	8
38	Botoșani	Copălău	Copălău	10
40	Botoșani	Tudora	Tudora	10
41	Botoșani	Vorona	Icușeni	5
44	Botoșani	Vorona	Vorona	5
49	Buzău	Bisoca	Lacurile	7
53	Buzău	Bisoca	Sările	10
55	Buzău	Calvini	Bâscenii de Jos	9
57	Buzău	Calvini	Calvini	20
64	Buzău	Merei	Merei	3
66	Buzău	Merei	Ogrăzile	7
72	Buzău	Viperești	Tronari	8
74	Buzău	Viperești	Viperești	14
75	Iași	Ceplenița	Buhalnița	5
76	Iași	Ceplenița	Ceplenița	10
80	Iași	Dolhești	Dolhești	3
81	Iași	Dolhești	Pietriș	14
82	Iași	Mironeasa	Mironeasa	10
83	Iași	Mironeasa	Urșița	4
86	Iași	Vânători	Hârtoape	6
87	Iași	Vânători	Vânători	8
91	Neamț	Bahna	Izvoare	10
93	Neamț	Boghicea	Boghicea	3
95	Neamț	Boghicea	Nistria	7
98	Neamț	Români	Români	9
100	Neamț	Săbăoani	Săbăoani	10
102	Suceava	Bogdănești	Bogdănești	9
103	Suceava	Dornești	Dornești	10
106	Suceava	Izvoarele Sucevei	Izvoarele Sucevei	8
107	Suceava	Valea Moldovei	Mironu	7
108	Suceava	Valea Moldovei	Valea Moldovei	3
110	Vaslui	Coroiești	Coroiești	25
112	Vaslui	Coroiești	Hreasca	15
117	Vaslui	Dragomirești	Doagele	6
118	Vaslui	Dragomirești	Dragomirești	5
123	Vaslui	Griviță	Griviță	8

Intervention Group Sample				
No.	**County**	**Commune**	**Village**	**Sample**
124	Vaslui	Griviţa	Odaia Bursucani	6
128	Vaslui	Tăcuta	Focşeasca	6
132	Vaslui	Tăcuta	Tăcuta	3
133	Vrancea	Popeşti	Popeşti	9
137	Vrancea	Sihlea	Sihlea	9
141	Vrancea	Slobozia Bradului	Lieşti	5
143	Vrancea	Slobozia Bradului	Slobozia Bradului	6
146	Vrancea	Vîrteşcoiu	Faraoanele	5
150	Vrancea	Vîrteşcoiu	Vîrteşcoiu	4
Total				**428**

Control Group Sample				
No.	**County**	**Commune**	**Village**	**Sample**
2	Bacău	Ungureni	Ungureni	5
5	Bacău	Ungureni	Bibireşti	4
7	Bacău	Berzunţi	Berzunţi	6
8	Bacău	Berzunţi	Dragomir	5
13	Bacău	Blăgeşti	Blăgeşti	15
16	Bacău	Blăgeşti	Buda	8
17	Bacău	Stănişeşti	Stănişeşti	6
29	Bacău	Stănişeşti	Crăieşti	8
31	Botoşani	Călăraşi	Pleşani	7
36	Botoşani	Călăraşi	Călăraşi	8
38	Botoşani	Răuseni	Răuseni	10
40	Botoşani	Todireni	Todireni	10
41	Botoşani	Hlipiceni	Hlipiceni	5
44	Botoşani	Hlipiceni	Victoria	5
49	Buzău	Brădeanu	Brădeanu	7
53	Buzău	Brădeanu	Smârdan	10
55	Buzău	Cătina	Cătina	9
57	Buzău	Cătina	Corbu	20
64	Buzău	Vadu Paşii	Vadu Paşii	3
66	Buzău	Vadu Paşii	Scurteşti	7
72	Buzău	Costeşti	Costeşti	8
74	Buzău	Costeşti	Pietrosu	14
75	Iaşi	Focuri	Focuri	15
76	Iaşi			
80	Iaşi	Cozmeşti	Cozmeşti	3
81	Iaşi	Cozmeşti	Podolenii de Sus	14
82	Iaşi	Aroneanu	Aroneanu	10
83	Iaşi	Aroneanu	Dorobanţ	4
86	Iaşi	Coarnele Caprei	Arama	6
87	Iaşi	Coarnele Caprei	Coarnele Caprei	8
91	Neamţ	Bâra	Bâra	10
93	Neamţ	Dragomireşti	Hlăpeşti	3
95	Neamţ	Dragomireşti	Vad	7

Control Group Sample				
No.	**County**	**Commune**	**Village**	**Sample**
98	Neamț	Oniceni	Solca	9
100	Neamț	Tămășeni	Tămășeni	10
102	Suceava	Pătrăuți	Pătrăuți	9
103	Suceava	Băcești	Băcești	10
106	Suceava	Vulturești	Valea Glodului	8
107	Suceava	Râșca	Râșca	7
108	Suceava	Râșca	Buda	3
110	Vaslui	Cozmești	Bălești	25
112	Vaslui	Cozmești	Fâstâci	15
117	Vaslui	Ivănești	Ivănești	6
118	Vaslui	Ivănești	Broșteni	5
123	Vaslui	Băcești	Băcești	8
124	Vaslui	Băcești	Băbușa	6
128	Vaslui	Puiești	Puiești	6
132	Vaslui	Puiești	Ruși	3
133	Vrancea	Movilița	Movilița	9
137	Vrancea	Cîrligele	Cîrligele	9
141	Vrancea	Gugești	Gugești	5
143	Vrancea	Gugești	Oreavu	6
146	Vrancea	Jariștea	Jariștea	5
150	Vrancea	Jariștea	Vărsătura	4
Total				**428**

Resulting sample

Intervention Group Sample			
County	**Commune**	**Număr propus de chestionare ?????????**	**Număr realizat de chestionare ?????????**
Bacău	Colonești	9	9
	Corbasca	11	11
	Gura Văii	23	23
	Răchitoasa	14	14
Botoșani	Albești	15	15
	Copălău	10	10
	Tudora	10	10
	Vorona	10	10
Buzău	Bisoca	17	17
	Calvini	29	29
	Merei	10	10
	Viperești	22	22
Iași	Ceplenița	15	14
	Dolhești	17	18
	Mironeasa	14	14
	Vânători	15	14
Neamț	Bahna	10	10
	Boghicea	10	10
	Români	9	9
	Săbăoani	10	10

Suceava	Bogdănești	9	9
	Dornești	10	10
	Izvoarele Sucevei	8	8
	Valea Moldovei	10	10
Vaslui	Coroiești	40	40
	Dragomirești	11	11
	Grivița	14	14
	Tăcuta	9	9
Vrancea	Popești	9	9
	Sihlea	9	9
	Slobozia Bradului	11	11
	Vîrteșcoiu	9	9
	Total	**429**	**428**

Control Group Sample			
County	**Commune**	**Număr propus de chestionare ?????????**	**Număr realizat de chestionare ?????????**
Bacău	Berzunți	11	11
	Blăgești	23	23
	Stănișești	14	14
	Ungureni	9	9
Botoșani	Călărași	15	10
	Hlipiceni	10	7
	Răuseni	10	8
	Todireni	10	10
Buzău	Brădeanu	17	17
	Cătina	29	29
	Costești	22	22
	Vadu Pașii	10	10
Iași	Aroneanu	14	11
	Coarnele Caprei	14	13
	Cozmești	17	17
	Focuri	15	15
Neamț	Bâra	10	10
	Dragomirești	10	10
	Oniceni	8	9
	Tămășeni	10	10
Suceava	Brodina	10	10
	Pătrăuți	9	10
	Râșca	10	10
	Vulturești	8	8
Vaslui	Băcești	8	14
	Cozmești	40	40
	Ivănești	10	11
	Puiești	10	9
Vrancea	Cîrligele	9	9
	Gugești	11	11
	Jariștea	9	9
	Movilița	9	9
	Total	**421**	**415**

Annex 8 – List of interviewees

Persons interviewed at national level

No.	First name/Last name	Institution
1	Viorica Ștefănescu	UNICEF
2	Voichița Tomuș	UNICEF
3	Alexandra Grigorescu-Boțan	UNICEF
4	Elena Dobre	MoLFSPE
5	Elena Tudor	NAPCRA
6	Lidia Onofrei	MoH
7	Dana Fărcășanu	CPSS
8	Patricia Mihăescu	PSI
9	Andrei Popescu	MoYS
10	Manuela Stănculescu	CERME

Persons interviewed in Bacău county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
SUPERVISORS				
1	Boghiu Simona	Bacău	GDSACP Head of Office	07.10.2016
2	Roșculeț Carmen	Bacău	DPH Head of Office	07.10.2016
SW/HW				
3	Tăbăcaru Constantin	Corbasca	Social referent	18.10.2016
4	Bădilescu Gabriela	Răchitoasa	Social worker	18.01.2016
5	Cristea Florin	Colonești	Social worker	21.10.2016
6	Cioclu Maria	Gura Văii	CHN	11.11.2016
7	Rusu Mariana	Găiceana	Social referent	21.11.2016
8	Chifane Elena	Parava	Mayoralty Secretary	21.11.2016
PARENTS				
9	Bița Maricica	Colonești	Parent	26.10.2106
10	Trifan Maria	Gura Văii	Parent	31.10.2106
FOCUS GROUP				
11	Brandiu Ionel	Colonești	Secretary	02.11.2016
12	Bojescu Vasile	Colonești	Local councillor	02.11.2016
13	Dănăilă Natalia	Colonești	Social worker (UNICEF)	02.11.2016
14	Dumbravă Alina	Colonești	Teacher	02.11.2016
15	Cristea Florin	Colonești	Social worker	02.11.2016
16	Marzac Iancu	Colonești	Mayor	02.11.2016
WORKSHOP				
17	Sion Elena Costinela	Colonești	Pupil	09.11.2016
18	Burghelea Maria	Colonești	Pupil	09.11.2016
19	Burghelea Sabin	Colonești	Pupil	09.11.2016
20	Ilasca Mihai	Colonești	Pupil	09.11.2016
21	Sion Vasile Florin	Colonești	Pupil	09.11.2016
22	Buiacu Alin	Colonești	Pupil	09.11.2016

Persons interviewed in Botoșani county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Radu Lăcrămioara	Botoșani	GDSACP Head of Office	25.10.2016
2	Hliban Carmen	Botoșani	DPH Head of Office	18.10.2016
		SW/HW		
3	Sauciuc Ionela	Copălău	Social worker	20.10.2016
4	Ivanov Roxana	Copălău	Social worker	20.10.2016
5	Catană Geanina	Vorona	Social worker	20.10.2016
6	Șmadici Corina	Vorona	CHN	18.10.2016
7	Vatavu Simona	Tudora	Daycare centre Director	25.10.2016
8	Raicu Gabriela	Tudora	CHN	18.10.2016
9	Luchian Mihaela	Călărași	Social referent	27.10.2016
10	Galanton Corina	Șendriceni	Daycare centre Director	27.10.2016
11	Sârbu Camelia	Albești	Social worker	27.10.2016
				PĂRINȚI
12	Argintaru Ioan	Tudora	Parent	25.10.2016
		FOCUS GROUP		
13	Vatavu Simona	Tudora	Daycare centre Director	25.10.2016
14	Raicu Gabriela	Tudora	CHN	18.10.2016
15	Niță Elena	Tudora	Social worker	26.10.2016
16	Mîrzan Maria	Tudora	CHN	26.10.2016
17	Liuțe Gheorghița	Tudora	Teacher librarian	26.10.2016
		WORKSHOP		
18	Aedin Nicușor	Tudora	Pupil	26.10.2016
19	Mihalăchiuțe Elena	Tudora	Pupil	26.10.2016
20	Moraru Raluca	Tudora	Pupil	26.10.2016
21	Chelariu Iuliana	Tudora	Pupil	26.10.2016
22	Poteraș Andrei	Tudora	Pupil	26.10.2016
23	Argintaru Marius	Tudora	Pupil	26.10.2016
24	Bunduc Sebastian	Tudora	Pupil	26.10.2016
25	Argintaru Dumitru	Tudora	Pupil	26.10.2016

Persons interviewed in Buzău county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Pîrvu Ciprian	Buzău	GDSACP Head of Office	17.10.2016
2	Apostol Camelia	Buzău	DPH	10.17.2016
		SW/HW		
3	Dragomir Tatiana	Calvini	Social worker	17.10.2016
4	Toncu Elena Alina	Calvini	Community health nurse	17.10.2016
5	Popescu Claudiu	Merei	Social worker	25.10.2016
6	Negoiță (Cosma) Isabela	Vipereşti	Community health nurse	17.10.2016
7	Bumbu Simona	Pietroasele	Social worker	26.10.2016
8	Constantin Marilena	Vernești	Social worker	25.10.2016
9	Baețelu Beşliu Marius	Bisoca	Social worker	30.10.2016
		PARENTS		
10	Codreanu Violeta	Bisoca	Parent	20.10.2016
11	Cobzaru Rodica	Bisoca	Parent	20.10.2016
		FOCUS GROUP		
12	Roșca Ionel	Bisoca	Priest	30.10.2016
13	Șerbănoiu Viorel	Bisoca	Prof., Head Teacher	30.10.2016
14	Șerbănoiu Săndica	Bisoca	Community health nurse	30.10.2016
15	Dobroiu Georgeta	Bisoca	Specialised educator	30.10.2016
16	Harpes Gina	Bisoca	Community health nurse	30.10.2016
17	Băețelu Beşliu Marius	Bisoca	Social worker	30.10.2016
		WORKSHOP		
18	Baltag Georgiana	Bisoca	Pupil	30.10.2016
19	Băjenac Daniela	Bisoca	Pupil	30.10.2016
20	Băețelu Mioara	Bisoca	Pupil	30.10.2016
21	Cobzaru Gabriel	Bisoca	Pupil	30.10.2016
22	Codreanu Ninel	Bisoca	Pupil	30.10.2016
23	Codreanu Mădălina	Bisoca	Pupil	30.10.2016
24	Pascoci Petruța	Bisoca	Pupil	30.10.2016
25	Turea Valentin	Bisoca	Pupil	30.10.2016

Persons interviewed in Iași county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Însurăţelu Iuliana	Iași	GDSACP Head of Office	17.10.2016
2	Mardare Daniel	Iași	DPH	17.11.2016
		SW/HW		
3	Marcu Ana	Dolhești	Rural land register officer	19.10.2016
4	Barău Gheorghiță	Ceplenița	Head of emergency volunteer service	19.10.2016
5	Dumitrache (Tudose) Liliana	Mironeasa	Social worker on maternity leave	21.10.2016
6	Câmpeanu Georgel	Mironeasa	Community health nurse	21.10.2016
7	Spulber Luminița	Țibănești	Librarian	10.19.2016
8	Pleșca Ana	Lespezi	Referent with social assistance duties	21.10.2016
9	Dumitriu Crenguța	Vânători	Outreach worker, not employed at the time of the interview	20.10.2016
10	Apintilesei Cristina	Vânători	Community health nurse	
		PARENTS		
11	Baba Nicoleta	Vânători	Parent/housewife	20.10.2016
		FOCUS GROUP		
12	Kui Arpad	Vânători	Teacher/mayoralty adviser	23.11.2016
13	Lupu Gheorghe	Vânători	Accountant/mayoralty adviser	23.11.2016
		WORKSHOP		
14	Baba Alexandru Ilie	Vânători	Pupil	23.11.2016
15	Ailenei Florin Vasilică	Vânători	Pupil	23.11.2016
16	Petrescu Anghel	Vânători	Pupil	23.11.2016
17	Palote Alexandru Pavel	Vânători	Pupil	23.11.2016
18	Chibac Ionuț	Vânători	Pupil	23.11.2016
19	Drugă Grigore Gheorghe	Vânători	Pupil	23.11.2016
20	Ignat Bianca	Vânători	Pupil	23.11.2016
21	Ignat Rareș	Vânători	Pupil	23.11.2016
22	Chibac Cosmina	Vânători	Pupil	23.11.2016
23	Baba Alexandru Ilie	Vânători	Pupil	23.11.2016
24	Ailenei Florin Vasilică	Vânători	Pupil	23.11.2016

Persons interviewed in Neamț county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Mazniuc Victoria	Piatra Neamț	GDSACP Head of Office	17.10.2016
2	Nictor Cristina	Piatra Neamț	DPH	17.10.2016
3	Marcoci Daniela	Piatra Neamț	DPH Director	17.10.2016
		SW/HW		
4	Neghină Maria	Bahna	Community health nurse	19.10.2016
5	Stafie Emilia	Boghicea	Retiree	19.10.2016
6	Segneanu Daniela	Boghicea	Librarian	19.10.2016
7	Lucaci Cecilia	Săbăoani	Inspector	19.10.2016
8	Pintilii Carmen	Români	Head of Office	20.10.2016
9	Asinionesei Ana	Români	Community health nurse	20.10.2016
10	Olariu Vasile	Brusturi	Teacher (first 4 grades)	28.10.2016
11	Marinela Ancuța	Valea Ursului	Head of Parliamentary Office	28.10.2016
		PARENTS		
12	Toma Viorica	Români	Parent	26.10.2016
13	Linguraru Vasilica	Români	Parent	26.10.2016
		FOCUS GROUP		
14	Adrian Maria	Români	Local councillor/retiree	28.10.2016
15	Aldea Mihaela	Români	Head Teacher	28.10.2016
16	Domnica Vasile	Români	Public administrator	28.10.2016
17	Trofin C-Tin Romeo	Români	Deputy Mayor	28.10.2016
18	Ciobanu Manole	Români	Mayor	28.10.2016
19	Cojocaru Petru	Români	Retiree	28.10.2016
20	Andrian Octavian	Români	Retiree	28.10.2016
21	Ursache Gheorghe	Români-Goșmani	Goșmani Parish Priest	28.10.2016
22	Purcariu Ioan George	Români-Siliștea	Siliștea Parish Priest	28.10.2016
		WORKSHOP		
23	Toma Edi Marian	Români	Pupil	26.10.2016
24	Toma Dumitrita	Români	Pupil	26.10.2016
25	Linguraru Gabriel	Români	Pupil	26.10.2016
26	Linguraru Petru Mihai	Români	Pupil	26.10.2016
27	Bontaș Mihaela	Români	Pupil	26.10.2016
28	Bontaș Marius	Români	Pupil	26.10.2016
29	Zadavă Loredana	Români	Pupil	26.10.2016
30	Matel Vasilica Ionela	Români	Pupil	26.10.2016

