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Mid-Term Review of the 'Social Inclusion through the Provision of Integrated Services at Community Level' Model
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CHPS	Centre for Health Policies and Services
CREAC	County Resource and Educational Assistance Centre
CSI	County School Inspectorate
DPH	Directorate for Public Health
EU	European Union
FG	Focus group
FNGOCP	Federation of Non-Governmental Organisations for Child Protection
GDSACP	General Directorate for Social Assistance and Child Protection
GMI	Guaranteed Minimum Income
GO	General objective
IES	Institute of Education Sciences
IMCC	Institute for Mother and Child Care
LPA	Local Public Administration
MEF	Ministry of European Funds
MLFSPE	Ministry of Labour, Family, Social Protection and the Elderly
MLSJ	Ministry of Labour and Social Justice
MNE	Ministry of National Education
MoH	Ministry of Health
MPS	Minimum Package of Services
MRDPA	Ministry of Regional Development and Public Administration
MTR	Mid-Term Review
NAPCRA	National Authority for the Protection of Children's Rights and Adoption
NAPSI	National Agency for Payment and Social Inspection
NGO	Non-governmental organisation
NIPH	National Institute for Public Health
NIS	National Institute of Statistics
OB	Objective
OP-HC	Operational Programme for Human Capital
PSAS	Public Social Assistance Service
QIE	Quality Inclusive Education
RAQAPUE	Romanian Agency for Quality Assurance in Pre-University Education
RIQL	Research Institute for Quality of Life
SEN	Special educational needs
SO	Specific objective
TTC	Teachers Training Centre
TTD	Teachers Training Department

The **'Social Inclusion through the Provision of Integrated Services at Community Level' model** was developed by UNICEF with the aim of providing an adequate response to the social challenges occurring in the national socioeconomic context of 2013, seriously affected by the economic crisis which resulted in increased poverty rates, with more than 40% of Romania's total population and 49% of the child population being at risk of poverty and social exclusion (EUROSTAT, 2015). One of the main challenges for vulnerable groups is access to health, education and social protection services. The model seeks to deliver a package of integrated services at community level for children and their families to reduce their social exclusion.

The goal of the model is to provide technical assistance to the Romanian Government with the aim of placing children on the public agenda and contributing to public policy development in the areas of health, education and child protection.

The model pursues the following objectives: 1) Testing the delivery of community-based services which are stipulated by law but are only implemented to a limited extent, in order to scale them up to national level; 2) Developing new protocols, standards, etc. to improve the quality of these services (so that they become cross-sectoral, inclusive, and preventive); 3) Developing new, innovative services for children and their families.

The model is being implemented in 45 rural and urban communities of Bacău County, from October 2014 to December 2018. It has three major components – the Minimum Package of Services (MPS), the Quality Inclusive Education Package (QIE), and Communication and Advocacy (the cross-cutting component). The Minimum Package of Services involves the provision of health, social protection and educational services at community level. The Quality Inclusive Education Package focuses on increasing both the quality of education and school participation for all children. The Communication and Advocacy component supports the implementation of the model's multiple interventions, ensuring the dissemination of outcomes and contributing to the overall effort of public policy development in education, health and child protection areas.

The main partners in the model are: ▪ at <u>central level</u>: the Ministry of Labour and Social Justice (particularly the National Authority for the Protection of Children's Rights and Adoption), the Ministry of Health, the Ministry of National Education, the Ministry of Regional Development, Public Administration and European Funds, the Romanian Agency for Quality Assurance in Pre-University Education (RAQAPUE), the Institute of Education Sciences, civil society organisations, the media; ▪ at <u>county level</u>: the County Council, the Prefect's Office, Bacău County General Directorate for Social Assistance and Child Protection, Bacău County Directorate for Public Health, Bacău County School Inspectorate, Bacău County Resource and Educational Assistance Centre, the Teachers Training Centre, County Directorate for Youth and Sports, Bacău County Committee on Social Inclusion, civil society organisations; ▪ at <u>local level</u>: local public authorities, non-governmental organisations, children and their families.

The model includes two management structures at national level: UNICEF's Central Management Unit and the Steering Committee, which plays an advisory role and counts representatives of central public institutions (Ministry of Labour and Social Justice, National Authority for the Protection of Children's Rights and Adoption, Ministry of Health, Ministry of National Education, Ministry of Regional Development, Public Administration and European Funds, Ministry of Youth and Sports,

National Agency for Equal Opportunities, Romanian Agency for Quality Assurance in Pre-University Education, Institute of Education Sciences) and civil society organisations ('Împreună' Community Development Agency, 'Step by Step' Centre for Education and Professional Development, HOLTIS Association, the Centre for Health Policies and Services, Romanian Centre for Economic Modelling – CERME, and AB4 System).

Mid-term review goal and objectives

The mid-term review of the model covered the period from October 2014 to December 2016, aiming to provide detailed information on implementation progress. The main objectives of the review are: 1) assessing the overall model as well as the MPS and QIE components in terms of relevance, effectiveness, and sustainability; 2) identifying key elements contributing to the model's success as well as main bottlenecks and barriers to implementation; 3) documenting lessons learned with regard to model implementation and proposing recommendations for improvement; 4) making recommendations for further action to ensure the sustainability and replication of MPS and QIE packages at national level.

Mid-term review methodology

The mid-term review methodology involved mixed data collection methods:

- Quantitative – two online surveys filled out by 125 members of community teams and county coordinators involved in MPS delivery as well as by 424 teachers, school principals, parent educators and other school and kindergarten staff who received support via the QIE package;
- Qualitative – interviews with stakeholders at local level (20), county level (7) and national level (11) as well as with representatives of partner organisations implementing the MPS and QIE packages (6), along with focus groups with adolescent and parent beneficiaries (6 groups), community workers (3 groups), and county coordinators (2 groups);
- Secondary data analysis, focusing on documents produced by stakeholders during project implementation or national public policy documents, inter-sectoral strategies, documents on funding opportunities for integrated social services.

The methodology and the tools used were assessed and endorsed by the Ethics Committee of the Research Institute for Quality of Life. Both the ethical principles embraced by the Romanian academic community and the legal provisions in force, as well as the UNEG Norms for Evaluation in the UN System (UNEG, 2016) and the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (UNICEF, 2015) were observed. All research stages were carried out with respect for confidentiality, the right to privacy and participant response anonymity, while respondent input was anonymised in the report and databases.

The selection of beneficiaries was guided by the principle of equal opportunities, focus group participants being randomly picked from the lists provided by UNICEF. Informed consent was obtained from all research participants, including from legal guardians in the case of adolescents. Interview and focus group participants were explained the purpose of the discussions and how the data would be used, they were asked for permission to record the discussions, they were informed that their participation was not mandatory and that they could withdraw from the survey at any time or that they could refuse to answer any of the researchers' questions, while discussion topics avoided any sensitive issues that might have had an emotional impact on the respondents. To ensure full observance of children's rights, children were accompanied by an adult during group discussions.

Main findings and conclusions

The analysis of the results achieved focused on the two phases of the model – preparation and implementation – and targeted both the overall model and its two key components – MPS and QIE. For each of these phases, key elements contributing to the model's success as well as the main challenges were identified. For the **preparatory phase of the model**, the analysis looked at the theory of change, partnerships concluded, the selection of human resources, and monitoring and evaluation issues:

- The theory of change was developed based on the experience gained during previous projects, with the involvement of relevant stakeholders from the very onset of the model design phase, thus identifying objectives and directions for action that could be shared by as many stakeholders as possible. Flexibility in setting and adjusting objectives, outcomes, and indicators constitutes an ingredient for success. There is insufficient information regarding the means to mainstream the two main packages, the MPS and QIE, into the theory of change, as this is something that will happen after gaining enough experience from the implementation of the proposed activities.

- Partnerships with county institutions competent in the model's areas of intervention facilitated the involvement of local public authorities in the implementation of the model. Key to model implementation was the openness of local authorities and the partnerships concluded with them were a sign of their commitment to cooperate towards certain actions as well as a clear ownership of their respective roles in the undertaking. The engagement of national stakeholders in the implementation process (via the Steering Committee) made it possible to identify timely solutions to existing challenges, in accordance with the legal framework.

- Qualified human resources are scarce at local level, which calls for additional training activities addressed to social workers. In certain local communities, the lack of human resources with the required skills led to implementation delays. The community team was not sized on the basis of local characteristics (population, community needs and required services, territorial distribution of the community), which caused implementation delays in the communities dealing with major social challenges.

- The model's target communities were determined using a methodology based on local development indicators, which made it possible to group them into six development clusters and understand their main features.

- The initial assessment conducted in all the 45 target communities and in six control communities from Galați is an important undertaking, necessary in order to acquire information about the baseline situation of the communities and to accurately establish the model's impact once implementation is over. The initial assessment involved measuring basic social, educational and health indicators. In the monitoring and evaluation process, the indicators on local public authorities' institutional capacity and performance related to model implementation could provide relevant information to ensure model sustainability.

The results of **the implementation phase** were reviewed based on the three components – the Minimum Package of Services, the Quality Inclusive Education Package, and the cross-cutting issues (communication, advocacy, monitoring and evaluation). For the Minimum Package of Services and Quality Inclusive Education, results were outlined considering the following dimensions: human

resources, capacity building/development, tools used, and service delivery. Success factors and key challenges were identified for each of these dimensions.

Local factors influencing model implementation include: partnership with the local government; institutional capacity of the latter; active participation of local and county stakeholders; qualification of human resources involved in service delivery; communication and cooperation of community workers; infrastructure available for implementing the interventions; local management of the model. The team which ensured the county-level management of the model and provided guidance and support to local teams was a key element in the implementation of both packages, helping address challenges in a timely manner and ensuring quality interventions at community level. The model's county management structure operates under a new paradigm which is cross-institutional and beneficiary-centred.

The main findings and conclusions of the mid-term review regarding the Minimum Package of Services are as follows:

- The proactive approach undertaken within the model, which was based on services centred on beneficiaries' needs, allowed for an enhanced understanding of community needs and the design of tailored services. At the same time, targeting beneficiaries with outreach or community-based social services/primary healthcare helped increase their level of trust in the LPAs, raise their level of information and awareness of their rights and, as a consequence, it helped address the challenges they were facing.

- The delivery of services at community level is more difficult in isolated communities lacking infrastructure (car, reimbursement of fuel expenses). The insufficient amount of consumables necessary for the work of community workers also encumbers service delivery.

- The working methodology for community workers is a necessary tool during model implementation, preventing task overlap among team members and enhancing the overall coordination of community work. The working methodology is to be developed after functional community teams are set up and local vulnerabilities are identified.

- AURORA is one of the model's elements that are subject to constant improvement following the feedback received from community workers, enabling in-depth knowledge of local children's vulnerabilities, the design of specific services to address those vulnerabilities, and real-time monitoring of service delivery status. However, the specialists working in the intervention areas tackled by the model (NGOs, national authorities) are not familiar enough with this application, which affects its endorsement as a tool that could be replicated nationwide.

- Teamwork and communication at the level of community teams facilitated MPS implementation, while the high turnover of human resources involved in carrying out the activities as well as difficulties in recruiting qualified personnel were some of the key challenges that delayed the implementation of the activities.

- The fact that the social worker and the community nurse were hired by the LPA helped build LPA capacities and created the basis for increasing the effectiveness and visibility of community team work and, consequently, the sustainability of the model at community level.

  - For over 70 per cent of community workers, the following are key project benefits: increased access to social services for community members, increased number of children whose social needs were identified, greater mayoralty focuses on addressing social issues, and increased number of social

Regarding the Quality Inclusive Education Package, the main findings and conclusions are as follows:

- The evaluation of education institutions and the training of their management structures led to increased school management capacities.
- Enhancing teaching staff's specific and cross-cutting competencies helped increase the quality of education through the use of modern student-centred teaching methods and tools.
- A key challenge in education is that specialised staff is less motivated to apply for school counsellor positions. This is largely due to the unrealistic workload (1 counsellor to at least 800 students), to the low number of graduates with a degree in psychology, education sciences, or educational psychology willing to work as school counsellors, and to a difficult access to certain educational establishments (remote communities, great distance between schools), all leading to the high turnover of school counsellors. In turn, this causes intervention discontinuity and unpredictability and increased school counsellor training costs.
- The activities conducted in partnership with other NGOs or public institutions known for their expertise in the field helped increase teacher responsiveness and interest in skill building, while the wide range of training tools employed in the process (lectures, demonstration lessons, online platforms, experience exchanges, etc.) and the novelty of the activities that were carried out facilitated teachers' professional and personal development.
- Parent engagement in the microgrant-funded extracurricular activities improved the parent-school relationship and increased parents' involvement in their children's education. At the same time, for the over 8,000 parents who attended parent education classes, the parent-child relationship improved.
- Due to QIE interventions, the teaching staff and school management gained a more comprehensive understanding of the inclusive education concept, though this is a long-term process.

- Over 75 per cent of teachers, school principals, parent educators and instructional support staff believe that the implementation of QIE activities resulted in improved teacher skills, increased number of extracurricular activities carried out, improved teaching methods, improved school capacity to determine the profile of children at high risk of dropping out and enhanced capacity to take action in support of at-risk children, increased visibility of school activities at community level.
- 67 per cent of teachers, school principals, parent educators and instructional support staff believe that school attendance increased, while 53 per cent believe that student learning outcomes improved.
- Over 60 per cent of teachers, school principals, parent educators and instructional support staff believe that, due to the activities conducted, parents improved their parenting skills, became more interested in their children's school work, and got more engaged in their children's extracurricular educational activities.

The main findings and conclusions regarding the cross-cutting issues include:

- The interventions run at local level need to be documented through case studies ("picture stories") for a better dissemination of the model's outcomes in view of its intended national scale-up.

- Advocacy activities helped increase model visibility and awareness of the importance of providing integrated community-based services and quality inclusive education. However, for a stronger 'pressure' on decision-makers to adopt the public policy measures required for implementing such interventions at national level, all relevant stakeholders need to join forces.

- Following monitoring and evaluation activities which considered the reports of community teams and county coordinators, the local-level intervention was consistently revised and fine-tuned.

- Many of the local authorities failed to identify the funding sources required for continuing to implement the model once UNICEF support is withdrawn, which indicates a reduced capacity to ensure model sustainability.

- The timeframe covered by the MTR shows a rather low degree of MPS and QIE mainstreaming. Prior to the mainstreaming phase, an amount of time is needed to allow the implementation of the two packages to generate enough information in order to find the best mainstreaming methods.

Recommendations

The recommendations derived from the analysis of mid-term review findings focused on both areas for improvement and areas for future action aimed at ensuring the sustainability and replication of the MPS and QIE packages nationwide. Recommendations were grouped according to the two phases of the model – preparation and implementation (for the latter, they are specifically tailored to each of the three main components of the model – MPS, QIE and cross-cutting issues).

As regards the preparatory phase of the model, key recommendations focus on issues related to better planning for national scale-up/replication:

- Conduct prospective studies on the local labour market prior to starting the intervention in order to gain information about training needs and plan training/qualification courses accordingly.
- Determine the number of human resources required in the community according to community characteristics (population, social issues, territorial distribution, etc.).
- Defining indicators for the monitoring of local and county institutional capacities is useful in the projects run in partnership with LPAs and enables the integration of capacity-building/boosting activities to ensure sustainability.
- In order to make LPA representatives more accountable, they should be involved in the monitoring and evaluation of the model and comparing their own results with those of other communities could act as a motivator.

Key recommendations regarding the Minimum Package of Services:

- Resize human resources at community level according to local characteristics (population, identified social needs, necessary social/health services).

- Develop a working methodology for the community team to avoid task overlap or responsibility failure.

- Promote the benefits and implementation approach of AURORA during meetings with representatives of central public institutions and NGOs (including public authority associations) to increase interest in its use.

- Increase LPA responsibility for identifying solutions to issues such as the lack of transportation means and consumables, as flagged by community workers.

Key recommendations regarding the Quality Inclusive Education Package:

- Continue and strengthen advocacy efforts to redefine school counsellors' workload. For increasing the capacity to influence public policies, it would also be useful to conclude new partnerships with interested organisations active in the field of education.

- Strengthen the partnership with the Teachers Training Centre that could take over the QIE training modules.

Key recommendations regarding the cross-cutting component of the model (communication, advocacy, monitoring and evaluation, mainstreaming of the two packages):

- Increase the local capacity (LPAs, educational establishments) to ensure model sustainability, including by identifying funding sources and writing project proposals.
- Scaling up/replicating the model nationwide and ensuring its sustainability at local level entail: documenting the model; conducting financial impact studies (cost-benefit analyses); stronger advocacy efforts, including by forming coalitions; developing model exit strategies to ensure that local authorities in Bacău County communities take over the model.
- Identify mechanisms for mainstreaming the two intervention packages of the model – MPS and QIE.

The **'Social Inclusion through the Provision of Integrated Services at Community Level'** model successfully capitalises on UNICEF's past experience and contributes to the development of efficient public policies guided by relevant intervention models. This three-tier intervention – at local, county and national levels – aims not only to test the provision of the community-based services set forth in the legislation and develop new services, but also to improve current public policies so as to ensure the institutionalisation of new tools as well as to increase the capacity of local and county stakeholders to deliver services in an integrated manner. Key recommendations for ensuring the national scale-up of the model include documenting the model, conducting studies regarding its financial impact, disseminating its outcomes, promoting the tools used/developed, and stepping up advocacy efforts.

1. MTR SCOPE

1.1. 'SOCIAL INCLUSION THROUGH THE PROVISION OF INTEGRATED SERVICES AT COMMUNITY LEVEL' MODEL

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model was developed by UNICEF with the aim of providing an adequate response to the social challenges occurring in the national socioeconomic context of 2013, seriously affected by the economic crisis which resulted in higher poverty rates, with more than 40% of Romania's total population and 49% of the child population being at risk of poverty (EUROSTAT, 2013). One of the main challenges for vulnerable groups is access to health, educational and social protection services. The model seeks to deliver a package of integrated community-based health, educational and social protection services for children and their families. The 'Social Inclusion through the Provision of Integrated Services at Community Level' model also aims to provide data for the development of public policies on social inclusion.

The model was developed based on the experience gained by UNICEF and its partners at local, county and national levels (in particular under two projects implemented in the areas of education – *The School Attendance Initiative* – and child protection – *First Priority: No More Invisible Children!*) and is meant to test the delivery of a package of integrated services at community level for children and their families in order to reduce their social exclusion.

The concept of integrated community-based services in the fields of education, health and social protection was developed following the joint initiative of the Ministry of Labour, Family, Social Protection and the Elderly, the Ministry of National Education and Scientific Research, and the Ministry of Health, with technical assistance from UNICEF. Under the model implemented in the county of Bacău, services are integrated at community level through the coordination of health, educational and social protection interventions, which are delivered by a team comprised of the community nurse, the social worker, the school counsellor and, where applicable, the school mediator and the health mediator. Based on an integrated approach, this team of community professionals delivers the minimum package of services to children in the community. The integrated approach starts from the identification of current needs, solutions and services required, which lowers the risk of failure since the intervention does not focus only on one need leaving the other ones uncovered. This type of approach entails identifying all the vulnerabilities/needs, which makes it possible to determine the actions needed to address them in an integrated manner.

For an integrated approach to community-based services, the model will seek to:
- Develop a mechanism for the early identification of at-risk children and families and for risk prevention through integrated interventions;
- Develop inter-sectoral working methodologies for education, social protection and community health care systems;
- Support all children's and adolescents' access to and participation in quality inclusive education.

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model is being implemented in 45 rural and urban communities from the county of Bacău, selected according to a methodology which ensures county representativeness, based on the local development index. The 45 communities are part of 38 localities, four in urban areas and 34 in rural areas. Each rural locality

is considered a community, whereas in urban areas a community is defined as the catchment area of a particular school (school district).

Figure 1. Bacău County localities included in UNICEF's model
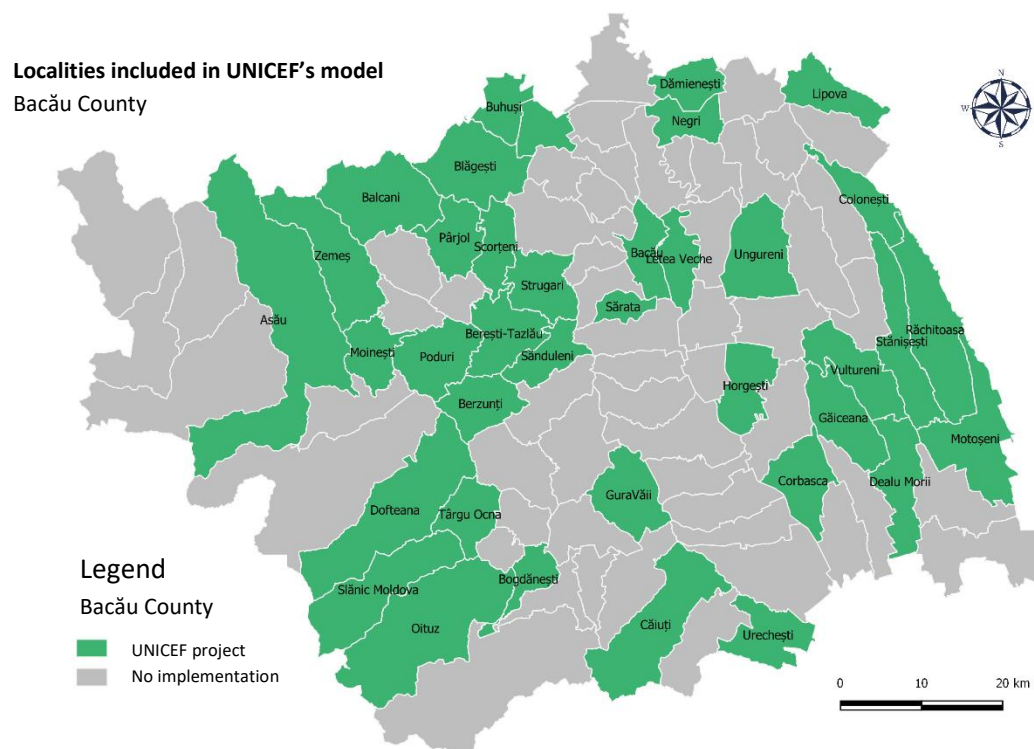
Implementation period: October 2014 – December 2018.

According to the **theory of change** on which this model is based, the integrated delivery of health, educational and social protection services at community level can reduce gaps and social exclusion while also lowering social costs in the medium and long terms.

The goal of the model is to provide technical assistance to the Romanian Government with the aim of placing children on the public agenda and contributing to public policy development in the areas of health, education and child protection.

The **objectives of the model** are in line with the provisions of the main national strategies in the field: the National Strategy for the Protection and Promotion of Children's Rights 2014-2020, the National Strategy for Reducing Early School Leaving 2014-2020, the National Health Strategy 2014-2020, the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, and the Strategy for Strengthening Public Administration 2014-2020. The model pursues the following objectives:

- Testing the delivery of community-based services which are stipulated by law but are only implemented to a limited extent, in order to scale them up to national level;
- Developing new protocols, standards, etc. to improve the quality of these services (so that they become cross-sectoral, inclusive, and preventive);
- Developing new, innovative services for children and their families.

Model testing is based on three key components – the Minimum Package of Services, the Quality Inclusive Education Package, and Communication and Advocacy (the cross-cutting component):

- The Minimum Package of Services (MPS) focuses on the provision of integrated social protection, educational and health services at community level by local teams of professionals comprising a social worker, a community nurse, and a school counsellor. In vulnerable communities, the team may also include a health mediator and a school mediator. The package is organised around seven types of services that may be provided: needs assessment, information, counselling, support, referral, monitoring, and evaluation.

- The Quality Inclusive Education Package (QIE) includes interventions targeting the quality and inclusiveness of education, meant to ensure that all children complete compulsory education and are equipped with basic academic, social and life skills. The multiple interventions carried out under this package aim to: a) promote a child-centred teaching approach with a view to making schools friendly and inclusive for all children and their parents; b) improve school management in order to create a quality, inclusive and equitable learning environment for all children and to better identify and properly address the needs of the most vulnerable students; c) strengthen school-family collaboration; d) develop parenting skills; e) develop non-cognitive skills.

- Communication and Advocacy is the cross-cutting component supporting the implementation of the model's multiple interventions, ensuring the dissemination of outcomes, and contributing to the efforts of changing public policies on education, health and child protection. Local-level communication includes three major campaigns meant to change social norms among the various target audiences and aiming at: a) raising children's expectations with respect to their educational pathways; b) changing behaviours among public service providers in the fields of healthcare, education and social protection so as to reduce stigma and discrimination against the Roma; c) supporting adolescents, including those of Roma ethnicity, to adopt a healthy lifestyle and avoid alcohol use.

The main benefit of the minimum package of integrated community-based services comes from the fact that it interconnects the main areas affecting children's lives, with a simple design based on the needs identified at local level. In this context, the focus is placed on identifying and covering the needs at local level and on an intervention coordinated by a single institution.

The local management of the model is ensured by a project manager, seven QIE package coordinators, and 15 MPS coordinators – four on the education component, four on the health component, and seven on the social protection component. Each of them is responsible for one or two areas, overseeing the work of community teams and facilitating contacts between their members and local or county authorities. The localities included in the intervention are grouped into seven areas, according to their location in the county, each of them being covered by four coordinators, three for the MPS (one on the education component, one on the health component, and one on the social protection component) and one for the QIE package. Here are the seven areas:

- Area 1:   City of Bacău, Letea Veche
- Area 2:   Blăgești, Buhuși, Dămienești, Negri, Racova
- Area 3:   Balcani, Berești, Tazlău, Berzunți, Pârjol, Sănduleni, Strugari
- Area 4:   Bogdănești, Căiuți, Dofteana, Oituz, Orbeni, Slănic Moldova, Urechești
- Area 5:   Moinești, Asău, Poduri, Scorțeni, Târgu Ocna, Zemeș
- Area 6:   Corbasca, Dealu Morii, Găiceana, Horgești, Sărata, Ungureni

- Area 7: Colonești, Lipova, Motoșeni, Stănișești, Vultureni, Răchitoasa

The activities conducted between October 2014 and December 2016 included:

- Selection of the 45 communities.
- Conclusion of partnerships with relevant institutions at national, county and local levels.
- Initial assessment – which included a baseline study against which model implementation progress was to be assessed.
- Selection and recruitment of human resources – county and local professionals involved in the delivery of the two packages (MPS and QIE).
- Software design for the real-time monitoring of children's vulnerabilities (AURORA).
- Capacity building for MPS delivery through the training of county and local teams.
- Delivery of the Minimum Package of Services: a census was conducted by social workers and community nurses in the 45 communities in order to identify the integrated services to be provided at community level.
- Capacity building for school and kindergarten staff: training of 335 teachers to promote a child-centred approach and prevent school dropout and absenteeism; training of 45 school principals in order to develop schools' capacities to monitor, identify and intervene in case of educational risk.
- Parent education – a parent educator network set up at county level and parenting sessions.
- Development and implementation of interactive learning activities meant to improve students' social and emotional skills (motivation, resilience, etc.) and a local communication campaign aimed at raising children's expectations with respect to their educational pathways by promoting role models.
- Communication and behaviour change campaign targeted at public service providers from the administration, health, education and social sectors with a view to reducing Roma stigmatisation.
- Local communication campaign meant to motivate vulnerable adolescents, including those of Roma ethnicity, to adopt a healthy lifestyle and avoid alcohol use.
- Communication: drawing up the model's communication plan, designing the website and promotional materials, rolling out communication campaigns.
- Monitoring: an ongoing activity including technical reports to the two donors, county coordinators' bi-monthly reports, community workers' monthly reports, community forms, field visit reports.
- Advocacy: an ongoing activity which included activities to promote the model and the intervention, field visits with national decision-makers, public figures and national journalists, meetings with national decision-makers, participation in working groups or meetings with decision-makers to develop the public policy framework required for effective model implementation.

The Minimum Package of Services includes health, social protection and educational services provided at community level. It is universal as every family can access it, but it focuses mainly on the most vulnerable children and their families. The Minimum Package contains a strong prevention component and it requires the presence in each community of at least one social worker, one community nurse, and one school counsellor. Together, they help vulnerable children and their families, assessing their needs and targeting them with tailored services. These three professionals work closely together for the benefit of the families and cooperate with local stakeholders, such as the mayoralty, NGOs, and other community partners. In the poorest communities, including those with Roma members, the Minimum Package of Services may include a school mediator and/or a Roma health mediator.

The objective of the Minimum Package of Services is to step up efforts for fulfilling children's rights and reducing the equity gap through increased access to health, educational and social protection services that are cross-sectoral, community-based, preventive, and family-centred.

The Minimum Package of Services helps:
- Improve children's and families' access to health, social protection and educational services;
- Give children the chance to grow up in a non-violent and protective family environment;
- Increase access to pre-primary education and completion of compulsory education;
- Assess the need for services at local level and improve resource planning and use at local, county and national levels.

At the same time, the Minimum Package of Services contributes to:
- Shifting focus from costly and remedial specialised interventions to cost-effective prevention services;
- Generating medium- and long-term savings for the state budget;
- Reforming the social protection system at community, county and national levels and making the cash benefit mechanism more effective;
- Reducing and preventing poverty and social exclusion among children and their families.

The local team of professionals (social worker, community nurse and school counsellor) works to:
- Identify vulnerable children and their families, assess their needs, offer them information and counselling, accompany and help them access local and specialised services in the fields of health, education and social/child protection, and regularly monitor the registered cases based on the online registration and management system which offers access to real-time data;
- Help local families become stronger and better equipped to take care of their children.

Source: UNICEF, 2017, Minimum Package of Services,
http://unicef.ro/serviciicomunitarepentrucopii/noutate/pachetul-minim-de-servicii-sociale-21

QUALITY INCLUSIVE EDUCATION PACKAGE

The Quality Inclusive Education Package aims at increasing both the quality of education and the school participation of all children, especially vulnerable ones. The package includes child-centred interventions at school, family and community levels. The education package is universal and all students and schools can benefit from its interventions. The package addresses equity, with a particular focus on the most vulnerable children and most disadvantaged schools.

The Quality Inclusive Education Package aims at: strengthening the capacity of the school management and teachers to support each and every child, according to his or her needs; improving teaching methods and tools; partnering with students' families and developing parenting skills; mobilising communities to support education; enhancing children's non-cognitive skills and motivation; encouraging diversity among students regardless of gender, ethnicity, religion, (dis)ability and socioeconomic status.

The objective of the Quality Inclusive Education Package is to step up efforts for fulfilling the right to education for all children, especially vulnerable ones, by improving the quality of teaching and school management and by mobilising schools, families and communities to support school participation and every single child.

The Quality Inclusive Education Package contributes to:
- Increasing school enrolment and regular school attendance for all children, including vulnerable ones, as well as completion of compulsory education;
- Creating the conditions for all children to study in a learning-friendly environment and acquire the knowledge and skills needed in a 21st century EU Member State;
- Offering all children the chance to benefit from pre-primary education;
- Creating inclusive schools that promote diversity.

In addition, the Quality Inclusive Education Package will help:
- Improve the quality of education, from pre-school to high school, through proper teachers training and modern teaching methodologies and tools;
- Mobilise children and adolescents, schools, families and communities to support education;
- Improve parenting skills and the parent-child-school relationship;
- Assess educational needs at local level and improve the planning and use of resources for quality inclusive education at local, county and national levels;
- Strengthen county authorities' school guidance, supervision and monitoring.

Source: UNICEF, 2017, Quality Inclusive Education Package,
http://unicef.ro/serviciicomunitarepentrucopii/noutate/pachetul-educatie-incluziva-de-calitate-22

1.2. MAIN STAKEHOLDERS INVOLVED IN THE MODEL

The main partners in the model include institutions organised into three levels – national, county and local:

- **At national level**: Ministry of Labour and Social Justice (in particular, the National Authority for the Protection of Children's Rights and Adoption), Ministry of Health, Ministry of National Education, Ministry of Regional Development, Public Administration and European Funds, Romanian Agency for Quality Assurance in Pre-University Education (RAQAPUE), the Institute of Education Sciences, civil society organisations, the media.
- **At county level**: County Council, Prefect's Office, Bacău General Directorate for Social Assistance and Child Protection, Bacău County Directorate for Public Health, Bacău County School Inspectorate, Bacău County Resource and Educational Assistance Centre, the Teachers Training Centre, County Directorate for Youth and Sports, Bacău County Committee on Social Inclusion, civil society organisations.
- **At local level**: local public authorities, civil society organisations, children and their families.

There are two management bodies at national level: UNICEF's Central Project Management Unit and the Steering Committee. The Steering Committee is an advisory structure counting representatives of:

- Central public institutions: Ministry of Labour and Social Justice, National Authority for the Protection of Children's Rights and Adoption, Ministry of Health, Ministry of National Education, Ministry of Regional Development, Public Administration and European Funds, Ministry of Youth and Sports, National Agency for Equal Opportunities, Romanian Agency for Quality Assurance in Pre-University Education, the Institute of Education Sciences.
- Civil society organisations: 'Împreună' Community Development Agency, 'Step by Step' Centre for Education and Professional Development, HOLTIS Association, the Centre for Health Policies and Services, Romanian Centre for Economic Modelling (CERME), and AB4 System.

2. MTR GOAL AND OBJECTIVES

2.1. GOAL AND OBJECTIVES

The goal of this mid-term review is to provide detailed information about the progress made in the implementation of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model and to look into the challenges faced by the children and families from the county of Bacău in accessing basic services (social services, healthcare and education). The review covers the period from October 2014 through December 2016. The main MTR objectives are:

- Assessing the overall model and its two components (MPS and QIE) in terms of relevance, effectiveness, and sustainability;
- Identifying key elements that contribute to the model's success as well as main bottlenecks and barriers to implementation;
- Documenting lessons learned with regard to model implementation and proposing recommendations for improvement;
- Making recommendations for further action to ensure the sustainability and replication of the MPS and QIE packages at national level.

In order to identify the main obstacles to model implementation as well as the early elements of success or failure and to determine the changes needed for the model to reach the expected outcomes and national scale-up, the MTR seeks to answer the following questions:

Preparatory phase of the model
- Is there a clear theory of change, outlining the main hypothesis, inputs, objectives and expected outcomes?
- Was a baseline study conducted at the start or in the early stages of implementation to later allow for the assessment of progress made towards expected outcomes?
- Were all relevant partners involved in the design and implementation of the model?
- Are there any clear specifications regarding the human resources required for the implementation of the model?
- Is there a clear mechanism in place for the monitoring and evaluation of the model to ensure proper documentation of progress and lessons learned?

Implementation phase
- To what extent are the objectives of the model still valid?
- Are the activities and outputs of the model consistent with the overall goal and do they contribute to the achievement of its objectives?
- To what extent is the model relevant to national policies and programmes and to cross-sectoral strategies?
- To what extent were the objectives of the model achieved?
- What were the major factors influencing the achievement or non-achievement of the objectives?
- Does the model contribute to building the capacity of local authorities to deliver the Minimum Package of Services?
- Does the model contribute to building the capacity of school staff to deliver the Quality Inclusive Education Package?

