Evaluation of the UNICEF Project – Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe (RMChild-Health Project)

Final Evaluation Report

Prepared for // UNICEF-ECARO

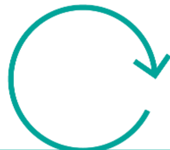
By // Rima Al-Azar, Team Leader
Ima Bishop, Senior Evaluator
Sonia Pérez, Senior Evaluator
Emma Buchy-Dury, Research Assistant

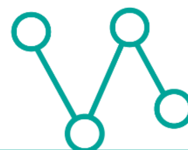
Date // May 2022

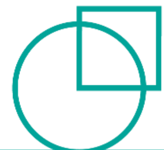
IOD PARC is the trading name of
International Organisation Development Ltd

Omega Court
362 Cemetery Road
Sheffield
S11 8FT
United Kingdom

Tel: +44 (0) 114 267 3620
www.iodparc.com







Acknowledgments

This report was prepared by an IOD PARC team of three evaluation consultants, plus supporting research assistance. The team was led by Rima Al-Azar, alongside Ima Bishop, Sonia Pérez, and Emma Buchy-Dury. Nick York provided independent expert advice and quality assurance.

We would like to acknowledge the many stakeholders, including UNICEF staff, EU officials, implementing partners, Government officials and others who kindly agreed to participate in this evaluation and provide valued insights and contributions.

The report has benefited from helpful advice, guidance, and support from the Evaluation Manager, Ashley Wax, and others at UNICEF ECARO including Sandra Gorini and Basil Rodriques.

Sincere thanks and appreciation is also given to staff within each of the Country Offices from the five participating countries of this evaluation particularly: Danijela Alijagic, Aldina Bukva-Mahmutovic and Fatima Cengic in Bosnia and Herzegovina; Diana Yovcheva and Elena Atanassova in Bulgaria; Myrsini Kazakou and Ioannis Papachristodoulou in Greece; Maria Margherita Maglietti, Anna Riatti, and Ivan Mei in Italy, and Milena Timotijevic, Ana Prodanovic, and Yosi Echeverry Burckhardt in UNICEF Serbia. We are grateful for their time and assistance connecting us to partners, providing documents for the inception and main data collection phases, and responding to requests from the evaluation team. We also wish to acknowledge all the interpreters who assisted with interpretation and translation throughout the process.

This is a publication by the independent evaluation team of IOD PARC. The analysis and recommendations of this report do not necessarily reflect the views of UNICEF.

Contents

Acknowledgments 1
Acronyms and Abbreviations 5
Executive Summary i
Objective, Intended Users, and Scope i
Context i
Methodology ii
Key Findings ii
Relevance ii
Coherence ii
Effectiveness iii
Efficiency iv
Sustainability iv
Conclusions iv
Lessons Learnt vi
Recommendations vii
1.Context and Object 1
1.1 Background 1
1.2 Refugee and Migrant Health 2
1.2.1 Immunisation Rates and COVID-19 3
1.2.2 Gender, GBV, and Protection 4
1.3 Project Description 6
1.3.1 RMChild-Health Project 6
1.3.2 Project Objectives 7
1.3.3 Project Target Groups 7
1.3.4 Implementing Partners (IP) 8
1.3.5 Project's (implicit) Theory of Change (ToC) 8
1.3.6 Project Budget and Expenditures 9
2.Evaluation Purpose, Objectives, and Scope 10
2.1 Purpose and Objectives 10
2.2 Object and Scope 10
2.3 Intended Users 11
3.Evaluation Framework 12
3.1 Evaluation Questions 12
4.Approach and Methodology 13
4.1 Approach 13
4.1.1 Theory-Based Contribution Analysis 13
4.1.2 Gender and Human Rights-Sensitivity 13