Persons interviewed in Suceava county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Tărnăuceanu Florin	Suceava	GDSACP Head of Office	13.10.2016
2	Zorescu Cătălina	Suceava	DPH Deputy Director	13.10.2016
		SW/HW		
3	Antonovici Dalina	Dornești	No occupation	24.10.2016
4	Pîrvu Anastazia	Izvoarele Sucevei	Elderly care centre Administrator	17.10.2016
5	Popiuc Luminița	Moldova-Sulița	On maternity leave	17.10.2016
6	Plămadă Radu	Ulma	Family physician practice Administrator	21.10.2016
7	Țăranu Cristina	Bogdănești	Nurse	14.10.2016
8	Ivanovici Mihaela	Valea Moldovei	Community health nurse – on maternity leave	01.11.2016
		PARENTS		
9	Mucileanu Adriana	Bogdănești	Parent (housewife)	14.10.2016
10	Marcu Cătălina Eufrosina	Dornești	Parent (housewife)	24.10.2016
11	Anchediu Lăcrămioara	Dornești	Parent (housewife)	24.10.2016
		FOCUS GROUP		
12	Antonovici Dalina	Dornești	Former social worker	28.10.2016
13	Popovici Mihaela	Dornești	Inspector (social worker)	28.10.2016
14	Dumitrescu Lăcrămioara	Dornești	Librarian	28.10.2016
		WORKSHOP		
15	Paslariu Cristina	Dornești	Pupil	28.10.2016
16	Olar Andrei Valenitin	Dornești	Pupil	28.10.2016
17	Hojda Tabita Alexandra	Dornești	Pupil	28.10.2016
18	Hojda Nicoleta Brandusa	Dornești	Pupil	28.10.2016
19	Marcu Alexandra	Dornești	Pupil	28.10.2016
20	Anchidin Mădălina Nadia	Dornești	Pupil	28.10.2016
21	Zlotar Florin	Dornești	Pupil	28.10.2016
22	Zlotar Anamaria Rebeca	Dornești	Pupil	28.10.2016

Persons interviewed in Vaslui county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Băbăscu Anca	Vaslui	GDSACP Head of Office	11.10.2016
		SW/HW		
2	Neamțu Teodora	Dragomirești	Social worker	20.10.2016
3	Lungu Gabriela	Coroiești	Social worker	17.10.2016
4	Alexa Cornelia	Tăcuta	Social worker	02.11.2016
5	Pascal Carmen	TBD – Gherești	Social worker	15.11.2016
6	Arteni Mariana	TBD – Fereşti	Librarian	16.11.2016
7	Silvestru Gina	Grivița	Nurse	18.10.2016
8	Brebine Viorica	Coroiești	Community health nurse	25.10.2016
9	Gherghescu Vasilică	Chetrosu	Teacher	15.11.2016
		PARENTS		
10	Călin Maricica	Coroiești	Parent, Personal assistant	25.10.2016
11	Lupu Lenuța	Coroiești	Parent	25.10.2016
		FOCUS GROUP		
12	Onofrei Dorin	Coroiești	Ocupația	27.10.2016
13	Dumitrașcu Daniela	Coroiești	Chief of police	27.10.2016
14	Zanet Rodica	Coroiești	Teacher	27.10.2016
15	Brebine Viorica	Coroiești	Cadastral engineer	27.10.2016
16	Gîlea Lenuța	Coroiești	Community health nurse	27.10.2016
17	Stan Elisabeta	Coroiești	Social worker	27.10.2016
18	Grigoraș Elena	Coroiești	Teacher	27.10.2016
19	Alexandru Andreia	Coroiești	Nurse	27.10.2016
20	Dudău Corneliu	Coroiești	Teacher (first 4 grades)	27.10.2016
21	Oprișan Maria	Coroiești	Family physician	27.10.2016
22	Filimon Elda	Coroiești	Accountant	27.10.2016
23	Lungu Gabriela	Coroiești	Teacher	27.10.2016
		WORKSHOP		
24	Bradea Carmen Mădălina	Coroiești	Pupil	25.10.2016
25	Ceapă Mihaela Mădălina	Coroiești	Pupil	25.10.2016
26	Chiru Andreea Silvia	Coroiești	Pupil	25.10.2016
27	Enache Denisa Georgiana	Coroiești	Pupil	25.10.2016
28	Grumeza Ana-Maria	Coroiești	Pupil	25.10.2016
29	Iorgu Denisa Maria	Coroiești	Pupil	25.10.2016
30	Stan Lavinia Alexandra	Coroiești	Pupil	25.10.2016
31	Tudor Andra Ștefania	Coroiești	Pupil	25.10.2016

Persons interviewed in Vrancea county

No.	Last name/first name	Community	Occupation/capacity	Date of interview
		SUPERVISORS		
1	Ivanciu Simona	Focșani	GDSACP Head of Office	17.10.2016
2	Draguna Cornelia	Focșani	DPH	17.11.2016
		SW/HW		
3	Paun Mariana	Sihlea	Social worker	19.10.2016
4	Bălaj Dumitru	Sihlea	Community health nurse	19.10.2016
5	Bratosin Diana	Popești	Social worker	21.10.2016
6	Manole Mentuta	Vîrteșcoiu	Social worker	21.10.2016
7	Duta Daniela	Dumbrăveni	Social worker	10.19.2016
8	Goia Georgiana	Milcovu	Social worker	21.10.2016
9	Grigore Anamaria	Slobozia Bradului	Social worker	20.10.2016
10	Antohe Alina	Slobozia Bradului	Community health nurse	
		PARENTS		
11	Ciobotaru Vica	Slobozia Bradului	Parent	20.10.2016
		FOCUS GROUP		
12	Costache Voica	Slobozia Bradului	Head Teacher	20.10.2016
13	Socol Săndica	Slobozia Bradului	Mayoralty Secretary	20.10.2016
14	Răcoreanu Florina	Slobozia Bradului	Mayoralty Inspector	20.10.2016
15	Luca Florica	Slobozia Bradului	Community health nurse	20.10.2016
16	Micu Medișor	Slobozia Bradului	Deputy Mayor	20.10.2016
17	Grigore Anamaria	Slobozia Bradului	School nurse	20.10.2016
		WORKSHOP		
18	Romanescu Abel	Slobozia Bradului	Pupil	20.10.2016
19	Neculai Adrian Daniel	Slobozia Bradului	Pupil	20.10.2016
20	Neicu Andrei	Slobozia Bradului	Pupil	20.10.2016
21	Gutui Marius Mihai	Slobozia Bradului	Pupil	20.10.2016
22	Cernat Mirel	Slobozia Bradului	Pupil	20.10.2016
23	Tudorache Alexandra	Slobozia Bradului	Pupil	20.10.2016
24	Duia Cristina	Slobozia Bradului	Pupil	20.10.2016
25	Gheorghe Iosif Bogdanel	Slobozia Bradului	Pupil	20.10.2016
26	Ionescu Bogdanel	Slobozia Bradului	Pupil	20.10.2016
27	Argesanu Adi	Slobozia Bradului	Pupil	20.10.2016

Annex 9 – Evolution of the rate of vulnerabilities recorded in the Aurora database

Incidence of vulnerabilities recorded using the Aurora questionnaire, at T0 (2014) and T1 (2015)

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 0–17)	Row N %	Reporting basis (children aged 0–17)
Child living in poverty	Sex	Male	44%	2682	13%	1818
		Female	43%	2496	14%	1667
	Nationality	Romanian	41%	3857	14%	2621
		Roma	51%	1268	12%	863
		Other	49%	53	0%	1
		Total	44%	5178	13%	3485
Child living in a household in income (monetary) poverty	Sex	Male	42%	2682	12%	1818
		Female	41%	2496	13%	1667
	Nationality	Romanian	40%	3857	13%	2621
		Roma	45%	1268	9%	863
		Other	49%	53	0%	1
		Total	41%	5178	12%	3485
Child living in a household in extreme poverty	Sex	Male	5%	2682	1%	1818
		Female	4%	2496	1%	1667
	Nationality	Romanian	2%	3857	0%	2621
		Roma	12%	1268	3%	863
		Other	0%	53	0%	1
		Total	5%	5178	1%	3485
Child not registered with a family physician	Sex	Male	1%	2682	1%	1818
		Female	1%	2496	1%	1667
	Nationality	Romanian	1%	3857	1%	2621
		Roma	2%	1268	1%	863
		Other	0%	53	100%	1
		Total	1%	5178	1%	3485
Child with chronic disease or living in a household whose members have chronic diseases	Sex	Male	11%	2682	11%	1818
		Female	13%	2496	14%	1667
	Nationality	Romanian	13%	3857	15%	2621
		Roma	10%	1268	5%	863
		Other	4%	53	0%	1
		Total	12%	5178	12%	3485
Child with chronic disease	Sex	Male	2%	2682	3%	1818
		Female	2%	2496	2%	1667
	Nationality	Romanian	2%	3857	3%	2621
		Roma	1%	1268	1%	863
		Other	0%	53	0%	1
		Total	2%	5178	3%	3485
Child living in a household whose members have chronic diseases	Sex	Male	9%	2682	9%	1818
		Female	11%	2496	11%	1667
	Nationality	Romanian	10%	3857	12%	2621
		Roma	9%	1268	4%	863
		Other	4%	53	0%	1
		Total	10%	5178	10%	3485

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 0–17)	Row N %	Reporting basis (children aged 0–17)
Adolescent/child with risk behaviours	Sex	Male	30%	2682	17%	1818
		Female	25%	2496	13%	1667
	Nationality	Romanian	27%	3857	16%	2621
		Roma	30%	1268	14%	863
		Other	4%	53	0%	1
		Total	28%	5178	15%	3485
Child at risk of violent behaviour	Sex	Male	5%	2682	3%	1818
		Female	1%	2496	1%	1667
	Nationality	Romanian	4%	3857	2%	2621
		Roma	2%	1268	1%	863
		Other	0%	53	0%	1
		Total	3%	5178	2%	3485
Child living in a household prone to violent behaviour	Sex	Male	16%	2682	9%	1818
		Female	16%	2496	7%	1667
	Nationality	Romanian	16%	3857	8%	2621
		Roma	16%	1268	8%	863
		Other	2%	53	0%	1
		Total	16%	5178	8%	3485
Child living in a family prone to child violence, abuse or neglect	Sex	Male	47%	2682	32%	1818
		Female	42%	2496	29%	1667
	Nationality	Romanian	43%	3857	29%	2621
		Roma	52%	1268	34%	863
		Other	0%	53	0%	1
		Total	44%	5178	30%	3485
Child living in a family prone to child violence	Sex	Male	38%	2682	25%	1818
		Female	32%	2496	20%	1667
	Nationality	Romanian	33%	3857	20%	2621
		Roma	43%	1268	29%	863
		Other	0%	53	0%	1
		Total	35%	5178	22%	3485
Child living in a family prone to child neglect	Sex	Male	28%	2682	17%	1818
		Female	26%	2496	18%	1667
	Nationality	Romanian	24%	3857	16%	2621
		Roma	36%	1268	23%	863
		Other	0%	53	0%	1
		Total	27%	5178	18%	3485
Child living in precarious housing conditions	Sex	Male	78%	2682	72%	1818
		Female	75%	2496	72%	1667
	Nationality	Romanian	74%	3857	72%	2621
		Roma	84%	1268	70%	863
		Other	92%	53	0%	1
		Total	77%	5178	72%	3485
Child living in overcrowded house	Sex	Male	74%	2682	70%	1818
		Female	72%	2496	68%	1667
	Nationality	Romanian	70%	3857	70%	2621
		Roma	80%	1268	67%	863
		Other	92%	53	0%	1
		Total	73%	5178	69%	3485

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 0–17)	Row N %	Reporting basis (children aged 0–17)
Child living in unhealthy housing conditions	Sex	Male	29%	2682	22%	1818
		Female	28%	2496	22%	1667
	Nationality	Romanian	25%	3857	21%	2621
		Roma	42%	1268	25%	863
		Other	2%	53	0%	1
		Total	29%	5178	22%	3485
Child with no ID papers	Sex	Male	1%	2682	0,4%	1818
		Female	1%	2496	0,4%	1667
	Nationality	Romanian	1%	3857	0,4%	2621
		Roma	1%	1268	0,2%	863
		Other	0%	53	100%	1
		Total	1%	5178	0,4%	3485
Child with only one or no parent at home	Sex	Male	23%	2682	23%	1818
		Female	25%	2496	27%	1667
	Nationality	Romanian	26%	3857	27%	2621
		Roma	20%	1268	17%	863
		Other	19%	53	0%	1
		Total	24%	5178	25%	3485
Child with only one parent at home	Sex	Male	2682	16%	1818	1818
		Female	2496	16%	1667	1667
	Nationality	Romanian	3857	18%	2621	2621
		Roma	1268	9%	863	863
		Other	53	0%	1	1
		Total	5178	16%	3485	3485
Child with migrant parents	Sex	Male	5%	2682	6%	1818
		Female	6%	2496	7%	1667
	Nationality	Romanian	5%	3857	7%	2621
		Roma	5%	1268	4%	863
		Other	8%	53	0%	1
		Total	5%	5178	6%	3485
Child with no parents at home, but with an adult carer in the household	Sex	Male	3%	2682	3%	1818
		Female	6%	2496	5%	1667
	Nationality	Romanian	5%	3857	4%	2621
		Roma	5%	1268	5%	863
		Other	8%	53	0%	1
		Total	5%	5178	4%	3485

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 0–17)	Row N %	Reporting basis (children aged 0–17)
Child with migrant parents and with no parents at home, but with an adult carer in the household	Sex	Male	2%	2682	2%	1818
		Female	3%	2496	2%	1667
	Nationality	Romanian	2%	3857	2%	2621
		Roma	2%	1268	1%	863
		Other	6%	53	0%	1
		Total	2%	5178	2%	3485
Child with no adult carer in the household	Sex	Male	0%	2682	0%	1818
		Female	0%	2496	0,1%	1667
	Nationality	Romanian	0%	3857	0,0%	2621
		Roma	1%	1268	0,1%	863
		Other	0%	53	0%	1
		Total	0%	5178	0,1%	3485
Child with disabilities	Sex	Male	4%	2682	5%	1818
		Female	4%	2496	4%	1667
	Nationality	Romanian	5%	3857	5%	2621
		Roma	2%	1268	2%	863
		Other	8%	53	0%	1
		Total	4%	5178	4%	3485
Child separated from his/her family or at risk of being separated from their family	Sex	Male	8%	2682	8%	1818
		Female	9%	2496	10%	1667
	Nationality	Romanian	8%	3857	8%	2621
		Roma	9%	1268	13%	863
		Other	0%	53	0%	1
		Total	8%	5178	9%	3485
Child in placement centre or foster care in risky conditions	Sex	Male	1%	2682	0,5%	1818
		Female	0%	2496	0,1%	1667
	Nationality	Romanian	1%	3857	0,4%	2621
		Roma	0%	1268	0%	863
		Other	0%	53	0%	1
		Total	1%	5178	0,3%	3485
Child at risk of being separated from his/her family – who cumulates 7 or more vulnerabilities	Sex	Male	0%	2682	0,3%	1818
		Female	1%	2496	0,1%	1667
	Nationality	Romanian	0%	3857	0,2%	2621
		Roma	2%	1268	0,1%	863
		Other	0%	53	0%	1
		Total	1%	5178	0,2%	3485
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care	Sex	Male	5%	2682	6%	1818
		Female	7%	2496	8%	1667
	Nationality	Romanian	6%	3857	6%	2621
		Roma	6%	1268	10%	863
		Other	0%	53	0%	1
		Total	6%	5178	7%	3485
Child at risk of being separated from his/her family – whose mother has underage children in public care	Sex	Male	1%	2682	1%	1818
		Female	1%	2496	1%	1667
	Nationality	Romanian	1%	3857	1%	2621
		Roma	1%	1268	2%	863
		Other	0%	53	0%	1
		Total	1%	5178	1%	3485

Vulnerability			Incidende at T0		Incidende at T1	
			Row N %	Reporting basis (children under 1)	Row N %	Reporting basis (children under 1)
Child aged up to 1 year, in a situation of risk	Sex	Male	61%	185	41%	88
		Female	61%	137	44%	68
	Nationality	Romanian	65%	240	47%	115
		Roma	50%	80	28%	40
		Other	0%	2	100%	1
		Total	61%	322	42%	156
Child with low birth weight	Sex	Male	5%	185	6%	88
		Female	3%	137	9%	68
	Nationality	Romanian	4%	240	7%	115
		Roma	4%	80	8%	40
		Other	0%	2	0%	1
		Total	4%	322	7%	156
Child not vaccinated	Sex	Male	10%	185	11%	88
		Female	8%	137	12%	68
	Nationality	Romanian	8%	240	12%	115
		Roma	14%	80	8%	40
		Other	0%	2	100%	1
		Total	9%	322	12%	156
Child not getting vitamin D and iron	Sex	Male	14%	185	13%	88
		Female	13%	137	7%	68
	Nationality	Romanian	12%	240	13%	115
		Roma	19%	80	3%	40
		Other	0%	2	0%	1
		Total	14%	322	10%	156
Child under 6 months not exclusively breastfed	Sex	Male	23%	185	13%	88
		Female	25%	137	12%	68
	Nationality	Romanian	28%	240	12%	115
		Roma	14%	80	13%	40
		Other	0%	2	0%	1
		Total	24%	322	12%	156
Child over 6 months not receiving complementary feeding	Sex	Male	21%	185	14%	88
		Female	23%	137	16%	68
	Nationality	Romanian	22%	240	17%	115
		Roma	24%	80	10%	40
		Other	0%	2	0%	1
		Total	22%	322	15%	156
Child not meeting development standards	Sex	Male	14%	185	5%	88
		Female	13%	137	3%	68
	Nationality	Romanian	14%	240	5%	115
		Roma	12%	80	0%	40
		Other	0%	2	0%	1
		Total	14%	322	4%	156