- Which model components are most (and least) effective? What are the factors that explain success? Does the integrated approach create any added value and what are the factors influencing the collaboration between community workers?
- Are all processes based on a child rights approach? Does service delivery consider age and gender issues?
- To what extent is the current context favourable to continuing such approaches in the near future?
- Are the interventions likely to continue when external support is withdrawn?
- Is the model replicable? As a whole or only some of its components? At which level (local, county or national)? Are any adjustments needed for model replication?
- What are the lessons learned at each level of intervention that should be taken into account for the further implementation and replication of the model?
- Are there any unplanned outcomes worth considering for addressing model implementation bottlenecks?
- What recommendations could be made to UNICEF and to the Romanian Government for model replication and national scale-up?

2.2. MTR LIMITATIONS

The mid-term review of the model has a number of limitations which are due to the short timeframe between the start of the intervention in some communities and the mid-term review, an uneven implementation given the local context, the review methodology employed, and the information obtained. The model was not uniformly implemented across the 45 communities because of local characteristics (lack of specialised staff, staff training needs, the support lent by public authorities, location, etc.), which caused time lags between the communities. Moreover, the short timeframe between the start of the intervention and the mid-term review did not allow for a detailed analysis of the information related to impact/effects or outcomes based on performance indicators. MTR methodology did not focus on examining the model in terms of efficiency (costs versus outcomes) and of the costs required for model replication and scale-up, which will be included in the final evaluation. Hence, the following questions were not answered:
- Are the activities and outputs of the model leading to the intended impact and effects?
- To what extent have the expected outcomes of the model been reached, considering the performance indicator targets?
- What are the main supply and demand constraints in the model?
- Does the model use resources in the most economical/efficient manner to achieve the expected outcomes? What is the added value (intended as financial value) of the model? What are the financial benefits of the integrated approach?
- Have the costs required for model replication and national scale-up been considered?

Moreover, the quite short amount of time available for model implementation in some communities and the large number of activities to be performed have led to more focus on conducting and strengthening the intervention at local level and less on clearly defining methods for mainstreaming the two packages – MPS and QIE. The theory of change, already defined in the model planning phase, cannot include all implementation details, but it can only set out the hypothesis, inputs, outputs and outcomes in a logical framework. The details related to the local-level mainstreaming of the

interventions under the two packages are to be established after the mid-term review and based on the experience gained from having implemented the model for a sufficient period of time.

3. MTR METHODOLOGY

In order to gather solid and comprehensive information and to facilitate a deeper understanding of the way the 'Social Inclusion through the Provision of Integrated Services at Community Level' model works, the review employed mixed data collection methods. The analysis was based on both data collected through quantitative and qualitative methods during the mid-term review process and secondary data consisting of documents produced by stakeholders during project implementation or public policy documents.

At the same time, with the use of mixed data collection methods, the methodology was better suited to the objectives of the mid-term review. Thus, the main source of information for the preparatory phase of the model (baseline study, inclusion of all relevant partners, model monitoring and evaluation mechanism) were the discussions held with the members of the model coordinating team, the interviews with local and county stakeholders and partner organisations, along with a secondary data analysis. The data related to model implementation (timeliness and relevance of objectives, effectiveness of implemented activities, relevance of the model to national programmes and strategies, enablers or impediments to implementation, benefits for the community, etc.) were collected both through qualitative and quantitative research and through secondary data analysis as a comprehensive picture could only be portrayed by combining data sources. Data source complementarity also enables a better understanding of the context and the extent to which it supports/hinders the implementation of such initiatives, model sustainability, and recommendations for model replication.

The following data collection methods and tools were used:
Quantitative data (primary data collected during the mid-term review)
- Online survey among the professionals involved in MPS provision (community workers and county coordinators)
- Online survey among teachers (including school principals), parent educators and other school and kindergarten staff who received support under the QIE package.

Qualitative data (primary data collected during the mid-term review)
- Focus groups with beneficiaries (adolescents and parents)
- Focus groups with community workers
- Focus groups with county coordinators
- Interviews with local stakeholders (mayor, school principal, mayoralty's social worker, doctor)
- Interviews with county stakeholders
- Interviews with national stakeholders
- Interviews with representatives of partner organisations having implemented the MPS and QIE packages

Secondary data analysis
- Documents provided by UNICEF: microgrant reports, project progress reports, project programmatic documents, baseline report.

- National public policy documents, inter-sectoral strategies, documents on funding opportunities for integrated social services.

3.1. QUANTITATIVE COMPONENT

The quantitative component of the study included two online surveys targeting, on the one hand, the professionals involved in the provision of the Minimum Package of Services (MPS) – community workers and county coordinators – and, on the other hand, teachers, parent educators and other school staff members supported under the Quality Inclusive Education Package (QIE).

Data were collected using the LimeSurvey[1] software, installed on the RIQL server.

Customised invitations to complete the online questionnaires were emailed to all community workers and teachers on the lists provided by UNICEF. The initial invitation was followed by two reminders, the first via e-mail and the second via a text message, which contributed to a high response rate.

ONLINE SURVEY AMONG PROFESSIONALS INVOLVED IN MPS PROVISION

THE TARGET GROUP OF THE ONLINE SURVEY ADDRESSED TO THE PROFESSIONALS INVOLVED IN THE DELIVERY OF INTEGRATED SERVICES UNDER THE MPS IN THE 45 PROJECT COMMUNITIES CONSISTED OF 170 PEOPLE DISTRIBUTED AS FOLLOWS: 16 COUNTY COORDINATORS, 58 SOCIAL WORKERS, 33 COMMUNITY NURSES, 32 SCHOOL COUNSELLORS, 26 SCHOOL MEDIATORS, AND FIVE HEALTH MEDIATORS. THE ONLINE QUESTIONNAIRE   (

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[1] LimeSurvey is a free and open-source software solution for online surveys, offering support at every quantitative research stage – questionnaire design, sample integration, contacting respondents, response monitoring, data collection and validation, saving the database in a format that is compatible with statistical analysis software. With LimeSurvey, personalised invitations and e-mail reminders can be sent to respondents while also ensuring response anonymity by dissociating personal details from the responses received. Thus, researchers can find out whether someone in the sample has filled out the questionnaire, but they cannot access his or her answers as these are located in an anonymised database. One of the major perks of LimeSurvey is its respondent friendliness.

Annex 5) was fully completed by 125 professionals, with a response rate of 74%. The online questionnaire gathered information about the provision of the Minimum Package of Services (health, education and social protection), main obstacles and challenges to model implementation, factors contributing to successful implementation, the added value of the integrated approach, factors influencing collaboration between community workers or between the latter and beneficiaries or other local stakeholders, key lessons learned, relevance of the intervention at community level, changes needed for project success.

ONLINE SURVEY AMONG TEACHERS

THE TARGET GROUP OF THE SECOND ONLINE SURVEY CONSISTED OF COUNTY COORDINATORS FOR THE EDUCATION COMPONENT AND TEACHERS (INCLUDING PRINCIPALS), PARENT EDUCATORS AND OTHER SCHOOL AND KINDERGARTEN STAFF MEMBERS SUPPORTED IN THE PROJECT. THE QUESTIONNAIRE WAS FULLY COMPLETED BY 424 OF THE 595 RESPONDENTS HAVING RECEIVED THE INVITATION, WITH A RESPONSE RATE OF 71.2%. THE ONLINE QUESTIONNAIRE (

Annex 5) gathered information about the second major project component – Quality Inclusive Education (QIE) – and focused on aspects like child-centred teaching, school management improvements in terms of quality, equity and inclusion, school-family collaboration, parent education, role models, obstacles to the implementation of quality inclusive education, factors contributing to successful QIE implementation, and transferability of the model to other schools/communities.

3.2. QUALITATIVE COMPONENT

The qualitative component of the study comprised interviews with local, county and national stakeholders and with representatives of partner organisations as well as focus groups with beneficiaries (adolescents and their parents), community workers and county project coordinators for the two components – MPS and QIE. Hence, information was gathered about the implementation of both packages (MPS and QIE), awareness of the model in the communities, key benefits of community members' participation in the activities, model correlation with public policies on child protection and education, and means to replicate the model or its packages nationwide. The selection of the communities for qualitative research was based on the methodology developed by Dumitru Sandu et.al. and included both rural and urban communities. For the interviews held with local stakeholders, one urban community and four rural communities were selected, based on their level of development, as follows: a poor community, an unevenly developed community, a moderately developed community, and a developed community.

In the following stage, rural communities were grouped into two categories: (1) poor communities (including a poor community and an unevenly developed community) and (2) developed communities (including a moderately developed community and a developed community). For focus groups with beneficiaries (adolescents and parents), an urban community and a rural community were randomly selected, one from each of the two previously mentioned categories. For focus groups with community workers, the number of both urban and rural communities from which members were selected was raised to ensure enough participants in the discussions.

Table 1. Communities selected for the qualitative research component

Data collection methods	Urban communities	Rural communities			
		Poor communities		Developed communities	
		Poor	Unevenly developed	Moderately developed	Developed
Interviews with local stakeholders	Moinești	Scorțeni	Strugari	Poduri	Zemeș
FG with adolescents	Moinești	Strugari		Poduri	
FG with parents	Moinești	Strugari		Poduri	
FG with community workers	Moinești Târgu Ocna	Scorțeni Strugari		Poduri Zemeș Căiuți	

GROUP DISCUSSIONS WITH COUNTY COORDINATORS LOOKED TO IDENTIFY THE ELEMENTS CONTRIBUTING TO MODEL SUCCESS, MAJOR IMPLEMENTATION DIFFICULTIES

– WITH A FOCUS ON DIMENSIONS LIKE COOPERATION WITH LOCAL AND COUNTY STAKEHOLDERS, HUMAN RESOURCES INVOLVED OR CONTEXTUAL FACTORS – AND THEIR RECOMMENDATIONS FOR INTERVENTION IMPROVEMENT (

Annex 5).

Total number of focus groups: two (1 – county QIE coordinators, 1 – county MPS coordinators)

Participants: seven county coordinators for the QIE component, eight county coordinators for the MPS component

FOCUS GROUPS WITH BENEFICIARIES

Focus groups with beneficiaries provided information about awareness of the model in the community, their participation in the activities carried out under the project implemented in their communities by local authorities with UNICEF support, and the main benefits they got from such participation.

Total number of groups: six

Participants: adolescents (two FGs in rural areas, one FG in urban areas), parents (two FGs in rural areas, one FG in urban areas)

Location: Moinești (one FG with parents, one FG with adolescents), Strugari and Poduri (one FG with parents, one FG with adolescents in each community)

Number of participants/focus group: 6-9 (

Annex 3).

ANNEX 5) AND ADOLESCENTS (THE FOCUS GROUP GUIDE IS INCLUDED IN

Annex 5) in three communities (one urban community and two rural ones) and for each one of them participants were randomly picked from the lists of community members benefiting from project support. For focus groups with adolescents, only those aged over 14 years were selected from the lists of beneficiaries provided by UNICEF. The lists of parents and adolescents were alphabetically ordered before selection. For both types of beneficiaries, a master sample and a reserve sample were selected in each community. For the master sample, the selection started from the first person on the alphabetically ordered list and then the sampling interval was applied. For the reserve sample, the selection started from the third person on the alphabetically ordered list and then the sampling interval was applied (Table 2). The sampling interval was set by dividing the total number of people (adolescents or parents) on the list by the maximum number of focus group participants (8) and all results with decimal places were rounded down (except for the adolescent focus group from Strugari where, given the very small number of children included in the initial list, the result was rounded up).

Table 2. Participant selection for focus groups with beneficiaries

	Strugari		Poduri		Moinești	
	adolescents	parents	adolescents	parents	adolescents	parents
Total number of beneficiaries on the selection list	15	112	28	43	30	140
Sampling interval	2	14	3	5	3	17
Number of FG participants	8	8	9	6	8	7

FOCUS GROUPS WITH COMMUNITY WORKERS

Community workers selected for the focus group come from two urban communities and four rural communities (two poor ones and two developed ones). Given the smaller number of community workers in some communities and the minimum number of participants required for the discussions, some communities with the same profile were selected from the reserve list (Târgu Ocna – urban community – and Căiuți – rural community). In order to analyse the way in which professionals collaborated, focus groups included specialists from the two components of the model – QIE and MPS (

Annex 3).

Number of focus groups: 3

Participants: community workers from both components of the model – QIE and MPS.

INTERVIEWS WITH LOCAL STAKEHOLDERS

IN EACH OF THE INITIALLY SELECTED COMMUNITIES (MOINEŞTI, STRUGARI, SCORŢENI, PODURI, AND ZEMEŞ), FOUR INTERVIEWS WERE CONDUCTED WITH **LOCAL STAKEHOLDERS** (THE INTERVIEW GUIDE IS INCLUDED IN

Annex 5): mayor, doctor, school principal, mayoralty's social worker (not involved in model implementation).

Total interviews: 20

INTERVIEWS WITH COUNTY STAKEHOLDERS

THE INTERVIEWS HELD WITH COUNTY STAKEHOLDERS (THE INTERVIEW GUIDE IS INCLUDED   IN

Annex 5) sought to identify the familiarity of Bacău county authority representatives with the model implemented by UNICEF as well as their perspective on the model in terms of relevance to the needs of local children and mothers, effectiveness and sustainability.

Total interviews: 7

THE INTERVIEWS HELD WITH THE REPRESENTATIVES OF THE MAIN RELEVANT INSTITUTIONS AT NATIONAL LEVEL (IN THE FIELDS OF CHILD PROTECTION, EDUCATION AND HEALTH) AIMED TO IDENTIFY THE VISIBILITY OF THE MODEL IMPLEMENTED BY UNICEF AT CENTRAL LEVEL AS WELL AS NATIONAL STAKEHOLDERS' PERCEPTIONS OF ITS RELEVANCE TO PUBLIC POLICIES ON CHILD PROTECTION AND THE MEANS TO REPLICATE IT NATIONWIDE (THE INTERVIEW GUIDE IS INCLUDED IN

Annex 5).

Total interviews: 11

INTERVIEWS WITH PARTNER ORGANISATIONS

THE INTERVIEWS WITH THE REPRESENTATIVES OF PARTNER ORGANISATIONS TRIED TO IDENTIFY THEIR OPINIONS ON MODEL RELEVANCE AND INNOVATION COMPARED WITH SIMILAR INITIATIVES AS WELL AS TO GATHER RECOMMENDATIONS FROM PARTNERS FOR MODEL ADJUSTMENT, SUSTAINABILITY AND NATIONAL REPLICABILITY (THE INTERVIEW GUIDE IS INCLUDED IN

Annex 5).

Total interviews: 6

3.3. SECONDARY DATA ANALYSIS

Secondary data analysis looked at the documents prepared in the model (reports on microgrants awarded to schools and local authorities, model progress reports, model programmatic documents, the baseline report, community selection methodology), statistical data (Tempo database, NIS; EUROSTAT) and relevant public policy documents (national policies, inter-sectoral strategies, funding opportunities) (Annex 4). Regarding the latter, we should mention the following ones:
- National Strategy on Social Inclusion and Poverty Reduction 2015-2020
- Programmatic documents – Operational Programme for Human Capital
- National Strategy for the Protection and Promotion of Children's Rights 2014-2020
- Strategy for the Inclusion of Romanian Citizens Belonging to the Roma Minority 2015-2020
- Strategy for Reducing Early School Leaving in Romania
- Child protection legislation (GD No 691/2015)
- Community health nursing legislation (GEO No 18/2017 on community health nursing).

3.4. METHODOLOGY LIMITATIONS

The use of complementary data collection methods helped avoid many difficulties associated with the exclusive use of quantitative or qualitative methods and provided a more comprehensive picture of model functionality. As regards the main limitations of the methodology employed, we should mention the following ones:
- Lack of an interviewer (for the online survey), which can pose some difficulties to respondents in understanding certain questions and can also make the researcher question the quality of the data provided by respondents. On the other hand, socially desirable responding is less common in self-administered surveys. Moreover, respondents can answer questions in their own time and even during multiple sessions as LimeSurvey allows them to interrupt questionnaire completion and resume it at a later stage.
- Online questionnaires usually feature lower response rates than phone or face-to-face surveys as well as higher break-off rates, but in this research the response rate has been far beyond expectations (over 70%).
- Potential lack of coverage in the case of online questionnaires. In this research, however, the contact details of most people of interest were available and the e-mails which didn't reach their intended recipients accounted for an insignificant proportion of all e-mails on the list.
- The downsized number of communities under review, particularly in rural areas, given the extensive use of (human, time, financial) resources associated with data collection via qualitative methods.
- Inclusion in the analysis of respondents that were hard to interview due to access and availability issues (county or national stakeholders), correlated with the recent political changes. This limitation resulted mainly in data collection delays against initial timeframes.

- Difficulties in maintaining the initial selection of beneficiaries (parents and adolescents) for focus groups. Since focus groups were held on working days and during regular working hours, it was difficult or even impossible for some parents to take part in the discussions. Also, the research team conducted fieldwork during school break, which created more problems regarding the focus group participation of some of the children that had been selected. Because of all these, reserve lists had to be used and even supplemented.

3.5. ETHICAL ISSUES, HUMAN RIGHTS AND EQUAL OPPORTUNITIES

DURING THIS REVIEW, BOTH THE ETHICAL PRINCIPLES EMBRACED BY THE ROMANIAN ACADEMIC COMMUNITY AND THE LEGAL PROVISIONS IN FORCE, AS WELL AS THE UNEG NORMS FOR EVALUATION IN THE UN SYSTEM (UNEG, 2016) AND THE UNICEF PROCEDURE FOR ETHICAL STANDARDS IN RESEARCH, EVALUATION, DATA COLLECTION AND ANALYSIS (UNICEF, 2015) WERE OBSERVED. THE LATTER IS BASED ON THREE FUNDAMENTAL PRINCIPLES: RESPECT FOR ALL PERSONS; PROMOTING THE WELLBEING OF INDIVIDUALS AND/OR COMMUNITIES ALONG WITH THE RESPECT FOR PARTICIPANTS' RIGHTS AND AVOIDING ANY HARM TO PARTICIPANTS; AND AVOIDING THE INJUSTICE ARISING FROM SOCIAL, RACIAL, SEXUAL OR CULTURAL BIASES INSTITUTIONALISED IN THE SOCIETY. BEFORE THE DATA COLLECTION STAGE, THE METHODOLOGY AND THE TOOLS USED WERE ASSESSED AND ENDORSED BY THE ETHICS COMMITTEE OF THE RESEARCH INSTITUTE FOR QUALITY OF LIFE (

Annex 6).

The selection of beneficiaries was guided by the principle of equal opportunities and focus group participants were randomly picked from the lists provided by UNICEF, without consideration of arbitrary or irrelevant aspects, such as educational attainment, gender, ethnicity or religion, sexual orientation or other personal characteristics (e.g. disability).

Informed consent was obtained from all research participants or their legal guardians (in the case of adolescent focus groups). Interview and focus group participants were asked for permission to record the discussions, they were informed that their participation was not mandatory and that they could withdraw from the survey at any time or that they could refuse to answer any of the researchers' questions. To ensure full observance of children's rights, children were accompanied by an adult during group discussions. Participants were explained the purpose of the discussions and how the data would be used. Also, discussion topics avoided any sensitive issues that might have had an emotional impact on the respondents.

All research stages were carried out with respect for confidentiality, the right to privacy and participant response anonymity. Respondent input was anonymised in the report and databases. Access to collected data was only given to report authors, who will not share them with third parties.

During the mid-term review process, researchers were not in a conflict of interest.

4. CONTEXT

4.1. NATIONAL CONTEXT

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model debuted at a time when Romania was dealing with a number of socioeconomic problems in the aftermath of the global economic crisis, such as higher unemployment rates, lower income, poor access to public services, deeper poverty. EUROSTAT data indicated for Romania an at-risk-of-poverty or social exclusion rate of almost 42% in 2013 and 40% in 2014, much higher than the EU mean of approximately 23% (EUROSTAT, indicator t2020_50). As to Romanian children, over 51% of them were at risk of poverty and social exclusion in 2013 and over 49% in 2014 (EUROSTAT, indicator ilc_peps01). Out of all demographics, children and youth face the highest risk of poverty, with those living in rural areas or of Roma ethnicity being at an even higher risk (Teşliuc et al., 2015, Preda et.al, 2013). The analyses conducted by the World Bank show that, in 2015, approximately one third of children were living in households affected by persistent poverty (Teşliuc et al., 2015,). Rural-urban disparities, which are still striking in Romania and marked by a much greater risk of poverty in rural areas (52.7% versus 33.4% in urban areas) (Eurostat, 2013, ilc_peps13 indicator), are largely due to rural population's poor access to health, educational and social protection services (Teşliuc et al., 2015).

Moreover, Romania's social assistance system is insufficiently developed and unable to cover existing needs for it is underfinanced, with social protection expenditure being among the lowest in the EU (only 14.8% of GDP in 2014) (EUROSTAT, indicator: spr_exp_sum). The spending on social services accounted for 0.77% in 2013 and 0.69% in 2014 of total expenditure on social assistance, with the difference being allocated to social benefits (MLFSPE, 2015). The scarcity of financial resources paired with the shortage of specialised workforce and a number of bureaucratic obstacles

to employment (e.g. the hiring freeze, a lack of flexible forms of employment) have led to the inadequate development of primary social services (Lazăr, 2015, MLFSP and Sera Romania, 2013; MLFSP and IRECSON, 2011).

CROSS-CUTTING PUBLIC POLICIES

Based on the experience gained during the previous projects implemented by UNICEF – the School Attendance Initiative and 'First Priority: No More Invisible Children!', the 'Social Inclusion through the Provision of Integrated Services at Community Level' model is in line with the priorities of the main strategic documents adopted in 2014-2016 for the purpose of developing community services for integrated interventions, increasing access to education for children from vulnerable groups, developing preventive services, or creating an e-assistance system. Among these, we should mention the following ones:

1. National Strategy on Social Inclusion and Poverty Reduction 2015-2020.
2. National Strategy for the Protection and Promotion of Children's Rights 2014-2020.
3. Strategy for the Inclusion of Romanian Citizens Belonging to the Roma Minority 2015-2020.

The objectives and activities of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model respond to certain intervention priorities laid down in the **National Strategy on Social Inclusion and Poverty Reduction 2015-2020 (NSSIPR)** with regard to social services, education, health, housing, employment, or social transfers**.**

- Develop an e-social assistance system, which requires the collection of data related to citizens' social needs using ICTs so that they can be accessed from a single database.
- Create community services for integrated interventions, aiming at the delivery of preventive and primary social services. These integrated community services should be provided by multidisciplinary teams comprising a social worker, a community nurse, a school mediator, a health mediator.
- Develop social services at local level by setting up or reorganising PSAS and providing them with appropriate funding.
- Increase access to education for children in vulnerable groups.
- Develop preventive health services at local level.
- Provide appropriate funding to social, educational and health services delivered at local level.

The model developed by UNICEF responds to these strategic priorities as follows:

- The AURORA methodology designed under the 'First Priority: No More Invisible Children!' project and developed under the UNICEF model involves collecting data on social vulnerabilities and determining the required services by means of a software application.
- Providing community-based health, educational and social assistance services in an integrated manner with the help of a multidisciplinary team comprising a social worker, a community nurse, a school counsellor, a school mediator, and a health mediator.
- Reorganising the work of PSAS/social assistance departments within mayoralties, with a greater focus on prevention and fieldwork as well as funding for additional positions so that such activities can be carried out.

- Identifying children's/students' needs and vulnerabilities and offering services contribute to facilitating access to quality education for all children and completion of compulsory education (with the appropriate acquisition of the skills set forth in the school curriculum).
- Employing community nurses in the pilot communities and training them to deliver preventive health services at community level. Also, with the monitoring activity and provision of county support to local community workers, the model has helped improve the relationship between different types of workers, the relationship with LPAs and other local stakeholders, thus boosting their work in the community.
- Building service delivery capacities at local level by funding a core team comprised of a social worker, a community nurse and a school counsellor (even when it was not possible to secure the adequate number of workers for the total/vulnerable population targeted in a certain community) is a decisive step towards addressing this strategic priority. The proactive documentation of vulnerable groups' needs along with the start of preventive service delivery at local level are a great plus in pursuing this strategic direction; adjusting professionals' workloads could be something to consider in the next programme stage.

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model also responds to the following objectives of the **National Strategy for the Protection and Promotion of Children's Rights 2014-2020** (NSPPCR):
- Specific objective 1.1 Increase service coverage at local level.
- Specific objective 2.1. Ensure minimum resources for children within a national anti-poverty programme, with a special emphasis on children.
- Specific objective 2.4. Reduce the opportunity gap between Roma and non-Roma children.

The activities included in the model which respond to these objectives are:
- Develop an integrated package of services (education, health and social protection) to cover the widest range of child needs. This package of integrated services is delivered by multidisciplinary teams comprising a social worker, a community nurse, a school counsellor, a school mediator, a health mediator.
- The AURORA application allows for a detailed understanding of children's vulnerabilities so that services can be determined and delivered as required.
- The services delivered under the Minimum Package of Services respond to children's needs in the three areas – education, health and social protection. In the communities included in the model, the number of children who have access to basic services has grown.
- Discrimination against the Roma diminished and Roma families and adolescents were empowered through: the delivery of educational kits for self-esteem development and the training of teachers on how to use them; demonstration lessons on how to use the educational kits for self-esteem development; methodology design for the selection of self-esteem development models; professional training of community workers on working with Roma ethnics.

The specific objectives of the *Strategy for the Inclusion of Romanian Citizens Belonging to the Roma Minority 2015-2020* to which the UNICEF model responds are:
- Reducing educational attainment (knowledge) and school attendance gaps, at all levels (pre-primary, primary, lower secondary, upper secondary, tertiary education), between Romanian citizens belonging to the Roma minority and the rest of the population.

- Reducing socioeconomic gaps between Roma and non-Roma students in areas that hamper educational inclusion (food, clothing, living conditions, health status), including through support provided for improving the family's economic circumstances or ensuring free home-to-school transport on a daily basis.
- Promoting inclusive education and reducing discrimination and school segregation on grounds of ethnicity, social status, disabilities or any other criteria affecting children and young people from disadvantaged groups, also by building a system for effective identification, monitoring and swift interventions to eliminate any cases of school segregation and supplementing the current anti-segregation legislation (Order No 1540 of 19 July 2007) with sanctions or compulsory actions in the event of school segregation.

The UNICEF model responds to these objectives of the *Strategy for the Inclusion of Romanian Citizens Belonging to the Roma Minority 2015-2020* as follows:
- Delivering the Minimum Package of Services, which provides educational, health and social protection services to all children in the communities where the model is being implemented, irrespective of ethnicity.
- Including health and school mediators in the community teams from the communities with Roma members so as to facilitate the local provision of the service package.
- Promoting quality inclusive education through a dedicated package.

CHILD PROTECTION

The child protection system is confronted both with funding issues, as the share of child and family expenditure in the overall spending on social protection dropped by nearly one third between 2005 and 2010 and the staff declined by 27% compared with 2007, and with insufficient inter-agency collaboration in implementing applicable laws, which poses some difficulties (NSPPCR 2014-2020).

The implementation period of the model saw the passing of GD No 691/2015 approving the *working methodology for the cooperation of general directorates for social assistance and child protection and public social assistance services, along with templates for the documents they have to develop,* which is based on the outcomes reached through the implementation of AURORA methodology. According to this methodology, the public social assistance service is to identify situations of risks affecting the child and requiring services and benefits, based on the following aspects: a) the economic circumstances of the family; b) the social circumstances of the family; c) family members' health status; d) family members' educational attainment; e) the living conditions of the family; f) risky behaviours detected at family level. This methodology includes an observation form for needs assessment and a risk detection form for Romanian families with children, which were designed based on the needs assessment questionnaire of the AURORA application. Within two years of entry into force, the forms were to be completed for all at-risk children in the administrative territorial unit, but they were not accompanied by a database for entering the information gathered, which made it impossible to centralise the data.

HEALTH

In terms of performance, the Romanian health system finds itself at the bottom of European Union rankings, with the highest rates in Europe for infant mortality (8.35 per 1,000 live births in 2014[2]) and under-five mortality (9.7 per 1,000 live births in 2014[3]). Moreover, maternal mortality, which stood at 12.27 per 100,000 live births in 2014, and the number of live births to mothers aged under 20 years (18,595 live births to mothers aged under 20 years in 2014) were the highest in Europe.

The National Health Strategy 2014-2020 approved under GD No 1028 of 18 November 2014 sets two general objectives aimed at addressing the issue of insufficient preventive services at local level; more precisely, GO1 aims to "improve the health and nutritional status of women and children" and GO4 aims to "ensure equitable access to quality and cost-effective healthcare, in particular for vulnerable groups". GO4 explicitly pursues a specific objective for the development of community nursing services ("SO 4.1. Develop integrated and comprehensive community nursing services, primarily addressed to people in rural areas and vulnerable groups, including the Roma"). The Strategy thus recognises the need for a better integration of medical and social services and suggests that community centres should be set up to provide the main integrated services at community level.

Given the need to clarify the institutional organisation and operation of Integrated Community Centres, to ensure the sustainability of community nursing activities from different pilot programmes and by virtue of the National Health Strategy 2014-2020, more precisely of the objectives aiming to develop integrated and comprehensive community nursing services, the Ministry of Health initiated GEO No 18/2017 on community health nursing, which was approved and entered into force as of March 1st, 2017, with a timeframe of 60 days for the development of implementing rules.

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model is in line with the two objectives of the National Health Strategy 2014-2020, namely "Improve the health and nutritional status of women and children" and "Ensure equitable access to quality and cost-effective healthcare, in particular for vulnerable groups". In fact, UNICEF was one of the main institutional partners which supported the Ministry of Health throughout the development and consultation process which helped define this Strategy.

EDUCATION

Over the past 25 years, the Romanian education system witnessed the development of numerous national strategies pursuing the objectives set out in the EU strategies, especially those included in the Europe 2020 strategy. The 2020 objectives to which Romania has committed in the education sector include: reducing early school leaving (a maximum rate of 11.3% by 2020), increasing children's participation in pre-primary education (at least 95% of children between the age of 4 years and the compulsory primary school age must benefit from pre-primary education), increasing the academic performance of students in the compulsory education system (the rate of 15-year-olds with poor reading, math and science skills should not exceed 15%) (European Commission, 2015, Apostu et al, 2012, Eurostat 2015). However, current data indicate that the Romanian education

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[2] http://data.euro.who.int/hfadb/
[3] http://data.euro.who.int/hfadb/

system is far from reaching those objectives: the rate of early school leavers has stagnated at 18% in the last years, participation in early childhood education stands at 87.3% and over 30 % of 15-year-old students have poor skills in reading, mathematics and science (PISA, 2015, European Commission, 2015). The causes that maintain our education system in a challenging state are both external (socioeconomic factors, a decrease in the social value of school degrees measured in labour market opportunities for graduates, etc.) and internal to schools (quality of education, technical and material conditions in schools, teachers' skills/level of training, the relationship of the school with the other public and private institutions, as well as the school-family relationship).

During the implementation period of the UNICEF model, a number of public policy measures were taken in the field of education with relevance to the Quality Inclusive Education component (some were actually the fruit of UNICEF's advocacy efforts):

- ORDER No 6158 of 22 December 2016 approving the action plan for school desegregation and better quality education in Romanian pre-tertiary educational establishments;
- ORDER No 6134 of 21 December 2016 on banning school segregation in pre-tertiary educational establishments;
- ORDER No 1985/1305/5805/2016 of 4 October 2016 approving the methodology for assessment and integrated intervention with a view to establishing the disability level of children with disabilities, providing school and vocational guidance to children with special educational needs and ensuring the habilitation and rehabilitation of children with disabilities and/or special educational needs;
- EMERGENCY ORDER No 96 of 8 December 2016 amending and supplementing certain legal acts in the fields of education, research, professional training, and health.
- A MNE-UNICEF cooperation agreement was signed for implementing the action plan for school desegregation and better quality education in Romanian pre-tertiary educational establishments.

4.2. LOCAL CONTEXT

At the last census, the county of Bacău had a population of 616,168, with 2.5 per cent identifying as Roma. Since the last census, population dropped to 602,399 in 2015, with 23% aged 0 to 18 years (Table 3). Out of all the people ages 0 to 18 years, 38% live in urban areas and 62% in rural areas.

Table 3. Population aged 0 to 18 years, by area of residence, Bacău County

Age groups	Area of residence	2012	2013	2014	2015
Ages 0-4	Total	33,071	31,784	31,295	31,954
	Urban	13,475	13,052	12,940	13,562
	Rural	19,596	18,732	18,355	18,392
Ages 5-9	Total	37,180	36,839	36,313	35,656
	Urban	13,831	14,049	14,184	14,190
	Rural	23,349	22,790	22,129	21,466
Ages 10-14	Total	39,298	38,771	38,155	37,574
	Urban	13,336	13,112	12,978	13,027
	Rural	25,962	25,659	25,177	24,547
Ages 15-18	Total	31,440	31,197	31,157	31,410

Urban	11,679	11,271	10,905	10,706
Rural	19,761	19,926	20,252	20,704

Source: NIS, TEMPO online database, POP106A

In Bacău, much like in other counties, due to a lack of financial resources, social assistance services are not sufficiently developed to cover current needs (Social Service Development Status in Romania, 2011). Thus, at the end of 2013, there were 74 social assistance providers in the county, with 40 in the private sector and 34 public providers. Thirty of the 34 public providers deliver services accredited by local authorities – 23 in rural areas and seven in urban areas (County Social Service Development Strategy 2014-2020, 2014, p.71). Since there are 85 communes in the county and only 23 accredited social assistance services, many rural communities obviously lack such services, meaning that a large number of potential beneficiaries cannot access them. The biggest public social service provider is the General Directorate for Social Assistance and Child Protection. Of all social assistance services delivered by public and private providers in the county, 45.7% were addressed to children (County Social Service Development Strategy 2014-2020, 2014, p. 72).

LOCAL PUBLIC POLICIES

Bacău County has two major strategic documents, adopted before the start of UNICEF model implementation, which set priorities/objectives in the fields of social inclusion, education and health:

- Bacău County Sustainable Development Strategy 2010-2021 (published in November 2010), which seeks to increase access to social, health and educational services as well as to basic utilities. Vertical strategic objective No 4 concerns the promotion of economic convergence and increased social inclusion through enhanced access to health and educational services in rural areas and facilitated access to quality educational services and social programmes for abandoned children, children in placement centres and the members of families affected by migration. Horizontal strategic objective No 4 aims at upgrading health and educational services through improved healthcare provision, especially in rural areas, healthcare standardisation, improvements in infrastructure and in the quality of education delivered, dropout reduction and prevention, particularly in rural areas. UNICEF's model responds to the strategic objectives identified at county level and to the need for improving the quality of health, educational and social protection services, thus contributing to the social inclusion of vulnerable groups.

- County Social Service Development Strategy 2014-2020 (approved on June 24th, 2014) with the following directions for action: ensure the child's welfare in the family environment; ensure the rights and social inclusion of vulnerable children; continue the transition from institutional care to community care; eliminate all forms of violence against children; and promote child participation in the life of the community. Some of these directions for action and specific objectives were also inspired by the outcomes reached through the implementation of UNICEF's 'First Priority: No More Invisible Children' project. With the objectives and activities it proposes, UNICEF's model responds to the specific objectives of this strategy aimed at improving the quality of public social assistance and social services at local level (SO 1.1), increasing access to education for all children (SO 1.2, SO 2.4), improving access to quality healthcare for children and their parents (SO 1.3), promoting children's access to leisure and free-time activities (SO 1.4), empowering beneficiaries' to access and use integrated community-based services

addressed to children and families (SO 1.5, SO 2.2), developing and implementing a child rights monitoring and evaluation system (SO 1.6).