iod parc

4.1.3 Quality Assurance 13
4.2 Methodology 14
4.2.1 Theory of Change Construction 14
4.2.2 Development of Evaluation Matrix 14
4.2.3 Mixed Methods 14
4.3 Ethical Approach 15
4.4 Methodological Limitations and Mitigation Measures 16
5.Evaluation Phases and Timeline 17
5.1 Evaluation Team Roles and Responsibilities 17
6. Evaluation Findings 19
6.1 Relevance 19
6.1.1 Alignment with UNICEF Country Strategies 19
6.1.2 Alignment with Global/Regional Policies 19
6.1.3 Alignment with SDGs 20
6.1.4 Responds to Needs and Priorities of Rights Holders 22
6.1.5 Difficulties/Obstacles in Reaching Target Population 24
6.1.6 Adaptation to Changing Contexts and Needs 25
6.2 Coherence 27
6.2.1 UNICEF's Added Value 28
6.2.2 Internal Coherence 28
6.2.3 External Coherence 29
6.2.4 Coordination 30
6.3 Effectiveness 32
6.3.1 Achievement of Results 33
6.3.2 Monitoring, Reporting, and M&E Framework 38
6.3.3 Enabling Factors 39
6.3.4 Constraining Factors 43
6.3.5 Unintended Results 47
6.3.6 Gender and Social Inclusion 49
6.4 Efficiency 52
6.4.1 Financial Resources 52
6.4.2 Human Resources 55
6.4.3 Timeliness 56
6.5 Sustainability and Resilience 57
6.5.1 Sustainability 58
6.5.2 Resilience 62
7.Reflections on the ToC 63
8.Conclusions 64
9.Lessons Learnt 66
10.Recommendations 67

iodparc

List of Tables

Table 1: Measles 1st Immunization Rates per Country in 2019 and 2020 3
Table 2: Measles 2nd Immunisation Rates per Country in 2019 and 2020 3
Table 3: DTP3 Immunisation Rate per Country in 2019 and 2020 4
Table 4: Implementing Partners Per Country 8
Table 5: Detailed Expenditures against EU Contribution (as of 31 August 2021 in US Dollars) 9
Table 6: Summary of Expenditures against EU Contribution by Recipient Office (as of 31 August 2021 in US Dollars) 9
Table 7: Evaluation Questions 12
Table 8: Number and Type of Stakeholder who Participated in KIIs, Sex-Disaggregated 15
Table 9: Challenges Faced and Mitigation Measures Undertaken 16
Table 10: Ratification of the 1951 Convention relating to the Status of Refugees and the 1967 Protocol 20
Table 11: Alignment with Select SDGs and Targets 21
Table 12: Budget Allocation/Expenditure per Line Item 53
Table 13: Initial Resource Allocation per Country 54
Table 14: Additional Assumptions which are Needed to Fulfil the ToC 64

List of Figures

Figure 1: Unaccompanied and Separated Children in Europe in 2020 by Sex 6
Figure 2: Unaccompanied and Separated Children in Europe in 2019 by Sex 6
Figure 3: Map of In-Scope Countries in Southern and South-East Europe 11
Figure 4: Evaluation Team 18

Acronyms and Abbreviations

ADRA	Adventist Development & Relief Agency
AMIF	Asylum, Migration, and Integration Fund
BiH	Bosnia and Herzegovina
BPRM	Bureau of Population, Refugees, and Migration
CBCPM	Community-based child protection mechanism
CCC	Core Commitments for Children (UNICEF)
CFSH	Child and Family Support Hubs (Greece)
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
CO	Country Office
CPD	Country Programme Document
CRC	Convention on the Rights of the Child
CRWB	Council of Refugee Women in Bulgaria
CSO	Civil Society Organisation
DEAPS	Association for Child and Adolescent Psychiatry and Allied Professions of Serbia
DG	Directorate General (EU)
DRC	Danish Refugee Council
DTP3	Diphtheria-Tetanus-Pertussis
EASO	European Asylum Support Office
ECARO	Europe and Central Asia Regional Office (UNICEF)
ECD	Early Child Development
EODY	National Public Health Organisation (Greece)
EQ	Evaluation Question
ERG	Evaluation Reference Group
EU	European Union
FGD	Focus Group Discussion
GBV	Gender-Based Violence
GBViE	Gender-Based Violence in Emergencies
GCM	Global Compact for Safe, Orderly and Regular Migration
GCO	Greece Country Office
GP	General Practitioner
HAC	Humanitarian Action for Children
HaDEA	European Health and Digital Executive Agency
HIS	Human Interest Story
HRBA	Human Rights-Based Approach
INMP	Istituto Nazionale per la promozione della salute delle popolazioni Migranti (Italy)
IOM	International Organisation for Migration
IP	Implementing Partner
IPHS	Institute of Public Health of Serbia
IRC	International Rescue Committee
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MBC	Mother and Baby Corner
MBU	Mother and Baby Unit
MCH	Maternal and Child Health
MdM	Medici del Mondo
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education (Serbia)
MoH	Ministry of Health (Italy and Serbia)