Vulnerability			Incidende at T0		Incidende at T1	
			Row N %	Reporting basis (children aged 1–4)	Row N %	Reporting basis (children aged 1–4)
Child aged 1 to 5 years, in a situation of risk	Sex	Male	63%	552	45%	386
		Female	63%	478	46%	320
	Nationality	Romanian	60%	703	46%	480
		Roma	71%	317	42%	226
		Other	0%	10	0%	0
		Total	63%	1030	45%	706
Child not vaccinated	Sex	Male	6%	552	4%	386
		Female	8%	478	5%	320
	Nationality	Romanian	5%	703	3%	480
		Roma	11%	317	10%	226
		Other	0%	10	0%	0
		Total	7%	1030	5%	706
Child not getting vitamin D	Sex	Male	59%	552	41%	386
		Female	59%	478	44%	320
	Nationality	Romanian	56%	703	44%	480
		Roma	66%	317	39%	226
		Other	0%	10	0%	0
		Total	59%	1030	42%	706
Child not meeting development standards	Sex	Male	6%	552	3%	386
		Female	4%	478	1%	320
	Nationality	Romanian	6%	703	2%	480
		Roma	5%	317	3%	226
		Other	0%	10	0%	0
		Total	5%	1030	2%	706

Vulnerability			Incidende at T0		Incidende at T1	
			Row N %	Reporting basis (children aged 1–5)	Row N %	Reporting basis (children aged 1–5)
Preschool child not enrolled in kindergarten	Sex	Male	18%	690	17%	482
		Female	22%	626	15%	415
	Nationality	Romanian	13%	917	8%	608
		Roma	36%	387	34%	289
		Other	25%	12	0%	0
		Total	20%	1316	16%	897

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 6–15)	Row N %	Reporting basis (children aged 6–15)
Child aged 6 to 15 years, not enrolled in school	Sex	Male	1%	1579	1%	1091
		Female	1%	1468	1%	984
	Nationality	Romanian	0%	2316	1%	1621
		Roma	2%	698	2%	454
		Other	0%	33	0%	0
		Total	1%	3047	1%	2075
Child at risk of dropping out of school	Sex	Male	15%	1579	13%	1091
		Female	11%	1468	8%	984
	Nationality	Romanian	10%	2316	10%	1621
		Roma	22%	698	15%	454
		Other	0%	33	0%	0
		Total	13%	3047	11%	2075
Child with special educational needs, at risk of dropping out of school	Sex	Male	4%	1579	3%	1091
		Female	4%	1468	3%	984
	Nationality	Romanian	5%	2316	4%	1621
		Roma	3%	698	0%	454
		Other	0%	33	0%	0
		Total	4%	3047	3%	2075
Child who dropped out of school	Sex	Male	9%	1579	7%	1091
		Female	11%	1468	8%	984
	Nationality	Romanian	6%	2316	5%	1621
		Roma	21%	698	15%	454
		Other	18%	33	0%	0
			10%	3047	8%	2075

Vulnerability			Incidence at T0		Incidence at T1	
			Row N %	Reporting basis (children aged 10–17)	Row N %	Reporting basis (children aged 10–17)
Adolescent with risk behaviour in terms of healthy lifestyle (nutrition and physical activity)	Sex	Male	0,1%	1206	0%	835
		Female	0,2%	1213	%	817
	Nationality	Romanian	0,1%	1878	%	1320
		Roma	0,4%	516	0%	332
		Other	0%	25	0%	0
		Total	0,2%	2419	%	1652
Adolescent with risk behaviour in terms of sexual activity	Sex	Male	28%	1206	11%	835
		Female	21%	1213	10%	817
	Nationality	Romanian	22%	1878	10%	1320
		Roma	35%	516	13%	332
		Other	4%	25	0%	0
		Total	24%	2419	11%	1652
Pregnant adolescent girl or teenage mother	Sex	Male	NC		NC	
		Female	7%	1213	5%	817
	Nationality	Romanian	6%	943	3%	650
		Roma	10%	255	10%	167
		Other	0%	15	0%	0
		Total	7%	1213	5%	817
Adolescent with risk behaviour in terms of substance use	Sex	Male	8%	1206	6%	835
		Female	3%	1213	2%	817
	Nationality	Romanian	5%	1878	4%	1320
		Roma	9%	516	4%	332
		Other	0%	25	0%	0
		Total	5%	2419	4%	1652

Evolution of vulnerabilities recorded using the Aurora questionnaire, at T0 (2014) and T1 (2015)

Vulnerability	Persons assessed at both T0 and T1						
	Number of initial cases (at T0)	No longer present (listed at T0 only)		New (listed at T1)		Persistent (listed at T0 and T1)	
	N	N	%	N	%	N	%
Child living in poverty	1570	1242	79%	109	7%	328	21%
Child living in a household in income (monetary) poverty	1464	1163	79%	103	7%	301	21%
Child living in a household in extreme poverty	203	180	89%	15	7%	23	11%
Child not registered with a family physician	38	38	100%	20	53%	0	0%
Child not enrolled in school, who dropped out of school or is at risk of dropping out	798	406	51%	212	27%	392	49%
Child at risk of dropping out of school	299	177	59%	100	33%	122	41%
Child with special educational needs, at risk of dropping out of school	80	44	55%	23	29%	36	45%
Child who dropped out of school	201	116	58%	69	34%	85	42%
Adolescent/child with risk behaviours	992	642	65%	162	16%	350	35%
Adolescent with risk behaviour in terms of healthy life-style (nutrition and physical activity)	3	3	100%	1	33%	0	0%
Adolescent with risk behaviour in terms of sexual activity	372	291	78%	88	24%	81	22%
Adolescent with risk behaviour in terms of substance use	77	58	75%	46	60%	19	25%
Child at risk of violent behaviour	122	90	74%	30	25%	32	26%
Child living in a household prone to violent behaviour	587	408	70%	86	15%	179	30%
Child living in a family prone to child violence, abuse or neglect	1602	832	52%	240	15%	770	48%
Child living in a family prone to child violence	1296	801	62%	253	20%	495	38%
Child living in a family prone to child neglect	936	530	57%	174	19%	406	43%
Child living in precarious housing conditions	2845	668	23%	229	8%	2177	77%
Child living in overcrowded house	2720	649	24%	239	9%	2071	76%
Child living in unhealthy housing conditions	1032	570	55%	270	26%	462	45%
Child with no ID papers	19	16	84%	4	21%	3	16%
Child with only one or no parent at home	860	195	23%	179	21%	665	77%
Child with only one parent at home	625	158	25%	82	13%	467	75%
Child with migrant parents	133	45	34%	126	95%	88	66%
Child with no parents at home, but with an adult carer in the household	165	61	37%	32	19%	104	63%
Child with no adult carer in the household	2	2	100%	2	100%	0	0%
Child with disabilities	149	21	14%	23	15%	128	86%
Child separated from his/her family or at risk of being separated from their family	316	191	60%	171	54%	125	40%
Child in placement centre or foster care in risky conditions	20	14	70%	5	25%	6	30%
Child at risk of being separated from his/her family – who cumulates 7 or more vulnerabilities	25	24	96%	2	8%	1	4%
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care	230	155	67%	160	70%	75	33%
Child at risk of being separated from his/her family – whose mother has underage children in public care	45	21	47%	23	51%	24	53%

Percentages were calculated relative to the no. of initial cases, those shown in the first column

NAT – nationality

Annex 10 – Case studies

Annex 10.1. Case study – Colonești commune, Bacău county

Background

No. of inhabitants: 2100

Commune structure: 6 villages, arranged in a straight line over 25 km. The paved county road crosses 4 of these villages, while access to the other villages is difficult during winter.

Social/outreach worker: Cristea Florin

Community health nurse: N/A

Children's and their families' needs

The community's needs are highlighted in the interviews and focus groups conducted. According to the LPA, children's and their families' main problems are poverty, the large number of members living in the household, but also parents' attitudes and practices regarding child raising and care. Discussions with project beneficiaries revealed the need for specialised services (i.e. psychological counselling), as well as leisure opportunities (e.g. daycare centres for children).

Project results

The project has built the LPA capacity to address children's and their parents' needs, on the one hand by hiring social workers, and on the other hand, by training them on the use of tools and methodologies developed to ensure the identification of 'invisible' children and delivery of services for them. Prior to project implementation, the commune had several cases which could only be referred to the GDSACP for resolution and which entailed child-family separation. According to the social worker's assessment, following the delivery of the minimum package of services, child-family separation was avoided in 75 percent of all cases managed, and "families in need no longer regard the social assistance service as a "Boogeyman", but as a friend, and they resort to it whenever they need advice or help".

Although everybody was positive about the workshops and activities carried out on the issue of violence, the outcomes were rather limited, especially at the family level, where most forms of violence are to be encountered. Parents' mentality is often considered an obstacle, given that domestic violence is regarded as "normal, no big deal". Even when the authorities intervened and obtained a restriction order against the offender and separate accommodation for the victim, there was only one case in which the victim did not return to their abuser.

The social worker underlined the results of the activities carried out in the micro-grant projects. The greatest win was that the funding received enabled them to bring in specialists otherwise unavailable in the commune/at the local level (e.g. psychologists). The mother of a child from the target group said that "in one year…" she learned to interact with people "…more than in all her life up to that point" and that such meetings were important to her because she received moral support that helped her move on.

What now?

Colonești continues to deliver the minimum package of basic community-based services and is part of the new UNICEF-funded intervention (initiated in 2015 to date). The community team was strengthened and was added a social referent and a community health nurse who, together with Florin, address the community's needs.

According to Florin, the project was like a "gauntlet thrown down to the Government" and he hopes legislation is passed to regulate the community team so that every SPAS may hire 2 social workers and 2 community health nurses each.

Annex 10.2. Case study – Tudora Commune, Botoșani county

Background

No. of inhabitants: 5200

Commune structure: large community, with one village with several hamlets, located far from Botoșani, with one accessible road and no connection to a sewerage system and running water.

Social worker: Simona-Lenuța Vătavu

Community health nurse: Gabriela Raicu

Children's and their families' needs

The problems facing the community involve social vulnerabilities, from education and health to housing conditions and low income level. Children's and their families' needs stem from these problems accordingly, covering education, housing, health as well as lack of information. In the children's opinion, the community's main problems which directly affect them include: squalor and the need to organise environmental cleaning activities; a large number of people with no money, no jobs and no housing; insufficient parks for leisure activities; unsanitary school lavatory.

Project results

As indicated by the specialists directly involved in the project, the services delivered helped reduce the vulnerabilities that were identified within the commune, though to a much lesser extent than the specialists had hoped for, due to the fact that the intervention covered a limited period of time and the local budget lacked the necessary financial resources. In this respect, **the specialists recommend an ongoing intervention based on financial resources that do not condition access to social services**.

Needs assessment became easier with the use of the Aurora application which specialists regard as a tool that makes social workers more responsible/accountable in their fieldwork and delivery of basic services. Nevertheless, local professionals believe that the accompaniment and support services worked only partially at the local level, due to lacking financial resources both on the part of the SPAS and on that of the service recipient.

Most outcomes were visible among the parents and children who participated in the micro-grant project activities. Many of the participants found themselves in novel situations, in that they had never before been involved in activities such as: leaving their community for the first time, taking part in a campaign, engaging in addressing the community's problems, dining in a restaurant, attending a theatre play etc.

One parent from Tudora commune who was interviewed revealed the fact that, while a responsible parent prior to project implementation, he/she found the project to be a source of new information that could be applied to improve his/her relationship with the 5 children in his/her care. The parent believed the most helpful information sessions were those on violence, enabling him/her to demonstrate a few child discipline methods learnt during the activities.

What now?

According to the specialists, continuing the project in the community would require the involvement of an NGO, an institution outside the LPA able to contribute financially as well, as it would seem there is no interest in continuing the project with local budget input. Willingness on the part of the mayoralty is not high as long as there are no external financial resources, however **local human resources are available, better trained and willing to engage and address the community problems**.

Annex 10.3. Case study – Bisoca Commune, Buzău county

Background

No. of inhabitants: 2700

Commune structure: commune formed of 8 villages located far from the commune centre, with unpaved roads and households far apart one from the other.

Social worker: Marius Băețelu Beșliu

Community health nurse: Gina Harpeș

Children's and their families' needs

Given the arrangement of the villages within the commune and of the households within the villages, as well as the large distances to the school, access to education is a challenge. The only available school bus has limited ccess to the villages and children have to walk large distances from home to the pick-up point. To address this challenge, a local weekly centre was set up to provide Monday to Friday accommodation for the children. The centre helped reduce school dropout and absenteeism, and children's learning outcomes improved visibly. Moreover, an increased number of children continued to attend school (i.e. the high school in Beceni or Buzău) after graduating the 8th grade. At the time of the summative evaluation, the centre was closed down for having failed to meet the operational standards established for this type of service, which caused a great deal of dissatisfaction among the community members, be they beneficiaries or other community resource persons.

At the same time, interventions were carried out to address the social problems of families with no income, who received the service package delivered as part of the UNICEF model implemented in the commune: the number of social aid family recipients increased and those who had health or family issues to solve received the necessary support.

Project results

Families received basic services and support to address the identified problems and, consequently, children's access to the services they needed also increased. Children and their families were registered with a family physician and receive health services. Due to the community health nurse's fieldwork, knowledge of health status improved and community members built a communication relationship with the family physician.

In addition to the professionals hired in the project, who contributed with their experience and expertise to reducing or eliminating children's and their families' vulnerabilities, the project facilitated the needs identification process and catalysed the local team into seeking and finding solutions.

What now?

Despite the fact that both the social worker and the community health nurse report having gained knowledge and experience, as well as the community members' trust and established relationship, they believe additional human resources are required to address the complex vulnerabilities affecting the community's children and their families.

Annex 10.4. Case study – Vânători commune, Iași county

Background

No. of inhabitants: 4600

Commune structure: 5 villages, of which 3 are close to each other on one side and 1 is on the outskirts. At times, when the weather is bad, access can be difficult.

Social worker: Mihailă Maricica, Dumitriu Crenguța (within the UNICEF-supported project)

Community health nurse: Chihaia Andreea, Apintilesei Cristina (within the UNICEF-supported project)

Children's and their families' needs

Main problems include poverty, lack of jobs, absence of a family physician, large distance to Pașcani and Iași municipalities, making it hard for commune members to access specialised services (i.e. health units, recovery centres, the County Employment Agency, vocational centres). Material deprivation, the bare necessities of families in need, the issue of alcohol consumption in some families could not be addressed. Professionals' intervention depends on the beneficiaries' involvement which, in this case, is low. The situation is hard to change given the extent of material deprivation and the fact that families here are used to receiving social benefits in cash. Though there are no job opportunities in the commune, most families do not regard subsistence agriculture as a self-supporting method.

Project results

The following contributed to achieving the expected project outcomes: the activities carried out to inform beneficiaries of their legal rights and obligations, the community needs identification and assessment activities, the Aurora application's solution-generating facility, the improvement of community workers' health care and social work skills/training, the fostering of cooperation between county supervisors and local stakeholders, the information sessions on preventing diseases, on the risk of unwanted pregnancies, cancer etc.

What now?

According to the interviews we conducted, multiple needs ought to be met in order to ensure project continuity, given that implementing the proposed model involves a considerable level of input. Requirements include a person assigned to deliver the services according to the project methodology, which entails a reshaping of that person's job description; funds for travel and activities, as well as the necessary space/premises/settings; a legislative and institutional framework that clearly sets out the duties of the person who implements the project and the mayoralty's responsibility/accountability.

The worth and merits of the project were best grasped by the community workers. In this particular commune, the other stakeholders continue to use the same outlook that preceded the implementation of the project. In this respect, it is worth noting that 2 CCS members participated in the focus group we organised.

Annex 10.5. Case study – Români commune, Neamț county

Background

No. of inhabitants: 3780

Commune structure: the commune is formed of 3 villages and is located 50 km away from Piatra Neamț and 10 km away from Buhuși. Houses are close to one another, but the villages are scattered across 5–6 km.

Social/outreach worker: Carmen Pintilii

Community health nurse: Ana Gabriela Asionesei

Children's and their families' needs

In the local stakeholders' opinion, the main problem is poverty, due to a lack of jobs in the proximity of the commune. Finding a job is challenging as most of the community members have a low level of educational attainment and vocational training. The lack of financial resources is most often associated with housing problems. The community does not acknowledge situations of abuse, while the local authority lacks the capacity to prevent and intervene in situations of violence. Children do not talk about their problems with any of the community stakeholders because they cannot trust them to ensure confidentiality and be discreet. It is their opinion that talking about their problems would only harm them.