SOCIAL INCLUSION

The county of Bacău is located in the Northeast region, the poorest of Romania, with 34% of the EU's average GDP (EUROSTAT, 2017). In Bacău County, 37% of urban population is marginalised – 6.4% lives in areas disadvantaged on housing, 12.5% lives in areas disadvantaged on employment, 12.6% lives in areas disadvantaged on human capital, 3.4% lives in marginalised areas, and 2.1% in areas with institutions or with less than 50 inhabitants (The Atlas of Urban Marginalized Areas in Romania, 2015, p. 274). In rural areas, 10.2% of the population lives in marginalised areas, 2.8% of which are Roma communities (The Atlas of Rural Marginalized Areas and of Local Human Development in Romania, 2015, p. 273). With a human development index of 49 in rural areas, the county of Bacău falls into the moderate development category (The Atlas of Rural Marginalized Areas and of Local Human Development in Romania, 2015, p. 372). Demographic distribution by local human development indicates that, in Bacău, 7.3% of the population lives in villages with the lowest development, 18.3% in villages with medium-low development, 37.8% in villages with medium development, 29.4% in villages with medium-high development, and 6.8% in those with comprehensive development (The Atlas of Rural Marginalized Areas and of Local Human Development in Romania, 2015, p. 170). Bacău is one of the 18 counties where 50 to 65 per cent of county and communal roads are dirt or gravel roads and need to be upgraded (Teşliuc et al., 2015, p. 301)

Figure 2. Bacău County localities, by level of marginalisation

Rural marginalised areas
Bacău County

Legend
Bacău County

- 0
- Below-average marginalisation
- Average marginalisation
- Above-average marginalisation
- Severe marginalisation

Source: The Atlas of Rural Marginalized Areas and of Local Human Development in Romania, 2016
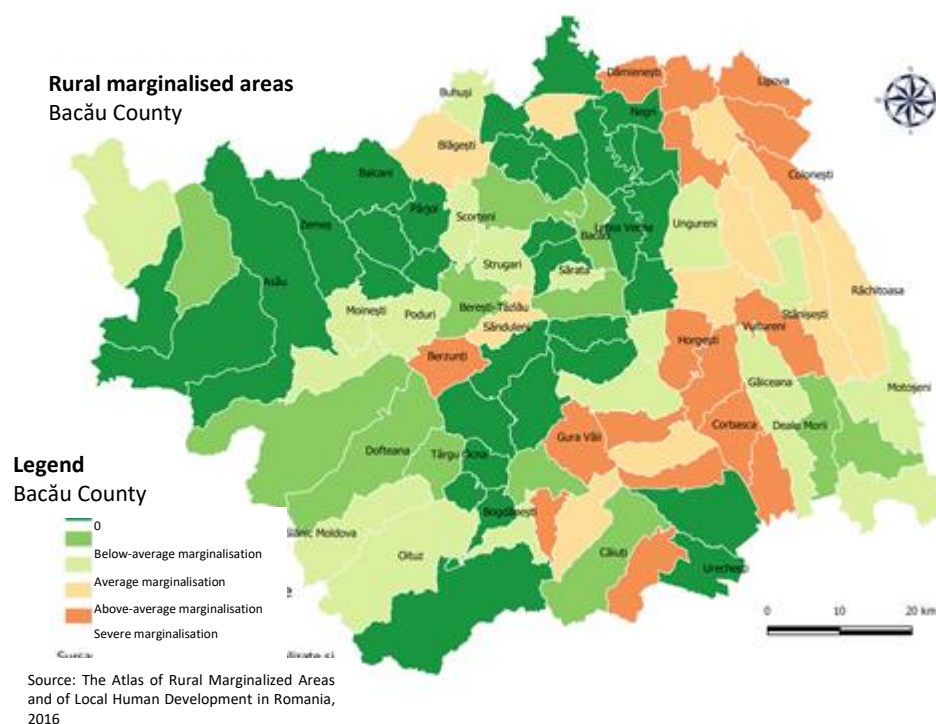
The 'First Priority: No More Invisible Children' project, implemented by UNICEF in 13 communities of Bacău County, identified 600 'invisible' children with multiple vulnerabilities who didn't benefit from services or support and faced a much higher risk of social exclusion (County Social Service Development Strategy 2014-2020, 2014, p.13).

The county of Bacău presents a number of social inclusion issues:

- It is one of the ten counties with the highest number of children with teenage mothers (Teșliuc et al., 2015, p. 153).
- 4.5% (around 7,500) of children with migrant parents (most of them with both parents abroad) live in the county of Bacău (Teșliuc et al., 2015, p. 150; County Social Service Development Strategy 2014-2020, p. 27).
- The risk of poverty and social exclusion is higher among vulnerable groups because of their poor access to healthcare, education, and social assistance. Things are worst in rural areas, where the quality and the number of these services are much reduced. (County Social Service Development Strategy 2014-2020, 2014, p.13)
- Roma children still have limited access to education, with two in ten not being enrolled in any form of education due to their families' material circumstances (County Social Service Development Strategy 2014-2020, 2014, p. 27).

CHILD PROTECTION

In Bacău County, the child protection system faces a number of issues, such as:

- A 33-percent decrease in the number of foster carers compared with 2006, which means that a foster carer has to look after more children. (County Social Service Development Strategy 2014-2020, p. 20).
- A large number of at-risk children, amounting to over 4,000 of the cases processed in the period 2006-2013, with 74% being cases of neglect/abuse/exploitation (County Social Service Development Strategy 2014-2020, p. 23).
- The number of children in residential care was 417 in 2013 and 233 of them were children with disabilities (County Social Service Development Strategy 2014-2020, p. 17).

EDUCATION

Based on the Report on the State of Education in 2014-2015, prepared by Bacău County School Inspectorate, we should mention some characteristics of the education system in Bacău County:

- In the 2014-2015 school year, Bacău County had 168 mainstream educational establishments with legal personality – 69 in urban areas and 99 in rural areas, five special education institutions – all in urban areas, and four children's centres and clubs, school sporting clubs and excellence centres. That school year, the number of affiliated mainstream educational establishments was 683.
- The county's school population dropped constantly from 141,636 students in the 2004-2005 school year to 120,063 in the 2012-2013 school year and 106,599 in the 2014-2015 school year.
- 80.65% of all posts were held by tenured teachers, an increase of less than 1% than in the previous year.
- Individual counselling was offered to 23% of pre-schoolers and 13% of students in grades 1 to 12 who had access to a counsellor.

HEALTH

Healthcare access shows major disparities across the county; hence, rural population – accounting for 56.64% of population in the county – is served by only 9% of the healthcare professionals available at county level.

The county has 297 family doctors, with 162 of them operating in urban areas and 135 in rural areas (NIS, Tempo online, SAN104B). Considering that more than half of county population (348,751 out of 616,168 people, which is the total county population as per the 2011 census) lives in rural communities, we can say that access to first-line services offered by family doctors is very much limited in rural areas, where one family doctor serves 2,583 people, on average, compared with 1,650 inhabitants to one family doctor in urban areas.

Also, the community nursing network is not evenly developed in the county and only 15 of the 85 communes in the county of Bacău have access to community nursing services and only four of them have health mediators.

Some worrisome phenomena caused by poor access to primary healthcare are frequent pregnancies at a young age, the persistent number of people who are not insured or registered with a family doctor, newborn or young children being abandoned at maternities or hospitals, etc.

5. MTR FINDINGS

5.1. PREPARATORY PHASE OF THE MODEL

The 'Social Inclusion through the Provision of Integrated Services at Community Level' model was based on a theory of change developed in September 2014, which defined the outcomes to be reached through the implementation of the two packages (Minimum Package of Services and Quality Inclusive Education Package) in the fields of social protection, health, and education. The theory of change was developed considering both the outcomes of and the lessons learned from the two previous projects implemented in the areas of education – the School Attendance Initiative – and child protection – 'First Priority: No More Invisible Children!', which laid a solid foundation for the intervention and ensured continuity in the activities implemented by UNICEF. The continuity of activities and their development/adjustment based on lessons learned contribute to providing intervention models needed to create effective public policies.

The preparation of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model involved: selecting the communities for the implementation of the activities proposed; running the initial assessment of community needs; establishing partnerships with local, county and national stakeholders; selecting and recruiting the human resources needed to carry out the activities; developing a model monitoring and evaluation mechanism.

5.1.1. THEORY OF CHANGE

The theory of change guiding the model was clearly defined in the preparatory phase, with the main hypothesis being properly formulated in line with the internationally recognised good practices, starting from the premise that a child who has access to and receives basic social, medical and educational services will develop optimally. The theory of change included the hypothesis, objectives, activities, and expected outcomes.

Following consultations with the national and local stakeholders involved in model implementation, the theory of change was further developed in 2015, with improvements made to the objectives and logical framework for most effective implementation. This flexibility in adjusting the theory of change and, ultimately, the model is beneficial for it leads to proper and effective implementation responding to existing needs and local realities.

Even if the theory of change talks about the impact estimated to be reached through the integrated/coordinated implementation of the two packages, it offers few details about ways to achieve such coordination/integration.

Elements of success:

- Theory of change developed based on the experience of the previously implemented projects, which inspired the hypothesis, objectives, activities, and expected outcomes
- Flexibility in adjusting initial outcomes to the needs identified throughout the implementation period – which allowed for a better response to the problems encountered and more effective implementation
- Flexibility in further developing the theory of change after consultations with relevant stakeholders, which led to a more efficient logical framework.

Key challenges:

- Insufficient information about ways to integrate the two packages of the model: MPS and QIE.

5.1.2. PARTNERSHIPS

The UNICEF model comes to support local communities and help them enforce applicable laws, which stipulate that local social needs are to be identified and primary social services are to be provided by public social assistance services operated by local authorities. At the same time, educational establishments should follow the principles of quality inclusive education. Therefore, a requirement for project implementation was that community workers – social workers, community nurses, health mediators – should be employed by local public authorities and school mediators and counsellors should be employed by CREAC, even if their salaries were funded by UNICEF. Later, this also contributed to rendering local authorities more responsible, building the population's trust in them and ensuring the sustainability of implemented activities.

The communities where the model was to be implemented were selected based on a methodology created by independent experts in the field, looking at the development of the communities (local development index), followed by their interest in the model and their desire to get involved. It was quite a challenge to find the 45 communities for local authorities responded differently to the programme – there were leaders who understood the importance of the model, but there were also communities which, at first, refused to take part in this undertaking and additional actions had to be taken to document and inform LPA representatives about the need, feasibility and added value of the model. In the communities where the model could not be implemented, two distinct situations were spotted: the first, where local authorities were not willing to get involved in such an endeavour and, the second, where implementation was hindered by a lack of human resources having completed at least upper secondary education and that could be trained to provide the services as established. Local authorities' acceptance to implement the model was positively influenced by the existing partnerships between UNICEF and county public institutions in the areas of education, health, social protection (including with the County Council). Since the model is expected to be scaled up in the future, to counter the risks associated with LPA representatives' low interest in the model, advocacy and communication efforts should be stepped up.

The model mentions the national involvement of the main public institutions with relevant responsibilities, namely the line ministries, as well as the Ministry of Finance, the Ministry of European Funds, etc. Such involvement mainly means participation in the model's Steering Committee and in the joint planning of project activities to ensure participatory management and institutional accountability so that these institutions can become active partners. At the same time, this participatory management structure was set up starting from the premise that the engagement of national stakeholders will ensure model sustainability and replicability. Nevertheless, interviews with national stakeholders call into question the capacity of different ministry representatives, involved in the Steering Committee, to include the lessons learned in the annual action plans budgeted by the public institutions they represent and to make decisions that support model sustainability.

The involvement of non-governmental stakeholders remains limited at both county and national levels, especially that of the NGOs known to provide integrated services to children in the community and whose activities are similar to those proposed in the model (Save the Children,

World Vision, Bacău Community Support Foundation, SERA Romania, etc.). The interviews conducted with NGO representatives revealed that they had not been involved in the preparatory phase of the model and that they believed that their input could have been useful in getting to know the local realities and a partnership would have facilitated the implementation of certain activities:

> "It might have been useful to talk to the NGOs working in Bacău for they knew the realities and were able to provide information that could have also helped them anticipate some of the problems. Partnerships with NGOs could have led to additional services." (Representative of an NGO active in the county of Bacău)

In the QIE package, some of the activities were planned to be carried out by NGOs holding expertise in the required fields – parent education, teachers training, ethnic discrimination reduction, etc.

Elements of success:

- Involving national partners in the Steering Committee to craft a common vision for planning and coordinating project activities;
- Establishing partnerships with LPAs to facilitate model implementation and sustainability;
- Diversifying partners under the QIE component to ensure child-centred interventions carried out at school and family levels.

Key challenges:

- Inertia of the sectoral approach embraced by national institutions and the lack of inter-ministerial coordination for the implementation of integrated community-based services;
- Difficult inter-institutional communication at county level;
- Lack of local partnerships with NGOs to involve them in model planning.

5.1.3. HUMAN RESOURCES

Effective model implementation required the recruitment/employment of staff for community-based service delivery, namely social workers, community nurses, school counsellors and, where applicable, school and health mediators. This preparatory activity was one of the toughest and was carried out in different rounds given the shortage of qualified candidates applying for the open competitions.

The human resources needed to implement the model were determined in the preparatory phase, namely community workers were envisaged to be hired for all the types of services intended to be provided in an integrated manner under the model: community nurse, school mediator, school counsellor. The initiative did not try to recommend an *a priori* standardisation, but started from the premise that these services could be delivered in an integrated manner at first and then, based on this experience, feedback could be offered regarding the standards stipulated in the national law.

UNICEF proposed to local public authorities a set of criteria for the selection of the human resources needed for model implementation and recommended them to consider current professional standards. UNICEF let each local public authority set the selection criteria, in accordance with the legislation into force. Based on local realities, the criteria for the selection of human resources were later adapted to ensure the staff needed for implementation. Thus, given the shortage of qualified social workers, these positions were filled by persons having completed a specialised social work course held by the GDSACP. Delivering such specialised courses in the field of social work was one of

the solutions that the project team identified to address the lack of social workers, yet it delayed the implementation of certain activities.

Elements of success:
- Flexibility in carrying out additional training activities for the employment of social workers;
- The long-term partnership with LPAs and CREAC which secures stable funding sources for community workers and school counsellors.

Key challenges:

- It was difficult to recruit specialised staff for the positions of community nurse, social worker and school counsellor and many of these job openings were filled after several open competition rounds or even after specialised courses, like in the case of social workers.
- Human resources required at community level were not sized based on community characteristics (population, social problems, territorial distribution, etc.);
- Lack of qualified school counsellors in remote communities due to low pay and the travel involved. At the same time, given the low student count in one school, a school counsellor has to cover two or three communities in order to meet his or her workload, which means high travel expenses that turn potential candidates off.

5.1.4. MONITORING AND EVALUATION

Considering that one of the model's objectives is testing the delivery of the community-based services which are stipulated by law but are insufficiently and/or inadequately implemented, in order to scale them up nationwide, the monitoring and evaluation component is extremely important not only for measuring the achievement of objectives, but also for rapidly identifying any problems arising during model implementation. Monitoring and evaluation also constitute key elements for the documentation and regular adjustment of the intervention so as to replicate the model in other communities. This component of the model features: an initial assessment conducted in the communities included in the model; a mid-term review to identify any difficulties and lessons learned; a final evaluation; and constantly monitoring the achievement of the indicators set out in the logical framework of the model as well as the implementation of the activities.

The initial assessment of the communities based on community development indicators was used to select the localities where the model was to be implemented. This made it possible to group the communities into six development clusters and detect their main features. The model sought to run an initial assessment in order to measure basic social, educational and health indicators in the 45 communities from Bacău as well as in six communities from Galaţi making up the control group. This initial assessment aimed to document the baseline situation of the communities where UNICEF's model was to be implemented and, along with the monitoring reports and the final evaluation, to help assess its relevance, effectiveness, efficiency, and sustainability.

The needs assessment and the real-time monitoring of the services delivered under the two packages also planned to make use of AURORA. The application includes an initial assessment of vulnerabilities/needs (a census) conducted proactively by community workers in the communities and the setting of the required interventions while also allowing for the services delivered in the communities to be monitored. Hence, based on the identified vulnerabilities, the application proposes a set of services whose delivery status is available to all community workers in real time.

Application functions were upgraded based on user feedback. At present, the application also includes references to relevant regulatory acts for quick consultation by community workers. In each community, the application allows for child data to be aggregated based on certain criteria, such as: address, age, gender, type of vulnerability. The information included in the application can help estimate the services needed in each and every community.

Elements of success:
- A needs assessment study conducted in the project communities and in six control communities, which made it possible to adjust the intervention to the local reality and which will facilitate the model impact assessment;
- The evaluation and real-time constant monitoring of children's vulnerabilities and services delivered to them with the help of the questionnaire included in the AURORA application.

Key challenges:
- Adjustments to the theory of change and to the documents produced during model implementation, which hinder the monitoring and evaluation process. This aspect also constitutes a model asset as it allows for objectives and actions to be adapted to the changing reality of the community.
- The primary use of indicators related to the reduction of the vulnerabilities presented by children and families; setting indicators for monitoring LPA institutional capacity and performance related to model implementation could offer useful information in the evaluation process, with relevance to the intended model scale-up.

5.2. MODEL IMPLEMENTATION PHASE

The implementation of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model involves the provision of community-based health, social protection and educational services in an integrated manner to reduce the risk of social exclusion for children and their families. The model is being implemented via several interventions grouped into two service packages – the Minimum Package of Services and the Quality Inclusive Education Package – which were designed with the thought of correlation and coordination in mind so as to offer interventions in the three areas (health, social protection, education) that can best respond to the complex needs identified at local level.

Within the model, these integrated community-based services should be provided by a community team comprised of a social worker/caseworker, a community nurse and a school counsellor and, in the communities with vulnerable ethnic groups, the team is to be completed by a school mediator and a health mediator. The application of the model has been influenced by a series of local factors; given the intended model replication, it is very important to know these factors as well as to analyse ways to mitigate their negative influence and enhance their positive influence at local level. Some of them are: partnership with the local public administration; institutional capacity of local administration; active participation of local and county stakeholders; qualification of human resources involved in service delivery; cooperation of community workers; infrastructure available for implementing the interventions; local management of the model.
- Partnership with the local public administration – the quality of the partnership with the local public administration can significantly influence the success or failure of such an undertaking, given that some of the community workers (social worker/caseworker, community nurse, health

mediator, school mediator) are employed by the LPA or that local (human, material, financial) resources need to be allocated for different activities.

- Institutional capacity of local administration – the interventions conducted require cooperation between the local team and the other local administration employees, especially on the social protection component. The provision of integrated services also depends on the institutional capacity of the LPA – social protection employee count and qualification.
- Active participation of local and county stakeholders – cooperation of local stakeholders from the three areas (health, social protection, education) and county stakeholders providing the necessary guidance and support. It is important to activate community advisory structures counting local stakeholders so as to solve various child problems.
- Human resources – effective and adequate model implementation depends on the level of qualification and experience of the human resources involved.
- Cooperation of community workers – provision of integrated services is conditional on the communication and cooperation of community teams and between the latter and the model's local management structure.
- Available infrastructure – carrying out the activities depends on the available infrastructure (means of transport, facilities for the activities, educational materials, etc.).
- Local management – at county level, local teams are managed by a project manager and 22 county coordinators (seven on the QIE package, 15 on the MPS package – four on education, four on health and seven on social protection) split into model implementation areas, ensuring the required monitoring, supervision, support, and guidance. These coordinators are highly experienced in their field and have great knowledge of the realities on the ground and of the legal instruments that can be used to solve different problems. This coordinating structure helped identify solutions to problems and improved communication with local authorities and institutions.

Even if model implementation started in all the communities at the same time, local factors caused some discrepancies. Thus, we can talk about "different speeds" in implementing the various model activities at local level. Despite the efforts, it was not always possible to close the gap between the communities, which means that some communities almost completed the community census, provided several services to address the vulnerabilities identified and carried out a larger number of model activities, whereas others are in a less advanced stage of implementation. If, in some communities, local authority support was mostly formal and limited to hiring the local MPS community workers, in others the authorities got more involved and provided means of transportation for local teams or facilities for the activities, mobilising other local workers or offering larger co-financing for microgrants.

The data collected during field research revealed that openness towards the project increased during its implementation: 42% of community workers who completed the online questionnaire believed that, at the start of the implementation period, people in the community were reluctant to the project and 84% of them believed that community members learned to ask for their help when they needed it. Twenty per cent of respondents think that the authorities showed resistance to the project at its onset.

"The LPA was reluctant to get involved; they thought the project was beneficial for the community, but they lacked a sense of ownership; it was UNICEF's project; the others' experience

mattered, the meetings of the mayors! Some mayors were so reluctant that we had to move to other communities, but this only happened in a few cases." (MPS county coordinator)

Changing the attitude of public authorities towards the need for model implementation is a long-term process and a great deal remains to be done, especially that some of the elected local representatives were replaced after the elections in 2016. The first outcomes of model implementation, however, contributed to changing the attitude of public authorities towards the model and making them more responsive.

"LPAs thought that this would create more problems for them; they didn't understand that they already had those problems and we were blamed for it. The success reached on all levels made LPAs engage more and the mayor himself is now striving to get funds." (County public institution representative)

5.2.1. MINIMUM PACKAGE OF SERVICES

The Minimum Package of Services is one of the two components in the model developed by UNICEF and it aims at stepping up efforts for fulfilling children's rights and reducing the equity gap through increased access to health, educational and social protection services that are cross-sectoral, community-based, preventive, and family-centred (MPS Brochure, p. 4). The Minimum Package of Services is universal and it includes health, social protection and educational services provided at community level, with a focus on prevention. MPS implementation requires the presence in each community of a team comprising a social worker, a community nurse and a school counsellor as well as a school mediator and a health mediator in marginalised ethnic communities, meant to first identify the needs of at-risk children and mothers and then provide tailored services.

The Minimum Package of Services successfully addresses a serious issue for which, although acknowledged by public policies in the social, health and education sectors, Romania has not yet managed to develop and apply coordinated policies or efficiently implement the policies already in place in order to tackle the matter. Most of the respondents interviewed during the qualitative research, be they representatives of local and central public administration or representatives of partner organisations, share this view and give credit to the UNICEF model as it helps local public authorities enforce applicable legal provisions that have not been implemented due to different reasons.

The main outcomes generated by the implementation of the Minimum Package of Services over the reference period will be analysed based on five key dimensions: human resources, capacity building, tools used, service delivery, and communication.

HUMAN RESOURCES

The implementation of the model's activities depends very much on the skills and qualification of community workers or teaching staff. Even if the conditions for employment were the same for all the communities included in the model, the members of local community teams do not have the same level of qualification, which affects activity implementation (the quality of the services provided, allocated time, etc.).

To boost the skills of community workers and change their behaviours with a view to reducing stigma and discrimination, the model held training sessions on topics like reproductive health, discrimination, domestic violence, personal development, etc. Thus, with increased capacities, awareness and understanding of these matters, ethnic discrimination, reproductive health, or domestic violence issues could be detected and partially or fully addressed among community workers and in the communities where they worked. More than that, training also focused on an appreciative approach to beneficiaries, which practically gave community workers the chance to get initiated in a different paradigm of working with the beneficiaries.

Teamwork and good communication within the project team, between community workers, between the latter and county coordinators and between the project team and local stakeholders are some of the factors that enable model implementation. This is not subject to strict rules, but it is adapted to the local context and to community workers' social capital (personal or professional relations established outside of the project) which they didn't hesitate to use for fulfilling their job duties. In some communities, community workers cooperate insufficiently, which affects activity implementation. One of the conclusions drawn from qualitative data analysis is that, in general, there is good collaboration between the social worker and the community nurse and less efficient collaboration between these two and the school counsellor.

Given the integrated nature of the community intervention, community workers communicate more often with the other members of the project team (65% do it a few times a week). Communication with the county coordinator is not that frequent, but in 72% of the cases it happens at least once a week. Things are different, however, in the case of community advisory structures, which generally meet once a month (35%) or less than every two months (34%). Whilst communication with the other project team members mostly happens face to face (67%) and less over the phone (27%) or via e-mail (3%), the relationship with the county coordinator is mostly mediated over the phone (76%) and via e-mail (12%), which is understandable if we consider the proximity and interdependence of community workers in their everyday work. In the relationship with the members of local teams from other communities, the phone is the most frequently used communication means (76%) and face-to-face communication comes before the e-mail (12% versus 8%). Online discussion groups are mentioned by very few respondents (2% in the communication with community workers from other communities and 1% with project team members).

Table 4. How often...

	More seldom	Every two months	Once a month	Every two weeks	Once a week	A few times a week	NR
Do you communicate with the other members of the local project team?	2%	2%	5%	5%	20%	65%	2%
Do you communicate with the county coordinator?	5%	2%	9%	10%	27%	45%	2%
Do community advisory structures meet?	34%	9%	35%	10%	7%	3%	3%

The territorial distribution of the communities and the difficult access to some of them, paired with the fact that some of the staff are not from the community where they work (according to the data collected, approximately 20% of community workers are commuters) affect the work of these employees and the time they allocate to persons in difficulty. If, at the beginning, in the communities where they were commuting they came across reluctant locals who didn't know them, almost two years into the project communication with them is no longer a problem and, in their day-to-day work, community workers are more confronted with the impossibility of covering beneficiaries' needs due to a lack of time or other resources as they sometimes have to use their own resources (e.g. personal car if there are no other means of transport; consumables) or they are less effective due to built-up fatigue, etc. Under these circumstances, 58% of the community workers interviewed said that the number of workers was insufficient compared with the number of beneficiaries in the community (Table 5). Regarding the time available, views are mixed and approximately half of respondents say that it is not enough to cover the needs of local vulnerable children and mothers.

Table 5. To what extent do you agree with the following statements related to the project implemented with UNICEF support?

	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK	NR
There is enough time available to cover the needs of local children in difficulty	11%	36%	38%	8%	1%	6%
There is enough time available to cover the needs of local mothers in difficulty	6%	41%	35%	7%	0%	11%
The number of community workers is enough for the number of beneficiaries in the community	20%	38%	27%	9%	0%	6%

The great distance to beneficiaries is a pressing matter for community workers (as mentioned by 59% of them) since much of their day-to-day work consists of visiting at-risk families: more than half of workers believe that they allocate at least 30 hours to this activity each month.

The poor understanding of the roles to be filled by the community workers hired for model implementation and/or the working practices of some institutions, where employees are also given administrative tasks other than those included in their job descriptions, affected the work of community workers. For instance, the social workers and community nurses employed for the implementation of the UNICEF model were also given administrative tasks unrelated to project activities and their job duties.

"In some mayoralties, the community nurse happened to receive other tasks than those related to the project; the DPH explained to mayoralty employees that they had other duties; or, in other cases, the mayoralty's social workers believe that those hired under the project are separate [professionals] and collaboration is not that good." (MPS county coordinator)

Although community workers are hired by the LPA, some of them identify as UNICEF staff and people in the community also perceive them as part of the UNICEF team, which affects their work in different ways. On the one hand, it maintains a tense relationship between community workers and the other LPA employees and, on the other hand, it builds locals' trust in UNICEF to the detriment of local authorities which are, however, the main pillar for ensuring model sustainability.

One of the issues raised during the focus groups held with community workers and the one conducted with county coordinators was the uneven pay for local public administration staff, with employees holding identical jobs in different mayoralties being remunerated differently. At the same time, community nurses were paid approximately two thirds of the salaries included in the pay scales because of requirements to fit into LPA average salaries.

School counsellors also mention insufficient time and that, given the ratio of 800 students to one counsellor and the fact that most schools in rural areas and small towns don't get near this student count, they have to cover this workload by working in several schools. Thus, the school counsellor can only be present in a community for one or two days a week, which affects not only the time allocated to counselling students, but also their collaboration with other members of the project team. Also, a number of communities, even some of the poorest ones, don't have a school counsellor. The analysis of the data collected during the research conducted in Bacău County has also highlighted the following aspects:

- The schools that a counsellor has to serve are not grouped based on distance to the counsellor's home, which makes it even more difficult for them to carry out the activities.
- The people that UNICEF hired as school counsellors in the model are not included in the MNE budget and, therefore, those positions are more unstable.
- The duties of the school counsellors hired under the model and those of the counsellors employed by CREAC are different in the sense that the former have more limited responsibilities (they don't have to teach) [according to counsellors' statements/focus group/interviews with county authorities]. Some school counsellors don't hold individual school counselling sessions but only group counselling due to the lack of facilities for that activity. School counsellors hired in the UNICEF model were primarily sent to disadvantaged schools which lacked such a professional. In many cases, it is very difficult or even impossible to arrange a facility (room) for individual counselling in these schools located in disadvantaged communities because they don't have that space available. Considering the instability of this staff category (school counsellors are hired on a fixed-term basis), school principals and school counsellors are not encouraged to invest in this area (identify and equip a facility with proper materials, etc.).
- Some of the school counsellors hired in the project already teach at those schools (they are usually schoolteachers) and they thus work both as counsellors on a part-time basis and as teachers. Besides the fact that these teachers have a much busier schedule, such a practice also seems to pose a deontological problem: the role of the school counsellor is to mediate between teachers and students and their parents. When you have a teacher or schoolteacher who teaches to a class where one or several students or parents have problems communicating/relating with the schoolteacher, how could s/he also meet his or her responsibilities as a school counsellor?

Another issue regarding the work of the community team is employee turnover, which represented one of the major problems in the first years of model implementation. For instance, the turnover of school counsellors due to their relocation often leads to school counselling discontinuity in the communities. Since the implementation of MPS activities very much depends on the presence of at least three community workers – social worker, community nurse and school counsellor – if one of them is missing, the work of the entire team is affected and implementation is delayed.

Elements of success
- Providing human resources complementary to the ones already available in the community, especially for the delivery of integrated services at community level (social protection, health, education);
- Multidisciplinary teams offering integrated services at community level;
- Ensuring that the LPA hired the social worker and the community nurse, which increased LPA capacities and created the basis for model sustainability;
- Increasing the number of school counsellors;
- The model's management structure, which facilitated its implementation (county coordinators), started to work under a new paradigm, with a cross-institutional and beneficiary-centred approach.

Key challenges
- Difficulties related to staff recruitment based on qualification requirements (e.g. social workers, school counsellors, community nurses);
- LPAs supplementing the tasks of community workers with administrative duties;
- Uneven pay for the human resources employed by LPAs (e.g. LPA representatives deciding to cap community nurses' salaries to the level of those paid by the mayoralty);
- High turnover of the human resources meant to carry out the activities;
- Poor communication within community teams and between community teams and the mayoralty employees not involved in the UNICEF model;
- Community workers identifying and being identified by the community as belonging to the UNICEF team, not to the LPA.

CAPACITY BUILDING/DEVELOPMENT

A key benefit of the model was the change produced in the service delivery paradigm towards more focus on beneficiaries' needs. As part of this approach, community workers travelled to the community to visit the beneficiaries and complete a questionnaire about their needs/various aspects related to the quality of life. It was a proactive process of "*making the community aware of its needs*" (MPS county coordinator). Through home visits and the community census, the model helped local authorities gain more knowledge of the social problems affecting the communities. Thus, it was possible to detect social problems that the authorities had not identified or had only partially known before the start of the UNICEF project, especially due to the lack of human resources. Many mayoralties had only one social worker who did not always hold a specialised degree, being overwhelmed with work and having to fulfil preponderantly administrative duties (preparing beneficiary records) to the detriment of fieldwork. With a proactive beneficiary-centred approach, the model helped gain deeper knowledge of children's vulnerabilities and identify the required concomitant services, unlike prior to the project when children were tackled together with

the other social assistance beneficiaries (the elderly, people with disabilities, etc.), which led to insufficient knowledge. Also, another UNICEF model asset is the focus on services aimed at preventing children's separation from their families and ensuring the conditions for children's adequate development in terms of health and education.

> *"People's needs were identified using a home-based approach; they were used to coming to the mayoralty themselves, to ask for things, to complain… for some of the families, it was probably the first time someone visited them; services are delivered at their homes."* (County public institution representative)

Table 6. To what extent do you think that, in the community where you work, thanks to the project implemented with UNICEF support…?

	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK	NR
The mayoralty focuses more on addressing social problems	0%	4%	48%	28%	2%	17%
Collaboration with commune-based institutions (mayoralty, medical office, school) has improved	1%	6%	51%	25%	1%	16%
Collaboration between commune-based institutions and county agencies responsible for social assistance and child protection has improved	0%	3%	46%	36%	2%	14%
Collaboration between commune-based institutions and county health agencies has improved	0%	4%	57%	23%	0%	15%

Eighty-one per cent of community workers think that the improved collaboration between community institutions and county agencies responsible for social assistance, child protection and health is one of the main benefits brought by the implementation of the UNICEF model. At the same time, 67% of them believe that inter-institutional relations in the area of education have improved following project implementation. It is also worth mentioning that 76% of respondents include improved relationships between local institutions (mayoralty, school, medical office) among project benefits.

Most family doctors responded well to the programme, which they thought raised the quality of healthcare in the community by supplementing the work of specialised medical staff with preventive duties.

> *"I don't know what I would have done during the vaccination campaign without the support of the community nurse who mobilised the community for vaccination."* (Family doctor)

Also, through microgrant applications, the UNICEF model built local authority representatives' capacity to write funding applications.

Elements of success
- Developing the competencies needed for the beneficiary-centred service paradigm (knowledge, skills, attitude towards beneficiaries), etc.;
- LPAs' increased awareness of social problems;
- Deeper and proactive knowledge of the vulnerabilities facing children in the community;
- Development of social assistance services at community level;
- Increased LPA capacity to write project proposals for funding (microgrants, but also under OP-HC).

Key challenges

- Low LPA capacity to develop and deliver social services;
- Very limited LPA funding for the provision of social/medical services;
- Focus on 'treatment', not on 'prevention';
- Delayed onset of the activities in some communities because of the need to qualify the staff (e.g. social workers);
- Inefficient communication between community workers and LPA employees, which sometimes generated dysfunctions in carrying out the model's activities (e.g. reimbursement of microgrant expenses);
- Local family doctors' different levels of involvement as they were not formally included in the model;
- Underqualified human resources within LPAs for implementing projects with extra-budgetary funds;
- LPA changes due to electoral cycles (mayors).

TOOLS USED

AURORA is considered one of the most important tools developed in the model and extremely useful for identifying social needs, monitoring service delivery at local level, and detecting cases early on. This methodology informed the tools developed to collect data about the circumstances of at-risk children (GD No 691/2015) and, according to qualitative research data, the Ministry of Health intends to integrate AURORA information into the data of its own community nursing application for a comprehensive picture of beneficiaries' situation (children, pregnant women, etc.).