MoI	Ministry of Interior (Italy)
MoL	Ministry of Health, Labour and Social Policy (Bosnia and Herzegovina)
MoLEVSA	Ministry of Labour, Employment, Veterans and Social Affairs (Serbia)
MoLSA	Ministry of Labour and Social Affairs (Greece)
MoMA	Ministry of Migration and Asylum (Greece)
MWF	Mission Wings Foundation (Bulgaria)
N/A	Not applicable
NCF	Nadja Centre Foundation (Italy)
NGO	Non-Governmental Organisation
NIHMP	National Institute for Health, Migration and Poverty
OAS	Open Accommodation Site
OECD DAC	Organisation for Economic Cooperation and Development - Development Assistance Committee
OHCHR	Office of the High Commissioner for Human Rights
PAAYPA	Temporary Aliens Provisional Insurance and Health Care Number
PFA	Psychological First Aid
PHC	Primary Healthcare
PPE	Personal protective equipment
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
Q&A	Questions and Answers
R/M	Refugee and Migrant
RIC	Reception and Identification Centre (Greece)
RIS	Reception and Identification Service
SADD	Sex-Age-Disaggregated Data
SAR	State Agency for Refugees with the Council of Ministers of Bulgaria
SCRM	Commissariat for Refugees and Migration of the Republic of Serbia
SDG	Sustainable Development Goal
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SSUAM	Special Secretary for Unaccompanied Minors (Greece)
ToC	Theory of Change
TRC	Temporary Reception Centre
UASC	Unaccompanied and Separated Children
UASG	Unaccompanied and Separated Girls
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WVI	World Vision International

Executive Summary

Objective, Intended Users, and Scope

The evaluation of the DG Health-funded Project 'Strengthening refugee and migrant children's health status in Southern and South-Eastern Europe (RMChild-Health Project) was commissioned by UNICEF's Europe and Central Asia Regional office (ECARO) for the dual purpose of accountability and learning. The evaluation covers the five countries participating in the RMChild-Health Project: Bosnia and Herzegovina, Bulgaria, Greece, Italy, and Serbia. It covers all Project activities planned and implemented between the period of January 2020 to December 2021, assessing the Project against the OECD DAC criteria of Relevance, Effectiveness, Efficiency, Coherence and Sustainability at the country and regional level.

The primary audience of this evaluation are UNICEF staff in the Europe and Central Asia Regional Office and UNICEF staff in each of the five countries covered by the RMChild-Health Project. As the funding partner, the DG Health is also a key user of the evaluation.

Context

Since 2014, over 1.5 million children have sought international protection in Europe, fleeing conflict, insecurity, and lack of opportunities in Syria, Afghanistan, Iraq, and in countries in Sub-Saharan Africa.[1] The five countries included in this evaluation (Bosnia and Herzegovina, Bulgaria, Greece, Italy, and Serbia) experienced a significant influx of refugees and asylum seekers. As of mid-2019, there were approximately 42,000 refugee and migrant (R/M) children in reception facilities throughout the Project countries.[2]

R/M children face numerous barriers to accessing basic health care in their host communities. 'Unfamiliarity with rights, entitlements and the overall health system; gaps in health literacy; social exclusion; and direct and indirect discrimination' are the primary barriers refugee and migrant children face when attempting to access basic health care.[3] Access can be a particular issue for children living with disabilities. R/M children are likely to experience severe health stressors during the pre-migratory, migratory, and post-migratory periods. R/M women are at higher risks of poorer pregnancy outcomes compared with women from host communities and issues around maternal and child health prevail. Mothers may be unable to breastfeed due to stress, lack of support and privacy, resulting in suboptimal child nutrition outcomes.

The RMChild-Health Project seeks to strengthen the health status of refugee and migrant children in the five countries by targeting four specific areas: (i) primary health care including immunization; (ii) mental health and psychosocial support; (iii) Gender Based Violence (GBV); and (iv) maternal and child health, including infant and young child feeding (nutrition). The Project's overarching objectives were to: (i) Strengthen national authorities' capacity to provide healthcare to refugee and migrant children; (ii) Increase health literacy among refugee and migrant children and their parents; and (iii)Strengthen implementation of national health policies.