Project results

Social services were much better during the project. Even when certain services were unavailable locally, efforts were made to identify outside providers. A success-generating factor was the involvement of the GDSACP coordinator. Thanks to the information received on existing services at county level, a broader range of services could be accessed to meet the needs identified in the commune. As a result, social services were enhanced and diversified (e.g. recovery/rehabilitation services, psychological counselling).

Information actions were efficient. One particularly successful outcome of this service was that children were vaccinated against measles. Information sessions covered social assistance rights, violence-related risk factors, health issues. The training received helped community workers increase their capacity to provide accurate and updated information to community members. With regard to counselling services, when the community workers were unable to deliver such services, the micro-grant projects enabled them to use a psychologist's services.

The integrated approach proved efficient in the service delivery process, as each specialist brings to the process his/her specific knowledge and information in the field they cover. Team members meet, discuss the case, identify solutions and decide on a common course of action.

What now?

In terms of legislation, an idea/suggestion of the GDSACP supervisor stood out: to include a minimum package of services in the official list/nomenclature of social services, which would be accredited and mandatory for all local authorities.

The community health nurse continues with her fieldwork duties as fulfilled during the project. The outreach worker, currently head of the emergency situations service, intervenes these days only when a case is brought to her attention, she no longer undertakes fieldwork to identify new vulnerabilities or to monitor the cases on file. CCS members are available to meet on a regular basis, are willing to get involved in addressing the community's social problems, but there is no one to coordinate them, to schedule the meetings and convene them.

Annex 10.6. Case study – Dornești commune, Suceava county

Background

No. of inhabitants: 3500

Commune structure: 2 villages and 2 peripheral areas. The road to Iazu village is not paved and is extremely difficult to use when it rains, while in winter it can get blocked by snow.

Social worker: Popovici Mihaela

Community health nurse: Mironiuc Angelica

Children's and their families' needs

The most visible problems are those related to the beneficiaries' poor health status, child neglect (children left home alone or in the care of their elder siblings during the agricultural seasons), dropout rate, especially after grade 8, and the level of school violence.

There are less visible problems as well, encountered at family level and revealed only by the social worker's and community health nurse's home visits: alcohol consumption, cohabitation relationships which result in children not acknowledged by their fathers and sometimes not even ID papers, domestic violence and teen pregnancies among girls who dropped out of school or who have to stay home to care for their younger siblings while their parents' are out to work. Another problem which the authorities are unaware of but which was pointed out by parents during the interviews is beggary (in town) on the part of some parents who also involve their children.

Project results

According to the social worker, access to social services increased a great deal, as the beneficiaries received information on their rights and on what they needed to do to claim them. Moreover, the micro-grant projects included activities which provided children with school-related material support, as well as with opportunities for socializing and community integration.

The social worker believes that the information sessions for children and parents on the topic of violence prevention helped protect some of the children against violence or physical abuse. However, some of the CCS members reported that there are children in school whose behaviour and accounts indicate they continue to be victims of physical and emotional abuse.

CCS members believe there ought to be separate funds for the social worker's salary and for the model-specific activities, from sources other than the local budget which barely covers the local infrastructure projects or the salaries of the mayoralty staff.

What now?

The SPAS increased its capacity due to the intensely active input of the social worker hired by the project. This capacity will go to waste or is likely to be lost during 2015–2016 unless the social worker is hired within the mayoralty beyond 2016. The social worker is willing to continue the activities, but not if that means working as a volunteer or under short-term (3 to 6 months) labour contracts which will only confuse the beneficiaries and cannot ensure sustainability of interventions.

The community health nurse has been a mayoralty employees since 2004 and will continue the work undertaken in the project, including identifying new cases and social service delivery, within her competence.

Annex 10.7. Case study – Coroiești commune, Vaslui county

Background

No. of inhabitants: 1866 (668 households)

Commune structure: 7 villages located 3–12 km away from the commune. The villages are connected via communal cobbled roads or county paved roads. Houses are scattered, located on hills, even outside the village (5 km away) at the sheepfold, hard to reach.

Social worker: Lungu Gabriela

Community health nurse: Brebine Viorica

Children's and their families' needs

Children's and their families' main vulnerabilities are poverty, the lack of jobs, parents' low level of education, closely connected to alcohol consumption and various forms of violence. For children, the main vulnerabilities are those related to education. Children work in the household and drop out of school as early as middle school, with only few who continue their studies beyond grade 8.

Project results

The minimum package of services delivered within the model helped vulnerable children and their families to access information about their rights and responsibilities, built community stakeholder awareness of issues affecting children and families in situations of risk and increased access to primary and specialised social and health services to meet the needs identified in the commune:

– Information available to all members of the households listed with the Aurora (on social rights, child rights, consequences of alcohol consumption and violence, obtaining ID papers etc).

– Counselling – service delivered to families in which parents consumed alcohol and/or reported acts of violence, as well as in connection with accessing social rights, organising one's daily life, personal hygiene, home hygiene, and changing child raising attitudes and practices.

– Accompaniment and support – mainly accompaniment for mothers to medical appointments, to the County Centre for Educational Resources and Assistance for children's school guidance service, for obtaining ID papers, accompaniment and support for parents on managing their relationship with the children's teachers.

The micro-grant projects helped increase quality of life for children covered by the project and proved community engagement was possible with limited resources. The main problems encountered during the implementation of the project activities were: the initial reluctance on the part of the parents who *"didn't understand why we kept telling them to come to the centre, what that centre was all about* [the counselling centre for children and parents]", claiming *"we have no problems, we can handle ourselves"*; the lack of specialists at local level.

Children in the commune experienced unforgettable moments thanks to the team activities, the trip some of them went on for the first time, the activities shared with their parents. For the mothers (the fathers did not take part in the activities), the activities that were organised were a good opportunity to socialise with other mothers in the community, talk about their experiences and receive advice.

What now?

The local stakeholders we interviewed were confident with regard to the prospects of continuing the project in the community, listing several enabling factors, such as: maintaining a social worker whose duties cover only prevention and the implementation of the minimum package of services, employment of the CHN and integrated approach to services for 'invisible' children and their families, the mayor's sustained

interest in continuing the model and allocating the resources needed to implement the activities, at the request of the community workers (e.g. transportation, meeting refreshments for meetings with children and parents).

Annex 10.8. Case study – Slobozia Bradului commune, Vrancea county

Background

No. of inhabitants: 7815

Commune structure: the villages that form the commune are close to one another and easy to reach

Social worker: Grigore Ana Maria Nicoleta

Community health nurse: Antohe Ana Maria

Children's and their families' needs

The lack of stable jobs and steady income and the low level of education, leading to a low standard of living, are the first issues mentioned by the representatives of the local authority when referring to the community's problems.

The commune population, 85 percent of which is Roma, is highly tradition and religion bound. According to custom, girls cease to attend school after completion of primary education and end up marrying early. They become sexually active at 12–13 years of age, having relationships with boys in the community and getting pregnant.

Even though these households do not report problems related to alcohol consumption or domestic violence, it is worth mentioning that they promote the patriarchal family model. To all appearances, families manage well, but as there are many children in the family, they raise one another, the older siblings caring for the younger ones. These families need information and counselling services to learn about the consequences of early marriages.

Project results

Support was provided to all community members without ID papers, enabling them to claim their social, educational and health rights and receive the primary services they needed, being registered with a family physician and enrolled in kindergarten/school.

The local authority team delivered services such as information and counselling, accompaniment and support to ensure all children go to school school, and as a result, the number of children attending school increased. However, the school dropout rate, in its turn, cannot be said to have decreased. In the case of the Roma community, school attendance registers gender disparities. Girls drop out of school right after completing the primary education stage, whereas more and more boys continue attendance to complete the compulsory education level, aware of the fact that this is the only way they'll be able to get a job and support their families.

What now?

To continue implementing the prevention activities which were typical of the pilot project, the community needs to secure the required financial resources and to be able to hire a person that would focus on field-work. Even if the mayoralty specialised department has 4 employees who, for the most part, work on the social benefits files, social services are delivered only for cases which are flagged as an emergency.

The local community pressures the local professionals and the local authority to continue providing the support it needs to deal with its problems.

Local professionals report ongoing delivery of information and counselling services, albeit not at the same level/to the same extent as in 2015.

Annex 11 – Evaluation tools

Annex 11.1. Household questionnaire

Hi, we are conducting an opinion poll at the request of UNICEF in Romania who wish to know about the outcomes generated by the implementation of "First Priority: No More 'Invisible' Children!" project which aimed to provide basic social services for children and their families in 32 communes of 8 counties. To this end, your opinion is highly relevant, which is why we are conducting brief questionnaires among parents and children above age 10. Our discussion will last around 30 minutes and you should know that you can quit at any time and that the data you provide are confidential (they will not be shared with anyone as such, only as anonymous statistics).

For interviewers:

! Collect data for all members of the sample household (including parents gone for work abroad or who are separated etc. as well as children who died or were sent to live with relatives or placed in public care etc.) so as to know who the household children's parents are and whether any of the children is missing.

! The reference person is the household member aged 15+ acting as the household child's/children's main caretaker (mother, father, grandmother etc.). The reference person should be the one to respond to the questionnaire, preferably.

! Children are persons under age 18.

NRCHEST |__|__|__|__|__|

Address:
County: .....
Commune: .....; Village .....
Street ..... No .....
Phone no. (including the area code): .....

In its capacity of personal data processor registered with the National Supervisory Authority for Personal Data Processing under numbers 30277 and 5974, C|C|S|A|S is entitled to process personal data. We assure you that all your answers will be confidential. Survey results will never be assessed in connection with the name of the interviewed persons or companies, they will be presented only as statistical data.

A. Intruduction

Household members. Please provide information on all household members.

The reference person will be listed on the first table row (CPERS = 01), the husband/wife (whether or not they live in the household) will be listed on the second table row (CPERS = 02). For ease of questionnaire use, list the other household members in DESCENDING order of age (oldest to youngest).

Person's code	**CPERS**	**01**	**02**	**03**
1.1. Household member (Interviewer should write down the persons' name/first name or initials!)	MEMBR			
1.2. Presence in the household 1 – person is present 2 – gone abroad to work 3 – in country to study or work 4 – in hospital for the short term (max. 45 days) 5 – child in public care 6 – child sent to relatives in another community 7 – child moved 8 – child deceased 9 – absent for other reasons (specify which) 10 – divorced/separated and moved out (only for parents absent from the household!) 11 – deceased (only for parents absent from the household!) 12 – unknown situation (only for parents absent from the household!)	PREZ			
1.3. As of what year are the persons no longer present in the household? Only for codes 2–9 under PREZ	ANN	|__|__|__|__|	|__|__|__|__|	|__|__|__|__|
1.4. Gender 1-M 2-F	SEX			
1.5. Age on last birthday	AGE			
1.6. Ethnicity 1 – Romanian 2 – Hungarian 3 – Roma 4 – German 5 – Other	ETN			
1.7. Marital status 1 – married 2 – concubine 3 – divorced 4 – widow(er) 5 – single 6 – separated	STACIV			
1.8. Kinship to the reference person 1 – reference person 2 – husband/wife/concubine 3 – son/daughter 4 – son-in-law/daughter-in-law 5 – nephew/niece 6 – father/mother/mother-in-law/father-in-law 7 – brother/sister/brother-in-law/sister-in-law 8 – other relative 9 – children in family placement 10 – not related	RELPERS	1		
1.9. What year was he/she placed in family care? Only for code 9 Under RELPERS	PLAS			

If the answer to q1.2 is 9, please write down the reason why the person is absent

B. Vulnerabilities

Vulnerabilities of household members. Please provide information on all household members who find themselves in the situations below.

Use the same persons' codes you used in section A. Write down code 1 for each child/person in the respective situation, except for the items which require a specific description.

Person's code	**CPERS**	**01**	**02**	**03**
2.1. Child with only one parent at home – whose mother/father is in hospital/long-term care centre/prison or divorced, separated and moved out/deceased or in an unknown situation	ACASA			
2.2. Child with no parent at home – who has neither parent at home, but has an adult carer in the household (aged over 18). Not applicable to children in placement centres or foster care.	ACASA0			
2.3. Child with one or both parents gone abroad	STRĂIN			
2.4. Child with underage mother	CMIN			
2.5. Underage mother	MIN			
2.6. Child with placement measure (with relatives up to the fourth degree or with a professional foster carer)	MONO			
2.7. Child reintegrated in their birth family when exiting the protection system – after having been in public care	REIN			

2.1.-2.7. Write down code 1 for each child/person in the respective situation.

Person's code	**CPERS**	**01**	**02**	**03**
3.1. Person with no ID papers Write down code 1 for each child/person in the respective situation.	ACTE			
3.2. Person registered with a family physician Write down code 1 for each child/person in the respective situation.	MEDIC			
3.3. Child is vaccinated according to the immunization schedule Write down code 1 for each child/person in the respective situation.	VACC			
3.4. Person with impairment or disability Write down code 1 for each child/person in the respective situation.	DIZ			
3.5. Person with a disability certificate Only for code 1 under DIZ Write down code 1 for each child/person in the respective situation.	CTFH			
3.6. Over the last 6 months, the person underwent a routine medical check-up Write down code 1 for each child/person in the respective situation.	CTRL			
3.7. Personal assessment of health status (on a scale from 1 – very poor to 10 – very good) Write down the code from 1 to 10 for each child/person	SAN			
3.8. Consumes alcohol 1 – occasionally 2 – once or twice a month 3 – once or twice a week 4 – daily 5 – not a user	ALC			
3.9. Smokes 1 – occasionally 2 – once or twice a month 3 – once or twice a week 4 – daily 5 – not a user	FUM			

Person's code	CPERS	01	02	03
3.10. Highest level of educational attainment 1 – no school graduated 2 – primary school (grades 1 to 4) 3 – gymnasium (grades 5 to 8) 4 – vocational, apprentice or complementary school 5 – first high school stage (grades 9 to 10) 6 – high school (grades 9 to 12) 7 – specialised or technical posthigh school studies 8 – short-term university education/college 9 – long-term university education (including a master degree) 10 – PhD **Attention**! Write down the level of education already attained, not in the process of being attained.	NIVEDU			

Children's vulnerabilities. Please provide information on the children in your household.

Person's code	CPERS	01	02	03
4.1. Child attends school/kindergarten daily[162] (ask the question depending on the child's age) Read each of the situations listed below and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation.	SCHOOL			
4.2. Child dropped out of school or intends to drop out Only for school age children (over age 6) Read each of the situations listed below and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation.	ABN			
4.3. Child repeated a school year Only for school age children (over age 6) Read each of the situations listed below and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation.	REPET			
4.4. How would you assess your child's learning outcomes? *On a scale from 1 – very poor to 10 – very good* Only for children who attend school on a daily basis Read each of the situations listed below and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation.	SIT			
4.5. Your child is sometimes left home alone[163] (with no adult supervision) or only with his/her siblings Read each of the situations listed below and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation.	CSING			
4.6. The most frequently used method to discipline the child[164] *(do not read the options out loud! Write down the code associated with the most severe of the situations mentioned by the reference person)* The most frequently used method to discipline the child 1 – through discussions, resorting to reason 2 – using deprivation/denial as punishment (he/she is not given sweets, not allowed to watch TV, to play etc.) 3 – the child is yelled at 4 – by threatening him/her with punishment 5 – by beating him/her 6 – by using humiliating and offensive language against the child	DISCIP			

158 The child attends school daily when he/she is present in class every day, except on those days when he/she has a medical exemption to miss classes. Unless this is the case, the box will be left empty/not filled in (i.e. when the reference person says children sometimes don't go to school because it's cold or that they do go to school but they occasionally stay behind to help with household chores).

159 For situations like "Child remains in the care of elder siblings when his/her parents go in the village for day labour", write down node 1.

160 When the question is not understood, use the alternative "What do you do when the child misbehaves or he/she commits the occasional blunder or causes trouble?".

C. Social Services

For each child, indicate the social services they received during January 2013 – September 2015.

Read each of the following services and write down code 1 (the other boxes shall remain empty/not filled in) for the children/persons in the respective situation:

Person's code	CPERS	01	02	03
5.1. Registration with a family physician	SV1			
5.2. Scheduling a doctor's appointment and/or accompanying the person to the doctor	SV2			
5.3. Ensuring transportation to the doctor	SV3			
5.4. Obtaining a disability certificate	SV4			
5.5. Facilitating access to social benefits (social aid, family support allowance etc.)	SV5			
5.6. Obtaining ID papers	SV6			
5.7. Information on rights and risks related to violence, abuse, exploitation	SV7			
5.8. Specialised individual counselling (on topics such as: the family's role in child development and education, development stages, institutionalisation outcomes, child abuse and neglect, care of children with disabilities, family planning, risks associated with sexually transmitted diseases, etc.)	SV8			
5.9. Counselling and support centre for children and parents	SV9			
5.10. School enrolment	SV10			
5.11. Discussing with teaching staff to solve school-related problems	SV11			
5.12. Referral to the public care system and/or other organisations providing specialised services	SV12			
5.13 Reintegration in the birth family after child's exit from public care	SV13			

The next questions are for the reference person

D. Information

(for each question, encircle the code that corresponds to the answer)

	To a very small extent	To a small extent	To a large extent	To a very large extent	Don't know	Non-response
6.1. To what extent are you informed about your right to social aid?	1	2	3	4	98	99
6.2. To what extent are you informed about your right to health care?	1	2	3	4	98	99
6.3. To what extent are you informed about the mayoralty services you should receive?	1	2	3	4	98	99
6.4. To what extent are you informed about the vaccines children need?	1	2	3	4	98	99
6.5. To what extent are you informed about children's right to education?	1	2	3	4	98	99
6.6. To what extent are you informed about the risks associated with alcohol consumption?	1	2	3	4	98	99
6.7. To what extent are the household adolescents informed about the risks associated with alcohol consumption?	1	2	3	4	98	99
6.8. To what extent are you informed about the risks associated with smoking?	1	2	3	4	98	99
6.9. To what extent are the household adolescents informed about the risks associated with smoking?	1	2	3	4	98	99
6.10. To what extent are you informed about the means to avoid unwanted pregnancies and sexually transmitted diseases?	1	2	3	4	98	99

	To a very small extent	To a small extent	To a large extent	To a very large extent	Don't know	Non-response
6.11. To what extent are the household adolescents informed about the means to avoid unwanted pregnancies and sexually transmitted diseases?	1	2	3	4	98	99
6.12. To what extent are you informed about transmissible diseases (including sexually transmitted diseases)?	1	2	3	4	98	99
6.13. To what extent are the household adolescents informed about transmissible diseases (including sexually transmitted diseases)?	1	2	3	4	98	99

E. Satisfaction with the social services and work undertaken by the local community workers

In your commune, do you know the... **(for each question, encircle the code that corresponds to the answer)**	**No**	**If yes, …**			**Don't know**	**Non-repsonse**
		Yes, but we never talked	Yes, we talked on occasion	Yes, we talk often		
7.1. Social/outreach worker	4	1	2	3	98	99
7.2. Community health nurse[166]	4	1	2	3	98	99
7.3. School counsellor	4	1	2	3	98	99
7.4. Health mediator	4	1	2	3	98	99
7.5. School mediator	4	1	2	3	98	99
7.6. 7.6. Another community worker. Specify:	4	1	2	3	98	99

If the answers to 7.1. were 2 or 3, go to question 8.1. If the answers were 1 or 4, go to question 8.2.