> *"An information system like AURORA is needed for you cannot make decisions without knowing the local realities. At the moment, public authorities don't have any application related to prevention."* (Central public administration representative)

The members of local communities were more reluctant at first as they were not very well informed about why they needed to provide data during the community census. Once they were informed and they understood the benefits, they cooperated better with the members of the local teams. In some communities, a significant role in convincing the locals to let community workers in and answer their questions was played by the mayoralty's social workers, who were already known in the community and who initially accompanied the other workers on the ground. Despite locals' resistance to providing some of the information that had to be entered in the AURORA application (a problem faced by 44% of community workers), over 70% of community workers consider the application useful at every stage of their work, from beneficiary identification and needs assessment to information, counselling and referral of beneficiaries, as well as for the monitoring and evaluation of the intervention and provision of integrated services to beneficiaries. Sixty-five per cent of community workers also see AURORA as one of the factors contributing to the success of the project.

As a working tool, AURORA is a perfectible system and the members of the project team made a number of suggestions for improvement, such as checking data consistency and logical links between the identified vulnerabilities and the services proposed to be provided (e.g. counselling services for one-month-old children) and introducing new case selection criteria along with novel functions. Not all of the weaknesses mentioned by community workers indicate app design hitches; some of them reveal community workers' poor understanding of AURORA data entry instructions

(e.g. adapting some questions to the ages of children in the household and to parents' literacy level or the relevance of certain questions), which calls for stepping up efforts to train them.

> *"AURORA is a good tool for identifying vulnerable people and the services they need. I think it should be upgraded so that it is not only an identification tool, but also a tool used for real-time service monitoring; thus, the software should be changed to make it more dynamic or to define priorities."* (Central public administration representative)

> *"It is extremely useful for identifying needs, [but] the service component is still insufficiently developed; ... whilst [AURORA] is very useful for needs identification and can be used for population mapping, the services in which institutions are interested are more complex than those included in AURORA; the solution could be its integration/an interface with other software applications!"* (Partner organisation representative)

Even if the model's approach included an integrated working methodology to be developed after setting up functional community teams and identifying local vulnerabilities, because of discrepancies between communities in the implementation of model activities, some community teams mentioned the need for a methodology and specified the difficulties they were facing due to the lack thereof (e.g. task overlap, failure to fulfil some duties).

> *"It lacks a service delivery methodology. Each community has its own practice."* (Community team member)

The UNICEF model sought to activate community advisory structures for the purpose of discussing the various community problems and identifying solutions for the more serious cases. In many localities, these community advisory structures are formal and they get very little involved in the resolution of serious cases as decisions are often made by the local authority. These CAS meet only when serious child abuse cases are detected in the community and their involvement as an advisory forum in the implementation of model activities was extremely limited. Nonetheless, the implementation of the UNICEF model was the first, yet timid, step towards mobilising these structures.

Elements of success
- AURORA helped identify local needs and plan the required integrated services;
- AURORA helped county decision-makers better understand the needs of children and their families;
- AURORA was constantly upgraded based on the feedback received from community workers;
- Community advisory structures were reactivated in some communities.

Key challenges
- Different understandings of the AURORA working methodology among community workers;
- Lack of a working methodology for the delivery of integrated services;
- Local stakeholders' (LPA, school) dissatisfaction with the differentiated access to AURORA, primarily due to deficient collaboration with community workers.

SERVICE DELIVERY

Regarding the coverage of needs identified at community level, 76% of community workers place the increase in the number of children whose social needs have been identified among the key benefits of model implementation and mention a positive change at the level of local authorities, which focus more on addressing social problems in the community. Nevertheless, according to community workers, the model implemented by UNICEF achieves very good results in detecting community needs, but they are more reserved about the way it covers the needs of local at-risk children and mothers (over 65% of workers scored the coverage of beneficiaries' needs as a 6 or more – where 1 is very poor and 10 is very good).

> *"As regards the identification of vulnerabilities, the project fully responds to the needs."* (Local public authority representative)

As to beneficiaries, the project implementation benefits gathering most answers from community workers are those related to the social component. Hence, over 70% of community workers include the following among key project benefits: improved access to social services, increased number of children whose social needs have been identified, greater mayoralty focus on addressing social problems, and increased number of social services delivered (Table 7).

From a medical perspective, according to the interviewed community workers, project gains include the increase in the number of newborns visited at home (during the first year of life) by the community nurse, in the number of pregnant women benefiting from monitoring throughout their pregnancy, in the number of children benefiting from doctor consultations at the local medical practice and, to a smaller extent, in the number of poor children with health problems who were consulted by family doctors and of disadvantaged community members registered with a family doctor (Table 7).

Table 7. To what extent do you think that, in the community where you work, thanks to the project implemented with UNICEF support...?

	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK	NR
People's access to social services has improved	0%	8%	69%	8%	0%	14%
The number of children with their social needs identified has increased	2%	12%	51%	25%	0%	10%
The number of social services delivered has increased	2%	14%	53%	22%	0%	10%
Community members' quality of life has improved	2%	32%	38%	9%	2%	18%
People in the community are more aware of their rights	0%	12%	55%	16%	0%	17%
The number of newborns visited at home (during their first year of life) by the community nurse has increased	4%	4%	47%	28%	2%	15%
The number of pregnant women benefiting from monitoring throughout their pregnancy has increased	2%	15%	53%	15%	0%	15%
The number of poor children with health problems (anomalies, dystrophies, etc.) consulted by family doctors has increased	15%	17%	45%	9%	0%	15%
The number of children benefiting from doctor consultations at the local medical practice has increased	2%	9%	53%	19%	2%	15%

On the other hand, the difficulties that community workers encountered in delivering social services include the low awareness and resistance of adult beneficiaries. Thus, parents' low awareness of appropriate child care (nutrition, hygiene) as well as their little information about recognising the

early signs of illness, looking after children and taking doctor's appointments in case of illness were considered an issue by 53% and 43% of respondents, respectively. To these adds future mothers' low awareness of the risks entailed by the lack of pregnancy monitoring (40%) or of newborn care rules (36%). In most cases, community members' resistance was addressed by having other local authority employees accompany the social worker and the community nurse on the ground or by delivering primary healthcare to the population. Moreover, the fact that community workers were mayoralty employees mattered a lot in earning the trust of people in the community.

"She [community nurse] managed to earn their trust by offering them medical services (weigh-in, blood pressure measurement)." (Community team member)

"We earned their trust through our people that they know." (Local public administration representative)

Table 8. To what extent have you had to deal with the following problems when implementing project activities?

	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK	NR
Parents' reluctance to answer AURORA questions	13%	32%	32%	12%	2%	8%
Future mothers' low awareness of the risks entailed by the lack of pregnancy monitoring	12%	40%	31%	8%	0%	8%
Future mothers' low awareness of newborn care rules	14%	41%	30%	6%	2%	8%
Parents' low awareness of appropriate child care (nutrition, hygiene)	4%	34%	45%	9%	0%	9%
Parents' little information about recognising the early signs of illness, looking after children and taking doctor's appointments in case of illness	11%	36%	36%	6%	0%	11%
Marginalisation of children from disadvantaged families in school						
Great distance to beneficiaries	25%	38%	23%	4%	3%	6%
	12%	17%	31%	28%	4%	8%

According to 54% of community workers, a higher number of poor children with health problems were consulted by the family doctor. Nonetheless, vulnerable children's access to family doctors is still considered an issue (15% of children from disadvantaged families are perceived as having difficult access to the family doctor, to a great and very great extent) and the relationship with the family doctor is not that good in some communities (13% of community workers think family doctors are not cooperative when it comes to the measures included in the model).

Family doctor participation was not initially included in the model's objectives. Still, community nurses had to coordinate their work with family doctors', especially that their responsibilities regarding the care provided to pregnant women and children or the institutional communication between these two groups of professionals were not clearly defined.

Elements of success
- A multidisciplinary approach and delivery of varied services, adapted to beneficiaries' needs;
- Provision of community health nursing and preventive healthcare for the pathologies affecting newborns, pregnant women, adolescents, etc.;
- Increased number of integrated preventive services at community level;
- Community health nursing of better quality, especially due to preventive activities (home-based monitoring of newborns and pregnant women, disadvantaged children's enhanced access to the family doctor);
- Proactive nature of the services provided – working in the community to deliver services.

Key challenges
- Awareness gained during implementation (not in the design phase) of the need to involve the family doctor in the model's activities;
- Some family doctors' resistance to supporting the activities in the model;
- Lack of correlation between the number of community workers and the number of beneficiaries, the complexity of their needs and services to be delivered;

- Parents' unawareness of the importance of pregnancy monitoring, newborn care, hygiene and nutrition, recognition of the main signs of illness, etc.

5.2.2. QUALITY INCLUSIVE EDUCATION

The Quality Inclusive Education Package is the second component of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model and aims at increasing both the quality of education and the school participation of all children, especially vulnerable ones. The package includes child-centred interventions at school, family and community levels and it is universal, with all students and schools benefitting from its interventions (UNICEF, 2016, p. 4). The objective of the Quality Inclusive Education Package is to step up efforts for fulfilling the right to education for all children, especially vulnerable ones, by improving the quality of teaching and school management, and by mobilising schools, families and communities to support school participation and every single child (UNICEF, 2016, p. 5).

QIE interventions aimed at producing changes at local level (in both preschool and school education) in order to improve the quality of education, at county level (building monitoring, guidance and support capacities), and at national level in order to develop/revise the regulatory framework so as to facilitate the implementation of such a model. The data collected during the qualitative research which included public institution representatives from the field of education (MNE, IES, RAQAPUE) have revealed that the objectives of the QIE package are compatible with those set forth in the national documents related to the organisation and operation of the education system in Romania. Therefore, the practices and objectives of the UNICEF model can be transposed into legislation and into the standards guiding the education system, thus creating the conditions for a sustainable QIE package. The MNE is preoccupied with finding solutions to raise the number of school counsellors, to reduce school counsellors' workload, to develop a Master of Teaching programme, and to design a curriculum on inclusive education/non-discrimination.

Research data analysis has identified the following key benefits in implementing the Quality Inclusive Education Package:
- Enhanced management capacities in schools through their participation in an initial assessment process which helps them diagnose the achievement of quality indicators, identify areas of improvement, draw up plans for future measures, provide professional training to their managing structures;
- Improved quality of education by sharpening teachers' specific and cross-cutting skills;
- Better quality and more efficient communication among principals and between them and the CSI, CREAC, TTC;
- Better quality human resources through constant training, with a focus on the acquisition of skills leading to more attractive classes for students and student-centred activities (IES training effects). Some teachers had not participated in any kind of training prior to the UNICEF model (for example, those in Area 7). Area 7 is one of the most geographically isolated regions in the county, with one of the lowest levels of socioeconomic development and difficult online communication caused by the lack of both skills and infrastructure (no mobile phone signal).
- Increased parent involvement in children's school activities – through common parent-child activities;

- Improved parenting skills for over 8,000 parents who learned how to communicate better with their children.

The findings of qualitative and quantitative research data analysis reveal the positive impact of QIE implementation on four levels: student participation, parent involvement, school management capacities, and collaboration with other community and county stakeholders. The data collected during the quantitative research involving teachers, principals, parent educators and instructional support staff indicate changes in children's school attendance, their academic performance, parent involvement in the educational process, and teachers' skills[4] (Table 9):

- Increased student participation in extracurricular activities (according to 85% of respondents) and class attendance (according to 67% of respondents) and even better academic results (53% of respondents).
- Parents improved their parenting skills (according to 64% of subjects): those who participated in parent education courses became more interested in their children's schoolwork (according to 60% of respondents). At the same time, they engage more in extracurricular activities (according to 61% of respondents).
- As to the quality of education, the impact on educational establishments is quite significant as teachers' professional skills developed (according to 82% of respondents), teaching methods improved (76% of respondents), the number of extracurricular activities increased (according to 83% of respondents), schools improved their capacities to determine the profile of children at high risk of dropping out (79%) and to initiate supportive actions for at-risk children (78%), the visibility of school activities increased in the community (75%), and schools improved their capacities to develop strategic and operational documents (72%) as well as project proposals (58%).
- The activities also intensified collaboration with local public authorities (62%) as well as their engagement in dropout reduction (57%).

Table 9. Local impact of the QIE package under UNICEF's model

	To a very small extent	To a small extent	To a great extent	To a very great extent	Do not know	NR
On parents						
Children's parents come more often to school/kindergarten to inquire about their children	4%	31%	46%	14%	3%	2%
Children's parents help them more often with homework	8%	34%	39%	7%	10%	2%
Children's parents participate more often in extracurricular activities (outdoor activities, trips, etc.)	5%	29%	48%	13%	3%	2%
Students' parents have improved their parenting skills	3%	23%	48%	15%	7%	3%

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[4] ** *The percentages given in brackets indicate the proportion of respondents agreeing (to a very great and great extent) with the statements included in the table.*

On children						
School/early childhood education (kindergarten) participation has increased	3%	16%	45%	22%	12%	2%
Students get more involved in extracurricular activities	1%	10%	63%	23%	1%	2%
Children's academic results have improved	3%	34%	44%	9%	6%	3%
On teachers						
Teachers have sharpened their professional skills	3%	9%	59%	23%	4%	2%
Teachers' teaching methods have improved in your school	1%	13%	58%	18%	8%	2%
On educational establishments						
School visibility has increased in the community	1%	13%	56%	19%	8%	2%
The number of extracurricular activities organised by the school has increased	2%	9%	64%	19%	3%	3%
The number of actions undertaken in partnership with other schools in the county has increased	5%	30%	34%	8%	20%	3%
The school has improved its capacity to determine the profile of children at high risk of dropping out	2%	9%	61%	18%	6%	3%
The school has improved its capacity to initiate supportive activities for at-risk children	2%	11%	62%	16%	6%	3%
The school has improved its capacity to write project proposals for funding	4%	19%	45%	13%	16%	3%
The school has improved its capacity to develop strategic and operational documents	2%	10%	58%	15%	13%	3%
Local authorities get more involved in dropout prevention	6%	21%	42%	15%	13%	3%
School-mayoralty collaboration has improved	6%	16%	39%	23%	14%	3%
Collaboration between the school and county institutions from the education sector has improved	2%	17%	40%	13%	24%	4%

NR – Non-response

** The percentages given in brackets indicate the proportion of respondents agreeing (to a very great extent, to a great extent, to a small extent, to a very small extent) with the statements included in the table.

The successful implementation of QIE interventions is influenced by a series of aspects, such as the management of the educational establishment, the quality of school guidance and counselling activities, parent involvement in education, at-risk student monitoring, promotion of role models among students to boost their self-esteem and motivate them, support from local authorities, collaboration of the educational establishment with the other local institutions/community-based

services, and the available financial resources. The analysis of quantitative research data places the following aspects among the most important factors contributing to the successful implementation of quality inclusive education: parent involvement (95%), school guidance and counselling (92%), school management (91%), at-risk student monitoring (91%), promotion of role models among students (91%), financial resources (89%), support from local authorities (88%), and school infrastructure (86%) (Table 10).

Table 10. Factors contributing to the successful implementation of quality inclusive education

	To a very small extent	To a small extent	To a great extent	To a very great extent	Do not know	NR
School management	0%	3%	34%	57%	3%	3%
School infrastructure	1%	5%	35%	51%	4%	4%
School guidance and counselling	1%	3%	40%	52%	1%	3%
At-risk student monitoring	1%	3%	39%	52%	1%	3%
Collaboration with community-based services	1%	5%	38%	49%	3%	4%
Parent involvement	0%	2%	29%	66%	1%	3%
Promotion of role models among students	0%	5%	40%	51%	1%	3%
Support from local authorities	2%	4%	36%	52%	2%	4%
Partnerships with NGOs	2%	12%	40%	35%	8%	3%
Financial resources	1%	4%	25%	64%	3%	3%
Legislation	3%	10%	39%	38%	7%	4%

NR – Non-response
** The percentages given in brackets indicate the proportion of respondents agreeing (to a very great extent, to a great extent, to a small extent, to a very small extent) with the statements included in the table.

The implementation of QIE activities encountered the following problems (according to quantitative research data): parents' low interest in children's academic performance (33%), parents' resistance to participating in counselling activities (25%), parents' non-involvement in the activities organised by the school (23%), parents' resistance to taking part in parent education courses (23%). Lack of cooperation from local stakeholders was mentioned only in a few cases: 13% of respondents mentioned uncooperative family doctors and 10% of them brought up uncooperative mayoralties. Both qualitative and quantitative research data have highlighted a number of challenges to be addressed by QIE interventions under the UNICEF model, most of them associated with staff qualification (teachers, school counsellors) and the relationship of the educational establishment with local and county stakeholders. We should mention the following ones:

- Shortage of qualified staff in all education institutions (especially school counsellors);
- High student-school counsellor ratio;
- Teachers' limited access to quality continuing training;
- Deficient relationships between local and central institutions with coordinating and control roles (CSI, CREAC, RAQAPUE, MNE) and subordinate institutions (schools);

- Poor collaboration between educational establishments and other local institutions (mayoralties, the County Council, the GDSACP, non-governmental organisations).

HUMAN RESOURCES

The interventions carried out under the QIE package aim at: "strengthening the capacity of the school management and teachers to support each and every child, according to his or her needs; improving teaching methods and tools; partnering with students' families and increasing parenting skills; mobilising communities to support education; enhancing children's non-cognitive skills and motivation; encouraging diversity among students regardless of gender, ethnicity, religion, (dis)ability and socioeconomic status (UNICEF, 2016, p. 4). Better quality education can be reached by creating a learning-friendly environment for all preschool and school children, providing adequate teachers training, ensuring modern student-centred teaching methodologies and tools, and fostering parent participation in education and collaboration among community-based institutions.

The findings of the online survey conducted among teachers, principals, parent educators and instructional support staff reveal that, in the educational establishments where the respondents work, student integration support staff consists of school counsellors in 71% of the cases, school mediators in 53% of the cases, and support teachers for SEN children in 20% of the cases. Looking at UNICEF model implementation areas, Area 7 (communes of Colonești, Lipova, Motoșeni, Stănișești, Vultureni, Răchitoasa) is noticed as counting the smallest number of instructional support staff given the great distance to large urban centres, which makes such positions unattractive. The areas including an urban centre (Area 1 - Bacău and Area 5 - Moinești) benefit from the biggest support staff, including school psychologists or support teachers for SEN children. Such support staff are not only required to ensure the integration of SEN or at-risk children, but also to provide professional/vocational guidance and counselling as well as psychological, emotional and social counselling to all students. In the educational establishments employing a school counsellor, collaboration with that professional in solving different student problems is good (29%) and very good (32%).

Achieving the objectives of the QIE package requires, first and foremost, qualified human resources – teachers, school managers and community workers (school counsellor, school mediator). Teaching staff play a very important role in students' school participation, motivation for learning, academic results and the school-family-community relationship. QIE activities include teachers training courses with a new and modern content to facilitate the use of quality inclusive education principles.

The fact that one of the institutions subordinate to the MNE and responsible for teachers training – the Teachers Training Centre – was not part of the model may constitute a model weakness in terms of continuing training. The involvement of this institution would have created the conditions for carrying on the type of training provided under the QIE package and for continuing and further developing the UNICEF model. However, talks were held with the Teachers Training Centre to include the model's Quality Inclusive Education package in their training offer.

At county level, guidance, monitoring and supervision capacities were also developed by setting up a county management structure for the implementation of QIE package interventions, counting seven county coordinators, one for each area of the model. These county coordinators hold the following primary duties: monitor the implementation of QIE activities; offer support for carrying out the interventions; identify existing needs and problems; and propose solutions. The analysis of the data

collected during the interviews conducted with principals and during the focus groups held with community teams has revealed the importance of such a support structure for the effective implementation of activities under the QIE package.

Elements of success
- Increased number of school counsellors;
- Varied topics tackled during training courses aimed to develop the skills of teachers, principals and instructional support staff;
- Dedicated county coordinators for the implementation of QIE interventions.

Key challenges
- Insufficiently adapted training offer in pre-primary education;
- High turnover of the school counsellors involved in the activities.

CAPACITY BUILDING/DEVELOPMENT

The achievement of QIE package objectives involves building and developing the capacities of educational establishments, which the QIE component did via the RAQAPUE evaluation of schools, teacher skill development, improvement of principals' management skills, and formation of parent education skills as well as funding application writing skills.

The analysis of quantitative research data shows that the respondents' educational establishments benefited from the activities conducted under the QIE package: RAQAPUE evaluation, microgrant, subject-specific teachers training, teachers training in extracurricular areas, learning activities on the online intercultural education platform, activities on the online school violence platform, school management training, counselling provided to the school management team, parent education courses, presentation of role models to boost students' self-esteem, interschool exchanges, demonstration lessons delivered by the Institute of Education Sciences. Most of the respondents mentioned that their educational establishments had benefited from parent education courses (99%), RAQAPUE evaluation (98%), microgrants (98%), subject-specific teachers training (97%), and teachers training in extracurricular areas (95%). The majority of respondents participated in the evaluation of the educational establishment conducted by RAQAPUE (74%), subject-specific teachers training (63%), and microgrants (58%).

RAQAPUE evaluation
Respondents think that Bacău County was chosen for model implementation because local public authorities and schools were more open to this particular type of intervention. All educational establishments included in the project were subject to an evaluation process conducted by RAQAPUE. This first evaluation drew attention, *inter alia*, to an aspect that concerns the educational process to a lesser extent: the relationship of the school with the local authority. Despite being regarded with reserve and even reluctance at first, the RAQAPUE evaluation had positive effects as regards the involvement of local public authorities. In many educational establishments where data were collected, principals confirmed that the RAQAPUE evaluation, which also included talks with local administration representatives, led to building renovations, the construction of new learning facilities, the purchase of teaching materials needed for the smooth running of educational activities. A key aspect is that certain institutions significantly improved their image:

"To teachers, RAQAPUE is a monster... but this monster took on a human face when people understood that the evaluation was not conducted to punish, but to help." (County public authority representative)

Management skill development

Another factor contributing to the success of interventions under the QIE package is good communication between the representatives of institutions that influence or can influence children's access to and participation in education. Since the relationship of the school with the other community-based institutions (mayoralties, clinics) is not always very good, meetings were organised under the UNICEF model to change things in this department. The analysis of the discussions held with the representatives of the educational establishments involved, especially at management level (CSI, CREAC, IES, principals, etc.), has revealed that those meetings, where people got to know and inform each other about the responsibilities of each institution, were extremely beneficial: the school informed the mayoralty about its planned activities and the mayoralty offered support for their smooth running (means of transport, facilities); where the financial resources of the school and families proved insufficient for certain activities, the uncovered costs were funded by local non-governmental organisations, etc.

According to online questionnaire respondents, the model developed by UNICEF and the QIE package, in particular, received quite a lot of support from local public authorities and children's parents (according to 64% of respondents), which eases the implementation of subsequent activities. Nevertheless, according to 33% of the interviewed teachers, the share of parents who do not support the implemented activities remains pretty high. Also, as mentioned by quite a large percentage of the respondents (34%), current public policies support the implementation of such a quality inclusive education model to a small extent, in particular because teachers are being overtasked with administrative duties, there is a lack of incentives for teachers to engage in extracurricular activities, a shortage of support staff in some schools, etc.

Parents, the local community and local public authorities are the first to sustain the work of educational establishments, whereas local businesses provide little to very little support. The latter are more supportive of educational establishments in the implementation areas that include industrialised urban centres (Bacău, Moinești), where there are big private companies or SMEs with significant business activities which can provide financial support to education institutions. Local stakeholders also support education institutions through joint actions, mostly in partnership with the police (85%), the church (82%), the mayoralty (74%), and family doctors (63%). It is with these local stakeholders that partnerships are traditionally concluded at community level. These partnerships with the police, family doctors and religious institutions can be extended to include new activities that could foster quality inclusive education.

School management training tackled topics such as: planning the institutional development of the school; the 'quality circle' for applications; strategic approaches to dropout prevention and school attendance improvement; delivering quality education to students from disadvantaged backgrounds; evaluation of the outcomes and impact of school activities; evidence-based development decision; using evaluation findings to support school development; operationalising development targets and setting operational objectives and output indicators; monitoring and evaluation (including monitoring and evaluation tools) based on national quality standards for education; developing projects and activities (including extracurricular ones) in support of school

participation; activity-based budgeting; monitoring and assisting students most at risk of dropping out. The purpose of this whole effort of training the school management staff is to improve the quality of education. Developing these skills at the level of school management contributes to building the capacity of these institutions to prepare strategic documents, to systematically collect data and use them in the decision-making process, to monitor and evaluate the educational process, to identify quality assurance solutions, to communicate effectively with the other community stakeholders as well as with teachers, students and their parents. These skills also helped address the various problems identified during the RAQAPUE evaluation. Besides the objectives of increasing students' school attendance, improving their academic results and raising parent involvement in the educational process, the idea is to also boost students' and parents' satisfaction with school activities and school life in general, to reduce school violence incidents or to improve the general 'wellbeing' in school. The online survey conducted among teachers, principals, non-teaching staff and parent educators has highlighted improved school capacities to determine the profile of children at high risk of dropping out (79%), to initiate supportive activities for at-risk children (78%), and to develop strategic and operational documents (73%).

The improved school capacity to write project proposals for funding (microgrants) was one of the outputs reached by involving teachers and principals in the writing of microgrant project proposals. During training sessions with school management teams, the project proposal structure was presented along with the information that had to go in each section of the application. In the first year, schools also received guidance and support from county coordinators for writing the microgrant applications. Online survey data show that 58% of respondents think that the school's capacity to write project proposals for funding has improved to a great and very great extent.

Teacher skill development

In the Romanian education system, 95% of the staff is qualified (Apostu et. al., 2012), which is a positive factor for students' education. Qualification received in the formal system (pedagogical high school, pedagogical colleges, universities), however, often proves insufficient for coping with the current demands of education. For example, teachers are not trained on working with SEN children, the number of teaching practicum hours has significantly lowered in the teachers training programme over the past few years, and there are no modules on anti-discrimination or way to address marginalisation and stigmatisation, etc. In UNICEF's model, training was held to help teachers work better with students, improve their teaching methods, understand and apply the concept of student-centred education, understand the concept of inclusion/inclusive education, diversify their methods of communicating with students' parents and with the community at large.

Qualitative research data indicate that UNICEF's partners involved in professional training activities under the QIE package came up with modern and accessible training content, adequate for teachers' needs, which made courses more attractive and facilitated knowledge acquisition and skill formation. Skill development brought about changes in teachers' teaching methods and greater student involvement in the educational process:

> "With this project, we <broke> the monotony, the routine of school activities – students would come to school, they would or would not understand what they were taught, they would go home, they would or would not do their homework, and the next day they would start over...All this has changed. Children now come up with initiatives, they have ideas about how we could run

some of the activities, they go home and tell their parents about it, parents now turn to us, they get involved…"(Rural educational establishment representative)

According to the representatives of the partners involved in the professional training of teachers, the training objective was to build a "friendly school" and the result is that some teachers changed their teaching styles and embraced a modern teaching model which focuses on creative thinking and engagement, not on rote and reproductive learning. IES concentrated on training teachers not only on subject-specific topics, but also on cross-cutting issues: education for health classes, education related to school violence and domestic violence, environmental education, etc. Whilst it got lots of teachers out of their 'comfort zone', this type of courses is expected to produce positive effects in the medium and long terms. The training of teachers sought to make them acquire teaching and learning methods and techniques whereby the student "is taught how to learn". Participatory teaching and learning methods are much more complex and require more teacher involvement. Much like in any other educational activity, the changes made to educational practices will yield results over time. Interview data analysis has revealed that, at the moment, results are only noticeable at the level of students' attitude towards school: they are more interested in attending classes, they ask teachers about future activities, etc.

Preschool teachers training was one of the components included in the Step by Step intervention implemented under the model, aimed at promoting early childhood education and equipping kindergartens with teaching materials. In rural areas, in particular, both types of interventions were highly appreciated by teachers and children's families, according to the information received during the interviews conducted with principals and the focus groups held with parents or community workers.

Besides sharpening their skills, getting to know and exchange ideas with other colleagues about ways to improve their work or establishing better relationships with CSI and RAQAPUE representatives, some teachers also detected unanticipated benefits in the UNICEF model. In rural communities, given the lowering numbers of school-age children, many educational establishments were closed down and students were moved to the nearest school. Many times, school closure also meant increased dropout or absenteeism rates among students. Some principals saw this model as an opportunity to 'prepare' the transfer of students from the schools to be restructured. Thus, those principals involved the students of the schools in the process of being restructured and their parents in project activities, they often took them to the school where they were to be transferred and, thus, not only did they mitigate the impact of that change, but the parents and students ended up requesting the move.

Elements of success
- Greater understanding of the QIE concept and its importance among school management structures through training sessions;
- Development of teachers' competencies (knowledge, skills) to run student-centred teaching activities;
- Improved school capacity to write project proposals for funding;
- Improved quality of education in the schools included in the model, following the RAQAPUE evaluation;
- Improved quality of preschool education following the Step by Step intervention;

- Change of perspective among schools with respect to the role of institutions (e.g. RAQAPUE, CSI): control → guidance.

Key challenges

- Teachers' difficulty to grasp the QIE concept: e.g. limiting the concept to the activities run for vulnerable children or to extracurricular activities with an extensive use of financial resources.
- Teachers' resistance, at first, due to them perceiving QIE activities as extra duties.
- Teachers' high mobility, in particular in the poorer communities included in the model.
- School management changes following legislative amendments.

TOOLS USED

The tools used in the QIE package were most diverse so as to cover the wide range of needs presented by different beneficiaries – pre-schoolers, school children, teachers, school management, and parents: training courses, microgrants, parent education courses, demonstration lessons, presentation of role models to boost students' self-esteem, online learning platforms, etc.

According to teachers, principals and parent educators, the most useful activities carried out under the QIE package were subject-specific training courses (80% gave them a score of 8, 9 or 10) and microgrants (80% scored them as a 8, 9 or 10), followed by training courses in extracurricular areas (75%), the diversity awareness package (74%), and demonstration lessons (74%) (Table 11). Sixty-four per cent of respondents found online platform learning useful, but they also mentioned some problems related to the accessibility and "rigidity" of online platform activities.

"For some subject matters, platform activities are too rigid and strictly enforced as topics which do not match the school's specific characteristics. Please keep in mind that all the teachers from all project components have their teaching load and job description activities which constantly lead to overtime. Some of these requirements are integrated into classroom activities, but accessing the platform which doesn't always work, preparing the materials and all the rest put pressure on teachers." (Teacher)

Table 11. Usefulness of activities

	1 Very low	2	3	4	5	6	7	8	9	10 Very high	NR
Diversity awareness package	1%	1%	1%	1%	6%	4%	9%	16%	21%	37%	4%
Subject-specific training courses	1%	1%	1%	1%	4%	4%	6%	15%	20%	45%	3%
Training courses in extracurricular areas	1%	0%	1%	1%	3%	5%	9%	14%	20%	41%	4%
Learning on online platforms	2%	1%	2%	3%	8%	5%	12%	17%	18%	29%	3%
Demonstration lessons	2%	1%	1%	1%	4%	5%	7%	14%	22%	38%	6%

Interschool exchanges	2%	0%	2%	2%	7%	5%	10%	15%	15%	37%	5%
Microgrants for schools	1%	0%	1%	1%	3%	4%	7%	10%	18%	52%	3%

NR – Non-response

One of the project's objectives was greater parent involvement in school life. To this end, HOLTIS (a partner in the QIE package) trained teachers to carry out parent education activities intended to boost parent participation in the educational process and improve the child-parent relationship. Quantitative and qualitative research findings (focus groups with parents, focus groups with community workers, interviews with principals) show that parent education courses were a success, with noticeable effects on parents' behaviours as they started to communicate better with their children, to be more responsive to children's emotional problems and understand the importance of listening to their children and offering them emotional support.

> *"Many parents said they had never hugged their children...and they had not understood, before these courses, how much a hug could do."* (Partner organisation representative)

> *"[I learned] about family stress, how to express my feelings and be calmer with the children."* (Parent)

> *"After these courses, I could look at my son with different eyes, I could understand his views and needs better; the course helped me start communicate better with him."* (FG parents, Moinești)

> *"Parent education courses were highly appreciated. If, in the beginning, we would ask parents to participate and they would tell us that they didn't have time, that they didn't need that, little by little they started coming in and they were thrilled. For some of them, those courses were also an opportunity to socialise a little bit, to get out and talk to other people than those they were used to. And they started communicating better with their children, too, and stopped scolding them."* (FG with community workers, Scorțeni)

Parent education courses facilitated meetings between teachers - trainers (of parent education) and parents, managing to forge closer bonds between them since the discussions were not held from teacher (representing the authority) to parent in precarious socioeconomic and financial circumstances (representing the subordinate), but from parent to parent.

> *"These courses allowed us to get to know parents better… we saw them with different eyes and we learned that we had extraordinary people in our commune...people who were staying in their own lane, with their problems, and we found out that they were actual encyclopaedias, that they had wonderful life principles and amazing values....you don't know how much we all learned from these people."* (Rural educational establishment representative)

A key activity under the QIE package was writing microgrant applications: the schools involved in the project had to identify certain needs and write a project proposal that they had to send to UNICEF for evaluation and funding. According to the representatives of county organisations, every school involved in the model wrote a project proposal and received funding for it. The difference between schools consisted of the timeframe between the moment they sent the proposal to UNICEF and the moment they received funding, which was influenced by teachers' experience in writing project proposals. In the schools that already had staff with project proposal writing experience, the applications were better designed, fewer adjustments/changes were needed and funding came

sooner, whereas in those with no experience in that department, things happened more slowly. For whatever reasons, teachers were not adequately informed about these issues and interpreted things differently. In some schools, the fact that they received funding later was seen as a lack of transparency from the donor:

> *"We talked to the colleagues...we uploaded all the activities on the platform...we all worked very hard...and others got the money faster than us."*(School representative)

The microgrants awarded to schools brought benefits, especially with regard to the number of extracurricular activities carried out, student involvement in activities other than school ones, increased school participation among students from vulnerable groups, parenting skill development. Nonetheless, the teachers who completed the online questionnaire also expressed some dissatisfaction with certain aspects of microgrant implementation, such as:

- Short period of implementation, which meant that teachers' workload was heavier than usual;
- Failure to reward teachers for their volunteer work;
- Lack of appropriate facilities for the implemented activities, either because the educational establishment lacked them or because the community didn't have any building meeting all the requirements for a place where educational activities could be conducted;
- A lot of bureaucracy, which required photos, reports, etc.

> *"Teachers involved in microgrant activities last year didn't receive any diploma or certificate as proof of their work in this project (keeping in mind that, in the education system, any achievement matters for the Appraisal Form scoring). The outcomes of the activities, children's joy and dedication were the only ones that offered satisfaction to the teachers involved in the microgrant. We would like our work to be acknowledged."* (Teacher)

The development of project proposal writing skills proved to be more important than the financial value of the grants. Microgrant-making is a way to ensure the sustainability of the UNICEF model: most of the interviewed people said that it was quite unlikely that local/county authorities took over the project upon its completion and that the only way to continue the activities would be to receive other funding. With these microgrants, many teachers gained some expertise in writing project proposals.

Elements of success
- Diversity and complementarity of the tools used to implement the QIE package (online platform, interschool exchanges, demonstration lessons, presentation of role models, counselling, microgrants, etc.).

Key challenges
- Teachers' limited skills and willingness to use certain tools (e.g. the online platform).