[1] These groups of people are considered the target population of the Project and are further referred to in this document as the refugee and migrant population

[2] UNICEF (2020). Project document for 'Strengthening Refugee and Migrant Children's Health Status in Southern and Southeastern Europe', p.3

[3] WHO (2018). Health of Refugee and Migration Children: Technical Guidance, p. 12

Methodology

The evaluation used a theory-based and mixed methods approach. Five country level theories of change and a regional level theory of change were developed to produce an analytical framework. Throughout, the evaluation integrated a gender sensitive and human rights-based approach. The evaluation was conducted remotely due to the COVID-19 pandemic. The team conducted an in-depth document review and content analysis and conducted 98 key informant interviews with stakeholders at the regional and national level including the EU, UNICEF regional and country office staff, representatives from host authorities, and UNICEF implementing partners. No primary data from rights-holders were collected.

Key Findings

Relevance

The evaluation found the Project to be highly relevant at both the national and global level. Per existing Country Programme Documents, the project is aligned with their outcomes on health and protection.[4] At the global level, the Project is aligned with several global and regional strategies and policies that address migration, health, and children's rights, including UN conventions and UNICEF, UNHCR, WHO and EU policies and guidance and SDGs 2, 3, 5, 16 and 17. The Project included several consultative processes to ensure continued relevance as well as to design new activities or to fine-tune existing UNICEF activities to better respond to refugee and migrant's needs.

The Project faced some challenges in effectively reaching the refugee and migrant population. The key reasons for this were (i) the Project – in Serbia, Bulgaria and Bosnia and Herzegovina – delivered services to refugees and migrants in camps or centres and found it challenging to reach the R/M population beyond these locations. Italy is the exception, while in Greece the Project only aimed to reach populations in camp Reception and Identification Centres); (ii) specific government rules which created obstacles (e.g., registration of refugees and migrants with general practitioners (GPs) in Bulgaria); and (iii) lockdowns due to the COVID-19 pandemic. However, the Project demonstrated a high-level of agility in responding to the COVID-19 pandemic by (i) changing its modalities of delivery; (ii) adapting the type of services offered to address new needs; (iii) modifying training content; (iv) greater targeting of vulnerable groups; and (v) dealing with logistical challenges.

Coherence

Stakeholders recognised UNICEF's credibility, neutrality, technical expertise, convening power, agility, and ability to work in a multi-sectoral manner as its main added value. This was demonstrated both as a partner and implementer in High Income Countries (Greece and Italy) and Upper-Middle Income Countries (Bosnia and Herzegovina, Bulgaria, and Serbia).

There were few examples of collaboration between countries and the Project missed key opportunities for regional-level cooperation, undermining its ability to achieve greater coherence. There was no evidence that regional level coordination with key UN and NGO partners took place. Combined with the fact that the Project was designed to respond to five very different country contexts, the Project evolved into a multi-country project rather than a regional one.

Internal coherence was strong both within this Project and with other UNICEF programmes, especially Child Protection (in Bulgaria, Greece, and Italy). In Bosnia and Herzegovina, there was close collaboration between the Project and most other UNICEF programmes (Health,

[4] But note that in Greece and Italy, UNICEF does not have a Country Programme Document

Early Childhood Development, Social Inclusion) and in Italy with UNICEF's Office of Research - Innocenti. External coherence was achieved by collaborating with other UN agencies such as IOM (in Bosnia and Herzegovina), UNFPA (in Italy), and WHO (in Serbia).

Different coordination mechanisms exist in each country and the degree of coordination differs from one country to another. In Bosnia and Herzegovina and Serbia, coordination is primarily led by the government whereas in Bulgaria and Greece UNICEF is a participant in wider refugee and migrant response coordination mechanisms that are led by other UN agencies and Italy demonstrated mixed forms of coordination. However, stakeholders (government, UN agencies, and implementing partners) noted that there were instances of overlapping and/or duplication of activities (e.g., training of same service providers by the different UN agencies) which could have been avoided with more timely and more efficient information exchange. There was no evidence however of regional coordination taking place.