8.1. Last year (2015), how often was your family visited by the social worker?
1. Once a week
2. A few times a month
3. Once a month
4. Less than once a month
5. Never

If the answers to 7.2. were 2 or 3, go to questions 8.1 and 8.2. If the answers were 1 sau 4, go to question 9.

8.2. Last year (2015), how often was your family visited by the community health nurse?
1. Once a week
2. A few times a month
3. Once a month
4. Less than once a month
5. Never

How would you rate the services provided by (questions 9.2 and 9.3 apply only to those communities which have a community health nurse):

	Very poor	Poor	Good	Very good	Not applicable	Don't know	Non-response
9.1. The social worker	1	2	3	4	97	98	99
9.2. The community health nurse	1	2	3	4	97	98	99
9.3. The two (SW and CHN) as a team	1	2	3	4	97	98	99

	Highly dissatisfied	Dissatisfied	Satisfied	Highly satisfied	Not a recipient	Don't know	Non-response
10. Overall, how satisfied are you with the social services you received?	1	2	3	4	9	98	99

161 Community professional employed within the mayoralty who carries out health activities and provides health services (i.e. home health care for pregnant women, newborns and mothers, elders or people who are chronically ill or mentally ill; promotion of reproductive health and family planning; health and social counselling etc.).

Questions 11 to 15 are to be asked only in the intervention communes

	Yes	No	Don't know	Non-response
11. Have you heard about the UNICEF project called "First Priority: No More 'Invisible' Children!" carried out in your commune between 2011 and 2015?	1	2	98	99

If yes (q11 = 1)

	Very poor	Poor	Good	Very good	Don't know	Non-response
12. What is your opinion of the activities of "First Priority: No More 'Invisible' Children!" carried out in your commune between 2011 and 2015?	1	2	3	4	98	99

	Yes	No	Don't remember/not applicable	Don't know	Non-response
13. Over the last years, were you invited by the social worker and/or community health nurse to participate in activities/thematic support groups organised at the Community Centre?	1	3	9	98	99

If not (q13 = 2), move on to q14. If yes (q13 =1), move on to q15.

	Yes	No	Don't know	Non-response
14. Were you ever invited to participate?	1	2	98	99

	To a very small extent	To a small extent	To a large extent	To a very large extent	Not at all	Don't know	Non-response
15. Considering the services you received as part of the project, would you say that, in 2015, your family's life improved compared to previous years?	1	2	3	4	5	98	99

If you were to consider the last 4 years (2011–2015), you would say:

	To a very small extent	To a small extent	To a large extent	To a very large extent	Not applicable	Don't know	Non-response
16.1. You received more support from the social/outreach worker than you did before	1	2	3	4	97	98	99
16.2. You received more support from the community health nurse	1	2	3	4	97	98	99
16.3. Your family's situation improved thanks to the involvement of the social/outreach worker	1	2	3	4	97	98	99
16.4. Your family's health improved thanks to the involvement of the social/outreach worker or of the community health nurse	1	2	3	4	97	98	99
16.5. That if you had a problem, you could count on mayoralty support to solve it	1	2	3	4	97	98	99

F. Income and expenditure

Person's code	CPERS	01	02	03
17.1. Main occupation during the last 12 months 1. employee 2. other status as working person *(day worker, illegal worker etc.)* 3. employer 4. working on his/her own in non-agricultural activities *(including self-employed person, family business, freelancer)* 5. working on his/her own in agriculture 6. family support 7. registered unemployed person 8. non-registered unemployed person *(no longer receives an unemployment benefit/support allowance and is looking for a job)* 9. pensioner for age limit 10. other type of pensioner 11. pupil, student *(Attention! Include children who attend kindergarten)* 12. housewife 13. person with incapacity for work 14. other status of inactive person *(pre-school child who does not attend kindergarten, dependent)*	OCUP			
17.2. Family allowance Write down code 1 for persons who received the social benefit in 2012.	BS1			
17.3. Monthly placement allowance Write down code 1 for persons who received the social benefit in 2012.	BS2			
17.4 Aid for persons with extremely serious health conditions granted for medical treatment and surgery abroad Write down code 1 for persons who received the social benefit in 2012.	BS3			
17.5. Monthly allowance for persons with severe and marked disabilities Write down code 1 for persons who received the social benefit in 2012.	BS4			
17.6. Monthly allowance for attendants of adults with severe visual impairment Write down code 1 for persons who received the social benefit in 2012.	BS5			
17.7. Monthly food allowance for HIV infected persons or people with AIDS	BS6			
17.8. Food support for children with HIV/AIDS disability	BS7			
17.9. Income support for securing the guaranteed minimum income	BS8			
17.10. Heating aid (heating allowance, wood logs)	BS9			
17.11. Emergency aid	BS10			
17.12. Food aid from the European Union	BS11			
17.13. Day centre	BS12			
17.14. Social canteen	BS13			
17.15. Powder milk for babies	BS14			
17.16. Other benefits, types of aid or social services, namely:	BS15			
17.17. Salaries Write down code 1 for persons who obtained income from salaries, independent or occasional activities in December 2012.	SAL			
17.18. Pensions Write down code 1 for persons who obtained any type of pensions in December 2012.	PNS			

BS: Beneficii sociale

..... RON

	No monetary income	Don't know	Non-response
18. VENG. Last month, the total amount of money obtained from salaries, pensions, allowances, social aid, sales etc. by all household members (including the respondent), was approximately …	9	98	99

	Don't know	Non-response
19. CONS. In a regular month, how much do you spend for food products? ..... RON	98	99

	Yes	No	Don't know	Non-response
20. Do you have a garden from where you obtain various food products?	1	2	98	99

	Yes	No	Don't know	Non-response
21. VNEED. Did last month's total monthly net income of the household allow you to cover the running expenses?	1	2	98	99

	They are not enough even for the bare necessities	They are enough only for the bare necessities	They are enough for a decent living, but we cannot afford to buy more expensive items	We manage to buy more expensive items, but with restrictions in other areas	We manage to have everything we need without depriving ourselves of anything	Don't know	Non-response
22. VENSUB. What is your opinion of the current incomes of your household?	1	2	3	4	5	98	99

G. Living conditions

	Daily	A few times a week	Once a week	A few times a month	Less often	Niciodată	Don't know	Non-response
23. How often were you unable to heat your dwelling and were cold last winter?	1	2	3	4	5	6	98	99

	Daily	A few times a week	Once a week	A few times a month	Less often	Niciodată	Don't know	Non-response
24. How often did you not have food to put on the table and children suffered from hunger in the past 6 months?	1	2	3	4	5	6	98	99

	Don't know	Non-response
25. How many rooms does your dwelling have, other than kitchen, hallways, bathroom and other auxiliary spaces? ..... rooms	98	99

	Don't know	Non-response
26. In how many rooms do the household members sleep[166]? ..... rooms	98	99

	Yes	No	Don't know	Non-response
27. Is the number of rooms in your dwelling enough for the household needs?	1	2	98	99

162 The number of rooms in which the household members sleep may exceed the number of rooms the house has (q25 bigger than q26), if sleeping spaces are set up in the kitchen, hallway etc.

Annex 11.2. Questionnaire for mayoralties

The questionnaire for mayoralties is a tool to be uploaded on an online platform and self-administered or administered via telephone. As an emergency solution, in communities were interviews are scheduled, the local experts of **International Consulting Expertise (ICE)** will administer this questionnaire in a face-to-face mode to the mayoralty official indicated by the social/outreach worker or by the community health nurse as being the most appropriate respondent.

The questionnaire for mayoralties mainly assesses the capacity of the mayoralty (of the administrative apparatus in the commune) and particularly of the Public Social Assistance Service (SPAS) to implement the UNICEF model. It serves to determine: (a) the relevance of the model and its effectiveness in increasing the administrative capacity for social assistance, (b) the sustainability of the model, (c) the perception regarding the potential for replicating the model in other communities.

During March 2016 – March 2017, **International Consulting Expertise (ICE)** is conducting an evaluation of the **"First Priority: No More 'Invisible' Children!" project**, implemented by **UNICEF in Romania** between April 2011 and September 2015. The project aimed to increase the impact of social protection policies among vulnerable children and families (the 'invisible' children) by increasing their access to basic social and health services and, as such, to build the local authorities' capacity to deliver a minimum package of integrated services.

Your commune participated in the implementation of this project in at least one of its implementation phases (at least the initial phase). To better understand the outcomes of the project in terms of increasing SPAS capacity to deliver social and health services, including integrated community-based services, to children and their families in rural areas, we kindly ask you to provide us with certain information.

Completing the questionnaire will take no longer than 15 minutes, and the data obtained will be used exclusively for statistical processing in the evaluation of the UNICEF project.

Section 1 – Commune environment and key characteristics

1. Name of commune:

.....

2. Name of person who fills in the questionnaire:

.....

3. Title of person who fills in the questionnaire:

.....

4. Villages forming the commune and number of inhabitants in each village (where available, breakdown the information by gender and ethnicity):

No.	Village	No. of inhabitants (of whom:)	Children (under age 18) – girls	Children (under age 18) – boys	Adults (over 18) – women	Adults (over 18) – men	Roma children	Roma adults

5. Please specify the source of the data provided above:

.....

6. If the requested data could not be provided, please indicate whether, in your opinion, it would be useful to have these data collected in your commune:

.....

7. The local budget over the last years amounted to:

	2011	2012	2013	2014	2015
Local budget (thousand lei)					

8. Number of commune recipients of social benefits over the last year:

..... (răspuns de tip cifră)

Section 2 – The commune and SPAS administrative apparatus

9. Total number of Mayoralty employees:

..... (răspuns de tip cifră)

9.1. Number of social workers with specialised studies[163] **hired full time** (for part time employment, fill in number fractions, for instance if you have a social worker hired for 4 hours/day, fill in 0.5 a.s.o.): .....

9.2. Number of persons with social assistance duties, but no specialised studies (social referents/social assistance operatives), hired full time (for part time employment, fill in number fractions, for instance if you have a person with social assistance duties hired for 4 hours/day, fill in 0.5 a.s.o.): ..... (răspuns de tip cifră)

Introduce a filter: if the number provided in response to the previous question is above 0, use question 9.3.

9.3. If your institution employs outreach workers, please specify their highest level of educational attainment:

a. Gymnasium

b. Secondary education (high school)

c. Specialised post-high school studies

d. Higher education (university, master degree) in fields other than social assistance

10. The social/outreach worker in the UNICEF project was:

a. recruited from the existing mayoralty employees with social assistance duties

b. recruited from the mayoralty employees with no previous social assistance duties

c. recruited from outside the mayoralty, but not made part of the mayoralty staff once the project ended

d. recruited from outside the mayoralty, but hired as social worker within the mayoralty once the project ended

e. recruited from outside the mayoralty, but hired within the mayoralty on a position outside the SPAS once the project ended

f. a different situation .....

g. no social worker was hired in the UNICEF project

11. Number of community health nurses hired full time (for part time employment, fill in number fractions, for instance if you have a community health nurse hired for 4 hours/day, fill in 0.5 a.s.o.): ..... (răspuns de tip cifră)

163 University studies in the field of social assistance

12. The community health nurse in the UNICEF project was:

a. recruited from the existing mayoralty employees with social assistance or health care duties

b. recruited from the mayoralty employees with no previous social assistance or health care duties

c. recruited from outside the mayoralty, but not made part of the mayoralty staff once the project ended

d. recruited from outside the mayoralty, but hired as community health nurse within the mayoralty once the project ended

e. recruited from outside the mayoralty, but hired within the mayoralty on a position outside the SPAS once the project ended

f. a different situation .....

g. no community health nurse was hired in the UNICEF project

Section 3 – Further education and training of SPAS employees

13. Has/have the social/outreach worker(s) participated in further education and training in the field of social assistance?

a. yes

b. no

Introduce a filter: if the answer to the previous question is "yes", use questions 13.1–13.2.

13.1. What was the topic of the training courses attended by the social/outreach worker(s)? ..... (open answer)

13.2. What was the cumulated duration (number of days) of the training courses attended by the social/outreach worker(s)? ..... (răspuns de tip cifră)

14. Has/have the community health nurse(s) participated in further education and training in the field of health care or community health care?

a. yes

b. no

Introduce a filter: if the answer to the previous question is "yes", use questions 14.1–14.2.

14.1. What was the topic of the training courses attended by the community health nurse(s)? ..... (open answer)

14.2. What was the cumulated duration (number of days) of the training courses attended by the community health nurse(s)? ..... (răspuns de tip cifră)

15. If both social/outreach workers and community health nurses work in your commune, have they attended training courses together?

a. yes

b. no

c. don't know

Introduce a filter: if the answer to the previous question is "yes", use questions 15.1–15.2:

15.1. What was the topic of the training courses the SPAS employees attended jointly? ..... (open answer)

15.2. What was the cumulated duration (number of days) of the training courses the SPAS employees attended jointly? ..... (răspuns de tip cifră)

Section 4 – Standardising of SPAS work

16. Are there operational procedures in place for the work of social/outreach workers? *(mayoralty internal procedures, other than regulations in force or UNICEF project procedures)*

a. yes

b. no

c. don't know

17. Are there handbooks, guidelines, manuals or other types of documents the employed social/outreach workers use in their activity?

a. yes. Specify which: .....

b. no

c. don't know

Section 5 – Social assistance projects

18. During 2011–2015, did the commune apply for non-reimbursable funding (European funds – Social and/or Cohesion Fund, EEA Grants, Norway Grants) for projects that had a social assistance, health or educational component? If yes, specify the funding mechanism.

a. yes, with the HRD SOP

b. yes, with the National Rural Development Programme

c. yes, with the Regional Operational Programme

d. yes, with a different funding mechanism. Specify which: .....

e. no

f. don't know

19. During 2011–2015, did the commune receive funding/implement grant projects that had a social assistance, health or educational component?

a. yes, via the HRD SOP

b. yes, via the National Rural Development Programme

c. yes, via the Regional Operational Programme

d. yes, via a different funding mechanism. Specify which: .....

e. no

f. don't know

Section 6 – Structures providing support and guidance to the SPAS

20. Does the commune have community centres that provide support and counselling to children and their families, which were set up during 2011–2015?

a. yes

b. no

c. don't know

21. Does the commune have a community consultative structure (CCS) tasked, among others, with managing the problems of children and their families?

a. yes

b. no

c. don't know

Introduce a filter: if the answer to the previous question is "yes", use questions 21.1–21.3.

21.1. Was the CCS formally established (based on a Mayoralty/Local Council decision)?

a. yes

b. no

c. don't know

21.2. If the answer to the previous question is "yes", was the CCS set up during the UNICEF project?

a. yes

b. no

c. don't know

21.3. If there is a CCS that deals with children's and their families' problems, how often do its members get together?

a. weekly

b. monthly

c. quarterly

d. half-yearly

e. once a year

f. less than once a year

g. on a need basis

h. don't know

22. In your opinion, which is the county institution the mayoralty and the SPAS most need technical and methodological support from?

a. the County Council

b. the General Directorate for Social Assistance and Child Protection

c. the Directorate for Public Health

d. the Prefecture

e. the NGOs

f. Other. Specify: .....

23. And which is the county institution that most assists you (with technical and methodological guidance and support) in general in the SPAS activity?

a. the County Council

b. the General Directorate for Social Assistance and Child Protection

c. the Directorate for Public Health

d. the Prefecture

e. the NGOs

f. Other. Specify: .....

Annex 11.3. Interview guide – The designated county supervisor

Interviews with the designated county supervisors will be conducted by the local experts of International Consulting Expertise (ICE).

The interview serves to collect information for the evaluation of project effectiveness and efficiency.

Instructions for the local experts who conduct the interviews

– The questions proposed provide guidance, the interview will be semi-structured and will enable the county supervisors to express themselves freely. The information thus collected will be analysed afterwards.

– If some of the questions reveal the need for further questioning, ask additional questions that will guide the discussion and provide clarity.

– If the questions you ask ellicit broad answers (lacking specifics), answers that refer to hypothetical cases or desirable answers, insist that respondents provide concrete examples.

– If the answer to one of the questions was already formulated during the discussions that covered a previous question, ask the participants if they have anything else they would like to add on the respective topic. If there is nothing else, move on.