SERVICE DELIVERY

The model's intervention was based on an approach which considered the use of current public policy instruments/mechanisms and the fact that model sustainability and national scale-up could be better achieved if a regulatory framework was already in place and there was no need to employ new resources. QIE package implementation used current public policy instruments, like the school counsellor, the school mediator, the evaluation of educational establishments based on RAQAPUE methodology, without having to create parallel mechanisms.

The delivery of services under the QIE package aimed at building capacities for different types of (direct or indirect) beneficiaries – teachers, educational establishments, communities – in order to support the participation of all children in quality inclusive education. According to the analysis of MTR research data (collected both during the teacher survey and in the interviews with principals or the focus groups with parents and adolescents), the services delivered under the QIE package – training courses, institutional evaluation run by RAQAPUE, microgrants for diversifying extracurricular activities, parent education courses – attained the following results (Table 9):

- Increased teacher capacities to use modern student-centred teaching methods and tools in order to improve the quality of education.
- Better school capacity to deliver quality inclusive education (evaluation and plans for improvement, demonstration lessons).
- Parent educators trained to work with parents on developing their skills to communicate with and relate to children.
- School managers' and teachers' skills developed for identifying and working with at-risk children in order to prevent school dropout.
- Better parent involvement in children's schoolwork through activities designed to engage them all.

The implementation of microgrant or extracurricular activities requires adequate facilities, teaching materials and involved teachers to guide the students. Unfortunately, not all the communities where the model is being implemented set up special centres/facilities for extracurricular activities. Another issue identified following the analysis of the data collected during the focus groups held with community workers is some teachers' weak involvement in the activities, which were often perceived as additional tasks.

The institutional evaluation conducted by RAQAPUE in all the educational establishments included in the model used the methodology available at national level and aimed to analyse the current situation and identify the problems to be addressed and the ways of doing that. Besides the evaluation of educational establishments, RAQAPUE representatives taught principals how to formulate an educational offer or an institutional development plan. This evaluation was considered an effort to develop the educational establishments and the quality of education they delivered to students. Support was also given to school management for implementing measures to address the identified problems. The post-evaluation support lent by RAQAPUE was very useful in solving the problems and identifying the best solutions.

The model's outcome related to the reduction of Roma discrimination and the empowerment of Roma families and adolescents was achieved via the following activities run by partner organisations (Institute of Education Sciences, 'Împreună' Community Development Agency) under the QIE package:

- Delivering educational kits for self-esteem development and training teachers on how to use them;
- Delivering demonstration lessons on how to use educational kits for self-esteem development;
- Designing the methodology for the selection of self-esteem development models;
- Professional training of community workers on working with the Roma population;
- Rolling out communication campaigns addressed to adolescents.

Elements of success
- QIE implementation by using current public policy instruments, without having to create parallel mechanisms or to look for additional funding sources
- Increased parent involvement in children's education
- Participation of many children and parents in extracurricular activities conducted under microgrant projects

Key challenges
- Lack of the infrastructure needed to run extracurricular activities (facilities, teaching materials)
- Some parents' reluctance to parent education courses
- Teachers' perceiving QIE package activities as additional tasks.

5.2.3. CROSS-CUTTING ISSUES

The model's communication component was implemented on four distinct levels: community (parents and children), professionals in the areas of intervention, local authorities, and central authorities (ministries and subordinate structures). An important endeavour was creating the model's identity (logo and label), one that would help with communication activities and would be easy to remember by those interested.

Documenting the model's interventions and benefits through pictures and case studies is one of the communication tools used to raise awareness of the importance of integrated community-based service delivery and of quality inclusive education, with a greater impact on policy decision-makers and professionals in the field.

In the model, communication was conducted on all possible dimensions so as to create an effective implementation framework for the interventions proposed:
- Interpersonal communication within community teams, with members of different expertise, addressed via training programmes and the feedback given by county coordinators in relation to their work.
- Community-level communication – community workers who carried out the census of vulnerable children's and mothers' needs at community level practically conducted a huge exercise of door-to-door programme communication, explaining the model's principles to each family.
- Interpersonal communication between parents and children following the courses delivered to parents and then their involvement in community activities.
- Inter-institutional communication at local level (partnership with the LPA; communication with LPA teams to carry out project activities, staff selection, contract conclusion, monitoring the work of community workers, etc.).
- Inter-institutional communication at county level between the institutions responsible for education, health and social protection in order to identify the best solutions for implementing the interventions proposed.
- Inter-institutional communication between national institutions with the involvement of their representatives in the Steering Committee.

The advocacy component implemented during the period under MTR included activities intended to promote the model and local interventions among decision-makers (the President, the Government,

the Parliament), field visits with decision-makers (the President, ministers) and public figures (e.g. Smiley, Andreea Marin), field visits with national journalists to grasp the importance of the intervention, meetings with decision-makers (MPs, ministers, MEPs, representatives of political parties), participation in working groups or meetings with decision-makers to develop the public policy framework needed for effective model implementation (public policies on community health nursing; changing the psychoeducational module to include elements specific to inclusive education; reducing school counsellors' workload; granting a merit bonus to teachers working with children from disadvantaged groups; implementation of the Minimum Package of Services).

Advocacy work needs to develop through coalitions that involve various stakeholders (NGOs, local authorities, local public administration associations – Association of Romanian Communes; Association of Romanian Towns; Association of Romanian Cities; National Union of Romanian County Councils) to create a stronger voice for the need to introduce integrated community-based services and quality inclusive education. Moreover, since traditional NGOs with large databases/beneficiary bases have not yet been drawn into partnerships, they could not be engaged in advocacy activities.

Over the period under MTR, model monitoring and evaluation – an ongoing activity needed to ensure smooth implementation – included: the initial situation analysis, preparation of two progress reports, county monitoring of community activities (based on community workers' monthly reports), national monitoring (based on county coordinators' bi-monthly reports, visit reports, etc.). All this monitoring and evaluation work is important both for documenting the model and for finding rapid and optimal solutions to the various problems encountered throughout the intervention. The data collected during field research (focus groups with community workers, focus groups with county coordinators) indicate that implementation problems were quickly fixed thanks to good communication within the model and appropriate monitoring and evaluation activities.

Strengths
- Building communication capacities at all project levels;
- Documenting case studies through pictures;
- Including various activities for different target groups (journalists, MPs, the President, ministers) in the advocacy campaign.

Challenges
- Lack of advocacy coalitions with a 'stronger voice' to promote integrated community-based services and quality inclusive education (a coalition including other organisations active at national level, with similar agendas for the welfare of children and their families).

5.3. OUTCOMES ACHIEVED

One of the major model analysis dimensions is the extent to which the implemented activities managed to reach the long-term outcomes as initially set. Testing the theory of change proposed in this model required implementing a minimum package of social services, developing and implementing an inclusive education approach at school level, and integrating the minimum package of services into the school-based intervention. The sustainability of such an intervention depends on the availability of an adequate public policy framework. Hence, the model's three outcomes focus on two levels of intervention: local level, to create an intervention model, and national level, to create the public policy framework needed for its implementation.

Expected outcomes of the model:

- Increase access of vulnerable children and their families to a minimum package of community-based services.
- Reduce Roma discrimination and empower Roma families and adolescents.
- Amend national laws, including secondary legislation, and increase allocation of resources based on the implemented model and the methodology and tools created.

The analysis of MTR research data highlights the following progress made from October 2014 to December 2016 in achieving the expected outcomes of the model:

R1. Increase access of vulnerable children and their families to a minimum package of community-based services

- Tools were created to identify children's social, health, and educational needs (AURORA was upgraded).
- Teams of community workers were set up to deliver the Minimum Package of Services (58 social workers, 33 community nurses, 32 school counsellors, 26 school mediators, and five health mediators).
- Community workers' specific and cross-cutting skills were developed.
- The social, health, and educational needs of children and their families were identified at community level (census completed in 26 rural communities and still in progress in six rural communities and four urban communities).
- Primary services started to be delivered, based on the needs identified.
- Teachers' capacity to use modern student-centred teaching methods and tools, intended to improve the quality of education, was increased (335 teachers participated in training sessions).
- The capacity of schools to deliver quality inclusive education was improved (evaluation and plans for improvement, demonstration lessons).
- Parent educators were trained and they worked with parents to develop their skills to communicate with and relate to their children (4,524 parents participated in parent education sessions).
- Teachers' skills were developed for identifying and working with at-risk children in order to prevent school dropout.
- Parent involvement in children's schoolwork was stimulated through activities designed to engage them all (400 parents involved in the activities carried out in schools).
- Microgrants were made both on the MPS component (35 microgrants) and the QIE component (45 microgrants).
- Community advisory structures were revitalised/founded in 38 localities.

R2. Reduce Roma discrimination and empower Roma families and adolescents

- Educational kits for self-esteem development were delivered and teachers were trained on how to use them;
- Demonstration lessons were delivered on the use of educational kits for self-esteem development;
- The methodology for the selection of self-esteem development models was designed;
- Community workers were trained on how to work with the Roma population;
- Communication campaigns were rolled out for adolescents.

R3. Amend national laws, including secondary legislation, and increase allocation of resources based on the implemented model and the methodology and tools created

- Relevant stakeholders (MoH, MNE, MLSJ, NAPCRA, MRDPAEF, MoF) were involved in the Steering Committee so as to give them access to information about the model and its outcomes as well as the opportunity to get actively involved in model development. Their participation in the Steering Committee was also meant to make them engage more in the development of the model so that it could be scaled up to national level.
- Model promotion activities were carried out, involving decision-makers (field visits conducted by politicians);
- Participation in working groups or meetings with decision-makers in order to develop the public policy framework needed for effective model implementation (public policies on community health nursing; changing the psychoeducational module to include elements specific to inclusive education; reducing school counsellors' workload; granting a merit bonus to teachers working with children from disadvantaged groups; implementation of the Minimum Package of Services).

6. CONCLUSIONS AND LESSONS LEARNED

Given the complexity of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model, small adjustments/changes were needed during its implementation so that the expected outcomes could be reached as efficiently and effectively as possible considering the local realities. Model analysis identified elements of success and challenges in the two phases – preparation and implementation. Drawing out lessons learned is key to model monitoring and evaluation as regards taking measures to improve the intervention so that the proposed objectives can be reached.

6.1. PREPARATORY PHASE OF THE MODEL

Theory of Change
- The experience gained in similar projects that were previously implemented and documenting the steps and lessons learned from previous experiences prove to be key elements for a successful theory of change.
- Consulting with relevant stakeholders during the model design phase, which helps jointly define the model's main objectives and directions for action, is another key factor to a successful theory of change.
- Flexibility in setting objectives, indicators, and outcomes contributes to the success of such an endeavour.
- For a better coordination of the model's two packages, working procedures need to be established already in the preparatory phase of the model.

Partnerships
- Developing partnerships with county institutions competent in the model's areas of intervention, including with county councils, is a key factor to facilitating the implementation. These county partnerships build more trust in the intervention proposed and influence the decision of local public authorities to engage in model implementation.

- Signing partnership agreements with local authorities to show partners' commitment to cooperate towards certain actions and specify each partner's role in the common undertaking is another key element in the implementation of such a model.
- Changing the paradigm at national level requires greater institutional involvement from line ministries (including budget departments, legal departments) in order to design national action plans in the spirit of the new paradigm.
- Developing partnerships with non-governmental organisations that provide services in the local communities of Bacău County was not a key element in the preparatory phase of the model although the projects they implement might be very similar and could provide numerous lessons learned.
- Local and county stakeholder involvement in the implementation facilitated mutual knowledge and inter-institutional communication.
- National stakeholder involvement in the implementation (in the Steering Committee) helped identify timely solutions to current problems, based on the applicable legal framework.
- The openness of local authorities was a key enabler of model implementation.

Human resources

- Qualified staff is scarce at local level and the fact that selection, training and employment were sufficiently flexible to allow for training courses addressed to social workers was a positive thing. This flexibility along with the rapid identification of solutions enabled the successful management of integrated services at community level. Before implementation, the local labour market should have been examined to find out details about workforce qualification and to plan various interventions for securing the required human resources. Lack of human resources with specific qualification delayed implementation in some of the local communities.
- The community team was not sized on the basis of the local needs identified and the territorial distribution of the community, which caused implementation delays in the communities dealing with major social challenges.
- The model design didn't formally include the activities of local family doctors, which affected their cooperation with the community nurse within the model.

Monitoring and evaluation

- In the monitoring and evaluation process, the indicators on LPA institutional capacity and performance related to model implementation could provide relevant useful information to ensure model sustainability.
- The initial assessment conducted in all the 45 model communities is an important undertaking, necessary to accurately determine the local impact of the model.

6.2. MODEL IMPLEMENTATION PHASE

6.2.1. MINIMUM PACKAGE OF SERVICES

- The county model management team plays an important role in facilitating communication and addressing various implementation problems. The work of county coordinators was essential to ensuring communication both within community teams and between community workers and local and county authorities. The guidance and support provided by county coordinators to local

teams helped find a quick fix to the problems encountered and ensure a quality intervention in the community. In addition, they contributed to building community workers' self-confidence.

- The duties of community workers are clearly set (in job descriptions) without overloading them with administrative tasks to the detriment of fieldwork. It has become quite a practice among local public authorities to overburden employees with additional tasks and value fieldwork to a lesser extent.

- The formal involvement of family doctors in the model's activities would have been useful to ensure their adherence to the new service delivery paradigm as well as to build closer collaboration and share responsibilities with the community nurse.

- The community opens up more to community workers if they are locals or if they were accompanied on the ground by other LPA representatives (with seniority and known at local level). These aspects facilitated the implementation of various activities.

- Under-skilled human resources at local level require additional financial resources in order to train them.

- The home-based delivery of primary social/medical services to beneficiaries contributed to building locals' trust in the LPA and to solving the problems of some groups of beneficiaries who were unaware of their rights. This service delivery approach centred on the beneficiary's needs and not on the provider's allowed for a better understanding of community needs as well as for tailored interventions.

- The working methodology for community teams is an important tool for preventing task overlap among workers and for ensuring a better coordination of their activities at community level. Even if it was supposed to be designed only after community census, caseload determination and the start of service delivery, some community teams felt they already needed it in the needs assessment phase.

- Community workers' feedback about the use of working tools throughout model implementation is essential to correct errors and offer improvements. It is the workers who use these working tools that can offer information about the way these work, problems encountered and improvements needed to enhance their effectiveness. This feedback is also useful to avoid misinterpreting the instructions for use of working tools, like in the case of AURORA.

- Given the insufficient and purely theoretic knowledge of AURORA methodology among the professionals working in the model's areas of intervention (NGOs, national authorities), it cannot be viewed as a nationally replicable tool. In order to be used at national level, the AURORA methodology has to be presented in a more comprehensive manner, examples of how to use it should be given along with an estimation of costs incurred by its implementation. Stakeholders with more knowledge of AURORA consider its expansion a desideratum that is impossible to reach given the lack of financial resources at both central and local levels. The costs of implementing such a methodology are believed to be high and, as useful as it is, the required financial resources are not available.

- Lack of infrastructure (car, reimbursement of fuel expenses) to facilitate community workers' visits to isolated areas and the lack of consumables are issues that hamper service delivery.

- The limited capacity of local authorities to deliver social services and preventive medical services was addressed through the MPS and, with a proactive approach, the community team managed to solve a number of problems, such as: lack of task monitoring, parents' low awareness of the early signs of illness, low access to medical services for children from poor families, etc.

6.2.2. QUALITY INCLUSIVE EDUCATION PACKAGE

- The tailored support offered by public institutions to schools improved their image at local level, their planning capacities and the quality of decision-making (e.g. RAQAPUE evaluation). The RAQAPUE evaluation sought not only to analyse the existing situation but also to help identify optimal and personalised solutions based on the specific features of the educational establishment. It also provided a learning opportunity for the school management as well as for the teachers involved.
- School counselling is difficult or almost impossible under current conditions (1 counsellor to at least 800 students, great distance between schools), which deters specialised staff from filling vacant positions.
- The novelty of the activities conducted by partners, their expertise and reputation helped raise participants' (teachers') interest. At the same time, the variety of training/learning tools used for teachers (training courses, demonstration lessons, online platforms, experience exchanges, etc.) made it easier to acquire new skills.
- Parents' participation in extracurricular activities (financed by microgrants) contributed to their greater involvement in children's education and to their improved relationship with the school.
- The presence of county coordinators dedicated to QIE interventions contributed to the implementation of the activities and facilitated communication between educational establishments and the other community stakeholders.
- The high turnover of school counsellors involved in the activities causes intervention unpredictability and discontinuity as well as additional costs for their training.
- The intervention conducted under the QIE package addressed the difficulties in understanding the QIE concept among teachers and principals and limiting the concept to activities run for vulnerable children or to extracurricular activities which use extensive financial resources. Introducing QIE principles is a long-term process that requires constant activities in the educational establishments.
- Some teachers showed resistance at first to getting involved in microgrants or extracurricular activities as they perceived QIE activities as extra duties. Identifying an additional motivator for teachers to participate in extracurricular activities was a way to ensure their involvement (awarding certificates of attendance that can be used in the teacher appraisal process).
- Lack of the infrastructure needed to run extracurricular activities (facilities, teaching materials) encumbered their implementation in some localities.
- Lack of a partnership with the Teachers Training Centre for teachers training activities, which could have contributed to TTC capacity building and to a better understanding of the quality inclusive education concept and, ultimately, to scaling up this approach to the communities in Bacău County which were not included in the model.

6.2.3. CROSS-CUTTING ISSUES

- Documenting local interventions through case studies and pictures is useful for the dissemination and national scale-up of the model.
- Media visits to the communities help raise awareness of the need to implement the model at national level, being a useful advocacy tool.

- Advocacy activities focused on building model visibility and awareness of its important role in addressing community issues and improving the current regulatory framework. Even if the messages conveyed convinced decision-makers about the importance of integrated community-based service delivery and quality inclusive education, the other stakeholders should have coalesced around these objectives for a stronger 'pressure' on decision-makers.
- Monitoring and evaluation is one of the activities that contributed to a better implementation of the model. The information from community team and county coordinator reports was used to improve the intervention at local level.
- Model implementation will wrap up at the end of 2018 for the Minimum Package of Services and at the end of the 2018-2019 school year for the Quality Inclusive Education Package. In this context, local public authorities are not sufficiently prepared to take over the implementation of the model as many of them say they have not yet identified the required funding sources.
- The two main packages – MPS and QIE – were mainstreamed only to a small extent over the period covered by the MTR. Prior to MPS and QIE mainstreaming, the interventions under the two packages should have been carried out for a period of time to generate information that is detailed enough to accurately determine mainstreaming methods.

7. RECOMMENDATIONS

7.1. PREPARATORY PHASE OF THE MODEL

- Set up working groups with national partners to discuss solutions for ensuring model sustainability and replicability. Greater involvement would have been needed from the departments of line ministries, namely budget departments, legal departments, etc.
- Prospective studies of the local labour market need to be conducted before the intervention. Thus, the required HR training activities can be determined so that they can be budgeted from the very beginning.
- Determine local human resource requirements according to community characteristics (population, social issues, territorial distribution, etc.) and 'backup' strategies to be applied if local staff needs to be supplemented.
- Identify 'allies' – NGOs providing integrated services to mothers and children in the community, organisations that can contribute not only with know-how, but also with advocacy efforts to reach the common goal: high-quality integrated services for mothers and children, with a focus on the most vulnerable ones.
- Defining indicators for the monitoring of local and county institutional capacities would be useful for such an undertaking which aims, via the intervention it proposes, to develop integrated services and whose success depends on LPA capacities.
- Involve LPA representatives in the monitoring and evaluation of the model with a view to motivating and making them accountable by comparing their own results with those of other communities.

7.2. MODEL IMPLEMENTATION PHASE

7.2.1. MINIMUM PACKAGE OF SERVICES

- Resize local human resources according to local characteristics (based on community census data), after having identified the needs and having determined the intervention services needed.
- Spur partnerships between the LPA/school and other local stakeholders (NGOs/the church, etc.) offering services complementary to those provided under the model (e.g. after-school activities).
- Develop a working methodology for the community team so as to avoid task overlap.
- Support LPAs to ensure the participatory development of local plans for integrated and preventive social, medical and educational services, the development of implementation plans, monitoring and evaluation, and the documentation of LPA budget requests for the implementation of these plans (submitted to CC under Law No 215/2001).
- Undertake joint actions and develop cooperation agreements with local family doctors laying down clear responsibilities for them and community nurses with regard to prevention/primary healthcare.
- Run workshops for representatives of central public institutions and NGOs (including public authority associations) to present the benefits of AURORA and raise interest in its use.
- Support NAPCRA with the expertise required for implementing GD No 691/2015.
- Conduct studies related to model implementation costs.
- Constantly gather feedback from community workers about the working tools (AURORA, community advisory structures).
- Organise experience exchanges between the communities included in the model, with the involvement of local administration decision-makers.
- Hold meetings with LPA representatives for identifying solutions to issues such as the lack of transportation means and consumables, as flagged by community workers.

7.2.2. QUALITY INCLUSIVE EDUCATION PACKAGE

- Step up advocacy efforts for reducing school counsellors' workload and conclude partnerships with any interested organisations active in the field of education with a view to building capacities to influence public policy.
- Identify mechanisms that can motivate teachers to engage in the activities.
- Run common workshops for LPA and school representatives to facilitate inter-institutional communication, coordination of the two packages, and the understanding of the QIE concept at the level of local authorities.
- Strengthen the partnership with the Teachers Training Centre for teachers training activities that can contribute to raising awareness and the understanding of the quality inclusive education concept not only among teachers from the communities included in the model but also among those from the other communities in the county.
- Support the MNE, RAQAPUE and IES with the expertise needed for implementing the action plan for school desegregation and better quality education in Romanian pre-tertiary educational establishments.

7.2.3. CROSS-CUTTING ISSUES

- Build the capacities of LPA representatives and school management to identify funding sources and write project proposals.

- Raise the visibility of model outcomes in the communities (among citizens and other stakeholders).
- Communicate to a greater extent the model's theory and outcomes to relevant national and county stakeholders (NGOs, public institutions) in order to extend partnerships and gain stronger buy-in for model implementation and scale-up.
- Continue to advocate for the national scale-up of the model. According to national stakeholders, there is no need for new laws, but only the revision of current ones to set forth mechanisms for the implementation of such an integrated package of services. A major issue is the institutional construction required for implementing the Minimum Package of Services as this involves coordinating the work of at least three ministries (MLSJ, MNE, and MoH). The institutional construction is believed to be most difficult to achieve and should be placed under the Prime Minister for greater authority.
- Form coalitions with NGOs, local/county authorities, local public administration associations in order to create a stronger voice to exert pressure on decision-makers for introducing integrated community-based services and quality inclusive education tools in the current public policies.
- At the end of model implementation (end of 2018 for MPS/end of the 2018-2019 school year for QIE), it is important to: document the model by developing operational guides (for each package) to allow its replication; step up advocacy efforts for model replication and national scale-up; develop model exit strategies to ensure that the local authorities from the communities of Bacău County take over the model.
- Identify ways to mainstream the model's two packages – MPS and QIE. The two packages need to be mainstreamed to ensure the smooth running of the model and its replication/scale-up to national level.

1. Context

In the context of the EU 2020 Strategy for smart, sustainable and inclusive growth, as well as the new framework of the structural funds for 2014-2020, the Romanian Government embarked on a series of reforms tackling poverty, social exclusion or early school leaving. National strategies on social inclusion, prevention of early school leaving or protection and promotion of children's rights have been developed and are currently under implementation. Key principles and directions in these areas were set in accordance with international standards and regulations, including the UN Convention on the Rights of the Child or the UN Convention on the Rights of Persons with Disabilities, already ratified by Romania. Recent developments at EU level (e.g.: The Social Investment Package, EU Recommendation 2013/112/UE on investing in children) complement the picture, outlining the need for early intervention and preventive approach, in order to reduce the risk of poverty and social exclusion. EU Member states are therefore encouraged to ensure access to essential quality services for children. Moreover, specific targets have been set at national level in the framework of the EU 2020 strategy, including reducing early school leaving to 11% and getting 580,000 people out of poverty.

In spite of the political commitment and general consensus in relation to reforms in education, health and child protection, there are still significant challenges to overcome. According to recent statistics, 39.5% of Romanians were at risk of poverty or social exclusion in 2014[5]. Following the global financial crisis that hit Romania in 2008, children are one of the most affected groups, as one-third of them still live in poverty. Inequities persist, with Roma children and children living in rural areas being the most affected: if in urban areas the absolute poverty rate was of 3.5%, in rural area it reached 12.4%; for Roma children, the absolute poverty rate is extremely high. Thus, in urban areas, 2% in Romanian children are living in poverty compared to 27.3% Roma children, and 10.6% versus 41.1% in rural communities[6]. According to the data from the National Authority for the Protection of the Rights of the Child and Adoption, poverty remains one of the causes of separation of children from their families (40%), followed by disability (26.82%), abuse and neglect (9.54%)[7]. Analysis of quantitative data also reflects an increasing number of reported cases of violence (from 8,142 cases reported in 2010 to 10,207 in 2015, including situations of neglect from 5,494 in 2010 to 7,270 in 2015).

The system's capacity to respond to the various challenges remains limited: at national level, the total expenditure on social protection was estimated in 2012 at 15.4% of GDP, one of the lowest in the EU[8]. Only limited amounts are allocated for provision of services, making extremely difficult to identify vulnerable children and their families, identify sources of vulnerability, as well as to address the needs of children in a holistic and comprehensive manner. As of today, there is only one social worker per 3,350 inhabitants, with many of them being involved especially in the provision of cash

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[5]http://ec.europa.eu/eurostat/tgm/refreshTableAction.do?tab=table&plugin=1&pcode=t2020_50&language=en

6 Marian Preda (coord.), *Situation Analysis of Children in Romania*, Vanemonde, Bucharest, 2013

7 National Authority for the Protection of Child Rights and Adoption, www.copii.ro.

8 http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00098&plugin=1

benefits. The institutional capacity of the public service of social assistance remains therefore extremely limited, especially if we consider rural areas. In the context of decentralisation of social assistance, limited resources also influence the unitary implementation of legislation, affecting children's access to basic social services.

In education, 9.8% of children in the age group 7-15 remain out of school.[9] Major disparities are registered when it comes to Roma children access and participation to education: the Roma preschool net enrolment rate in Romania (children aged 3 -6) in 2011 was 37%, comparing with the national preschool net enrolment rate of 77%; 95% of non Roma children aged 7-15 are enrolled in primary and secondary education, compared to only 78% of Roma children[10]. Gender disparities are also relevant when it comes to access to upper secondary education of Roma girls: 18% of Roma women attended upper secondary education compared to 86% of non-Roma women, 29% of Roma men attended upper secondary education compared to 81% of non-Roma men [11]. Social norms that encourage tolerance towards multiple forms of discrimination contribute to the social exclusion of vulnerable children, including Roma.

Limited financial commitment to education (2.8 % of GDP in 2013 compared to 5.0% EU average, according to EUROSTAT) coupled with a lack of continuity and coherence of the educational reforms undermine children's access to quality inclusive education. The effectiveness of the educational system would also require improvements: according to the last PISA results, 37 % of the Romanian 15 years old could be defined as functionally illiterate.[12] Limited access to early childhood education and care (ECEC) services (mainly in rural areas), insufficient training of teachers, limited mechanisms of interaction between schools and parents influence the system's capacity to retain in school vulnerable children. As a result, the early school leaving reached 18.1% in 2014, well above the EU average (11.1%)[13].

As generally children face multiple sources of vulnerability, an integrated approach is key to ensuring efficiency and effectiveness of the interventions. Still, evidence shows there is limited dialogue and cooperation among sectors, making it difficult to maximize linkages and ensuring a consistent approach.

Considering the multiple challenges that impede the full realization of children's rights, as well as the strategic directions set out in the Partnership Agreement between UNICEF and the Romanian Government for the period 2014-2017, UNICEF provides technical assistance to relevant ministries, in order to influence public policies in health, education and child protection. Through a systemic and multi-sectoral approach, UNICEF actively contributes to the development of public policies so that children enjoy their rights to live in a healthy family environment and benefit from quality inclusive education.

To propose evidence-based policy options, UNICEF and its partners are implementing a model "Social Inclusion through Integrated Services", based on the hypothesis that: delivery at national

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9 UNESCO Institute of Statistics, *Global Initiative: Out of School Children, National Study: Romania*, Bucharest, 2012.

10 World Bank, *Toward an equal start: Closing the early learning gap for Roma children in Eastern Europe*, (http://siteresources.worldbank.org/EXTROMA/Resources/RomaECD_FinalReport.pdf, page 12, table 2, preschool net enrolment rates

11 World Bank, *Diagnostics and Policy Advice for Supporting Roma Inclusion in Romania*, 2014, pg. 23

12 OECD, Pisa 2012. Results in focus, available at : https://www.oecd.org/pisa/keyfindings/pisa-2012-results-overview.pdf

13 http://ec.europa.eu/education/library/publications/monitor15_en.pdf

level of a universal package of preventive social services (health, education, social protection) in an integrated/coordinated way to children and their families will reduce equity gaps and deprivations children suffer while also reducing the medium and long term costs in the social sector.

This model of community-based, preventive and inclusive services is implemented in 45 communities in the Bacau county to 1) test outreach services that already exist in the law but are not properly implemented to expand their implementation at national level; 2) develop new protocols, standards etc. to improve the quality of these services (make them more cross-sectoral, inclusive and preventive); 3) develop new, innovative services.

After 18 months of implementation, in line with donor proposals, UNICEF will conduct a review to identify what is on track and what needs adjustments. The moment of this review has been chosen because so far the data and evidence generated would allow to assess the effectiveness, efficiency and relevance, as well as elements of sustainability (e.g. replicability at national level).

2. Object of the mid-term review

The object of this mid-term review is the **"Social inclusion through the provision of integrated community services at community level"** model implemented between October 2014 and December 2018. The Theory of Change for the modelling project developed in September 2014 is based on the hypothesis that delivery at national level of a universal package of community-based services (health, education, social protection) coupled with a quality inclusive education package in an integrated/coordinated way to children and their families will reduce the equity gaps and the deprivations children suffer, while also reducing the medium and long-term costs in the three sectors.

The model is implemented in 45 communities at the level of 38 urban and rural localities from Bacau county, situated in the North-East of Romania. Communities are including 34 rural communities (one community = one administrative territorial unit), as well as 11 urban communities (one community = defined as the catchment area of a school). In order to ensure representativity of the sample at county level, the selection of the 45 communities has been made based on an initial assessment, applying a socio-development index. Following the identification of the urban and rural communities, 45 schools have been selected from the respective communities. Schools providing the longest educational cycle (pre-school, primary, lower secondary, upper secondary) were selected from several educational units present in the 45 communities.

The budget allocated for this modelling project is approximately 5 million EUR (for the period 2014-2017) and the donors are: Norway Grants and other UNICEF resources.

1.1 Brief history of the model

Taking into account the socio-economic context and situation of children and their families, especially of the most vulnerable ones, including Roma, the modelling project was designed to ensure access to integrated community-based services (health, education and social/child protection) and quality inclusive education in one of the poorest counties, Bacau, in 38 localities (out of 93), both in urban and rural areas. The model was designed based on recent literature, consultations with relevant stakeholders, as well as two previous modelling experiences tested by UNICEF in education (The School Attendance Initiative) and child protection (First Priority: No invisible children!).

The goal of the model is in line with current UNICEF Country Programme 2014-2017, respectively to provide technical assistance to the Romanian Government in order to put children of the public agenda and contribute to the development of public policies in health, education and child

protection. The model seeks to demonstrate that delivery at county level of a universal package of community-based services (health, education, social protection) in an integrated/coordinated way to children and their families will reduce the equity gaps and the deprivations children in the respective county face. The model's aim and objectives are in line with the provisions of relevant national strategies, including (approved in chronological order): National Strategy on the Protection and Promotion of Child Rights 2014-2020, National Strategy on Reduction of Early School Leaving 2014-2020, National Health Strategy 2014-2020, National Strategy on Social Inclusion and Poverty Reduction 2015-2020 and Government Strategy on Acceleration of Public Administration Reform 2014-2020.

The main **objectives of the model** include to: 1) test outreach services that already exist in the law but are not properly implemented to expand their implementation at national level; 2) develop new protocols, standards etc. to improve the quality of these services (make them more cross sectoral, inclusive and preventive); 3) develop new, innovative services. While these services aim to be universal, they will focus on vulnerable families and children, including (explicitly, but not exclusively) Roma.

There are several **principles guiding the model's approach**: universality, equity, integration, innovation and prevention in the provision of services.

The model is based on an extensive public-private partnership in the design, as well as implementation of the intervention's strategy, gathering relevant stakeholders at national, county and local levels, as follows:
   a. **National level** : public (Ministry of Labour, Ministry of Education, Ministry of Health, Institute of Educational Sciences, Romanian Agency for Quality Assurance in Pre-university Education) and private institutions (Holt Foundation, Step by Step, Centre for Health Policies and Services) have been involved in the design of the model, as well as well as implementation of several activities (capacity building, development of tools and guidelines, monitoring);
   b. **County authorities** (Prefecture, County Council, General Directorate of Social Assistance and Child Protection- GDSAPC, Directorate for Public Health - DPH, County School Inspectorate, County Centres for Resources and Educational Assistance - CJRAE) are providing technical and methodological guidance to local professionals, while ensuring complementarity of the model with institutional priorities and Bacau County Strategy for Social Inclusion 2014-2020; in order to test the minimum package of services, CJRAE Bacau extended its network of school counsellors and school mediators;
   c. **38 Mayoralties from Bacau county** were responsible for: selection and recruitment of social workers and community nurses, activation of community consultative structures, delivery of the minimum package of services, drafting and implementing a project proposal responding to community needs through a micro grant provided through the model;
   d. **45 Schools from Bacau county** were responsible for: creating local teams for the implementation of the QIE component, identification of children at risk of drop out and absenteeism, drafting and implementing a project proposal responding to community needs through a micro grant provided through the model, provision of parenting education.

The model's implementation strategy is focused on two pillars:
   a) **Minimum package of services (MPS)**: an umbrella concept for the provision of integrated services in health, education and social/child protection at community level; the package is organized around a set of seven services (identification; information; counselling; support; referral; monitoring; evaluation) provided in an integrated manner by a local team composed of a social worker, a community nurse and a school counsellor. In vulnerable

communities, the team can be extended, in order to include also a school mediator and/or a Roma health mediator. In parallel with horizontal cooperation, vertical collaboration is also enhanced, with county institutions providing technical and methodological guidance to their local counterparts.

b) **Quality inclusive education (QIE):** a package of interventions targeting the quality and inclusiveness of education, so that all children complete compulsory education and are equipped with basic academic, social and life skills. The multiple interventions organized within this package aim at several outcomes: a. promote a child-centred teaching approach, so that schools are welcoming and inclusive for all children and their parents; b. strengthen school management to generate a quality, inclusive and equitable educational environment for all boys and girls and to better identify and address especially the most vulnerable students; c. enhance school-family collaboration; d. support parenting education, so that children live in a protective and nurturing environment; e. support the development of non-cognitive skills (e.g. role models).