Effectiveness

Largely, the Project succeeded in meeting its planned targets in the five countries. However, the evaluation faced two main challenges in assessing effectiveness. First, since the M&E system did not envisage outcome level monitoring, the evaluation was unable to determine the extent to which the outcomes were achieved. Second, it is hard to assess effectiveness when dealing with populations on the move who may only access UNICEF IP's services for a matter of days. Overall, given the short-term nature of the Project and the length of time required to initiate behaviour and systems change, it is hard to draw concrete analyses at the outcome level.

The Project's M&E was an overall weakness. The M&E framework was inadequate, illustrated through weak indicators in the logical framework and at outcome level. A Project dashboard was not set up during implementation, presenting a missed opportunity to properly and regularly monitor both output level and financial information. Data quality was also inconsistent across the countries. IPs monthly monitoring reports were produced in a timely fashion, SADD were provided, however this was not reflected in the Interim Report.

Based on information obtained through Key Informant Interviews (KIIs), the evaluation identified several factors enabled the achievement of outcomes. Most important were UNICEF's agility and flexibility, and the fact that other grants were used to complement this Project, reflecting strong coherence as well as effectiveness. The use of cultural mediators and multiple means of communication, physical outreach to Refugee and Migrant populations, capacities and long presence of IPs on the ground, and cutting-edge research also contributed. COVID-19 was a major constraint, affecting both the supply side (provision of services) as well as the demand side (inability of R/M to access services because of lockdowns and movement restrictions).

UNICEF and its IPs endeavoured to address both the needs of boys, especially the large population of male unaccompanied and separated children (UASC), while also providing services to girls and women who face greater risks. However, ensuring gender equality and social inclusion (GESI) is not uniform across the five countries as COs targeted activities to address the needs of boys or girls, depending on the groups present in local migration flows and populations. UNICEF's approach to GBV is in line with its Theory of Change and with the definition of GBV in the IASC's guidelines which focus on girls and women's safety[5] (and also the gendered dimensions of certain forms of violence against men and boys). The Project Document specified that GBV prevention and response services should be provided to "youth up to 24 years old, without discrimination, as well as women more broadly". Although the evaluation found limited evidence as to how male children and adolescents – especially UASCs – benefitted from GBV services, the evaluation team note that work on sexual violence against boys has occurred but as part of Child Protection programming rather than GBV

[5] UNICEF (2019). Gender-Based Violence in Emergencies Operational Guide. P. 17.
https://www.unicef.org/sites/default/files/2020-05/Gender-Based-Violence-in-Emergencies-Operational-Guide-May-2019.pdf

programming. In some countries, such Bulgaria, Italy and Serbia, engagement of male UASCs in GBV awareness raising sessions was strong but this was not reflected in the other countries.

Efficiency

The Project was efficient from a financial dimension. Financial implementation at the end of month 20 (August 2021) of the Project, stood at 88 per cent of total implementation (3,765,522 Euros). The Project was granted a three-month no cost extension to compensate the delays in implementation mostly caused by COVID-19 and to allow more time to deliver results. Other delays result from a mutual insufficient awareness of rules and procedures between UNICEF, implementing partners and CHAFEA/HaDEA and delays in approval at the EU and UNICEF regional level. Most Government counterparts and IPs appreciated UNICEF's speed in responding to requests, agility in responding to changing contexts on the ground, and its flexibility in addressing emerging needs.

At the regional level, the Project suffered from staff turnover and a change in divisional responsibility which affected during the first year (i) regional coordination, (ii) ownership of the Project by UNICEF Regional Health staff, and (iii) interaction with the EU on operational matters. However, at the country level, the Project benefitted from highly dedicated UNICEF staff. In each country, the Project was shaped according to staff expertise, human resource capacities, country needs, office strategies and priorities which were reflected in the extent health was emphasized in country-level programming and in the way it was programmatically interpreted for each country office.

UNICEF ECARO applied a One UNICEF Response approach with the UNICEF National Committee in Italy and established a full-fledged country office in Greece in November 2020. However, this did not occur in Spain which prevented the Project from implementing activities there.