– The section dedicated to presenting the project is to be tailored to each interviewee, providing answers to all the participants' questions.

– Questions regarding community health nurses are to be asked only in those communities where these are present.

Interviewees

Interviews will target the **designated county supervisors** from the following institutions:

– the GDSACP

– the DPH

Intro

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/project implemented by **UNICEF in Romania** between April 2011 and September 2015, a model in whose implementation you were also involved.

Everything we discuss here is strictly confidential – nothing will be shared with anyone outside this project and you will be cited in reports as "interviewed supervisor". You need to know that your opinions will not be treated as good/bad or as right/wrong and that we are not here to judge you in any way.

We would also like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Needs of children living in the county and of their families

1. Which would you say are the main problems and needs of children and their families in your county? Are these problems and needs visible in their communities / known to the main stakeholders/professionals expected to address them (e.g. does the head teacher know what children are not enrolled in school or does the family physician know who is not registered on his/her lists and do these professionals carry out activities to reduce vulnerabilities?)? Which are visible and which are not? What vulnerabilities and needs could not be addressed through the model? Why do you think certain problems and needs were not targeted by the model?
2. In your experience, do the services delivered by the community workers you supervised in the modelling project help address/reduce vulnerabilities and meet needs?
3. What is your view of the minimum package of services? What should be changed? What package services should be removed/replaced?

SPAS capacity and chances of sustainability

4. How would you assess the SPAS capacity to address the needs of the community and to deliver social services? Can you compare the situation in 2015 to that in 2011? In your opinion, how did the model implementation influence the attitude of the community's mayor? How about that of the mayoralty staff?
5. How would you describe the cooperation between the community workers and the Community Consultative Structures and other community actors (e.g. clinic, school etc.)?
6. What changes has the UNICEF project generated in the communities in which it was implemented? Please compare the communes which implemented the model until its end (2015) to the communes in which the model was implemented only partially. What do you think of service delivery in the communes that were dropped from the project?
7. What do you think is required (at all levels: institutional, legislative, human and financial resources) to continue the model in the communities of your county? Which would be the enabling factors? To what extent is the current environment favourable to continuing the model? In your opinion, which are the obstacles/bottlenecks?

Model effectiveness

8. According to the project design, the social services delivered to children and their families (information, counselling, guidance, referral, needs assessment and reassessment) and the other project elements contribute to reducing vulnerabilities:

   8.1. If the project helps reduce vulnerabilities, please describe how.

   8.2. If the project does not help reduce vulnerabilities, please specify why not, in your opinion.

Address, one by one, the following potential project outcomes:

Access to certain services

a. Increased access to social services
b. Children have increased access to health services
c. Children have increased access to education
d. Education participation and school attendance

Quality of services received

e. Increased family care, including in terms of health and nutrition (better food, provision of vitamins etc.)

f. Better social services for children

g. Better health services for children

h. Improved health care for pregnant women, including pregnant adolescent girls

i. Increased quality of care for children with disabilities or special needs

Reduced risks due to services received

j. Reduced risk of teen pregnancies

k. Reduced risk of poverty and unsanitary housing

l. Children are protected against the risk of child-family separation

m. Children are protected against violence / reduced violence

n. Prevention of risk behaviour (particularly alcohol consumption) among children and especially adolescents

o. Children (including adolescents) and their families have increased knowledge of their rights

Community-level outcomes

p. Increased SPAS capacity to further deliver social services

q. Increased community interest for addressing children's issues

(the underlined items are part of the ToC and the answers related to them help assess project effectiveness and impact as well as relevance)

9. What do you think of the Aurora application and online platform? What did the use of Aurora change for you at county level? And for the community workers?

r. To what extent is the Aurora useful to you and your institution at county level? Please provide examples/arguments.

s. What elements of the Aurora help you most in your work?

t. What additional elements would Aurora require so as to provide you with all the information you need in your work?

10. How successful was each of the project components? If a component was successful, please specify in what way. If it was not successful, please specify why not.

Address the following items separately, explaining to what extent and via what mechanisms they were effective:

u. Services (Identification, Needs assessment (using the Aurora), Information and guidance, Counselling, Accompaniment and support, Referral, Monitoring, Reassessment (reapplication of the Aurora).

v. If you consider the risk of child-family separation and the priority zero services, how would you assess the procedure developed in the project? Do you believe community-level intervention can reduce pressure on the child care system? Please provide a few examples.

a. Integrated approach to services (at community level and involving the Community Consultative Structures) and team approach to service delivery (where applicable) – by the social worker and the community health nurse.

b. County coordination and supervision, including ongoing activity monitoring and evaluation.

w. Capacity building for professionals (at both local and county level)

x. Micro-grants

11. Do you think the project duration was long enough to generate impact for the children and their families who received the services?

12. What changes do you think the model implementation determined/influenced at local level/for its beneficiaries?

Cooperation with local institutions and chances of sustainability

13. With reference to the project, what can you tell us about the GDSACP/DPH (depending on the person you are interviewing) cooperation with the local institutions? And with the outreach worker(s)? How did things work? Give examples.

14. Which were the activities/elements with best results? Which were the barriers? What were the strong points of the resource centres/support provided by the GDSACP/DPH? How would you describe the work of methodological supervision you carried out in the project? What should be improved with regard to this methodological coordination?

15. How would you assess the impact and relevance of the experience exchanges facilitated by the project?

Cooperation among county institutions

16. What is your opinion of the cooperation between the 2 partner county institutions in the everyday work? And in the project? How did it work? Give examples. For the GDSACP supervisors: What changes resulted from adding the health component to the project in 2013?

17. What is your opinion of the capacity-building activities? Which ones were the most successful (training, working meetings, visits etc.)?

18. What were the main benefits of working in an integrated manner? What can you tell us about the professional network this project helped create?

Lessons learned and recommendations

19. What lessons learned in the project should be considered for future reference when carrying out activities related to continuing or scaling up, at county or national level, a minimum package of preventive services? What would you recommend?

20. Did the project generate significant unexpected outcomes, such as building local capacity to respond to and/or address other issues related to child rights protection and promotion? What about at county level?

Annex 11.4. Interview guide – Social/outreach workers and community health nurses from the intervention communes

Interviews with the social/outreach workers and the community health nurses from communities which implemented the model/project will be conducted by the local experts of **International Consulting Expertise (ICE)**. They will be organised separately, at the beginning of the field data collection mission.

The interview serves to collect information for all the evaluation criteria.

Instructions for the local experts who conduct the interviews

– The questions proposed provide guidance, the interview will be semi-structured and will enable the social/outreach workers to express themselves freely. The information thus collected will be analysed afterwards.

– If some of the questions reveal the need for further questioning, ask additional questions that will guide the discussion and provide clarity.

– If the questions you ask ellicit broad answers (lacking specifics), answers that refer to hypothetical cases or desirable answers, insist that respondents provide concrete examples.

– If the answer to one of the questions was already formulated during the discussions that covered a previous question, ask the participants if they have anything else they would like to add on the respective topic. If there is nothing else, move on.

– The section dedicated to presenting the project is to be tailored to each interviewee, providing answers to all the participants' questions.

Intro

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/ project implemented by **UNICEF in Romania** between April 2011 and September 2015, a model in whose implementation you were also involved.

Everything we discuss here is strictly confidential – nothing will be shared with anyone outside this model/ project and you will be cited in reports as "interviewed community worker". You need to know that your opinions will not be treated as good/bad or as right/wrong and that we are not here to judge you in any way. This discussion will help us understand whether the model/project has met the community's and professionals' needs and will enable us to formulate recommendations for the national replication of an intervention model.

We would also like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Community needs

1. Which would you say are the main problems/challenges and needs of children and their families in your community?

2. Would you say that these problems/challenges and needs are visible to the community / known to the main stakeholders/professionals expected to address them (e.g. does the head teacher know what children are not enrolled in school or does the family physician know who is not registered on his/her lists and do these professionals carry out activities to reduce vulnerabilities?)? Which ones are visible and which are less so? Why?

   Can you give an example of problem/vulnerability which is difficult to identify? (i.e. violence, abuse, neglect etc.)

3. From your experience, do the services delivered in the project help address problems, meet needs? Give us some examples of services you delivered. Were there services you were unable to provide? Why is that (for reasons of capacity, existing resources, services that were not available/in place etc.)? What would you do differently if you could?

4. What problems/challenges and needs could not be addressed in the model?

The work of community workers

5. What are your duties within the mayoralty? How do you cooperate with the other community workers in the commune?

6. How do you generally divide your work time between field and office duties? Describe a regular week at work (as it was a year ago, until September 2015).
7. What do you do to identify vulnerable children and persons in the commune?
8. What are your strategies to encourage children to attend school? And to determine the household children and adults to register with a family physician and undergo regular health checkups?
9. What are your strategies to identify and combat situations of violence against children? Were the training courses you attended useful? The materials you received? What about the support you got from county/national level?
10. How many cases were you able to manage in a regular month? How did you prioritise your intervention?
11. For those who worked individually: Did you feel the need to get help from other co-workers? What kind of help would you have needed?
12. For those who teamed up with a community health nurse: What do you think about team work? Does it make your work easier or, on the contrary, harder? How did you go about establishing the work plan? How did you take decisions?

Model effectiveness

13. According to the model/project design, the social services delivered to children and their families (information, counselling, guidance, referral, needs assessment and reassessment) and the other project elements contribute to reducing vulnerabilities:

    13.1. If the project helps reduce vulnerabilities, please describe how.

    13.2. If the project does not help reduce vulnerabilities, please specify why not, in your opinion.

Address, one by one, the following potential project outcomes:

Access to certain services

a. Increased access to social services
b. Children have increased access to health services
c. Children have increased access to education
d. Education participation and school attendance

Quality of services received

e. Increased family care, including in terms of health and nutrition (better food quality, provision of vitamins etc.)
f. Better social services for children
g. Better health services for children
h. Improved health care for pregnant women, including pregnant adolescent girls
i. Increased quality of care for children with disabilities or special needs

Reduced risks due to services received

j. Reduced risk of teen pregnancies
k. Reduced risk of poverty and unsanitary housing
l. Children are protected against the risk of child-family separation

m. Children are protected against violence / reduced violence

n. Prevention of risk behaviour (particularly alcohol consumption) among children and especially adolescents

o. Children (including adolescents) and their families have increased knowledge of their rights

Community-level outcomes

p. Increased SPAS capacity to further deliver social services

q. Increased community interest for addressing children's issues

(the underlined items are part of the ToC and the answers related to them help assess project effectiveness and impact as well as relevance)

14. What do you think about the Aurora application and the way it can help you manage cases of vulnerable children and women in the community?

    a. With regard to the identification services (children recorded in the 2011 database), has the Aurora also helped you identify unknown vulnerabilities/vulnerabilities other than those you knew of?

    b. Have you identified new cases using the Aurora (newborns, cases of violence etc.)? How did you identify them? Were they referred to you by other local stakeholders?

    c. Do you think the services generated by the Aurora are relevant to the types of cases you are dealing with?

    14.1. What additional elements would Aurora require so as to provide you with all the information you need in your work?

15. Were the individual project components successful? If a component was successful, please specify in what way. If it was not successful, please specify why not.

    Address the following items separately, explaining to what extent and via what mechanisms they were effective:

    a. Identification

    b. Needs assessment (using the Aurora)

    c. Information and guidance

    d. Counselling

    e. Accompaniment and support

    f. Referral

    g. Monitoring

    h. Reassessment (using the Aurora again). What are the benefits of re-administering the questionnaire?

    i. Priority 0 service (please refer to how the risk of child-family separation is assessed as well as to the implementation of the service)

    j. Integrated approach to services (at community level and involving the Community Consultative Structures) and team approach to service delivery (where applicable) by the social worker and the community health nurse

    k. Micro-grants

16. Would you say the project duration was long enough to generate impact among the children and their families who received the services?

17. What changes do you think the model implementation determined/influenced at local level/for its beneficiaries?

SPAS capacity and chances of sustainability

18. How would you assess the SPAS capacity to deliver social services? Can you compare the situation in 2015 to that in 2011?

19. What services were you able to deliver? Were there services you were unable to deliver? What were the main barriers?

20. In your opinion, how do service recipients/community members view the social services (versus social benefits) /health services (for the community health nurse, where applicable)? What do other local professionals think of these services?

21. What is your opinion of the integrated approach? Did it help/would it have helped to team up with another community worker? How did you manage to split the tasks between the two of you/How would you have split the tasks had you worked together with a CHN?

22. If you consider priority 0 service, do you think it is a useful service? Does it accurately indicate the cases of child-family separation (Attention! Not the emergency situations)? In what way do you think the procedure that needs to be initiated can help you in your intervention? Please give some examples.

23. How do you cooperate with the Community Consultative Structure and with other community actors (e.g. clinic, school etc.)?

24. In your opinion, how did the model implementation influence the attitude of the community's mayor? How about that of other mayoralty staff?

25. What do you think is required (at all levels: institutional, legislative, human and financial resources) to continue the model in the community? Which would be the enabling factors? To what extent is the current environment favourable to continuing the model? In your opinion, which are the obstacles/ bottlenecks?

Cooperation with county institutions (GDSACP and DPH) and chances of sustainability

26. How is your cooperation with the GDSACP? What kind of support do you receive from them and what kind of support would you need? What were the strong points of the resource centres/support provided by the GDSACP? How necessary and relevant would you say was the methodological coordination/supervision provided by the GDSACP in the project? What aspects of this methodological coordination/supervision should be improved?

27. And with the DPH? What kind of support do you receive from them and what kind of support would you need? What were the strong points of the resource centres/support provided by the DPH? How necessary and relevant would you say was the methodological coordination/supervision provided by the DPH in the project? What aspects of this methodological coordination/supervision should be improved?

How would you assess the impact and relevance of the experience exchanges facilitated by the model/project?

27.1. What about the relationship with other county-level institutions? Would you say the county supervisors facilitated access to other county institutions?

28. In your opinion, does the model increase or reduce pressure on the child care system? Why so? Can you give some examples?

Model efficiency

29. Would you say the model made an efficient use of its resources? Financially speaking, what can you tell

us about the benefits of the integrated approach promoted by the model? Can you compare the model costs to the regulated standard costs?

Can you assess the costs and results of the model – of the services delivered to children and their families – versus the costs and results of the social benefits paid according to the law? Please compare the outcomes of the UNICEF model to the outcomes of the social benefits. Consider the children who could have qualified to receive project services (given their high vulnerability) and who received only social benefits. Give examples.

Lessons learned and recommendations

30. Which of the lessons learned at the local level should be considered for future reference when carrying out activities related to continuing or scaling up, at county or national level, a minimum package of services to prevent child-family separation?
31. Did the project generate significant unexpected outcomes, such as building local capacity to respond to and/or address other issues related to child rights protection and promotion?
32. Do you have any recommendations in view of a potential replication/scale-up of the model at county level (all communities in a county) and/or national level?

Annex 11.5. Interview guide – Social/outreach workers from the control communes

Interviews with the social/outreach workers from the control communes will be conducted by the local experts of **International Consulting Expertise (ICE)**. Depending on the local context, if the social/outreach worker involved in the project in 2011 changed in the meantime and there is another mayoralty employee who knows more about the initial identification carried out in 2011 and about the SPAS activity, the interview will be conducted with that person.

The interview serves to collect information for comparison with the information collected in the communes which implemented all project phases.

Instructions for the local experts who conduct the interviews

– The questions proposed provide guidance, the interview will be semi-structured and will enable the social/outreach workers to express themselves freely. The information thus collected will be analysed afterwards.
– If some of the questions reveal the need for further questioning, ask additional questions that will guide the discussion and provide clarity.
– If the questions you ask ellicit broad answers (lacking specifics), answers that refer to hypothetical cases or desirable answers, insist that respondents provide concrete examples.
– If the answer to one of the questions was already formulated during the discussions that covered a previous question, ask the participants if they have anything else they would like to add on the respective topic. If there is nothing else, move on.
– The section dedicated to presenting the project is to be tailored to each interviewee, providing answers to all the participants' questions.
– Questions regarding community health nurses are to be asked only in those communities where these are present.

Intro

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/project implemented by **UNICEF in Romania** between April 2011 and September 2015.

The model/project aimed to increase the impact of social protection policies among vulnerable children and families (the 'invisible' children) by delivering a prevention-based minimum package of services and, as such, to build the local authorities' capacity to support basic social services. In your commune, the model was implemented in 2011 in the phase concerned with the identification of 'invisible children'. After that, the model was further implemented in other communes of the county.

Everything we discuss here is strictly confidential – nothing will be shared with anyone outside this model/project and you will be cited in reports as "interviewed community worker". You need to know that your opinions will not be treated as good/bad or as right/wrong and that we are not here to judge you in any way. This discussion will help us understand whether the model/project has met the community's and professionals' needs and will enable us to formulate recommendations for the national replication of an intervention model.

We would also like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Community needs

1. What are the main problems/challenges and needs of children and their families in your community?
2. Would you say that these problems/challenges and needs are visible to the community / known to the main stakeholders/professionals expected to address them (e.g. does the head teacher know what children are not enrolled in school or does the family physician know who is not registered on his/her lists and do these professionals carry out activities to reduce vulnerabilities?)? Which ones are visible and which are less so? Why? Can you given an example of problem/vulnerability which is difficult to identify? (i.e. violence, abuse, neglect etc.)
3. From your experience, do the SPAS services help address problems, meet needs? Give us some examples from your everyday work. What services are available locally?
4. What problems/challenges and needs cannot be addressed by the SPAS? What are the reasons why the SPAS and you in your work are unable to cover all the problems or needs of children and their families?