The two pillars are also complemented by a communication for development component including three main campaigns targeting social norms:

a. Local communication campaign to increase children's expectations in relation to their educational pathway;
b. Local communication and behaviour change campaign targeting public service providers from administration, health, education and social sector for reducing stigma and discrimination against Roma;
c. Local communication and education campaign to provide education and behaviour motivation to vulnerable adolescents, including Roma, to adopt healthy lifestyle and avoid alcohol consumption.

The strategy includes a communication plan to make sure that the model's activities and results are disseminated to a wide audience through various channels (national and local media, on line channels, promotional materials, etc.). Advocacy efforts contribute to the overall goal of the model, so that thorough documentation and evaluation of results, lessons learned and best practices influence public policies (national strategies, programmes and projects) in health, education and child protection.

As of today, the **activities** of the model are carried out according to the calendar (see Annex 1). The following interventions were developed during the period **October 2014-June 2016**:

a) **Initial assessment:** a selection of 45 urban and rural communities covering 6 development clusters and ensuring representatively at county level was made by a team of independent researchers (status: done; deliverable: 45 communities selected).
b) **Partnerships:** partnership agreements with national, county and local institutions developed (status: done; results: partnerships signed with: 4 public and private institutions at national level, 7 institutions at county level, 45 mayoralties and 45 schools)
c) **In-depth assessment:** collection of baseline by independent research against which the progress of the model will be assessed (status: done; deliverable: 1 research report, with baseline collected from 45 communities from Bacau county, as well as 6 control communities from Galati county);
d) **Selection and recruitment of human resources:** professionals from county and local level were recruited for the delivery of the 2 packages (MPS and QIE), as follows: a. at county level: 22 coordinators in health, education and child protection acting at county level, providing technical and methodological guidance to local teams; b. at local level : 53 social workers, 33 community nurses, 6 school counsellors and 12 school mediators; (status; done;

functional inter-sectorial teams in 45 communities, receiving guidance from county institutions)

e) **Design of software for the online real time monitoring of children's vulnerabilities** (status: done; deliverable: 1 software application – AURORA-used by community workers for community census and case management in an integrated manner, allowing for real time monitoring of vulnerable children and their families)

f) **Capacity building for delivery of the minimum package of package of services:** county and local teams were trained in order to enhance their knowledge and skills, so that they are able to deliver the minimum package of services, while actively challenging social norms that perpetuate Roma discrimination, risky behaviour of adolescents and low expectations regarding the educational pathway of vulnerable children (status: in progress; deliverables: training curricula, training reports);

g) **Delivery of the minimum package of services:** a social census was carried out by social workers and community nurses at the level of the 45 communities; based on the real needs of children and women, as identified through the social census, integrated services are provided at community level (status: ongoing; results: 17,000 vulnerable children and women identified, …services provided)

h) **Capacity building for schools and kindergartens staff:** 335 teachers received support in order to promote a child-centred approach and prevent school dropout and absenteeism (status: in progress; deliverables: training curricula, training reports);

i) **Parenting education:** a network of parent educators was done at county level and parenting sessions were organized for …..parents (status: on going, deliverables: guides on parenting education, training reports, lists of participants);

j) **Local communication campaign** to increase children's expectations in relation to their educational pathway: a methodology for the selection of positive role models was designed (status: ongoing; deliverable : methodology for selection of Roma role models);

k) **Local communication and behaviour change campaign** targeting public service providers from administration, health, education and social sector for reducing stigma and discrimination against Roma: capacity building of local professionals was enhanced in order to recognize and fight discrimination related to the access of public services (status: ongoing; deliverables: training/ workshop curricula, training/workshop reports, etc.)

l) **Local communication and education campaign** to provide education and behaviour motivation to vulnerable adolescents, including Roma, to adopt healthy lifestyle and avoid alcohol consumption (status: ongoing, deliverables: media materials, training curricula);

m) **Communication:** activity done on a permanent basis (status: ongoing; deliverables: communication plan, web site, promotional materials, etc.)

n) **Monitoring:** activity done on a permanent basis (status: ongoing; deliverables: technical reports, activity reports, community fiches, field trip reports, etc.);

o) **Advocacy:** activity done on a permanent basis, including high level visits, high level events, (status: ongoing).

Documenting and evaluating the results of the model is critical to generate evidence for policy change. This will be completed by studies on education and child protection. A formative evaluation of the model is planned in 2017, and a summative evaluation in 2018. UNICEF will use the evidence generated by the model to conduct a costing analysis of the model to further mainstream community-based services (health, education and social/child protection) into national policies and leverage resources from the EU, national and sub-national budgets with a view to replicate it at national level.

1.2 Theory of Change[14]

The Theory of Change (ToC) was developed in September 2014, in a format which provides a clear picture on how results would be achieved in the modelling project. It focuses on the expected impact on equity gaps and deprivation of children and their families provided that a universal package of community-based services (health, education, social/child protection) and a quality inclusive education package will be provided in an integrated/coordinated way. The ToC includes activities, outputs and outcomes to be achieved especially in the social/child protection, health and education areas, considering mainly the services developed at community level with special focus on prevention.

To this end, in 2015, in consultation with various stakeholders at national and local levels, the ToC was further developed and expanded including the necessary details for effective implementation of the model at county and community levels. In this context, the expanded ToC includes refined objectives and logical framework/sequence for activities required for the provision of the universal package of the community-based services (health, education, social protection) and quality inclusive education package in an integrated/coordinated way. These include therefore additional milestones linked to: 1) test the delivery of a minimum package of integrated social services[15] to increase the social inclusion of vulnerable families with children, including Roma; 2) develop and implement an integrated approach at school level to increase participation, reduce absenteeism, prevent early school leaving and improve quality and 3) integrate the minimum package of services with the school intervention in all the 45 communities.

It is to be mentioned that the expanded ToC (Annex 2) is expected to be further reviewed and adjusted according to the findings, conclusions and recommendations of the current review and of the formative evaluation to be conducted in 2017.

3. Rationale for the mid-term review

The modelling project started in October 2014 (18 months ago) and this is the first independent review that will assess the status of implementation and determine if the project is progressing as planned and if it needs any adjustments to reach its objectives. The MTR will assess the validity of the logical framework and of the initial stage assumptions made as part of the whole theory of change of the modelling project. It will look at the relevance of the model, whether it is implemented in an efficient and effective manner, and whether the results are sustainable and replicable. Quantitative and qualitative data will be collected and analysed to assess the progress of the modelling project up to date.

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[14] 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.

[15] 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 fieldwork 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.

It is expected that the MTR will come with findings and recommendations that will impact on parts or even on the overall approach used in the modelling. The modelling project already employed several innovative instruments and methodologies and they will have to be assessed from the perspective of producing the expected results at the moment of this review. At the same time, it is expected to identify barriers and bottlenecks, as well as solutions not planned for and validate the practices used.

The MTR will promote a participatory approach by involving partners at all levels and from this perspective it will be an opportunity for improving the capacity of national, county and local authorities level of understanding about the process of adequate monitoring and evaluation as part of the project cycle management and to make them active part of the review and validation mechanism. As the model is developing inter-sectoral approach methodologies and services, the MTR will also be an inter-sectoral one and will seek and report progress at the level of service joint planning, implementation, monitoring and evaluation.

The primary audience for the MTR are UNICEF, national and county and local authorities, and implementing partners. The findings will be used by UNICEF to inform the future implementation of the integrated model. UNICEF will use the evidence generated and the lessons learned for advocacy, policy advice and technical assistance to the Ministry of Labour, Family, Social Protection and Elderly (MLFSPE), National Authority for the Protection of Children's Rights and Adoption (NAPCRA), Ministry of Education (MoE) and Ministry of Health (MoH) to ensure that legislation and policies incorporate an adequate focus on the Minimum Package of Services (MPS) and Quality Inclusive Education package and to mobilize resources from the national and local budgets, as well as for leveraging funds from the new EU Structural Funds 2014-2020 to ensure the sustainability at local level and replicability of the model developed at national level.

All partners will benefit from the conclusions and recommendations to further their own research, interventions and advocacy work. Local authorities will use the findings further develop and sustain integrated services for vulnerable children and families.

UNICEF and its partners will be responsible for the dissemination of the MTR findings and ensuring an equitable participation of all interested stakeholders in the process. A consultation to share the preliminary findings and a national workshop at the end of the process to share the key findings, conclusions and recommendations, including progress, challenges and lessons learned, will be organized by UNICEF. The national workshop will be an opportunity for reflection and discussions and for validating the strategies for the second half of the project to maximize the relevance and impact. The second year of implementation will also provide the opportunity for exchanges and study visits for Romanian experts from local and national level to Norway based of a future identification of opportunities and best practices that can be shared.

A short version of the findings, conclusions and recommendations will be shared at local level to explain what adjustments will be implemented and to provide feedback to local communities involved in the modelling.

4. Objectives of the mid-term review

 ✓ Assess the overall model, as well as each component, in terms of its relevance, effectiveness, efficiency and elements of sustainability;
 ✓ Identify key elements that contribute to the model's success, as well as main bottlenecks and barriers in implementation;
 ✓ Document lessons learned, in relation to the model's implementation and propose recommendations for improvement;
 ✓ Make recommendations for further action related to the sustainability, scaling up and mainstreaming of the minimum package of services and quality inclusive education package at national level.

5. Scope and focus

The overall scope of the MTR is to assess the implementation status of the modelling project **"Social inclusion through the provision of integrated community services at community level"** addressing the challenges faced by the children and families from 45 urban and rural communities in Bacau county in accessing basic services (social, health and education).

The MTR will cover the period October 2014 – June 2016 based on the Theory of Change. The focus will be on the 45 urban and rural communes in Bacău County, the community census providing the baseline.

This MTR 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 CCSs and members of the communities, local public authorities, schools from 38 urban and rural localities from Bacau county; county stakeholders – local coordinators (social, health, education) and other professionals from GDSACP and Directorate for Public Health (DPH), County School Inspectorate, County Centres for Resources and Educational Assistance, County Council and Prefecture; and as well national stakeholders – MLFSPE and NAPCRA, MoH, MoE, Romanian Agency for Quality Assurance in Pre-university Education - RAQAPUE. Other stakeholders should be involved as well, such as: other Ministries – Regional Development and Public Administration, Public Finance, European Funding, relevant NGOs, academia, mass media, donors, etc.

Potential limitations and risks may be linked to the fact that some of children and their families may have moved or migrated, participation of key informants. Additionally, the changes in the county and local public authorities as a result of the local elections to be held in June 2016 and political changes in the Government may interfere with the implementation of data collection and consultations. However, technical staff is not expected to be changed.

5.1 Mid-term review questions

The mid-term review will specifically address the following questions which are expected to provide accurate insights related to the objective of the MTR, 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 mid-term review.

Questions for assessing the preparatory phase of the model
 ✓ Is there a clear theory of change of the model, outlining main hypothesis, inputs, objectives and expected results?

✓ Was there a baseline established initially, or in early stages of the implementation in order to assess progress against expected results?

✓ Were all relevant partners involved in the design and implementation of the model?

✓ Are there any clear specifications related to the human resources required for the implementation of the model?

✓ Is there a clear termination date of the model?

✓ Is there a clear monitoring and evaluation mechanism of the model, ensuring proper documentation of progress and lessons learned?

Questions for assessing implementation of the model

- To what extent are the objectives of the programme still valid?
- Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives?
- Are the activities and outputs of the programme leading to with the intended impacts and effects?
- To what extent is the modelling project relevant to national policies and programmes and cross-sectoral strategies[16]?

- To what extent were the objectives achieved / are likely to be achieved?
- What were the major factors influencing the achievement or non-achievement of the objectives?
- What is the degree of achievement of the modelling project's expected results in accordance with the targets set for the performance indicators?
- Does the model contribute to the capacity development of the local authorities to deliver the minimum package of integrated services?
- Does the model contribute to the capacity development of the schools staff to deliver the quality inclusive education package?
- What are the main constraints on supply and demand? Which parts of the modelling project are most and least effective? What factors explain success? Is there a value added of the integrated approach and what factors influence the collaboration between the community workers?
- Are all processes based on a child rights approach? Are any age and gender issues considered in providing the services?
- Does the modelling project use resources in the most economical/efficient manner to achieve expected results? What is the value added (in terms of financial value) of the modelling project? What are benefits of the integrated approach from financial point of view?
- Are the cost implications for scaling up considered?
- To what extent is the current context more or less favourable to continue such approaches in the near future?
- Are the interventions modelled 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? Are any adjustments of the model needed for replication?
- What recommendations could be made to UNICEF and to the Government of Romania to replicate and scale up such a model?

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[16] National Strategies on Health and Health Services, on Youth, on the Protection and Promotion of Child Rights, on Social Inclusion and Poverty Reduction, on Antidrug, etc.

- What are the lessons learned at each level of intervention that should be taken into account for implementation and further replication of the modelling project?
- Are there any unplanned outcomes worth considering for filling in capacity gaps and/or addressing remaining bottlenecks?

6. Methodology

The approach followed from the outset of the MTR will be as participatory as possible. Stakeholders at all levels, including children and their families, will participate in the MTR through discussions, consultations, provision of comments on draft deliverables and some will reply to the recommendations made by the MTR. In gathering data and views from stakeholders, the MTR team will ensure that it considers a cross-section of stakeholders with potentially diverse views to ensure the MTR findings are as impartial and as representative as possible.

The MTR will apply the UNEG norms and standards[17], and the UNEG ethical guideline[18], including 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 MTR process. Moreover, the MTR should mainstream gender and human rights considerations throughout. Concerning gender, the MTR 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 MTR 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.

As concerns evaluability, the theory of change and data available allow for the assessment of the progress achieved and the review of the modelling project results. In this context, the MTR will consider the baselines and will also use relevant available data collected through monitoring and evaluation, such as: data management tools (AURORA[19]); reporting materials from community workers and local coordinators; 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 on age, gender, ethnicity and other criteria, since control mechanisms have been in place at all data collection levels (community, county, and at model level) and the on-line application allows aggregation of the data at different levels.

The MTR will use mixed methods and could integrate:
- Primary quantitative data, collected through survey among users of services, staff working in services and/or communities. The MTR will seek to collect disaggregated data based on the following criteria: geographical – county and community levels (all communities are in rural

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[17] UNEG Norms for Evaluation in the UN System. 2005, http://www.uneval.org/document/download/562

[18] UNEG Ethical Guidelines for Evaluation. 2008, http://www.uneval.org/document/download/548

[19] AURORA – a smart online application was developed as a tool i) ensuring a unitary methodology for the identification of vulnerabilities for all children by all community professionals and across all communities; ii) facilitating the generation of an integrated service plan for children and their families to be provided by the community professionals; iii) providing real-time monitoring of 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.

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, we recommend the use of AURORA as main instrument.

– 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 organizations (civil society and intergovernmental organizations), service beneficiaries, staff working in services and/or communities and with different stakeholders in the MTR.

Additionally, together with the data sources a contact list of all relevant stakeholders, project implementing partners and consultants will be made available to the MTR team once a contractual agreement has been made:

– Rapid assessment of the social, health and education status of children and adolescents and their families in one county (Initial Assessment) to inform modelling in "Social inclusion through the provision of integrated social services at community level"

– In-depth assessment of the social, health and education status of children and adolescents and their families in one county to inform modelling in "Social inclusion through the provision of integrated social services at community level".

– UNICEF programme materials, such as country programme documents, strategies, project proposals and reports to the donors.

– Modelling project documents, such as monthly and annual reports of community workers and local coordinators, microgrants that are currently implemented by the public local authority and by school, etc.

The quality assurance process will consist in 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 Policy and Knowledge Coordinator, Local Partnerships Officer, Child Protection Specialist, Education Specialist and Child Rights Systems Monitoring (M&E) Specialist.

7. Work plan and tentative time frame

In this context, phases and tentative time frame are proposed in the table below:

Phases and time frame	*Expected activities*
Methodology and instruments	
Mid-June 2016	Inception meeting
Mid-July 2016	Submission of the methodology
End-July 2016	Comments on proposed methodology
Mid-August 2016	Finalization of methodology
Data collection	
Mid-August 2016	Submission of the data collection instruments
End-August 2016	Comments on proposed instruments
Mid-September 2016	Pre-testing of the instruments

End-October 2016	Field data collection
Reporting	
End-November 2016	Submission of the draft report
Mid-December 2016	A PowerPoint presentation of the preliminary findings and conclusions of the MTR for the meeting with key stakeholders, discuss and finalise the recommendations (to be organized by UNICEF)
Mid-January 2017	Submission of the final MTR report
Mid-January 2017	A PowerPoint presentation summarizing key findings of MTR, relevant policy issues and recommendations
Dissemination	
February 2017	Launch of the MTR report

8. Deliverables

All deliverables will be submitted in Romanian language, while an executive summary of the draft report, PowerPoint presentations of preliminary and final findings and final report will be translated into English (by a professional translator).

– MTR methodology approved and data collection instruments finalized and pre-tested by Mid-September 2016
– Field data collection completed by End-October 2016
– Draft MTR Report according to UNICEF standards by End-November 2016
– A PowerPoint presentation of the preliminary findings and conclusions of the MTR by Mid-December 2016
– Final MTR Report (including an executive summary and a bibliography – see Annex 3), complying with UNICEF Evaluation Report Standards by Mid-January 2017
– A PowerPoint presentation summarizing key findings of the MTR, relevant policy issues and recommendations by Mid-January 2017

MTR team will participate in the meeting with major stakeholders to present the findings and preliminary conclusions, discuss and finalise the recommendations and in the launch of the final MTR report.

9. Mid-term review team, required experience and credentials

The independent MTR team, institution/organization and/or consortium should be built of national experts. The team should be led by an experienced evaluator to be supported by at least three experts on social/child protection, education and health. To strengthen their capacity for performing the task, applicants may establish cross-sector forms of association, such as between experts and/or organizations/institutions in various fields of practice. The MTR team will have to comply with the Ethical Code of Conduct for Evaluation on the UN System (UNEG/FN/CoC[2008])[20] and UNEG ethical guideline.

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[20] Ethical Code of Conduct for Evaluation on the UN System (UNEG/FN/CoC[2008]), http://www.unevaluation.org/document/detail/100

Competencies required by the team to carry out the MTR 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 science or public policy, educational sciences and health;
– Comparative knowledge on child rights, child/social protection, education and health systems and on 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, incl. participatory approaches and methods; proven ability to conduct interviews, focus group discussions and writing 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 synthesize 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 an asset;
– Availability for 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 & policies evaluations.

10. Roles and responsibilities of stakeholders in the MTR

External stakeholders

– At local level: children and their families, local stakeholders – community workers, professionals in the CCSs and members of the communities, local public authorities, schools from 38 urban and rural localities from Bacau county are already informed about the MTR process and are expected to contribute during data collection process and some to provide feedback on draft report.
– At county level: local coordinators (social, health and education) and other professionals from GDSACP, DPH, County School Inspectorate, County Centre for Resources and Educational Assistance, County Council and Prefecture,
– At national level: MLFSPE and NAPCRA, MoH, MoE, Romanian Agency for Quality Assurance in Pre-university Education - RAQAPUE and other stakeholders (other Ministries – Regional Development and Public Administration, Public Finance, European Funding, relevant NGOs, academia, mass media, donors, etc.) will participate in the MTR through discussions, consultations, provision of comments on draft documents and some will address the recommendations made by the MTR in collaboration with UNICEF.

UNICEF Country Office

– The UNICEF focal point for the Mid-Term Review (MTR) is the Child Rights Systems Monitoring Specialist (M&E) who ensures that the MTR process is carried out as per UNICEF policies and provide technical support to the MTR throughout the process.
– The Policy and Knowledge Coordinator, Local Partnerships Officer, Child Protection Specialist and Education Specialist, Communication for Social Change Officer are the key informants throughout the MTR process: prepare the TORs for the MTR exercise in consultation with the Child Rights Systems Monitoring Specialist (M&E) and suggest the best proposal for the MTR; liaise with MTR team and provides initial briefing to the selected team on the framework and

expectations of the MTR; provide feedback on MTR design and research tools and all reports and deliverables; facilitate contact with county and local stakeholders included in the MTR exercise; facilitate access to complementary background documents to be included in the desk review and to all necessary documents throughout the MTR process.

Mid-term review team
- Has the overall responsibility for successful completion of all phases of the MTR including inception, 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 that are related to the implementation of the MTR;
- Submits deliverables and invoices (if applicable) in a timely manner.

11. MTR budget and sources of funding

A detailed budget for the MTR will be part of the financial proposal from the MTR teams when they express their interest for conducting the MTR.

The estimated budget for the MTR is around 25,000 USD and the source of funding is SC140918, funding from Norway Grants. This amount does not include organization of consultative meetings with stakeholders and launch of the report, which will be covered by UNICEF separately.

12. General conditions

Reporting. The contractors will report to UNICEF Child Rights Systems Monitoring (M&E) Specialist and will work closely as well with UNICEF Policy and Knowledge Coordinator, Local Partnerships Officer, Child Protection Specialist, Education Specialist and Communication for Social Change Officer.

Payment calendar. Taking into account the tasks and timeframe mentioned above, fees will be paid in three instalments after submission of deliverables and upon approval by supervisor, as follows:
- 40% of the contract total will be paid after approval by UNICEF of the draft report;
- 60% of the contract will be paid after submission and approval by UNICEF of final report and all requested deliverables.

Ownership. UNICEF will have sole ownership of all final deliverables; no parts of the methodology will be reproduced without the permission of UNICEF.

13. Annexes

Annex 1. Calendar of activities of "Social inclusion through the provision of integrated social services at community level" model

Annex 2. Theory of Change for the "Social inclusion through the provision of integrated community services at community level" model

Annex 3. Writing a good Executive Summary

Prepared by,   Approved by,
Eduard Petrescu   Sandie Blanchet

Knowledge and Policy Coordinator   Representative

Social Inclusion through the Provision of Integrated Social Services at Community Level
Expanded Theory of Change

Delivery at national level of a universal package of preventive social services (health, education, social protection) in an integrated/coordinated way to children and their families will reduce the equity gaps and reduce the deprivations children suffer while also reducing the medium and long term costs in the social sector

Time	Assumptions (context + inputs)	Intermediary results	Milestones (indicators)	
M 2 To 12	(1)Presence and quality activity of a sufficient[21] number of outreach workers (social worker + community nurse + school counsellor + health mediator + school mediator) in selected communities to deliver **minimum package of services - MPS** (2)Presence and quality activity of selected partners and school staff at the level of schools in community delivering the **quality inclusive education – QIE** package	3) All the children at risk[22] and their families in selected communities are identified 4) All children at risk in selected schools are identified	Sufficient number of outreach workers recruited, benefitting of an initial training and actively mapping the community 100% coverage of the communities with minimum package of services Sufficient number of school staff included in the project activities, benefiting of training and actively applying the project methodology 100% coverage of the schools with quality inclusive education package	**P H A S E 1**
M 12 48	5) as (1) and (2)+ applying coordinated/integrated work methodology	6) All children and families at risk in communities monitored through an integrated system having access to basic services and referred to appropriate specialized services. Impact at community level on the equity gaps and children deprivations 7) All children at risk of school exclusion and their parents having access to quality inclusive education and parental education	Integrated monitoring system operational Joint working methodology (case management) in place and widely used (% of outreach workers using it) % of children at risk benefitting of the minimum package of services % of children at risk benefiting of quality inclusive education package	**P 2**
M 18 48	8) as (5)+ documentation of the results and advocacy with local and national authorities	9) Intervention at county level documented and recognized as model. Model showing impact[23]	Model evaluated and evidence shared with local and national authorities. Cost of the model and influence of the model on the costs in social sector documented % of children with reduced level of deprivations	**P 3**
	10) as (9) + inclusion of the model	11) Political decision of model scale up reflected in	National programme for integrated services	**P**

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[21] To be defined as per existing or agreed standards

[22] As per agreed definition

[23] Impact will be measured against a set of key indicators whose baselines will be measured at the beginning of the intervention

M **18** **30**	methodology in national policies and model scale-up incorporated in national strategies	budget allocation and appropriate planning	established. Funding mechanisms for the programme in place (including access to EU funding)	**4**
M **30** **48**	12) as (10) + Technical assistance from UNICEF provided at national and local level for scaling up the model	13) Impact at national level on the equity gaps and children deprivations	% of counties adopting the programme out of the priority counties	**P** **5**

Logical framework of the model

Project preparatory phase (M1 – 2)			
Inputs	**Activities**	**Outputs**	**Outcomes**
Staff time Travel Sub-contracts	Meeting with national stakeholders (line ministries) Selecting the county based on internal review and review with partners Establish the model national steering committee Identify the local project partners Select project team Select partner to conduct rapid assessment Select contractor to develop the application for joint registration/monitoring of the beneficiaries (mobile technology based) Select partner to develop the methodology for coordinated/integrated service delivery Select the partner to provide support for the implementation of the pre-school component Select the partner to provide support for the implementation of the school component	Intervention work-plan and budget developed Project coordination mechanisms in place Project team operational	Ownership of the local authorities and of the national authorities over the project
Phase 1 (M2 – 12)			
Identification of all the children at risk and their families in selected communities and schools			
Inputs	**Activities**	**Outputs**	**Outcomes**
Staff time Salaries Travel Sub-contracts Equipment	**Integrated** Conduct rapid situation assessment Select the communities[24] where model to be implemented, establish the contact with local partners, agree partnership agreement with local authorities and schools Conduct the in-depth situation analysis in the selected communities and schools	Situation analysis and baseline indicators to measure the impact of the model developed, discussed with the project partners and finalised. Partnership agreements with municipalities and schools operational Communication materials and instruments for the C4D campaigns developed and tested	

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[24] One community is not equal to one municipality there can be more than one community in one municipality

	Select partner for developing and implementing the adolescents C4D component Mobilize community networks, coordinate the delivery of 2 packages MPS and QIE, coordinate the development of the 2 types of micro grants at community and school level Mid-term assessment of the project implementation	
	Minimum package of services Identify and recruit 40 social workers, 30 community nurses, xx school counsellors, 18 school mediators and 18 health mediators (106 workers) Identify and recruit the supervisors of the outreach workers (17) Develop and test the application for joint registration/monitoring of the beneficiaries - AURORA Develop and translate in training modules the methodology for coordinated/integrated service delivery Procure the mobile equipment used for beneficiaries registration and monitoring Procure the medical consumables to be used by the community nurses Train the recruited supervisors, recruited outreach workers and the rest of the outreach workers recruited by public agencies and distribute the mobile equipment Conduct a social census to register the beneficiaries and assess the level of vulnerability of children and their families through the new methodology and recording them in the new data base Deliver services as part of the minimum package of services to the vulnerable children and their families Identify children priority issues at community level and build	38 municipalities (34 rural and 4 urban) committed to the results of the project. Mayors and Secretaries of mayoralty having knowledge about the project objectives and strategies and sensitised about social inclusion. 38 municipalities having capacity to receive and manage funding from the project, and use it to cover delivery of integrated services. Municipal staff able to hire required social assistants and community nurses Tablet-based application (called AURORA) tested and operational. Community workers are using tablets with this software to assess families with children, identify vulnerabilities based on a common methodology, develop action plans tailored to the needs of each family and monitor progress. 126 community workers hired, having capacity and assessing families using the tablet-based application AURORA. Over 85% of the estimated number of households in the 45 targeted communities assessed. 126 community workers ready to deliver integrated services in their communities and	

	the capacity to address them through the use of the community micro grant	having increased capacity to identify and address vulnerabilities leading to social exclusion. Training package for integrated approach at local level developed, tested and ready to be certified as part of the national accreditation system for professional training	
	Quality inclusive education Conduct the RAQAPUE pre-school and school evaluation in the selected schools Procure and deliver the education materials for the selected pre-schools Conduct needs assessment in selected pre-schools and schools Select partner for developing and implementing the Roma C4D component (role models and discrimination) Capacity development activities for the staff of the pre-schools selected Capacity development for the staff of the schools selected Extracurricular activities with children Activities with parents at school level, involving teachers, parents and students Parental education sessions Promote Roma role models in 46 schools Apply a monitoring methodology for identifying children at risk of dropout in need of social support Identify children priority issues at school level and build the capacity to address them through the use of the school micro grant	45 schools and 45 kindergartens management staff committed to the project. School and kindergarten directors having improved knowledge and capacity to implement the school-based interventions and sensitised to the impact of social exclusion on school participation and outcomes. 45 school staff having the capacity to conduct school and kindergarten evaluation using the Ministry of Education methodology. Package of intervention at the level of kindergarten and school discussed and agreed upon with implementation partners. Package of intervention for parenting developed with implementation partners. Capacity to deliver parenting education at the level of 45 schools and 45 kindergartens in place aiming to provide 9,000 parents with information and advice Preschool structures of the 46 schools involved 335 teachers in 7 curricular areas and 9 transversal themes having improved teaching capacity XXX children benefiting of curricular and extracurricular activities promoted in QIE Model XXX parents benefiting in teachers / parents / students activities 900 parents having improved parental skills	

		XXX Roma and non-Roma children participating at the open courses; 46 school micro grants provided to schools	

Phase 2 (M12 – 48)			
All children and families at risk monitored through an integrated system having access to minimum package of services and quality inclusive education			
Inputs	**Activities**	**Outputs**	**Outcomes**
Staff time Salaries Travel Sub-contracts Equipment	Minimum package of services delivered to eligible children and families Children in schools and their parents receiving the support through the quality inclusive education package Supervision of outreach workers Refreshment training, on the job training and capacity development for the outreach workers and school staff Coordinated/integrated working methodologies adjusted and revised for improved reach and impact C4D campaigns implemented Technical support for local communities to access the public funding to take over the salaries covered from project	Revised project plan after the mid-term assessment % of at risk children and families monitored and receiving integrated/coordinated package of services % of outreach workers using the integrated/coordinated methodology % of target groups for the C4D campaign reached by the campaign activities % of positions whose salaries were transferred to public funding	

Phase 3 (M18 – 48)			
Intervention at county level documented and recognized as model. Model showing impact			
Inputs	**Activities**	**Outputs**	**Outcomes**
Staff time Salaries Travel Sub-contracts Equipment	Integrated package of services delivered to eligible children and families Supervision of outreach workers C4D campaigns implemented Technical support for local communities to access the public funding to take over the salaries covered from project Project evaluation contracted and implemented National conference to promote the county model	% of at risk children and families monitored and receiving integrated/coordinated package of services % of outreach workers using the integrated/coordinated methodology % of target groups for the C4D campaign reached by the campaign activities % of positions whose salaries were transferred to	

| | | public funding | |
| | | Project evaluation report | |

Phase 4 (M24 – 48)

Inputs	Activities	Outputs	Outcomes
Staff time Salaries Travel Sub-contracts Equipment	Integrated package of services delivered to eligible children and families Supervision of outreach workers C4D campaigns implemented Technical support for local communities to access the public funding to take over the salaries covered from project Technical support and capacity building for national authorities (line ministries) to develop and approve the legal instruments required for scale up of the model of provision of integrated services at national level	% of at risk children and families monitored and receiving integrated/coordinated package of services % of outreach workers using the integrated/coordinated methodology % of target groups for the C4D campaign reached by the campaign activities % of positions whose salaries were transferred to public funding Legislation, norms and methodologies at national level approved National programmes incorporating the model and ensuring funding for the model scale up approved	Increased access to a basic package of community-based services for vulnerable children and their families Reduction in the level of stigma and discrimination against Roma and increased empowerment of Roma families and children Reduction of the rate of children hospitalization Reduction of the rate of children separation from families, reduction of rate of institutionalization Increased level of knowledge and reduced level of stigma and discrimination towards Roma Increased level of safe behaviour knowledge for adolescents

Phase 5 (M30 – 48)

Inputs	Activities	Outputs	Outcomes
Staff time Salaries Travel	Integrated package of services delivered to eligible children and families Supervision of outreach workers	% of at risk children and families monitored and receiving integrated/coordinated package of services	Changes in national legislation, policies and secondary legislation, as well

Sub-contracts	C4D campaigns implemented Technical support for local communities to access the public funding to take over the salaries covered from project Technical assistance at national and local level for county model replication	% of outreach workers using the integrated/coordinated methodology % of target groups for the C4D campaign reached by the campaign activities % of positions whose salaries were transferred to public funding No of counties apply for replication of the model	as increased resource allocation, based on the model of integrated community service provision for scaling them up at national level as a major strategy for social inclusion and poverty reduction Increased access to a basic package of community-based services for vulnerable children and their families Reduction in the level of stigma and discrimination against Roma and increased empowerment of Roma families and children Reduction of the rate of children hospitalization Reduction of the rate of children separation from families, reduction of rate of institutionalization Increased level of knowledge and reduced level of stigma and discrimination towards Roma Increased level of safe behaviour knowledge for adolescents

Focus groups with community workers

		Urban	Rural	
		FG 1	FG 2	FG3
Selected communities		Moineşti	Strugari	Poduri
		Târgu Ocna	Scorţeni	Zemeş
				Căiuţi
Total focus groups participants		8	8	7
	Of whom			
	Social workers	3	2	2
	Community nurses	3	2	2
	School counsellors	1	2	2
	School mediators	1	2	1

Interviews conducted at county level

Organisation
Bacău County Council
General Directorate for Social Assistance and Child Protection (two interviews)
Bacău Directorate for Public Health
County Resource and Educational Assistance Centre
County School Inspectorate
Community Support Foundation

Interviews conducted at national level

Organisation
Ministry of Labour and Social Justice – National Agency for Payment and Social Inspection
National Authority for the Protection of Children's Rights and Adoption (NAPCRA)
Ministry of National Education
Ministry of Health
Ministry of European Funds
National Institute of Statistics
Federation of Non-Governmental Organisations for Child Protection (FNGOCP)
SERA Romania Foundation (two interviews)
Institute for Mother and Child Care
National Institute of Public Health

Interviews conducted with representatives of partner organisations

Organisation
Romanian Agency for Quality Assurance in Pre-University Education (RAQAPUE)
Institute of Education Sciences
Step by Step Centre for Education and Professional Development
'Împreună' Community Development Agency
HOLT – Consulting and Social Service Foundation for Children and Families, Iaşi
Centre for Health Policies and Services

Documents provided by UNICEF
- Reports on microgrants awarded to schools
- Reports on microgrants awarded to local authorities
- Model progress reports (Romania Social Inclusion Project progress report 1, Romania Social Inclusion Project progress report 2, UNICEF Romania Social Inclusion Project progress report 1, UNICEF Romania Social Inclusion Project progress report 2 – final)
- Model programmatic documents
- Baseline report – Voicu, B., Tufiș, C. 2016. *In-depth assessment of the social, health, and education status of children and their families in target areas of the Bacău County. Baseline report.*
- Community selection report – Bojincă, Marian, Gotca, Alexandru, Sandu, Dumitru, Tudor, Elena, Tufiş, Claudiu, Voicu, Bogdan. (2015). *Incluziune socială prin furnizarea de servicii integrate la nivelul comunității în județul Bacău. Metodologia de selecție a comunităților [Social Inclusion through the Provision of Integrated Services at Community Level. Community Selection Methodology]*, Bucharest
- *Minimum Package of Services* presentation brochure
- *Quality Inclusive Education Package* presentation brochure
- Minimum Package of Services training materials
- Quality Inclusive Education Package training materials
- Lists of Quality Inclusive Education Package training participants
- *First Priority: No More Invisible Children!* project evaluations (Helping-invisible-children-Project-evaluation-report-2011, Helping-invisible-children-second-evaluation-report -2013)
- *School Attendance Initiative* evaluation (SAI-REPORT-FINAL)

Statistical data analysis (Tempo database, NIS and EUROSTAT):
- Population ages 0 to 18 years, by area of residence, Bacău County (POP106A)
- Healthcare professionals by category, type of employer, county and locality, SAN104B
- Resident population by sex and age group – county, city, town, commune, 2011 Population and Housing Census, NIS, http://www.recensamantromania.ro/rezultate-2/
- *2015 GDP per capita in 276 EU regions. News release 52/2017*. Available online from http://ec.europa.eu/eurostat/documents/2995521/7962764/1-30032017-AP-EN.pdf/4e9c09e5-c743-41a5-afc8-eb4aa89913f6
- People at risk of poverty or social exclusion**,** EUROSTAT, indicator t2020_50
- People at risk of poverty or social exclusion by age and sex, EUROSTAT, indicator ilc_peps01

Relevant public policy documents
At national level:
- National Strategy on Social Inclusion and Poverty Reduction 2015-2020
- Programmatic documents – Operational Programme for Human Capital
- National Strategy for the Protection and Promotion of Children's Rights 2014-2020
- Strategy for the Inclusion of Romanian Citizens Belonging to the Roma Minority 2015-2020
- Strategy for Reducing Early School Leaving in Romania

- Child protection legislation (GD No 691/2015)
- Community health nursing legislation (GEO No 18/2017 on community health nursing)

County level:
- General Directorate for Social Assistance and Child Protection. (2014). *County Social Service Development Strategy 2014-2020*, Bacău
- Bacău County Council. (2010). *Bacău County Sustainable Development Strategy 2010 – 2021*, Bacău
- Bacău County School Inspectorate. (2016). *Report on the state of education in 2014-2015*, Bacău

Other documents
- Ministry of Labour, Family, Social Protection and the Elderly (MLFSPE) and SERA Romania. (2013). *Studiu conclusiv, bazat pe evaluarea la nivel național a DGASPC, SPAS şi a altor instituții şi organizații implicate în sistemul de protecție a copilului [Conclusive study based on the national evaluation of GDSACP, PSAS and other institutions and organisations involved in the child protection system]*. Available online from https://www.sera.ro/seraromania/images/Raport-final-studiu-conclusiv.pdf.
- Ministry of Labour, Family, Social Protection and the Elderly (MLFSPE). (2015). Social Assistance Developments in 2015. Statistical bulletin. Available online from http://www.mmuncii.ro/j33/images/buletin_statistic/Asistenta_2015-f.pdf.
- Ministry of Labour, Family and Social Protection (MLFSP) and IRECSON. (2011). Stadiul dezvoltării serviciilor sociale în 2011. Evaluarea stadiului dezvoltării sistemului național de servicii sociale din România [Social Service Development Status in 2011. Evaluation of Social Service System Development Status in Romania]. Available online from http://profitpentruoameni.ro/wp-content/uploads/2012/08/Stadiul-Serviciilor-sociale-in-2011_Irecson-WEB.pdf.
- Preda, M. (coord.), Buzducea, D., Fărcășanu, D., Grigoraș, V., Lazăr, F. și Rentea, G. C. (2013). Analiza situației copiilor din România [Situation Analysis of Children in Romania]. UNICEF, Bucharest: Vanemonde.
- Swinkels, R. (coord.). (2015). *The Atlas of Urban Marginalized Areas in Romania*. Bucharest: MRDPA.
- Teșliuc, E., Grigoraș, V. și Stănculescu, M. (coord). (2016). *The Atlas of Rural Marginalized Areas and of Local Human Development in Romania*. Bucharest: World Bank Group.
- Teșliuc, E., Grigoraș, V. și Stănculescu, M. (coord). (2015). *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*. Bucharest: World Bank Group.