Sustainability

There was some evidence of sustainability in the five countries. These included: (i) government ownership; (ii) existence of an exit/handover strategy; (iii) institutional arrangements; (iv) advocacy for policy/legislative changes; (v) capacity building of government and IP staff; (vi) sustainable approaches (community-based vs integration into national system); (vii) continuity of funding; and (viii) policymaking based on research. However, the short span of the Project did not allow sufficient time to carry out effective advocacy since significant time is required to advocate for and achieve policy/legislative changes. There is no evidence that any of the countries in this evaluation will be able to sustain service provision at the same level and quality due to decreasing resources, particularly as the situation in Southern and South-East Europe is no longer considered an emergency on a global level. That said, UNICEF (Greece, Italy, and Serbia), are engaging in advocacy with donors for sustaining the Project's results.

The evaluation considered how far the Project built resilience. The Project contains elements which could, over time, lead to a more resilient health system in the five countries. The Project has enabled the development of stronger networks and linkages for crisis response (enabled by the COVID-19 response), the producing of GBV and psychosocial support packages, and a focus on prevention activities.

Conclusions

Conclusion 1: Notwithstanding the challenges brought by COVID-19, and the severe overstretching of the national public health systems in the five countries as well as UNICEF Health staff both at country and regional level, the Project was able to deliver and over-achieve several of its planned outputs. However, the Project's aim of improving policy implementation

was constrained by the short timescales for policy change to take effect. The evidence of whether the intended outcomes were met was weak due to limitations in the M&E systems such as inadequate logic and coherence in the M&E framework and an unrealistic expectation of what the Project could achieve in two years. Furthermore, by not setting up a dashboard at the beginning of implementation for aggregate monitoring at both the national and regional level, the Project missed an opportunity to properly and regularly monitor both output level and financial information. Although the Project's duration was short, and it did not envisage carrying out a baseline study, the Project could have made greater efforts to capture outcome-level results by using qualitative/participatory methodologies, such as Most Significant Change techniques.

Conclusion 2: The Project's key drivers of success were UNICEF and implementing partners' agility, effective communications, leveraging of local contextual knowledge, and ability to reach refugee and migrant populations. UNICEF's well-regarded reputation secured successful interactions with national governments, and, in some countries, it supported high levels of national ownership. A major constraining factor was the COVID-19 pandemic which coincided with the start of the Project. This affected the supply of services as lockdowns and closures of camps made it hard for IPs to reach the R/M community. Many activities shifted to a remote modality, altering how IPs and beneficiaries interacted. Equally, COVID-19 affected the demand side as R/M were less able to access services due to lockdowns and movement restrictions. While this raised challenges, particularly in identifying new vulnerabilities and providing safe spaces for GBV and MPHSS activities, the Project adapted well and there were no insurmountable challenges.

Conclusion 3. The Project led to several unintended consequences, mostly positive, stemming from the shift to remote activities. With the exception of Greece, which experienced challenges with delivering activities remotely, these included increased active participation in online webinars, lower number of school dropouts and better learning opportunities, improved social cohesion, and greater capacity to use digital devices. Many IPs reported that activities (remote and in-person) were more popular than anticipated which resulted in a positive demand for more information and a greater demand for safe spaces. This highlights the need for similar services in future programming. One serious unintended consequence was increased threats that IP staff have received from both smugglers and perpetrators of violence. To respond to these threats, some of UNICEF's IPs have developed risk management protocols. Unplanned results provide an opportunity for learning and disseminating these experiences with other countries and regions with high R/M populations.

Conclusion 4: The Project's multisectoral approach and strong linkages with other UNICEF projects/programmes was a key strength. In particular, the provision of both mental/psychosocial protection and physical health services helped build trust with the R/M population and meet their needs in a holistic and efficient manner. However, there was a missed opportunity to better link the activities and share information. Consequently, the Project evolved into five separate country projects rather than a regional one where greater information and experience could have been shared, and deliverables, such as the health literacy package, could have been jointly produced. While localization is undoubtedly essential, the Project could have benefitted from a greater balance between country-specific activities (to ensure relevance) and maintaining greater internal coherence (to ensure greater efficiencies and sharing of lessons and experiences). Finally, although there were instances of cooperation with other UN agencies in some countries (Italy, Greece, Serbia), Project could have been further strengthened by more consistently leveraging the expertise of and strategic partnerships with other UN agencies. with whom UNICEF already works in the Project countries. If leveraged consistently, this would ensure the delivery of better services to R/M population; tap into the comparative advantages and technical expertise of the different UN agencies; and facilitate joint resource mobilization efforts.