The work of community workers

5. What are your duties within the mayoralty? How do you generally divide your work time between field and office duties? Describe a regular week at work.
6. What strategies do you use to identify vulnerable children and persons in the commune?
7. What are your strategies to encourage children to attend school? And to determine the household children and adults to register with a family physician and undergo regular health checkups?
8. What are your strategies to identify and combat situations of violence against children?
9. Do you think you need help/support to better identify vulnerabilities of children and their families? And to address those vulnerabilities?
10. How many cases are you able to manage in a regular month? How do you prioritise your intervention?

Effectiveness of community workers' activity

11. The work you carry out within the SPAS result in: …..

    11.1. If your work helps reduce the listed vulnerabilities, please describe how.

    11.2. If your work does not help reduce the listed vulnerabilities, please specify why not.

Address, one by one, the following potential outcomes of SPAS work:

Access to certain services

a. Increased access to social services

b. Children have increased access to health services

c. Children have increased access to education

d. Education participation and school attendance

Quality of services received

e. Increased family care, including in terms of health and nutrition (better food quality, provision of vitamins etc.)

f. Better social services for children

g. Better health services for children

h. Improved health care for pregnant women, including pregnant adolescent girls

i. Increased quality of care for children with disabilities or special needs

Reduced risks due to services received

j. Reduced risk of teen pregnancies

k. Reduced risk of poverty and unsanitary housing

l. Children are protected against child-family separation

m. Children are protected against violence / reduced violence

n. Prevention of risk behaviour (particularly alcohol consumption) among children and especially adolescents

o. Children (including adolescents) and their families have increased knowledge of their rights

Need for tools and approaches initiated by the UNICEF model

12. To address the multiple vulnerabilities of children and their families in your community, would you need guidance/tools/ methodological supervision and coordination?

    a. And to prepare an intervention plan?

    b. Would you say a digital tool (a program on a tablet computer) based on a household questionnaire serving to assess vulnerabilities for each household would be of use in the SPAS activity? What should such a tool include?

    c. Do you believe a minimum package of (social, health, educational) services can better help reduce the vulnerabilities mentioned previously?

    d. If you were to consider the monitoring and evaluation of the cases you have on file, what would be your needs?

13. What is your opinion of the integrated approach? Do you think it would be useful for you and the other SPAS co-workers (e.g. the community health nurse, the health mediator etc.) to have common/ shared working tools? How about a common database?

Institutional capacity

14. How would you assess the SPAS capacity to deliver social services? Can you compare the situation in 2016 to that in 2011? What kind of support does the social/outreach worker receive from the mayoralty? What resources are available to them?
15. What community support (from institutions other than the mayoralty) do you receive to fulfil your social worker tasks? How do you cooperate with the school, the clinic etc.?
16. How do you cooperate with the GDSACP? And with the DPH? What kind of support do you receive from them and what kind of support would you need?

Model replication

17. What do you think is required (at all levels: institutional, legislative, human and financial resources) to implement the UNICEF model/project in your community as well? Which would be the enabling factors? To what extent is the current environment favourable to implementing this kind of working approach? In your opinion, which are the obstacles/bottlenecks?

Very brief presentation: *The UNICEF model/project was based on the delivery of a minimum package of basic social and health services, following an initial assessment conducted using standardised questionnaires. The social services planned after having identified and assessed the vulnerabilities included information, counselling, accompaniment and support, monitoring and regular needs reassessment.*

Annex 11.6. Interview guide – Parents (recipients of model services)

Interviews with parents will be conducted by the local experts of **International Consulting Expertise (ICE)**. To determine which parents to interview, enlist the support of the social/outreach worker and/or of the community health nurse.

The interview serves to collect information on model/project relevance and effectiveness.

Instructions for the local experts who conduct the interviews

- The questions proposed provide guidance, the interview will be semi-structured and will enable the parents to express themselves freely. The information thus collected will be analysed afterwards.
- If some of the questions reveal the need for further questioning, ask additional questions that will guide the discussion and provide clarity.
- If the questions you ask ellicit broad answers (lacking specifics), answers that refer to hypothetical cases or desirable answers, insist that respondents provide concrete examples.
- If the answer to one of the questions was already formulated during the discussions that covered a previous question, ask the participants if they have anything else they would like to add on the respective topic. If there is nothing else, move on.
- The section dedicated to presenting the project is to be tailored to each interviewee, providing answers to all the participants' questions.
- Questions regarding community health nurses are to be asked only in those communities where these are present.

Introduction

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/project implemented by **UNICEF in Romania** between April 2011 and September 2015.

The model/project aimed to ensure delivery of social and health services for children and their families to improve the way the state supports rural children's development.

This discussion will help us understand whether the project has met the needs you had at the time and whether it was truly useful to you.

Everything we discuss here is strictly confidential – nothing will be shared with anyone outside this model/project and you will be cited in reports as "interviewed parent". You need to know that your opinions will not be treated as good/bad or as right/wrong and that we are not here to judge you in any way.

We would also like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Children's and their families' needs

1. Tell us/Talk about your children and family (consider the household structure, income, housing conditions, any particular issues). What major problems/challenges does your family have? How have they changed over the last 5 years?
2. What kind of support do you need? Do you think the social/outreach worker or the community health nurse could provide the support you need?
3. What kind of support do you receive from the mayoralty: cash, goods, items? How important are these to you? Would you be able to live without social aid?

Model effectiveness

4. Do you know the social/outreach worker in the commune? Do you know his/her name, what he/she does or what his/her role is?

   4.1. Do you know the community health nurse? Do you know his/her name, what he/she does or what his/her role is?

5. Did the social/outreach worker visit you? How often was your household visited? When was it visited (when the community worker was available, on a need basis etc.)?

   5.1. Did the community health nurse visit you? How often was your household visited? When was it visited (when the community worker was available, on a need basis etc.)?

6. Briefly describe your relationship with the social/outreach worker. And with the community health nurse. What is your opinion of their work?
7. How do you let the social/outreach worker and/or the community health nurse know what your needs are?
8. Have you ever asked the social/outreach worker and/or the community health nurse for help? In what circumstances? How? Tell us about the last time you remember you asked for their help.
9. Did the social worker provide you with the information you needed to solve the problem you had? Did he/she tell you what rights children and adults have? Did he/she refer you to other relevant institutions and/or specialists (i.e. specialised physician, psychologist, the GDSACP, the County Employment Agency etc.)? Did he/she accompany you to other institutions to receive services (i.e. family physician, school etc.)? Did he/she help take decisions?

   9.1. What about the community health nurse? (repeat the above questions regarding the main types of services)

Model impact

10. Five years ago, were all your family members registered with a family physician? What about now? If not, why not?

    10.1. Did the social/outreach worker and/or the community health nurse help you register the children in your household with a family physician?

11. Five years ago, were all the family's school age and preschool age children enrolled in school or kindergarten? What about now? If not, why not?

    11.1. Did the social worker help you enrol the children in school?

12. Did the teaching staff (preschool teacher/primary school teacher/high school teacher) ever complain about your children? Do your children have school problems (poor performance or bad behaviour – fights etc.)? If yes, did the social worker help you manage the situation? How?

13. Do all your children live in the household?

    – If not, where are those who don't? Are any of your children in public care? What is their status? Do you want to take them back?

    – Was there ever a time when one of your children could have ended up in public care? Why? What did the social worker do then? Tell us more about this.

14. What do you do when your children do something stupid? How do you react? Do you use punishment to discipline the children? If yes, how are children punished in your family? Has anything changed in the past few years in the way you talk to/discipline your children? Did the social worker help you find discipline methods that don't involve beating the child?

15. Do you have your children help you run the household? Starting what age? Did the social worker talk to you about the consequences of child labour?

16. With what other problems/matters did the social worker help you? And the community health nurse? (depending on the parents' openness, explore issues such as: child vaccination, obtaining ID papers or other documents (e.g. disability certificate etc.), contraception for the parents or the adolescent members of the family)

17. Did you take part in activities organised by the social worker and/or the community health nurse? If yes, please describe the activity and your participation. What did you learn in those activities? What else would you have liked to learn? Would you participate in such activities again? What would you add?

General assessment

18. Which would you say was the biggest help you received from the social worker? And from the community health nurse? What do you think would have happened had you not received that help?

19. What aspects of their work are you not satisfied with? Which were insufficient? What do you think could be done better? Or what else could the social worker and the community health nurse do in addition to what they have done so far?

    19.1 If both workers were available in the commune, what is your opinion of how the two of them worked/work together?

    19.2 If the social worker worked/works by himself/herself, do you think he/she would need additional help? From whom? What kind of help?

    19.3 How about you, what else could you do to support the social worker and the community health nurse?

Annex 11.7. Interview guide – National decision-makers

Interviews conducted at national level with representatives of key ministries and institutions serve to collect information on model/project relevance and effectiveness in relation to national strategies and on model replication nationwide.

Interviews will be conducted by a senior expert from the national expert team of International Consulting Expertise (ICE).

Remarks

- The interview will be semi-structured, the questions will serve as basis for dialogue and will guide the discussion, they don't have to be used word for word.
- If the interviewees find it useful to add information, this should be encouraged.
- In all cases, insist that interviewees provide concrete examples to illustrate their statements.
- Each participant will receive a brief presentation of the model/project, explaining the UNICEF approach and the key concepts. The introduction will cover the main model/project activities, phases and most relevant definitions to ensure common understanding. As we do not know what level of knowledge the panel participants share, this presentation cannot be standardised and will represent the first (unstructured) part of the discussion.

Interviewees

Interviews will target representatives of the following institutions:

- The Minister of Labour, Family, Social Protection and the Elderly
- the National Authority for the Protection of Child Rights and Adoption
- the Ministry of Health
- the Ministry of Youth and Sports

Introduction

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/project implemented by **UNICEF in Romania** between April 2011 and September 2015. The model/project aimed to increase the impact of social protection policies among vulnerable children and families (the 'invisible' children) by delivering a prevention-based minimum package of services and, as such, to build the local authorities' capacity to support basic social services.

We would like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Model relevance

To guide the discussion, you can use the following questions:

1. To what extent and in what way would you say the UNICEF project addressed the needs of the most vulnerable children and reduction of inequities?
2. How would you assess the relevance of the UNICEF model in relation to national policies and programmes, sectoral or cross-sectoral strategies?

a. In relation to which of the priorities of the strategy for the protection and promotion of children's rights would you say the model was/is most relevant?

b. How about in relation to other strategies? (list the strategies relevant to the public authority where the interview is conducted)

c. What necessary information to develop a strategy/decide on certain prioritites did the UNICEF model provide you?

Model effectiveness

To guide the discussion, you can use the following questions:

3. To what extent would you say the model helped reduce children's vulnerabilities and, as such, contributed to the realisation of children's rights, as set out in the UN Convention on the Rights of the Child?

   a. Does the minimum package of services address all children's vulnerabilities?

   b. What would you say is the added value of the integrated approach promoted by the model?

   c. In your opinion, how do the micro-grants (awarded to mayoralties) contribute to reducing vulnerabilities?

4. Do you think the model increases or reduces the pressure on the child care system? Justify.

5. In your opinion, how did the model contribute to strengthening national strategies and focus on prevention of child-family separation and of violence against children?

Model efficiency

To guide the discussion, you can use the following questions:

6. What are the financial benefits of the integrated approach promoted by the model/project? What is your opinion of this model/project costs (present the findings of the PwC study) compared to those set out in the regulated cost standards?

Model replication

To guide the discussion, you can use the following questions:

7. Do you think the model/project can be replicated at national level? As a whole or only certain components (specify which components)? Do you think adjustments are necessary in view of replication?

8. What do you think is required (at all levels: institutional, legislative, human and financial resources) to scale up the model at national level? Which would be the enabling factors? To what extent is the current environment favourable to scaling up the model/project nationwide? In your opinion, which are the obstacles/bottlenecks?

9. Do you have any recommendations in view of a potential model replication/scale-up at national level?

Model impact

To guide the discussion, you can use the following questions:

10. What changes would you say the model has determined/influenced at national/county/local/the beneficiaries' level (ask for the interviewees' opinion on all the levels they know of)?

11. To what extent did the model determine an increase in the impact of social protection policies on the most poor and vulnerable children? What are the current outcomes of implementing the strategies the model influenced?

Lessons learned and unexpected outcomes

To guide the discussion, you can use the following questions:

12. Which of the lessons learned at the national level should be considered for future reference when carrying out activities related to the national scale up of a minimum package of services to prevent child-family separation?
13. Did the model generate significant unexpected outcomes, such as building local capacity to respond to and/or address other issues related to child rights protection and promotion?

Annex 11.8. Interview guide – National NGOS

Interviews conducted at national level with UNICEF partner representatives serve to collect information on model implementation, sustainability and impact as perceived by the partners, including the reasons/arguments regarding model sustainability and impact and whether the model is replicable on a larger scale (county, multi-county, national level).

Interviews will be conducted by a senior expert from the national expert team of **International Consulting Expertise (ICE)**.

Remarks:

- Given that the interviewees are familiar with the topic, a detailed presentation of the project is not necessary.
- The interview will be semi-structured, the questions will serve as basis for dialogue and will guide the discussion, they don't have to be used word for word.
- If the interviewees find it useful to add information, this should be encouraged.
- In all cases, insist that interviewees provide concrete examples to illustrate their statements.

Interviewees

Interviews will target representatives of the following organisations:

- CERME
- CPSS
- PSI

Introduction

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** model/project implemented by **UNICEF in Romania** between April 2011 and September 2015. The model/project aimed to increase the impact of social protection policies for vulnerable children and families (the 'invisible' children) by delivering a prevention-based minimum package of services and, as such, to build the local authorities' capacity to support basic social services.

We would like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

Questions

Model relevance

To guide the discussion, you can use the following questions:

1. To what extent and in what way would you say the UNICEF model/project addressed the needs of the most vulnerable children and reduction of inequities?

2. How would you assess the relevance of the UNICEF model in relation to national policies and programmes, sectoral or cross-sectoral strategies?

   a. In relation to which of the priorities of the strategy for the protection and promotion of children's rights would you say the model was/is most relevant?

   b. How about in relation to other strategies?

   c. What necessary information to develop a strategy/decide on certain prioritites did the UNICEF model provide?

Model effectiveness

To guide the discussion, you can use the following questions:

3. To what extent would you say the model helped reduce children's vulnerabilities and, as such, contributed to the realisation of children's rights, as set out in the UN Convention on the Rights of the Child?

   a. Does the minimum package of services address all children's vulnerabilities?

   b. What would you say is the added value of the integrated approach promoted by the model?

   c. In your opinion, how do the micro-grants (awarded to mayoralties) contribute to reducing vulnerabilities?

4. Do you think the model increases or reduces the pressure on the child care system? Justify.

5. In your opinion, how did the model contribute to strengthening national strategies and focus on prevention of child-family separation and of violence against children?

Model efficiency

To guide the discussion, you can use the following questions:

6. Would you say the model/project used resources in an efficient/economical manner? What is your opinion of the model/project costs compared to those of other similar projects you know or implement?

7. Financially speaking, what can you tell us about the benefits of the integrated approach promoted by the model? What is your opinion of this project costs (present the findings of the PwC study) compared to those set out in the regulated cost standards?

Model replication

To guide the discussion, you can use the following questions:

8. Do you think the model/project can be replicated at national level? As a whole or only certain components (specify which components)? Do you think adjustments are necessary in view of replication?

9. What do you think is required (at all levels: institutional, legislative, human and financial resources) to scale up the model/project at national level? Which would be the enabling factors? To what extent is the current environment favourable to scaling up the model/project nationwide? In your opinion, which are the obstacles/bottlenecks?

10. Do you have any recommendations in view of a potential model replication/scale-up at national level?

Model impact

To guide the discussion, you can use the following questions:

11. What changes would you say the model/project has determined/influenced at national/county/local/the beneficiaries' level (ask for the interviewees' opinion on all the levels they know of)?

12. To what extent did the model/project determine an increase in the impact of social protection policies

on the most poor and vulnerable children? What are the current outcomes of implementing the strategies the model influenced?

Lessons learned and unexpected outcomes

To guide the discussion, you can use the following questions:

13. Which of the lessons learned at the national level should be considered for future reference when carrying out activities related to the national scale up of a minimum package of services to prevent child-family separation?
14. Did the model/project generate significant unexpected outcomes, such as building local capacity to respond to and/or address other issues related to child rights protection and promotion?

Annex 11.9. Focus group guide

The focus group will be organised by the local experts of **International Consulting Expertise (ICE)** towards the end of the field data collection mission, and its participants will consist of members of the Community Consultative Structures (CCS) and, where applicable, of representatives of local NGOs. The social/outreach workers and/or community health nurses will be asked to support the local experts in identifying the focus group participants and the most suitable location to organise it. Participants and location will depend on the local context, but organising the focus group on the mayoralty or school premises should take priority. Where a commune lacks an operational CCS, the focus group will consist of relevant local stakeholders (who would have otherwise been part of the CCS had it been functional).

The focus group will serve to collect information on the needs of the community, the main model outcomes, the CCS contribution to the model implementation and on the chances of continuing the model in the community once the UNICEF project ends.

Instructions for the local experts who conduct the focus groups

– The questions proposed provide guidance, the focus group guide being semi-structured.
– If some of the questions reveal the need for further questioning, ask additional questions to guide the discussion.
– If the questions you ask ellicit broad answers (lacking specifics), answers that refer to hypothetical cases or desirable answers, insist that respondents provide concrete examples.
– If the answer to one of the questions was already formulated during the discussions that covered a previous question, ask the participants if they have anything else they would like to add on the respective topic. If there is nothing else, move on.
– Given the long list of topics for discussion under question 5, please print the list of topics tackled by question 5 and hand it to the participants when you reach that question.
– The sections dedicated to presenting the project (at the beginning and preceding a set of questions) is to be tailored to each group, providing answers to all the participants' questions.
– During the focus group, the terms "model" or "project" will be used with reference to the UNICEF initiative "First Priority: No More 'Invisible' Children!", depending on which term is most familiar to the focus group participants.