ONLINE QUESTIONNAIRE FOR COMMUNITY WORKERS

Social worker, community nurse, school counsellor (health mediator, school mediator)

q1. Name of the locality where you work in the project implemented with UNICEF support
(Predefined list of all the localities to choose from)

q2. Position in the project:
- *Social worker*
- *Community nurse*
- *School counsellor*
- *Health mediator*
- *School mediator*

Note:
Only some of the following questions will be displayed, according to the position of each respondent (as selected under question q2). For social workers, the questions highlighted in the colour corresponding to that position will be displayed. Questions without a distinctive colour are addressed to all respondents.

AWARENESS OF THE MODEL

To what extent do you agree with the following statements related to the project implemented with UNICEF support? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q3. People in the community were reluctant to the project supported by UNICEF at the start of its implementation	1	2	3	4	98
q4. Local authorities were reluctant to the project supported by UNICEF at the start of its implementation	1	2	3	4	98
q5. Local authorities support project activities	1	2	3	4	98
q6. People in the community know what I do	1	2	3	4	98
q7. People in the community contact me when they need help	1	2	3	4	98

PARTICIPATION AND COOPERATION

To what extent have the following members of the community where you work got involved in the project implemented with UNICEF support? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q8. People in the community	1	2	3	4	98
q9. School	1	2	3	4	98
q10. Mayoralty	1	2	3	4	98

q11. Family doctor	1	2	3	4	98
q12. Church	1	2	3	4	98
q13. Police	1	2	3	4	98
q14. Parents of children benefiting from the project	1	2	3	4	98

In the past 12 months, have you undertaken at least one action with…? *(One answer per row)*	Yes	No
q15. The police	1	2
q16. The school *(applies to community workers, except for those from the education sector)*	1	2
q17. The social worker *(applies to community workers, except for social workers)*	1	2
q18. The church	1	2
q19. NGOs	1	2
q20. Family doctors	1	2
q21. Local or county health authorities	1	2
q22. Bacău General Directorate for Social Assistance and Child Protection	1	2
q23. Bacău County Resource and Educational Assistance Centre/County School Inspectorate	1	2
q24. Other. Please specify _____	1	2

How would you describe…? *(One answer per row)*	Very poor / inexistent	Poor	Good	Very good	DNK
q25. Collaboration with the other members of the local team for case/problem resolution	1	2	3	4	98
q26. Collaboration with county coordinators for case/problem resolution	1	2	3	4	98
q27. Communication with local beneficiaries	1	2	3	4	98
q28. Communication with the parents of students benefiting from project support	1	2	3	4	98
q29. Collaboration with the mayoralty	1	2	3	4	98
q30. Collaboration with the mayoralty's social worker	1	2	3	4	98
q31. Collaboration with teachers	1	2	3	4	98
q32. Collaboration with the family doctor	1	2	3	4	98
q33. Collaboration with Bacău General Directorate for Social Assistance and Child Protection	1	2	3	4	98
q34. Collaboration with County School Inspectorate	1	2	3	4	98
q35. Collaboration with Bacău County Resource and Educational Assistance Centre	1	2	3	4	98
q36. Collaboration with Bacău Directorate for Public Health	1	2	3	4	98

DAY-TO-DAY ACTIVITIES

How often… *(One answer per row)*	A few times a week	Once a week	Every two weeks	Once a month	Every two months	More seldom

q37. Do you communicate with the other members of the local project team?					
q38. Do you communicate with the county coordinator?					
q39. Do community advisory structures meet?					

What are the means that you use most frequently to communicate with…? *(One answer per row)*	Telephone	E-mail	Online discussion groups (e.g. Facebook)	Face to face	Other. Please specify
q40. The other members of the local project team					
q41. County coordinator					
q42. Members of other local teams from other communities					

In the past month, how much of your working time have you spent…?	Percentage
q43. In the field, visiting families	
q44. In the field, talking to the neighbours of the families needing your help	
q45. In the office, talking to those who come in and ask for support	
q46. Discussing work-related issues with other local authorities (mayoralty employees, police officers, the mayor, etc.)	
q47. Preparing administrative papers/files	
q48. Conducting group activities with students	
q49. Conducting individual counselling	
q50. Other (please specify: _____)	

To what extent do you agree with the following statements related to the project implemented with UNICEF support? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q51. There is enough time available to cover the needs of local children in difficulty	1	2	3	4	98
q52. There is enough time available to cover the needs of local mothers in difficulty (*does not apply to school counsellors and mediators*)	1	2	3	4	98
q53. The number of community workers is enough for the number of beneficiaries in the community	1	2	3	4	98

To what extent have you had to deal with the following problems when implementing project activities? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q54. Parents' reluctance to let their children take part in the activities carried out by the school	1	2	3	4	98
q55. Parents' reluctance to let their children benefit from social services	1	2	3	4	98
q56. Parents' reluctance to let their children benefit from healthcare	1	2	3	4	98
q57. Parents' reluctance to answer AURORA questions – *applies only to the social worker and community nurse*	1	2	3	4	98
q58. Future mothers' low awareness of the risks entailed by the lack of pregnancy monitoring	1	2	3	4	98
q59. Future mothers' low awareness of newborn care rules	1	2	3	4	98
q60. Parents' low awareness of appropriate child care (nutrition, hygiene, etc.)	1	2	3	4	98
q61. Parents' little information about recognising the early signs of illness, looking after children and taking doctor's appointments in case of illness	1	2	3	4	98
q62. Marginalisation of children from disadvantaged families in school	1	2	3	4	98
q63. Lack of access to the family doctor for children from disadvantaged families	1	2	3	4	98
q64. Uncooperative mayoralty	1	2	3	4	98
q65. Uncooperative school	1	2	3	4	98
q66. Uncooperative family doctor	1	2	3	4	98
q67. Lack of cooperation from Bacău General Directorate for Social Assistance and Child Protection	1	2	3	4	98
q68. Lack of cooperation from the County School Inspectorate	1	2	3	4	98
q69. Lack of cooperation from Bacău County Resource and Educational Assistance Centre	1	2	3	4	98
q70. Lack of cooperation from Bacău Directorate for Public Health	1	2	3	4	98
q71. Great distance to beneficiaries	1	2	3	4	98
q72. Case resolution difficulties caused by incomplete legislation/conflicting legal provisions	1	2	3	4	98
q73. Other. Please specify _____- **q74.** _____	1	2	3	4	98

For those who opted for answer 3 or 4 to q72:

q75. Please exemplify *(open question)*

_____

How much does AURORA help you with the following activities? *(One answer per row)* – *This applies only to the social worker and community nurse*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q76. Identifying beneficiaries	1	2	3	4	98
q77. Assessing beneficiaries' needs	1	2	3	4	98
q78. Informing beneficiaries	1	2	3	4	98
q79. Counselling beneficiaries	1	2	3	4	98
q80. Accompanying and supporting beneficiaries	1	2	3	4	98
q81. Referring beneficiaries	1	2	3	4	98
q82. Monitoring and evaluating interventions on beneficiaries	1	2	3	4	98
q83. Delivery of integrated services to beneficiaries	1	2	3	4	98

EFFECTIVENESS

To what extent do you think that, in the community where you work, thanks to the project implemented with UNICEF support…? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q84. People's access to social services has improved	1	2	3	4	98
q85. The number of children with their social needs identified has increased	1	2	3	4	98
q86. The number of social services delivered has increased	1	2	3	4	98
q87. Community members' quality of life has improved	1	2	3	4	98
q88. People in the community are more aware of their rights	1	2	3	4	98
q89. The mayoralty focuses more on addressing social issues	1	2	3	4	98
q90. The number of newborns visited at home (during their first year of life) by the community nurse has increased	1	2	3	4	98
q91. The number of pregnant women benefiting from monitoring throughout their pregnancy has increased	1	2	3	4	98
q92. The number of poor children with health problems (anomalies, dystrophies, etc.) consulted by family doctors has increased	1	2	3	4	98
q93. The number of children benefiting from doctor consultations at the local medical practice has increased	1	2	3	4	98
q94. The number of disadvantaged people in the community registered with a family doctor has increased	1	2	3	4	98
q95. Parents of school- (& kindergarten-) age children come more often to	1	2	3	4	98

school/kindergarten to inquire about their children					
q96. Parents of school-age children help them more often with homework	1	2	3	4	98
q97. Parents of school-age children participate more often in extracurricular activities (outdoor activities, trips, etc.)	1	2	3	4	98
q98. The number of dropouts has diminished	1	2	3	4	98
q99. School/early childhood education (kindergarten) participation has increased	1	2	3	4	98
q100. Children's academic results have improved	1	2	3	4	98
q101. Collaboration with commune-based institutions (mayoralty, medical office, school) has improved	1	2	3	4	98
q102. Collaboration between commune-based institutions and county agencies responsible for social assistance and child protection has improved	1	2	3	4	98
q103. Collaboration between commune-based institutions and county agencies responsible for education has improved	1	2	3	4	98
q104. Collaboration between commune-based institutions and county health agencies has improved	1	2	3	4	98

q105. What do you think are the main benefits that the implementation of the Minimum Package of Services has brought to your community?

_____

On a scale of 1 to 10, where 1 is the lowest score and 10 is the highest score, how would you rate the following aspects? *(One answer per row)*	Very poor									Very good
q106. Project operation	1	2	3	4	5	6	7	8	9	10
q107. Project usefulness for the community	1	2	3	4	5	6	7	8	9	10
q108. Coverage of local children's needs	1	2	3	4	5	6	7	8	9	10
q109. Coverage of local at-risk mothers' needs – *does not apply to school counsellors and mediators*	1	2	3	4	5	6	7	8	9	10

What do you think are the main factors contributing to successful project implementation: *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q110. AURORA application – *applies only to the social worker and community nurse*	1	2	3	4	98
q111. Skilled human resources	1	2	3	4	98
q112. Staff training courses organised in the project	1	2	3	4	98
q113. Integrated delivery of social,	1	2	3	4	98

What do you think are the main factors contributing to successful project implementation: *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
educational and health services					
q114. Rapid communication within the project team	1	2	3	4	98
q115. Support from local authorities	1	2	3	4	98
q116. Parent participation in parent education courses	1	2	3	4	98
q117. Local stakeholder involvement in community advisory structures	1	2	3	4	98
q118. Flexibility – possibility to adjust the intervention to the reality on the ground	1	2	3	4	98
q119. Adjustment of activities to community characteristics	1	2	3	4	98
q120. Direct intervention in the community (activities carried out in the midst of the disadvantaged community)	1	2	3	4	98
q121. Prompt service delivery to beneficiaries	1	2	3	4	98
q122. Constant support from UNICEF team – *provision of information and assistance for case resolution*	1	2	3	4	98
q123. Other. Please specify_____	1	2	3	4	98

q124. What do you think is the main weakness of the project? *(open question)*
_____

q125. What do you think are the main improvements that should be brought to the project? *(open question)*
_____

q126. What do you think should happen in your community to improve the delivery of integrated social services at community level?

q127. Sex 1. Male 2. Female

q128. What is the highest level of education you have completed?

No school	0
Primary school (1-4 grades)	1
Lower secondary school (5-8 grades)	2
Lower high school or school of arts and trades (9-10 grades)	4
Vocational, apprenticeship or complementary school	3
High school (11-13 grades)	5
Specialised post-secondary school or technical foreman school	6
Short-term university courses/college	7

Long-term university courses	8
Master's programme	9
Doctoral school	10
No response	98

For higher education graduates (codes 7, 8, 9, 10):

In which of the following fields are you specialised (Bachelor's, Master's or PhD degree)? *(One answer per row)*	Yes	No
q129. Social work	1	2
q130. Sociology	1	2
q131. Psychology	1	2
q132. Medicine	1	2
q133. Economics	1	2
q134. Public administration	1	2
q135. Political sciences	1	2
q136. History	1	2
q137. Education sciences	1	2
q138. Other	1	2

q139.   When were you hired in the project? _____ *(month)* _____ *(year)*

q140.   Type of post held in the project:
1. Full time (8 hours/day)
2. Part time (4 hours/day)
3. Part time – 3 hours/day
4. Part time – 2 hours/day   → q139

q141.   Do you also work elsewhere?
1. No
2. Yes → q140

q142.   On what position? _____

q143.   Overall work experience as a social worker/community nurse/school counsellor/health mediator/school mediator _____ years _____ months

q144.   Work experience as a social worker/community nurse/school counsellor/health mediator/school mediator **in the local community** _____ years _____ months

q145.   Do you live in the community where you work?
1. Yes
2. No, I commute

ONLINE QUESTIONNAIRE FOR TEACHERS AND PARENT EDUCATORS

Teachers, school staff and parent educators who received support under the QIE component

q1. Name of the locality where you work.... *(Predefined list of all the localities to choose from)*

q2. *You are:*
   A teacher
   Instructional support staff member
   A parent educator

At the school where you teach, is there a…? *(One answer per row)*	Yes	No
q3. School mediator	1	2
q4. School counsellor	1	2
q5. School psychologist	1	2
q6. Support teacher for SEN children	1	2

At the school where you teach, would you say students…? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q7. Have good academic results	1	2	3	4	98
q8. Get involved in extracurricular activities	1	2	3	4	98
q9. Come from poor families	1	2	3	4	98
q10. Have parents working abroad	1	2	3	4	98
q11. Have behavioural problems	1	2	3	4	98
q12. Are at risk of dropping out	1	2	3	4	98
q13. Have special educational needs (SEN)	1	2	3	4	98
q14. Have learning difficulties (failed classes, grade retention)	1	2	3	4	98
q15. Have school integration problems	1	2	3	4	98

In the project implemented with UNICEF support, have your school benefited from…? *(One answer per row)*	Yes	No	DNK	In which activities have you taken part? *(multiple-choice question)*
q16. RAQAPUE evaluation	1	2	98	
q17. Microgrant	1	2	98	
q18. Subject-specific teachers training	1	2	98	
q19. Teachers training in extracurricular areas	1	2	98	
q20. Learning activities on the online platform	1	2	98	
q21. School management training	1	2	98	
q22. Counselling provided to the school's management team	1	2	98	
q23. Parent education courses	1	2	98	
q24. Presentation of role models for boosting students' self-esteem	1	2	98	
q25. Interschool exchanges	1	2	98	
q26. Demonstration lessons held by the Institute of Education Sciences or 'Împreună' Agency	1	2	98	

q27. Other. Please specify _____	1	2	98	

To what extent do you agree with the following statements related to the project implemented with UNICEF support? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q28. Students' parents were reluctant to the project supported by UNICEF at the start of its implementation	1	2	3	4	98
q29. Local authorities were reluctant to the project supported by UNICEF at the start of its implementation	1	2	3	4	98
q30. Local authorities support project activities	1	2	3	4	98
q31. Students' parents support the activities organised by the school in the project	1	2	3	4	98
q32. The current legal framework supports the implementation of a quality inclusive education model	1	2	3	4	98

PARTICIPATION AND COOPERATION

Regarding the school where you teach, to what extent do you agree with the following statements? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q33. Parents get actively involved in the activities organised by the school	1	2	3	4	98
q34. The local community supports school activities	1	2	3	4	98
q35. The mayoralty supports school activities	1	2	3	4	98
q36. Businesses support school activities	1	2	3	4	98

In the past 12 months, has the school where you teach undertaken at least one joint action with…? *(One answer per row)*	Yes	No	DNK
q37. The police	1	2	98
q38. The mayoralty	1	2	98
q39. The church	1	2	98
q40. NGOs	1	2	98
q41. Family doctors	1	2	98
q42. Businesses	1	2	98
q43. Bacău County Resource and Educational Assistance Centre	1	2	98
q44. The County School Inspectorate	1	2	98
q45. Other. Please specify _____	1	2	98

How would you describe…? *(One answer per row)*	Very poor / inexistent	Poor	Good	Very good	DNK

How would you describe…? *(One answer per row)*	Very poor / inexistent	Poor	Good	Very good	DNK
q46. Collaboration with the school counsellor for case/problem resolution[25]	1	2	3	4	98
q47. Collaboration with the school mediator[26]	1	2	3	4	98
q48. Communication with students' parents	1	2	3	4	98
q49. Collaboration with the social worker from the team of the project implemented with UNICEF support for case/problem resolution	1	2	3	4	98
q50. Collaboration with the community nurse for case/problem resolution	1	2	3	4	98
q51. Collaboration with the family doctor	1	2	3	4	98
q52. Collaboration of the school with the mayoralty	1	2	3	4	98
q53. Collaboration of the school with the County School Inspectorate	1	2	3	4	98
q54. Collaboration of the school with Bacău County Resource and Educational Assistance Centre	1	2	3	4	98

DAY-TO-DAY ACTIVITIES

How often do you…? *(One answer per row)*	A few times a week	Once a week	Every two weeks	Once a month	Every two months	More seldom
q55. Contact your students' parents						
q56. Consult with the school counsellor[27]						
q57. Consult with the school mediator[28]						

To what extent have you had to deal with the following problems in your work? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q58. Parents' reluctance to let their children take part in the activities carried out by the school	1	2	3	4	98
q59. Parents' non-involvement in the activities organised by the school	1	2	3	4	98
q60. Parents' reluctance to let their children benefit from social services	1	2	3	4	98
q61. Parents' reluctance to let their children benefit from healthcare	1	2	3	4	98
q62. Parents' low interest in children's academic	1	2	3	4	98

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[25] This answer choice will only be displayed to those who have answered 'There is a school counsellor' to q3.

[26] This answer choice will only be displayed to those who have answered 'There is a school mediator' to q2.

[27] This answer choice will only be displayed to those who have answered 'There is a school counsellor' to q3.

[28] This answer choice will only be displayed to those who have answered 'There is a school mediator' to q2.

To what extent have you had to deal with the following problems in your work? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
performance					
q63. Parents' reluctance to participate in counselling activities	1	2	3	4	98
q64. Parents' reluctance to participate in parent education courses	1	2	3	4	98
q65. Marginalisation of children from disadvantaged families in school	1	2	3	4	98
q66. Uncooperative mayoralty	1	2	3	4	98
q67. Uncooperative family doctor	1	2	3	4	98
q68. Lack of cooperation from the County School Inspectorate	1	2	3	4	98
q69. Lack of cooperation from Bacău County Resource and Educational Assistance Centre	1	2	3	4	98
q70. Other. Please specify _____	1	2	3	4	

EFFECTIVENESS

To what extent to you think that, in the community where you teach, thanks to the project implemented with UNICEF support…? *(One answer per row)*	To a very small extent	To a small extent	To a great extent	To a very great extent	DNK
q71. Children's parents come more often to school/kindergarten to inquire about their children	1	2	3	4	98
q72. Children's parents help them more often with homework	1	2	3	4	98
q73. Children's parents participate more often in extracurricular activities (outdoor activities, trips, etc.)	1	2	3	4	98
q74. Students' parents have improved their parenting skills	1	2	3	4	98
q75. School/early childhood education (kindergarten) participation has increased	1	2	3	4	98
q76. Students get more involved in extracurricular activities	1	2	3	4	98
q77. Children's academic results have improved	1	2	3	4	98
q78. Teachers have sharpened their professional skills	1	2	3	4	98
q79. Teachers' teaching methods have improved in your school	1	2	3	4	98
q80. School visibility has increased in the community	1	2	3	4	98
q81. The number of extracurricular activities organised by the school has increased	1	2	3	4	98

q82. The number of actions undertaken in partnership with other schools in the county has increased	1	2	3	4	98
q83. The school has improved its capacity to determine the profile of children at high risk of dropping out	1	2	3	4	98
q84. The school has improved its capacity to initiate supportive activities for at-risk children	1	2	3	4	98
q85. The school has improved its capacity to write project proposals for funding	1	2	3	4	98
q86. The school has improved its capacity to develop strategic and operational documents	1	2	3	4	98
q87. The local authority gets more involved in dropout prevention	1	2	3	4	98
q88. School-mayoralty collaboration has improved	1	2	3	4	98
q89. Collaboration between the school and county institutions from the education sector has improved	1	2	3	4	98

On a scale of 1 to 10, where 1 is the lowest score and 10 is the highest score, how would you rate the usefulness of…? *(One answer per row)*	**Very poor**									**Very good**
q90. Diversity awareness package	1	2	3	4	5	6	7	8	9	10
q91. Subject-specific training courses	1	2	3	4	5	6	7	8	9	10
q92. Training courses in extracurricular areas[29]	1	2	3	4	5	6	7	8	9	10
q93. Learning on online platforms	1	2	3	4	5	6	7	8	9	10
q94. Demonstration lessons	1	2	3	4	5	6	7	8	9	10
q95. Interschool exchanges	1	2	3	4	5	6	7	8	9	10
q96. Microgrants for schools	1	2	3	4	5	6	7	8	9	10

q97. What do you think are the main benefits that the microgrant has brought to your school? *(open question)*

_____

What do you think are the main factors contributing to the successful implementation of quality inclusive education? *(One answer per row)*	**To a very small extent**	**To a small extent**	**To a great extent**	**To a very great extent**	**DNK**
q98. School management	1	2	3	4	98
q99. Teachers training	1	2	3	4	98
q100. School infrastructure	1	2	3	4	98
q101. School guidance and counselling	1	2	3	4	98
q102. At-risk student monitoring	1	2	3	4	98
q103. Collaboration with community-based	1	2	3	4	98

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[29] The items will only be displayed to those who have previously stated that they participated in these courses.

	services					
q104.	Parent involvement	1	2	3	4	98
q105.	Promotion of role models among students	1	2	3	4	98
q106.	Support from local authorities	1	2	3	4	98
q107.	Partnerships with NGOs	1	2	3	4	98
q108.	Financial resources	1	2	3	4	98
q109.	Legislation	1	2	3	4	98
q110.	Other. Please specify _____	1	2	3	4	98

q111. What do you think are the main improvements that should be brought to the quality inclusive education model? *(open question)*

_____

q112. What legal amendments do you think are necessary to ensure quality inclusive education? *(open question)*

_____

SOCIO-DEMOGRAPHICS

q113. Sex   1. Male   2. Female

q114. What is the highest level of education you have completed?

High school (11-13 grades)	1
Specialised post-secondary school or technical foreman school	2
Short-term university courses/college	3
Long-term university courses	4
Master's programme	5
Doctoral school	6
No response	98

q115. Teaching experience _____ years

q116. Employment with the current educational establishment _____ years

q117. Position in the current educational establishment
   a. Tenured teacher
   b. Substitute teacher

q118. Do you live in the community where you work?
   3. Yes
   4. No, I commute

FOCUS GROUP GUIDE – MPS COUNTY COORDINATORS

MPS Package county coordinators (social assistance, health and education)

Introduction
- Brief introduction of the moderator and the topic for discussion
- Explanations are given about what a focus group is and what the 'discussion rules' are: there are no right or wrong answers; discussions will remain confidential; the views of all the participants are considered interesting; spontaneous interaction is very important.

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented with UNICEF support in Bacău County and on their response to the needs of children and young mothers. We would like to find out your views on the matter. But, first, let's get to know each other…."

Participants' introduction *(each participant will have to answer the questions; you will have to go around the table with each question)*
- We will start with a brief introduction: first name, education, profession, experience in the social/health sector, and seniority in the current project position.

Awareness of the model
1. Are there any other social assistance projects being implemented in the communities you coordinate? What is the difference between those and the intervention carried out under the project supported by UNICEF?
2. Are there any other community health nursing projects being implemented in the communities you coordinate? What is the difference between those and the intervention carried out under the project supported by UNICEF?
3. Are there any other educational projects being implemented in the communities you coordinate? What is the difference between those and the intervention carried out under the project supported by UNICEF? What is the innovation that the UNICEF-supported project brings?

Participation
1. In which project activities have you been involved?
2. How many localities are under your coordination?
3. How many people are under your coordination? How do you work with them? / How often and what means do you use to communicate with them? Are you confronted with the issue of high staff turnover?
4. What do you think about the ratio between community workers and beneficiaries? What should change in order to ensure that the needs of beneficiaries are better covered?
5. How do you work with the other social assistance coordinators? How do you work with the other community health nursing coordinators? How about with educational coordinators? How often do you talk? On what occasion?

6. With which local stakeholders do you cooperate? How about at county level? On what matters?

7. Which county institutions are most supportive of project implementation? Which ones 'have showed resistance'?

8. Did you participate in the project's training courses? How useful were they? If you were to suggest any improvements (e.g. related to content, duration, organisation, etc.), what would those be? What other courses would you need?

Effectiveness

1. What are the main benefits of the UNICEF-supported project for children and their families?

2. What are the benefits for the public social assistance services operating in the communities/county? What has changed since the project started?

3. What are the benefits for community health nursing in the communities/county? What has changed since the project started?

4. When you think about the social needs (social assistance/community health nursing) of at-risk children and mothers, which do you think have been the most important project outcomes so far? Which of the social issues identified in the community have only been partly addressed or cannot be addressed at all? Why?

5. What are the main difficulties you come across in your project activities?

Relevance

1. Do you think that the project supported by UNICEF responded/responds to the needs of children? What child needs remain uncovered?

2. Do you think that the project supported by UNICEF responded/responds to the needs of mothers? What maternal needs remain uncovered?

3. What are the main benefits of using AURORA in the project? How about key challenges?

4. What would you change in this project?

Sustainability

1. What factors enabled the implementation of the minimum package of integrated services in the communities you coordinate? How about those which hampered implementation?

2. Do you think the activities carried out in the project supported by UNICEF will continue after current funding is withdrawn? If YES, how and with what funds? If NO, why not?

3. Do you think the minimum package of integrated community-based services could also be developed in other counties? If YES, how? If NO, why not?

4. What kind of measures (legislative measures, institutional construction changes, etc.) should be taken at national level in order to mainstream the model?

Introduction
- Brief introduction of the moderator and the topic for discussion
- Explanations are given about what a focus group is and what the 'discussion rules' are: there are no right or wrong answers; discussions will remain confidential; the views of all the participants are considered interesting; spontaneous interaction is very important.

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented with UNICEF support in Bacău County and on their response to the needs of students and schools. We would like to find out your views on the matter. But, first, let's get to know each other…."

Participants' introduction *(each participant will have to answer the questions; you will have to go around the table with each question)*
- We will start with a brief introduction: first name, education, profession, experience in the educational sector, and seniority in the current project position.

Awareness of the model
1. Are there any other educational projects being implemented in the communities you coordinate? What is the difference between those and the quality inclusive education package under the project implemented with UNICEF support?
2. What is the innovation that this project brings to the field of education?

Participation
1. In which project activities have you been involved?
2. How many localities are under your coordination?
3. How many schools/educational establishments are under your coordination? How do you work with them? / How often and what means do you use to communicate with them? Are those schools/educational establishments confronted with a high staff turnover?
4. How do you cooperate with the other coordinators of the educational component under the Minimum Package of Services? How do you cooperate with the other community health nursing coordinators? How about with social assistance coordinators? How often do you talk? On what occasion?
5. With which local stakeholders do you cooperate? How about at county level? On what matters?
6. Which county institutions are most supportive of project implementation? Which ones 'have showed resistance'?
7. Did you participate in the project's training courses? How useful were they? If you were to suggest any improvements (e.g. related to content, duration, organisation, etc.), what would those be? What other courses would you need?

Effectiveness

1. What are the main benefits of the UNICEF-supported project for children? What has changed since the project started? How did the role model presentation impact children in the communities?
2. What are the main benefits of the UNICEF-supported project for children's parents? What has changed since the project started (parents cooperate better with the school, they are more involved in children's education, etc.)?
3. What are the benefits for the schools in the communities? What has changed since the project started?
4. How useful was RAQAPUE's school evaluation? What was its impact on the educational establishments?
5. What was the impact of the project's training activities on teachers in the communities (relationship between teachers, relationship with parents, teaching methods, etc.)?
6. How did microgrant project proposal writing and implementation impact schools?
7. What are the main difficulties you come across in your project activities?

Relevance
1. Do you think that the project supported by UNICEF responded/responds to the needs of children? What child needs remain uncovered?
2. Do you think that the project supported by UNICEF responded/responds to the needs of schools? What school needs remain uncovered?
3. What would you change in this project?

Sustainability
1. What factors enabled the implementation of the quality inclusive education package in the communities you coordinate? How about those which hampered implementation?
2. Do you think the activities carried out in the project supported by UNICEF will continue after current funding is withdrawn? If YES, how and which activities from the quality inclusive education package could be replicated by other education institutions in the country?
3. Do you think the quality inclusive education package could also be developed in other counties? If YES, how? If NO, why not?
4. What kind of measures (legislative measures, institutional construction changes, etc.) should be taken at national level in order to mainstream the quality inclusive education package?
5. What conditions should an educational establishment meet to be able to deliver quality inclusive education?

FOCUS GROUP GUIDE – PARENTS

Parents of children who benefited from the project supported by UNICEF

Three to four parents of children who benefited from the activities carried out under the QIE package and three to four parents of children who benefited from MPS package activities will be selected. Relevant lists will be requested to the communities where FGs will be conducted and the participants will be randomly selected.

Introduction
- Brief introduction of the moderator and the topic for discussion
- Explanations are given about what a focus group is and what the 'discussion rules' are: there are no right or wrong answers; discussions will remain confidential; the views of all the participants are considered interesting; spontaneous interaction is very important.

"Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented by the mayoralty and the school from the commune of… with UNICEF support and on their response to the needs of children and their families. We would like to find out your views on the matter. But, first, let's get to know each other…."

Participants' introduction *(each participant will have to answer the questions; you will have to go around the table with each question)*
- We will start with a brief introduction: first name, education, profession, number of children (age and educational stage – early childhood education, primary education, lower secondary education)

Community
1. Briefly describe your community and its inhabitants (for example, it is a community where people help each other)
2. Are you satisfied with the social, health and educational services available in the community? What would you improve?

Awareness of the model
1. Are you familiar with the project implemented by the mayoralty/school with UNICEF support in your community? What do you know about it? How about the project staff?
2. What activities have been conducted with UNICEF support in your locality? How about at school/kindergarten?

Participation
1. With which of the community workers (social worker, community nurse/health mediator, school counsellor/school mediator) did you get in contact? On what occasion? How did those meetings go? / How would you describe the interaction with project team members – did you get the required information, were you provided the services you needed, etc….? (*If they don't spontaneously answer the previous questions:* Were you visited at home by the UNICEF-supported project team members? On what occasion?)
2. What are the social services delivered in the project that you/your spouse benefited from? How about your children? (Information, counselling, support, etc.) Do you still benefit from those services?
3. What are the medical services delivered in the project that you/your spouse benefited from? How about your children? Do you still benefit from those services?
4. Are all your family members registered with a family doctor? How often do you go to the doctor? When was the last time? For what problem?
5. How do you (you or your spouse) get involved in children's education? (You help them with homework, you take part in extracurricular activities carried out in school, etc.)

6. How often do you go to school? On what occasion? Only to parent-teacher conferences? On what other occasions do you go there? When was the last time?
7. How do you cooperate with the teachers?
8. In what activities organised at school/kindergarten under the project supported by UNICEF did you participate? Who took the initiative for those activities (parents or teachers)?
9. Did you attend parent education courses? What did you like about those courses? What didn't you like? What are the main benefits of parent education participation? / How did such participation help you? What other courses would you like to attend?
10. In what activities organised by the mayoralty under the project supported by UNICEF did you participate? Who took the initiative for those activities (the citizens or the mayoralty)?

Effectiveness
1. What are the main benefits of the project supported by UNICEF for your locality?
2. If you think about school activities, what has changed since the start of the project supported by UNICEF?
3. If you think about healthcare in your locality, what has changed since the start of the project supported by UNICEF?
4. If you think about mayoralty activities in your locality, what has changed since the start of the project supported by UNICEF?
5. What are the main benefits of the project supported by UNICEF for you and your family?
6. What has changed in your children's lives since the start of the project supported by UNICEF?

Relevance
1. Do you think the project supported by UNICEF responded to the needs of local children? How about to the needs of young mothers/pregnant women in your community?
2. What other activities do you think should be implemented to better respond to their needs?
3. What would you change in the project supported by UNICEF?

FOCUS GROUP GUIDE – ADOLESCENTS

Adolescents who benefited from the project supported by UNICEF

Three to four adolescents who benefited from the activities carried out under the QIE package and three to four adolescents who benefited from MPS package activities will be selected. Relevant lists will be requested to the communities where FGs will be conducted and the participants will be randomly selected.

Introduction
- Brief introduction of the moderator and the topic for discussion
- Explanations are given about what a focus group is and what the 'discussion rules' are: there are no right or wrong answers; discussions will remain confidential; the views of all the participants are considered interesting; spontaneous interaction is very important.

"Hello,

I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented by the mayoralty and the school from the commune of… with UNICEF support and on their response to the needs of young people. We would like to find out your views on the matter. But, first, let's get to know each other…."

Participants' introduction *(each participant will have to answer the questions; you will have to go around the table with each question)*
1. We will start with a brief introduction: first name, age, grade, siblings (how many)?
2. If you were to pick one thing that you could change/improve in your life, what would that be?
3. What do you want to do after you finish school?

About school
1. What do you like about your school? What would you change about your school?
2. Do you have friends your age who are not in school? Why aren't they?
3. How about friends/schoolmates with parents working abroad? How do they handle school?
4. Is there a school counsellor in your school? When did you last talk to them? About what? Was the talk with the school counsellor any useful?
5. Do you know anyone else (a schoolmate/a friend) who talked to the school counsellor? Who started the discussion (the student or the counsellor)? What did they talk about? Was the talk any useful?
6. What other topics would you like to discuss in school? What extra activities would you like to carry out in school?

Relationship with parents
1. How do you get along with your parents? What do you talk about with them?
2. Do your parents come to school often? When was the last time they came and why?
3. Did your parents participate in the parent education courses? If YES, has anything changed in your relationship with them after they attended those classes?

Community
1. Briefly describe your community and its inhabitants (for example, it is a community where people help each other)

Mayoralty/school project implemented with UNICEF support
1. Are you familiar with the project implemented by the mayoralty/school with UNICEF support in your community? What do you know about it?
2. In what project activities were you involved (in the community, at school)? How were you involved? For how long? What would you change about the activities in which you took part?
3. Did you interact/talk with the social worker/community nurse/school counsellor/health mediator/school mediator? How did they help you? Do you trust them enough to turn to them in the future? (The question will be asked in relation to each of the community workers mentioned)
4. Did your parents interact/talk with the social worker/community nurse/school counsellor/health mediator/school mediator? What was the reason for that interaction/talk? Has anything changed about your parents after that interaction/talk? What exactly?

5. Have you noticed any change in teachers' behaviour during the project implemented by the school with UNICEF support? What exactly? (e.g. teaching methods, extracurricular activities performed, being closer to students, etc.)
6. Has anything changed in your life since the project started? What?

FOCUS GROUP GUIDE – COMMUNITY WORKERS

Social worker, community nurse, school counsellor, health mediator, school mediator

Introduction
- Brief introduction of the moderator and the topic for discussion
- Explanations are given about what a focus group is and what the 'discussion rules' are: there are no right or wrong answers; discussions will remain confidential; the views of all the participants are considered interesting; spontaneous interaction is very important.

"Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented by the mayoralty and the school from the commune of… with UNICEF support, on their response to the needs of children and mothers and on ways to implement the project in other counties. We would like to find out your views on the matter. But, first, let's get to know each other…."

Participants' introduction *(each participant will have to answer the questions; you will have to go around the table with each question)*
We will start with a brief introduction:
- First name, project position (social worker, school counsellor, community nurse, etc.), type of post (full-time, part-time)
- What is your background? Before the UNICEF-supported project, did you ever work on an identical or similar position?
- How did you end up working for this project?
- For how long have you been involved in the project supported by UNICEF?
- Do you live in the community where you work or do you have to commute?

Relationship with beneficiaries
1. How was the project supported by UNICEF received in the community (by local authorities/school/medical practice/beneficiaries)? In your opinion, has their attitude towards the project changed throughout implementation? How?
2. What are the main project implementation challenges you had/have to face in the community? How did/do you address them?
3. How much time do you spend in the field on a regular day? How many beneficiaries do you manage to visit on a regular day?

Participation
1. How do community advisory structures work in your community? (How often do they meet? What community stakeholders do they comprise? How do they get involved?)?

2. What is your relationship with the social worker/family doctor/school principal/mayor? How often do you interact with them? On what matters?

Relationship with the other community workers/coordinators/other institutions
1. How do you work with county coordinators *(each one will refer to their collaboration with their own coordinator)*? How often do you interact with them?
2. How do you work with the other community workers in your locality? How often do you consult with them? On what matters?
3. How do you work with the community workers from other localities in the county where the project is being implemented? How often do you consult with them? On what matters?
4. How does AURORA help you in your work? What would you improve about it?
5. Have you ever interacted directly with other county institutions (GDSACP, CSI, CREAC, DPH, the County Council)? If YES, please exemplify and specify the outcomes.

Effectiveness
1. What are the main project benefits for your community (children and their families, citizens, institutions, etc.)? How about for the school?
2. How do you think the project supported by UNICEF has influenced the work of local authorities?
3. What are the main project implementation problems in your community? Were there any project implementation delays? Why?
4. Did you participate in the project's training courses? How useful were they? If you were to suggest any improvements (e.g. related to content, duration, organisation, etc.), what would those be? What other courses would you need? What areas should improve in the project supported by UNICEF?

Relevance
1. Do you think that the project supported by UNICEF responded/responds to the needs of local children? What needs presented by local children remain uncovered?
2. Do you think that the project supported by UNICEF responded/responds to the needs of local mothers? What needs presented by local mothers remain uncovered?
3. What other activities do you think should be carried out to better respond to the needs of local children/mothers? Whose responsibility should that be?

Sustainability
1. Upon project conclusion, do you think it will be possible to continue to deliver the minimum package of integrated community-based services in your community? If YES, how? If NO, why not?
2. What factors enable the implementation of such a minimum package of integrated community-based services in your locality? How about that of the quality inclusive education package?
3. What factors hamper the implementation of such a minimum package of integrated community-based services in your locality? How about that of the quality inclusive education package?

Mayor/mayoralty secretary, social worker, doctor, school principal

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented by the mayoralty/school of… with UNICEF support and on their response to the needs of children and their families/schools. We would like to find out your views on the matter.

Awareness of the model
1. Are you familiar with the project supported by UNICEF in your community? What does it involve? What are its objectives? What are the expected outcomes for your community? What are the main project outcomes that have been reached so far in your community?
2. What are the main activities carried out in your community? How about in school? (Main services delivered, types of beneficiaries)
3. What employees are involved in the implementation of project activities in your community? How about in school? (Number, status – part-time employee, full-time employee, etc.) How do you find their number compared with the needs of the community? Do local people turn to community workers?
4. Are there any social/health/educational projects implemented in the community by other organisations? What do they involve? What is the difference between those and the project supported by UNICEF?

Participation
1. How was the community (mayoralty, school, family doctors, citizens, etc.) involved in project implementation? (e.g. involvement of the local community in school life; relationship with local authorities, with parents)
2. What were/are the main challenges related to the involvement of community stakeholders in the project?
3. How do you cooperate with the project team in your community? How about with county project coordinators? What does this cooperation involve?
4. What stakeholders are involved in the community advisory structure in your locality? How does this structure work – how often does it meet, what matters does it discuss, how are local stakeholders involved, are there any responsibilities clearly set, etc.?
5. Do you take part in any consultations held with the officers responsible for social/educational/medical matters at county institutions or the County Council? (Please detail: how often, what matters do you discuss, etc.?)
6. Are there any joint projects implemented with other schools from other localities/from the local community? (What type of projects?)
7. Does the mayoralty have a framework/plan in place for collaborating with the institutions competent in the areas of child protection/protection of pregnant women? What does it involve?

Effectiveness
1. What are the main project implementation problems in your community? What do you think causes those problems?

2. Have there been any project implementation delays? What caused them?
3. What areas should improve in the project supported by UNICEF to better respond to the needs of children/pregnant women/schools in your community?
4. Did you apply for the microgrants made under the project? What kind of problems did you address/wanted to solve with those microgrants? How useful were the microgrants for the local administration? How about for the school?
5. What are the main project benefits for the local administration/school?
6. What are the main benefits for your community (beneficiaries and their families, citizens, institutions, etc.)?

Relevance
1. To what extent does the minimum package of integrated community-based services developed under the project supported by UNICEF respond to the needs of local children/pregnant women?
2. What other needs of children/pregnant women are still not covered in your community?
3. Which of the project activities best respond to the needs of children/pregnant women from your community? What other activities do you think should be implemented to respond to the needs of local children/pregnant women?
4. To what extent does the quality inclusive education package implemented under the project supported by UNICEF respond to the needs of local children and schools? What other needs of children/schools are still not covered in your community?

Sustainability
1. What factors enable the implementation of such a minimum package of integrated community-based services in your locality? How about that of the quality inclusive education package?
2. What factors hamper the implementation of such a minimum package of integrated community-based services in your locality? How about that of the quality inclusive education package?
3. Upon project conclusion, do you think it will be possible to continue to deliver the integrated community-based services/quality inclusive education in your community? If YES, how? If NO, why not?
4. Have you identified any other funding sources for addressing the social, health or educational issues specific to your community?
5. What conditions do you think a rural/urban community from Romania should meet to implement such a project?

INTERVIEW GUIDE – COUNTY STAKEHOLDERS

GDSACP, DPH, CREAC, CSI, CC, NGO, LAG

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented with UNICEF support by local public authorities and the schools from 45

communities in Bacău County and on their response to the needs of community members and educational establishments. We would like to find out your views on the matter.

Awareness of the model
1. Are you familiar with the project supported by UNICEF in the communities of your county? What does it involve? What does the project aim at? What outcomes have been reached so far?
2. Does the project involve enough staff to cover the services that need to be delivered? How about to cover the number of beneficiaries in the communities?
3. Are there any social projects for children and their families/health/educational projects implemented in the county by other organisations? What do they involve? What is the difference between those and the project supported by UNICEF?

Participation
1. How has your institution engaged in project implementation? What have been the main challenges regarding the institution's project involvement?
2. How have county public institutions (GDSACP/CSI/CREAC/DPH) been involved in project implementation? What were/are the main challenges regarding the involvement of county public institutions in the project? (Please specify the county institutions involved)
3. Could you describe the added value created by the project involvement of these county institutions?
4. How do you cooperate with county project coordinators? What does this cooperation involve?
5. How do you cooperate with local authorities? What does this cooperation involve?
6. Is there a county framework/plan in place for ensuring the collaboration between the institutions competent in the areas of child protection/education? What does it involve?

Effectiveness
1. What were the main project implementation problems in your county? What do you think causes those problems?
2. What are the main project benefits for your county?
3. What areas should improve in the project supported by UNICEF to better respond to the needs of children in your county? / What would you change about the project supported by UNICEF?
4. Looking at the way social services are provided in your county, what would you say has changed with this project?
5. Looking at the way school counselling is provided in your county, what would you say has changed with this project?
6. Looking at the way community health nursing is provided in your county, what would you say has changed with this project?

Relevance
1. To what extent does the quality inclusive education package implemented under the project supported by UNICEF respond to the needs of schools in your county/children and families in your county?

2. To what extent does the minimum package of integrated community-based services developed under the project supported by UNICEF respond to the needs of children in your county?

3. To what extent does the minimum package of integrated community-based services developed under the project supported by UNICEF respond to the needs of at-risk pregnant women in your county?

Sustainability

1. What factors enable the implementation of such a minimum package of integrated community-based services in your county? How about that of the quality inclusive education package?

2. What factors hamper the implementation of such a minimum package of integrated community-based services in your county? How about that of the quality inclusive education package?

3. Which of the elements developed in the project supported by UNICEF have you already embedded in the day-to-day practice of your institution?

4. Upon project conclusion, do you think it will be possible to continue to deliver the integrated community-based services in your county? If YES, how? If NO, why not?

5. Upon project conclusion, do you think it will be possible to continue to deliver the quality inclusive education package in your community? If YES, how? If NO, why not?

6. How do you think funding could be obtained for the required human resources? Who should provide it?

7. Have you identified any other funding sources for addressing the basic social issues specific to your county? How about health issues? How about educational issues?

8. Do you think the minimum package of integrated community-based services could also be developed in other communities in the county? If YES, how? If NO, why not?

9. Do you think the quality inclusive education package could also be developed in other communities in the county? If YES, how? If NO, why not?

10. What conditions should a rural community from Romania meet to implement such a project? How about an urban one?

INTERVIEW GUIDE – NATIONAL STAKEHOLDERS

NAPCRA, MNESR, MLFSPE, MRDPA, MoH, IMCC, WB, the media, Prime Minister's Office, NIS, NGOs

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented with UNICEF support by local public authorities and the schools from 45 communities in Bacău County and on their response to the needs of community members and educational establishments. We would like to find out your views on the matter.

Awareness of the model

1. Are you familiar with the 'Social Inclusion through the Provision of Integrated Services at Community Level' project implemented with UNICEF support in the county of Bacău? What does the project aim at? What project outcomes do you know? (How did you find out about those project outcomes?)

2. What are the innovative elements brought by the project supported by UNICEF compared with other similar initiatives for children?

3. What is the novelty of the minimum package of integrated community-based services/quality inclusive education developed under the project supported by UNICEF compared with the approach proposed by EU-funded projects? How about compared with the one proposed by relevant strategies (National Strategy on Social Inclusion and Poverty Reduction, National Strategy for the Protection and Promotion of Children's Rights, Strategy for Reducing Early School Leaving)?

Effectiveness

1. If we were to look at the objectives of the relevant national policies, to what extent does the UNICEF-supported project contribute to their achievement?

Sustainability

1. What factors enable the implementation of such a minimum package of integrated community-based services? How about that of the quality inclusive education package?

2. What factors hamper the implementation of such a minimum package of integrated community-based services? How about that of the quality inclusive education package?

3. Do you think the minimum package of integrated community-based services could be scaled up to national level? If YES, how? If NO, why not?

4. What kind of measures (legislative measures, institutional construction changes, etc.) would be necessary in order to mainstream the minimum package of integrated community-based services at national level?

5. Do you think the quality inclusive education package could be scaled up to national level? If YES, how? If NO, why not?

6. What kind of measures (legislative measures, institutional construction changes, etc.) would be necessary at national level in order to mainstream the quality inclusive education package?

7. Which of the elements developed in the project supported by UNICEF could be embedded in the day-to-day practice of public institutions?

8. Are you familiar with the AURORA application used in the UNICEF-supported project? If YES, how useful do you think it is for identifying the needs and centralising the interventions addressed to beneficiaries? To what extent could AURORA be taken over by relevant public institutions?

9. How do you think funding could be obtained for the required human resources? Who should provide it?

INTERVIEW GUIDE – REPRESENTATIVES OF PARTNER ORGANISATIONS

HOLTIS, 'Împreună' Agency, IES, STEP by STEP, RAQAPUE, CHPS

Hello,
I am……….. and I represent the RIQL, which is conducting a study on the activities carried out under the project implemented with UNICEF support by local public authorities and the schools from 45

communities in Bacău County and on their response to the needs of community members and educational establishments. We would like to find out your views on the matter.

Awareness of the model
1. What are the innovative elements developed in the project supported by UNICEF?

Participation
1. How was your organisation involved in the implementation of the project supported by UNICEF – on which component; what were the main activities in which you were involved? For how long?
2. Are there any activities that you would carry out differently? How do you think your products/services could be improved?
3. How did the community (community members, the school, the local administration, the family doctor) get involved in the activities carried out by your organisation in the project supported by UNICEF?
4. At present, are you implementing any projects in the county of Bacău that are complementary to the one supported by UNICEF? If YES, is it in the same communities as those of the project supported by UNICEF? What kind of projects?

Effectiveness
1. What were the main problems you/your organisation encountered in the implementation of project activities in schools/communities? What do you think caused those problems?
2. What are the benefits for your organisation following the involvement in the project supported by UNICEF?
3. What are the main project benefits for the local administration/school/social assistance services/medical services? How about for the community?

Relevance
1. To what extent does the minimum package of integrated community-based services developed under the project supported by UNICEF respond to the needs of children and their families?
2. To what extent does the quality inclusive education package developed under the project supported by UNICEF respond to the needs of schools?
3. What areas should improve in the project supported by UNICEF to better respond to the needs of children/schools?

Sustainability
1. What factors enable the implementation of such a minimum package of integrated community-based services? How about that of the quality inclusive education package?
2. What factors hamper the implementation of such a minimum package of integrated community-based services? How about that of the quality inclusive education package?
3. Which of the elements developed in the project supported by UNICEF could be embedded in the day-to-day practice of public institutions/your organisations? To what extent could AURORA be taken over by public institutions (applicable only to the CHPS)?
4. How do you think funding could be obtained for the required human resources? Who should provide it?

5. Do you think the minimum package of integrated community-based services could also be developed in other communities? If YES, how? If NO, why not?
6. Do you think the quality inclusive education package could also be developed in other communities? If YES, how? If NO, why not?

ROMANIAN ACADEMY

'COSTIN C. KIRIŢESCU' NATIONAL INSTITUTE FOR ECONOMIC RESEARCH

RESEARCH INSTITUTE FOR QUALITY OF LIFE

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> INCOMING/OUTGOING 12/10-JAN-2017

Approval

Compliance of the Mid-Term Review of the 'Social Inclusion through the Provision of Integrated Community Services at Community Level' model with ethical research standards

Between September 1st, 2016 and March 30th, 2017, the Research Institute for Quality of Life under the Romanian Academy is conducting an evaluation research to examine the activities implemented in the '**Social Inclusion through the Provision of Integrated Services at Community Level**' project carried out with UNICEF support in 45 communities of Bacău County. Claudia Petrescu, scientific researcher, is in charge of scientific research coordination.

General objective: document the implementation status of the 'Social Inclusion through the Provision of Integrated Services at Community Level' model. The main objectives of the review are as follows:

- Determine the progress made towards model implementation and outputs;
- Analyse model adequacy for the needs identified in the communities;
- Check model complementarity with other initiatives under national public policies on child protection, health and inclusive education/delivery of integrated community-based services.
- Identify model activities/elements with the highest potential for national replication.

Procedures and tools:
The research methodology proposed includes a combination of methods and tools, as follows:

    I.   **Quantitative component**

- Online survey among community workers (social worker, community nurse, school counsellor, school mediator, and health mediator) – target group: 170 community workers involved in the delivery of integrated services at local level (16 county coordinators, 58 social workers, 33 community nurses, 32 school counsellors, 26 school mediators, and five health mediators);

- Online survey among teachers, parent educators and other school and kindergarten staff members who received project support – target group: 595 people who benefited from the activities carried out under the Quality Inclusive Education Package.

II. **Qualitative component:**
- Focus groups with county project coordinators (Minimum Package of Services – social assistance coordinator, education coordinator, health coordinator; Quality Inclusive Education - education coordinator) – two focus groups (1 – local QIE coordinators, 1 – local MPS coordinators). All county QIE coordinators will participate in the focus group – seven persons in total. In the case of MPS, participants will be selected from those 16 coordinators, as follows: four of the eight social assistance coordinators, two of the four education coordinators, and two of the four health coordinators. A sampling interval of two will be applied to the lists provided by UNICEF for each MPS component.
- Focus groups with service beneficiaries (focus groups with adolescents, focus groups with adolescents' parents) – six focus groups with adolescents (two FGs in rural communities and one FG in an urban community) and with parents (two FGs in rural communities and one FG in an urban community) will be conducted. For each focus group, participants will be randomly selected from the lists of community members having benefited from project support. For focus groups with adolescents, only those aged over 14 years will be selected from the lists of beneficiaries provided by UNICEF. For both types of beneficiaries, a master sample and a reserve sample will be selected in each community, using a sampling interval. The sampling interval will be set by dividing the total number of people (adolescents or parents) on the list by the maximum number of focus group participants (8) and all results with decimal places will be rounded down.
- Focus groups with community workers – three focus groups. Community workers selected for the focus group will come from two urban communities and four rural communities (two poor ones and two developed ones).
- Interviews with local stakeholders (mayor, school principal, mayoralty's social workers, doctor) – four interviews will be conducted in five communities where the project is being implemented.
- Interviews with county stakeholders – six or seven interviews will be conducted with relevant county stakeholders (GDSACP, DPH, CSI, CREAC, CC, NGOs).
- Interviews with representatives of partner organisations (having implemented project activities) – six interviews will be conducted.
- Interviews with national stakeholders – ten interviews will be conducted with representatives of public institutions, non-governmental organisations and international organisations active in the field.

III. **Secondary analysis:**
➢ Secondary analysis of UNICEF documents:
- Local coordinators' reports;
- Project progress reports;
- Microgrant reports.
➢ Public policy analysis.

We hereby certify that, following the evaluation, the Ethics Committee of the Research Institute for Quality of Life has found that the research project methodology complies with ethical research standards.

Project methodology includes clear provisions that guarantee the following:

- Respondents' voluntary participation;
- Respondents' informed consent;
- Informed consent from the parents of adolescents included in the research;
- Possibility for respondents to withdraw from the interview at any time, without any pressure or penalty from the project team or anyone else;
- Anonymity of collected data;
- Confidentiality of discussions.

The Parent/Legal Representative Information Form and the research tools used are included in the Annex.

Bucharest 9 January 2017	Sorin Cace, PhD – Scientific Researcher I President *Undecipherable signature* Ethics Committee Research Institute for Quality of Life	Prof. Cătălin Zamfir, PhD Corresponding Member of the Romanian Academy *Undecipherable signature* *Research Institute for Quality of Life stamp* Director Research Institute for Quality of Life

ANNEX 7. MTR TEAM

Founded in 1990, as part of 'Costin C. Kirițescu' National Institute for Economic Research under the aegis of the Romanian Academy, the Research Institute for Quality of Life (RIQL) is one of the most prominent social research institutions in the country. The RIQL has vast experience in social data collection, analysis, and interpretation. With its team of highly qualified researchers, the Institute conducts fundamental research on a wide range of topics, such as: quality of life and social indicators; education; health; social policies and social inclusion; employment; social development; social economy and social entrepreneurship; social capital; etc. As a reference institution in the national research and socioeconomic environment, the RIQL has specifically focused on the social issues affecting the Romanian population, in particular those faced by vulnerable groups like children, young people, senior citizens, or ethnic minorities. RIQL research findings were published in over 220 volumes and 1,000 studies were featured in domestic and international journals as well as in more than 300 reports, including analyses for the public at large. In its over 25 years of operation, the RIQL has implemented numerous research projects, accessing national or international funding (for instance, the European Social Fund, EU framework programmes – FP6, national funding schemes managed by the UEFISCDI) and worked with many research institutions from the country and abroad.

SERVICE OFFER

The RIQL provides specialised consulting and contributes to institutional development and legislative design in the social sector as well as to the evaluation of public policy measures at both national and European levels. The vast experience of RIQL researchers is also confirmed by the significant number of partnerships concluded with public institutions, including the Presidency, the Romanian Government, central and local public administration agencies, research institutes and universities from Romania and abroad, and international organisations like the World Bank, UNICEF, UNDP, or IOM. The RIQL carries out studies at local, regional and national levels for public and private organisations, on a variety of topics:

- Quality of life
- Poverty and social inclusion
- Education
- Social assistance
- Health
- Social stratification
- Vulnerable groups (children, young people, senior citizens, the Roma, etc.)
- Migration
- Social economy
- Values
- Social capital
- Labour, employment, unemployment
- Social programme and policy evaluation

RESEARCH METHODS

The RIQL portfolio includes studies employing the following research methods:
- Face-to-face and online surveys;
- In-depth face-to-face interviews;
- Face-to-face focus groups;
- Case studies;
- Content analysis;
- Secondary data analysis.

The RIQL is highly experienced in using mixed research methods and working with various tools simultaneously. Some of RIQL's recent projects confirming this are presented below:

- Project name: *A Comparative Perspective on Precarious Prosperity and Household Strategies in Romania and Switzerland in Times of Economic Strain*.
    o Funding: Swiss National Science Foundation & Executive Unit for Financing Higher Education, Research, Development and Innovation (UEFISCDI). Partners: University of Neuchatel, Switzerland; January 2013-June 2016.
    o Qualitative component: 100 in-depth interviews with members of households in precarious prosperity, conducted in two waves (2013 and 2015; longitudinal approach);
    o Quantitative component: monitoring changes in subjective and objective indicators on the quality of life in Romania and Switzerland to determine the social group situated between poverty and prosperity and to assess the way in which that group experienced the recent economic crisis.

- Project name: *Inclusive-Active-Efficient*
    o UEFISCDI funding; Partners: HOLT Romania, Catalactica Association, 'Împreună' Community Development Agency; July 2012-June 2016.
    o Quantitative component: surveys on samples comprising 1,227 subjects (adult population) at national level and 280 representatives of social economy organisations from the North-East, South-East and Bucharest-Ilfov development regions;
    o Qualitative component: 30 interviews with representatives of social economy organisations, 20 interviews with social economy experts, six focus groups.

- Project name: *Prometheus – Promoting Social Economy in Romania through Research, Education and Training at European Standards.*
    o Funding: ESF, SOP HRD 2007-2013. Beneficiary: Civil Society Development Foundation. Partners: University of Bucharest – School of Sociology and Social Work, EURICSE Italy, National Centre for Statistical Training; September 2010-September 2013.
    o Quantitative component: survey conducted among 2,994 social economy entities (1,132 consumer, worker and credit cooperatives; 794 agricultural associations; 556 commons; 512 employees' and pensioners' mutual aid associations), secondary data analysis of REGIS (database of the National Institute of Statistics containing tax-related information) for 29,226 social economy entities in 2010.
    o Qualitative component: 12 case studies on social economy entities, eight focus groups with representatives of social economy entities, 30 in-depth interviews.

Other relevant projects implemented by the RIQL in the past five years:

- Project name: *Social Change under the Impact of International Migration: Value Patterns, Civic and Political Participation, Life Satisfaction*. 2011-2015. Methods: secondary data analysis using large-scale comparative data sets (European Values Survey, World Values Survey).
- Project name: *Quality of Life and Social Inequalities in Romania under a European Comparative Perspective: Twenty Years of Social Transformation*. Funding: UEFISCDI, October 2011-October 2014. Quantitative component: longitudinal analysis of key quality-of-life areas – Quality-of-Life Diagnosis (1990-2010), EQLS, the Eurobarometer series.
- Project name: *Support for Roma and Turkish Students in Constanța County*. Beneficiary: 'Spiru Haret' School from Medgidia. Partners: 'Spiru Haret' School from Medgidia, Medgidia Local Council. September 2010-June 2011. Qualitative component: focus group with parents and focus group with teachers in each of the eight schools included in the study.
- Project name: *Sociologist on the Labour Market*. Beneficiary: University of Bucharest – School of Sociology and Social Work, June-September 2010. Quantitative component: sociology graduate tracer study – online survey among 2,343 graduates from the period 1992-2008 (656 valid questionnaires).

An important component of RIQL work is the design and evaluation of social programmes and policies. The RIQL contributed to the development of different anti-poverty programmes and strategies adopted by both the Presidential Administration and the Government. Some of the RIQL evaluations are listed below:

- Impact assessment for the programmes delivered by REF and its partners based on a panel survey conducted on three samples: an experimental group (composed of children benefiting from the programmes and their families) and two control groups – under the project *On Your Marks, Get Set, Go! – Improving Early Childhood Development Outcomes for Roma Children.*
- Evaluation of public policies on vocational and technical education in Romania. Beneficiary: Graffiti BBDO for OMV Petrom; May-December 2016.
- Advocacy capacity assessment for 'Omenia' National Federation of Pensioners' Mutual Aid Associations in Romania, under the project called *Old Age – A Public Agenda Priority,* which also included the participatory strategic planning of the Federation's advocacy strategy; March 2015-April 2016.
- Evaluation of the implementation of the National Strategy for the Roma 2011-2013. Beneficiary: National Agency for the Roma; 2014.
- Evaluation of the capacity of the National Agency for the Roma to coordinate its own activities as well as to manage European funds. Beneficiary: Ministry of Labour, Family, Social Protection and the Elderly; 2013-2014.
- Ex-post evaluation of the ESF support provided in the period 2000 to 2006 under the Open Method of Coordination in the area of social protection and social inclusion, analysis of ESF projects across the EU. Beneficiary: European Commission – Directorate for Employment, Social Affairs and Equal Opportunities; 2009.

The RIQL works with a dynamic team of sociologists, graduates of the University of Bucharest – School of Sociology and Social Work, as well as with external consultants holding a vast experience in social projects. Also, the team members completed master's programmes, PhD programmes and other courses in the fields of social sciences and health, in the country and abroad. The team members are experienced in working with quantitative and qualitative research methods, in designing and implementing social research and evaluations while they also have solid knowledge of social protection, education and health systems and reforms.

Claudia Petrescu is a scientific researcher grade II with the RIQL and a graduate of the University of Bucharest – School of Sociology and Social Work, holding a PhD in sociology from the same school (2010), with a thesis on Public Participation and Local Development. Claudia Petrescu has more than 12 years' experience in research project implementation in areas like education, community development, social services, social economy, and quality of life. Her area of expertise includes public policy analysis, project and programme evaluation, research design, quantitative and qualitative research methods, research report preparation, and research project coordination. She has worked as a research expert in numerous programmes run by Romanian NGOs (FDSC, World Vision, FPDL, OSF) and international organisations (UNDP, UNICEF). Claudia Petrescu has designed and conducted many educational and community development programme evaluations, such as:

- Evaluation of public policies on vocational and technical education in Romania. Beneficiary: Graffiti BBDO for OMV Petrom; May-December 2016.
- Advocacy capacity assessment for 'Omenia' National Federation of Pensioners' Mutual Aid Associations in Romania, under the project called *Old Age – A Public Agenda Priority,* which also included the participatory strategic planning of the Federation's advocacy strategy; March 2015-April 2016.
- Evaluation of the 'Croissant and Milk' programme implementation and an opportunity analysis for the 'School after School' programme. Beneficiary: World Vision Romania, June-September 2010.
- Ex-post evaluation of the ESF support provided in the period 2000 to 2006 under the Open Method of Coordination in the area of social protection and social inclusion, analysis of ESF projects across the EU. Beneficiary: European Commission – Directorate for Employment, Social Affairs and Equal Opportunities; 2009.
- 'Children of Romania' – impact assessment. Beneficiary: World Vision Romania, September-November 2009.
- 'Children First' – mid-term review and project redesign. Beneficiary: World Vision Romania; May-June 2008 and February-April 2009.
- Constanța Area Development Programme – initial assessment. Beneficiary: World Vision Romania; October-November 2008.
- Roma Community Development Programme (evaluation conducted in the community of Bălțești). Beneficiary: Open Society Foundation; January-March 2008.

Vlad Achimescu is a University of Bucharest graduate (2010), with a Master's degree in social research methods, and a KU Leuven graduate (2016), with a Master's degree in statistics and a thesis on the multilevel analysis of social exclusion. As a quantitative researcher, Vlad Achimescu has

worked with a number of public and private research institutions from Romania and has coordinated numerous face-to-face, phone or online surveys, focusing mostly on sampling, data processing and data analysis. He has been involved in studies covering a diverse range of topics, from education and the labour-market integration of young people to social exclusion and political culture. Since August 2016, Vlad Achimescu has been working as a teaching and research assistant at the University of Mannheim, in the Statistics and Methodology Department.

Eugen Glăvan received a PhD in sociology in 2012 from the University of Bucharest – School of Sociology and Social Work, with a doctoral thesis called 'The Image of Rural Space in Romanian Society'. He currently works as a scientific researcher grade III at the Research Institute for Quality of Life, Romanian Academy, with an interest in visual sociology and rural studies. He has been involved in research projects on the public understanding of science (2008-2010), social stratification (2008-2011) or social economy (2013-2014). His more recent interests concern traditional economic activities, such as beekeeping (2015), and social media (2017).

Gabriela Neagu, RIQL researcher grade II, holds a PhD in sociology (obtained in 2011, with the thesis 'Opportunities for Accessing Education in Today's Romanian Society'). Her main areas of interest are sociology of education, social mobility, social structure, transition from school to the labour market, social and professional integration. These interests were analysed in various articles (Journal of Innovation in Psychology, Education and Didactics, Vol. 19, 2/2015; Gabriela Neagu, *Transition from school to the labour market – an analysis on the basis of qualitative data;* Romanian Journal for Multidimensional Education, Volume 7 1/ 2015, Gabriela Neagu, *Public policies of professional integration of young people in the EU and in Romania;* Mediterranean Journal of Social Sciences, Vol. 5, 22/2014;) or volumes (Gabriela Neagu, 2 *Şanse de acces la educaţie în societatea românească actuală [Opportunities for Accessing Education in Today's Romanian Society]*, 2012, Editura Lumen, Iaşi; Cace, S. (coord), Gabriela Neagu, C.Raţ, A.Ivasiuc (authors), *Politici de incluziune a romilor din statele membre ale UE [Roma Inclusion Policies in EU Member States],* Editura Institutul European din România, 2014, Bucureşti; M.Larionescu, I.Mărginean, Gabriela Neagu, *Constituirea clasei mijlocii în România [Middle Class Establishment in Romania]*, Editura Economică, 2007, Bucureşti). Throughout her research work, she has also participated as a research team coordinator or member in different research projects implemented with national or international funding (*Study on the measures included in the Government's Strategy for Improving the Condition of the Roma,* 2012, project funded by the Policy Centre for Roma and Minorities, Bucharest; *Support for Roma and Turkish Students in Constanţa County,* RIQL, contract funded under SOP HRD, 2010-2012; *Polarised population access to educational and health services, a source of poverty in the future,* RIQL, contract funded by MER under the VIASAN programme (Life and Health), 2003-2005).

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Gabriel Stănilă is a sociologist, with a PhD from the University of Bucharest – School of Sociology and Social Work. He has tremendous experience in research project implementation in areas like education, local and regional development, social inclusion, social economy, and quality of life among the elderly. He has over eight years' experience in sociological research, having contributed to research methodology design, data collection and data analysis. Over the past few years, his projects have included an analysis of rural non-farm employment (2011), a study on the role of 'school after school' programmes in rural children's education (2011), case studies on social economy entities (2011, 2013) and vocational and technical education in Romania (2016).

Cristina Vladu is a public health expert with considerable experience in public policy development at local, national and international levels (more than 15 years) and in social development/poverty alleviation (more than five years). Dr. Vladu is highly experienced in project and programme design, implementation, monitoring and evaluation, having managed or conducted programme evaluations for a number of organisations, such as the European Patients' Forum, the World Bank Institute, the World Bank, the World Health Organisation, or the Romanian Social Development Fund. Moreover, as a senior official with the Ministry of Health, Dr. Vladu has contributed to the rapid assessment and redesign of national health programmes. Dr. Vladu has extensive knowledge of the logical framework approach – she has worked as a trainer and has applied this concept in most of her professional endeavours.

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