Introduction

My name is ..... and I represent **International Consulting Expertise (ICE)**, a company conducting during March 2016 – March 2017 the **evaluation of "First Priority: No More 'Invisible' Children!"** project implemented by **UNICEF in Romania** between April 2011 and September 2015. The project aimed to increase the impact of social protection policies for vulnerable children and families (the

'invisible' children) by delivering a prevention-based minimum package of services and, as such, to build the local authorities' capacity to support basic social services.

The focus groups (such as the one you are participating in right now) will help us understand the community's needs, the main project outcomes, the CCS contribution to the project implementation and the chances of continuing the project in the community once the UNICEF model/project ends.

Everything we discuss here is strictly confidential – nothing will be shared with anyone outside this project and you will be cited in reports as "focus group participant". You need to know that your opinions will not be treated as good/bad or as right/wrong and that we are not here to judge you in any way.

The ground rules should be discussed with all focus group participants: 'All answers are welcome!', 'We respect everyone's views, even if they are different from ours!', 'We encourage everyone to actively participate in the discussion!'.

Our discussion will focus on the model/project and on the Community Consultative Structure you are part of. We will ask you to talk about your experience with these. If you were not involved in this type of activities, please let us know and we will provide you with more details.

We would also like to have your permission to record our discussion so as to keep track of details and ensure complete and accurate data. Your input is considered highly relevant. If you agree, I will turn on the recorder.

We estimate this meeting will last around 90 minutes.

Questions

Community's, children's and their families' needs, important in evaluating the UNICEF project relevance

1. What are your community's main problems/challenges and needs?
2. What are the main problems/challenges and needs of children and their families in your community?
3. Of all the problems and needs children and their families have, which ones are most visible (easily identifiable by everyone) and which ones are least visible? Can you tell us why some of the problems are more visible than others?
4. What resources are there available in your community to address these problems? To what extent does the community need support in addressing these problems and what kind of support would that be?

Project effectiveness and outcomes

Very brief presentation: *The UNICEF project was based on the delivery of a model minimum package of basic social and health services, following an initial assessment conducted using standardised questionnaires. The social services planned after having identified and assessed the vulnerabilities included information, counselling, accompaniment and support, monitoring and regular needs reassessment. Not all identifiable vulnerabilities could be addressed by the project directly, but we would also like to know whether any of the problems and needs of children and their families could have been addressed by the project indirectly.*

5. According to the project design, the social and health (where applicable) services delivered to children and their families (information, counselling, guidance, referral, needs assessment and reassessment) and the other project elements contribute to reducing vulnerabilities:

   5.1. If the project helps reduce vulnerabilities, please describe how.

   5.2. If the project does not help reduce vulnerabilities, please specify why not, in your opinion.

Address, one by one, the following potential project outcomes:

Access to certain services

a. Children have increased access to social services

b. Children have increased access to health services

c. Children have increased access to education

d. Education participation and school attendance

Quality of services received

e. Increased family care, including in terms of health and nutrition (better food, provision of vitamins etc.)

f. Better social services for children

g. Better health services for children

h. Improved health care for pregnant women, including pregnant adolescent girls

i. Increased quality of care for children with disabilities or special needs

Reduced risks due to services received

j. Reduced risk of teen pregnancies

k. Reduced risk of poverty and unsanitary housing

l. Children are protected against the risk of child-family separation

m. Children are protected against violence / reduced violence

n. Prevention of risk behaviour (particularly alcohol consumption) among children and especially adolescents

o. Children (including adolescents) and their families have increased knowledge of their rights

Community-level outcomes

p. Increased SPAS capacity to further deliver social services

q. Increased community interest for addressing children's issues

(Explanatory note for the experts: the underlined items are part of the Theory of Change (ToC) and the answers related to them help assess project effectiveness and impact as well as relevance. The items not underlined are potential vulnerabilities which the project did not address directly. We are interested in assessing whether the project was able to generate indirect outcomes relative to these).

6. What changes do you think the model/project implementation determined/influenced at local level/ for its beneficiaries? Please provide concrete examples.

Community Consultative Structure (CCS) role

7. How is the CCS organised? How, where and how often does it get together? What topics of discussion does it cover? How has its activity progressed over the last years (go back at least 3 years)? Please give us specific examples from the model/project implementation, keeping the identity of those involved confidential.

8. How did you, as CCS, participate in the implementation of the model/project?

UNICEF project efficiency

9. How would you assess the SPAS capacity to deliver social services? Can you compare the situation in 2016 to that in 2011? Have county-level institutions contributed to increasing SPAS capacity? If yes, which institutions and how?
10. Would you say the model makes an efficient use of its resources? From an economic point of view, what can you tell us about the benefits of the integrated approach promoted by the model, its ensuring the delivery of a package of basic social and health services?
11. Can you assess the results of the model – the services delivered to children and their families – versus the results of the social benefits paid according to the law?

UNICEF project sustainability

12. Do you think the results achieved are likely to continue in 2016 and beyond, even if the model/project ended?
13. What do you think is required (at all levels: institutional, legislative, human and financial resources) to continue the model/project in your community? Which would be the enabling factors? To what extent is the current environment favourable to continuing the model? In your opinion, which are the obstacles/bottlenecks?

Lessons learned, unexpected outcomes and recommendations

14. Do you have any recommendations in view of a potential replication/scale-up of the model/project at county level (all communities in a county) and national level?
15. Which of the lessons learned at the local level should be considered for future reference when carrying out activities related to continuing or scaling up, at county or national level, a minimum package of services to prevent child-family separation?
16. Did the project generate significant unexpected outcomes, such as building local capacity to respond to and/or address other issues related to child rights protection and promotion?

Annex 11.10. Guide for conducting workshops with children

Prior to organising the workshops with children, you need to ask for the parents' written informed consent to their children's participation and recording.

Introduction

- **Introduce the facilitator**.
- **Present the evaluation according to the children's level of understanding**: UNICEF carried out certain activities for them and we wish to understand whether or not these activities achieved all the intended results.
- **Cover the rules governing group work**.

Tips for the local experts

- Workshops with children will be conducted at the end of the data collection mission, for best use of the information collected.
- To facilitate communication with the children, avoid using the professional title and instead, to the extent possible, use the professionals' name or term they are known to go by in the community.
- During the workshop, the local expert will interact with the children and will guide their presentations (oral ones – via the living library and visual ones – via the collage technique) to best reflect the children's needs and their connection with the project, including their participation in the micro-grant projects.

Facilitation methods of acquiring information

1. Collages

   1.1. Children will receive:

   - a set of 10 newspapers and magazines
   - scissors (several pairs)
   - glue (several sticks), scotch tape for paper (several rolls)
   - markers of different colours
   - flipchart paper

   1.2. Form groups of 3–4 children each

   1.3. Children will be asked to prepare 2 collages:

   - one depicting their current life in the commune (including their needs, problems as well as joys),
   - one depicting how the social worker and community health nurse helped improve their life.

   1.4. Children with then be asked to present their collages.

   At the end of the workshop, the local expert will draft a report on:

   – project relevance, based on the collages that depict children's life and needs;

   – project effectiveness, based on the collages that depict children's interaction with the social worker and community health nurse;

   The report will include pictures of the collages.

2. Living library

Children will be asked to tell a true story about how they came to know the social worker and the community health nurse in the village and how they were helped by them.

At the end of the workshop, the local expert will draft a brief report summarising the situations depicted in the stories, which will serve to assess project effectiveness.

Questions asked will cover:

– micro-grant project activities;

– the extent of their participation in community life (major events, knowledge of local officials);

– whether they are asked for their opinion on the activities they are involved in, including the micro-grant project activities;

– their participation in the campaign against violence.

Annex 11.11. Observation protocol

– to be filled in at the end of the data collection mission by the local expert involved in the evaluation, using the information collected from the interviews and visits in the community, analysed based on the local expert's experience;

– photos of the community will be attached, to be used by the experts and in the report, if appropriate. To use photos of human subjects, adults'/parents' written consent will have to be obtained. Otherwise, there can be photos of the surroundings/household etc.

1. Context

Community name: ___

Number of inhabitants: ___

Number of villages: ___

Community structure (how remote are the villages, how scattered are the houses in the villages. Assess how challenging social workers' fieldwork is here): ___

Name of social worker: ___

Name of community health nurse: ___

Was the social worker hired by the project or was he/she already a mayoralty employee? – YES/NO / additional remarks: ___

Did the social worker remain in place (employed) after project completion? – YES/NO / additional remarks: ___

Was the community health nurse hired by the project or was he/she already a mayoralty employee? – YES/NO / additional remarks: ___

Did the community health nurse remain in place (employed) after project completion? – YES/NO / additional remarks: ___

(aceste informații pot fi culese în primul rând prin interviurile cu asistenții/lucrătorii sociali și asistenții medicali comunitari și prin chestionarele pentru primării)

2. General, economic and social context, community needs and problems

– Give a brief description of the community (how far from the town, structure – dispersal etc. Assess how challenging social workers' fieldwork is here) and of the existing services: water supply, sewerage, natu-

ral gas, family physician(s) (location of clinic(s), working hours), school(s) (up to what grade, separate classes or simultaneous teaching? etc.);

– Briefly describe the community population (age distribution, education level, main occupations etc.);

– Give a brief description of the community's socio-economic environment: inhabitants' main income sources, main economic activities, investors/economic initiatives;

– Identify the obvious community needs and problems (as they emerge from the interviews conducted with professionals, parents, from the workshops with children etc., as well as from the local experts' direct observation)

2. Social workers

2.1. Assess the social/outreach worker's training/qualification in the area of child protection, as resulting from your discussion with him/her (refer to their practical skills/competencies, in addition to the certification they possess).

Unsatisfactory / Insufficient to implement the project	Satisfactory / Sufficient at a minimum level to implement the project	Good	Very good

Justify: Refer to their studies, as well as the knowledge and competencies acquired during the project.

2.2. Assess the community health nurse's training/qualification in the area of child protection and child care (where CHNs are available), as resulting from your discussion with him/her (refer to their practical skills/competencies, in addition to the certification they possess).

Unsatisfactory / Insufficient to implement the project	Satisfactory / Sufficient at a minimum level to implement the project	Good	Very good

Justify: Refer to their studies, as well as the knowledge and competencies acquired during the project.

3. Stakeholders

3.1. Assess the relationship between the social worker and the community health nurse (where CHNs are available), as resulting from your discussion and from the focus group.

Very poor	Poor	Neutral	Good	Very good

Justify: .....

3.2 Assess the relationship between the social worker, the community health nurse (where CHNs are available) **and the community and various institutions** (as resulting from the interviews, discussions and focus group).

	Very poor	Poor	Neutral	Good	Very good
Community Consultative Structure / CCS members					
Children					
Families / parents					
GDSACP					
DPH					

Justify: .....

3.3. Assess the CCS work (as resulting from the interviews, discussions and focus group)

Very poor	Poor	Neutral	Good	Very good

Justify: .....

3.4. Assess how well the SPAS is organised in the community. Attention, according to Law 292/2011, the SPAS can be a department within the mayor's specialised apparatus.

Very poorly organised	Poorly organised	Neither good, nor bad	Well organised	Very well organised

Justify: .....

4. Motivation

Assess the motivation and capacity to continue the activities, the prevention-based approach and the community integrated approach, on the part of both social/outreach workers and community health nurses and the stakeholders. Justify.

Annex 12 – Structure of databases used in evaluating model pressure on child care and health care systems

Annex 12.1. Structure of dabase of entries into and exits from the child care system, in the intervention and control communes

County		Bacău	Botoșani	Buzău	Vrancea	Vaslui	Iași	Neamț	Suceava
Commune									
Year									
Total children separated from their family									
Total children separated from their family, of whom, according to cause of separation:	Parents deceased								
	Parents disappeared								
	Parents deprived of parental rights								
	Poverty								
	Abuse and neglect								
	Child disability								
	Parental disability								
	Other								
	For other, specify which								
Children who exited the system	Total								
	Of whom, children re-integrated in the family/ per commune								

Data collected and instructions for collection

Variable	**How to fill in. Answer options**
Child's first and last name	Enter the child's full name, not just the initials
Commune of origin (selection)	Enter the name of the commune of origin
Child's age (on last birthday) at the time of entry with the Child Protection Commission	Number, in years on last birthday. If child is below age 1, enter 0 (zero)
Did the child live with both parents?	Answer options: YES NO No information Not applicable
Number of child's siblings under age 18	Number
Child has other siblings in public care	Answer options: YES NO No information Not applicable
If yes, how many?	Number
Child living in poverty	Answer options: YES NO No information Not applicable
Child not registered with a family physician	Answer options: YES NO No information Not applicable

Variable	How to fill in. Answer options
Child aged up to 1 year, în a situation of risk	Answer options: YES NO No information Not applicable
Child aged 1 to 5 years, in a situation of risk	Answer options: YES NO No information Not applicable
Child with chronic disease or living in a household whose members have chronic diseases	Answer options: YES NO No information Not applicable
Child not enrolled in school, who dropped out of school or is at risk of dropping out	Answer options: YES NO No information Not applicable
Adolescent/child with risk behaviours	Answer options: YES NO No information Not applicable
Child living in a family prone to child violence, abuse or neglect	Answer options: YES NO No information Not applicable
Child living in precarious housing conditions	Answer options: YES NO No information Not applicable

Variable	How to fill in. Answer options
Child with no ID papers (no Personal Numerical Code)	Answer options: YES NO No information Not applicable
Child with only one or no parent at home	Answer options: YES NO No information Not applicable
Child with disabilities	Answer options: YES NO No information Not applicable
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care	Answer options: YES NO No information Not applicable
Child at risk of being separated from his/her family – whose mother has underage children in public care	Answer options: YES NO No information Not applicable
Date of child's entry into the system (DD/MM/YYYY)	Date format
Who made the notification and how?	Answer options: The child – using the children's hotline The child – calling the GDSACP Professionals – using the children's hotline Professionals – calling the GDSACP Regular persons – using the children's hotline Regular persons – calling the GDSACP
Main cause of separation according to the child's case file (selection)	Answer options: Parents deceased Parents disappeared Parents deprived of parental rights Poverty Abuse and neglect Child disability Parental disability Other (specify)
Main cause of separation according to the child's case file – Other. Specify which.	If the answer to the previous question was Other, please explain.
Child for whom the GDSACP director decided on emergency placement	Answer options: YES NO No information Don't know Not applicable
Child for whom the court decided on emergency placement, based on presidential ordinance	Answer options: YES NO No information Don't know Not applicable

Structure of database on vulnerabilities of children listed with the child care system

County	
Commune of origin (selection)	
Child's first and last name	
Child's age (on last birthday) at time of entry with the Child Protection Commission	
Did the child live with both parents? (Yes/No)	
Number of child's siblings under age 18	
Child has other siblings in public care (Yes/No)	
If yes, how many?	
Child living in poverty (Yes/No)	
Child not registered with a family physician (Yes/No)	
Child aged up to 1 year, in a situation of risk (Yes/No)	
Child aged 1 to 5 years, in a situation of risk (Yes/No)	
Child with chronic disease or living in a household whose members have chronic diseases (Yes/No)	
Child not enrolled in school, who dropped out of school or is at risk of dropping out (Yes/No)	
Adolescent/child with risk behaviours (Yes/No)	
Child living in a family prone to child violence, abuse or neglect (Yes/No)	
Child living in precarious housing conditions (Yes/No)	
Child with no ID papers (no Personal Numerical Code) (Yes/No)	
Child with only one or no parent at home (Yes/No)	
Child with disabilities (Yes/No)	
Child at risk of being separated from his/her family – whose mother has underage children not living in the household, but also not in public care (Yes/No)	
Child at risk of being separated from his/her family – whose mother has underage children in public care (Yes/No)	
Date of entry into the system (DD/MM/YYYY)	
Who made the notification and how? (selection)	
Main cause of separation according to the child's case file (selection)	
Main cause of separation according to the child's case file – Other. Specify which.	
Child for whom the GDSACP director decided on emergency placement (Yes/No)	
Child for whom the court decided on emergency placement, based on presidential ordinance (Yes/No)	
Special remarks	

Annex 12.2. Structure of database on the work of community health nurses, in the intervention and control communes

Commune	Year	General population covered			Child population (0–18)						Pregnant women						
		No. of women of reproductive age (15–45 yrs)	No. of women using contraception	No. of persons not registered with a family physician (FP)	No. of cases of infectious diseases	No. of children with chronic diseases	No. of cases of rickets prophylaxis (vitamin D)	No. of cases of anemia prophylaxis (iron)	No. of deaths – at home	No. of deaths – in the hospital	Total no. of pregnant women in the area	No. of pregnant women registered with a FP by the CHN	No. of pregnant women with medical issues (risk pregnancy)	No. of home deliveries recorded	No. of deaths of pregnant/postpartum women – at home	No. of deaths of pregnant/postpartum women – in the hospital	No. of deaths of pregnant/postpartum women - elsewhere
Albești	**2013**																
Călărași*	2013																
Copălău	**2013**																
Hlipiceni*	2013																
Răuseni*	2013																
Todireni	**2013**																
Tudora	**2013**																
Vorona	**2013**																
Albești	**2014**																
Călărași*	2014																
Copălău	**2014**																
Hlipiceni*	2014																
Răuseni*	2014																
Todireni	**2014**																
Tudora	**2014**																
Vorona	**2014**																
Albești	**2015**																
Călărași	2015																
Copălău	**2015**																
Hlipiceni	2015																
Răuseni*	2015																
Todireni	**2015**																
Tudora	**2015**																
Vorona	**2015**																
Total	**2013**																
	2014																
	2015																