Conclusion 5: UNICEF tried to address the needs of both girls and boys (UASC boys in particular) and women through the Project activities. However, while SADD was compiled by

COs in their monthly reporting, it was not included fully in the interim report. As such, while knowledge of the number of R/M girls and boys assisted by the Project was known at country level, it was not reflected at regional level. This is problematic for two reasons. Firstly, there are large number of male UASCs present in the five project countries, in Italy and along the Balkan route in particular, where they account for most child refugees and migrants. Secondly, UASC girls are often unreported in migration data and as such their vulnerabilities are not always understood and addressed in programming. Consequently, the Project missed an opportunity to fully report on and understand its effects on girls and boys beyond the country level and across the region; this is important given the transitory nature of the R/M population across the Project countries. Furthermore, ensuring GESI was not uniform across the five countries, partly due to the prevailing political discourse regarding gender equality in some countries, and driven by the fact that each country's intervention is shaped by different political and institutional contexts, necessitating different and flexible approaches.

Conclusion 6: Some important conditions for sustainability were met. The Project helped to build capacity amongst frontline workers and the Project's response to the COVID-19 pandemic has built more resilient networks and ways of working amongst Project stakeholders. The likelihood of intended results being sustained is rather low, due mainly to decreasing resources and an inability to handover Project activities to most national authorities however efforts are being made in some countries, advocating with donors for sustaining the Project's results. Greater resource mobilization and advocacy efforts, as well as further integrating R/M health services into national ones will be necessary to ensure that R/M needs continue to be addressed.

Lessons Learnt

The evaluation team identified the following lessons which may be useful for learning beyond this Project:

Lesson 1. The importance of both vertical and horizontal coordination in a regional project. The Project demonstrated the necessity of having strong and effective coordination between the regional office and the five countries included in the Project. The existence of such vertical coordination would have allowed for better technical backstopping, increased information sharing among the countries and the region, and ensured greater efficiencies (when jointly producing deliverables). Similarly, coordination among all stakeholders within the same country – especially when led by the government – resulted in greater national ownership, ensured complementarity of efforts, and decreased the risk of duplication.

Lesson 2. The effectiveness of a multi-sectoral approach to deliver services to R/M population. By offering basic public health services, combined with protection and psychosocial support, the IPs were able to address more sensitive issues (such as GBV). Furthermore, the pairing of cultural mediators/interpreters with the health service providers ensured the establishment of trust which allowed for better service delivery and resulted in more effective psychosocial support for the R/M population.

Lesson 3. The need to establish structures and processes for ensuring better management and monitoring of both financial and programmatic information. Setting up an M&E framework with measurable indicators that capture input, output and outcome level is essential for monitoring Project progress. Relevant indicators need to provide SADD information, and this should be a requirement in the IP reporting to be able to aggregate SADD, first at the country level, and then at the Project/regional level. The M&E framework would need to include financial information (allocation and expenditures) based on source of funding. Finally, establishing a "live" dashboard during the Project's Inception Phase would facilitate monitoring on a quarterly basis the number of R/M receiving services.

Lesson 4. The importance of involving the technical division during the design phase. The Project highlighted the consequences of not involving the Regional Office's Health Division from the very start of the project design. This is essential to: (i) ensure that technical expertise and aspects are included in project design and implementation; (ii) develop a long-term peer-to-peer relationship with funding counterparts (DG-Health); (iii) establish and strengthen partnerships with national Ministries of Health, WHO and other health institutions where such partnerships are not already well-formed; and (iv) provide technical backstopping to country offices.

Recommendations

The evaluation team developed draft recommendations based on the findings and conclusions which were further refined and finalized based on inputs from ECARO and UNICEF staff in the five countries covered by the evaluation.

Recommendation 1. *For ECARO and Country Office Senior Management as well as National Committees (where applicable), strategically*, advocate that health services for R/M are better integrated into national health systems and continue to support their provision by (i) partnering with strategic UN organisations both at the regional and national levels, such as WHO, IOM and UNFPA to jointly mobilise resources and implement programmes that address R/M needs; (ii) advocating at the national and decentralised levels with Ministries of Health, Interior, and other key government institutions for ensuring that R/M children's rights are guaranteed and their needs continue to be addressed; and (iii) integrating R/M children into the Child Guarantee Programme[6] to ensure greater sustainability and social inclusion and cohesion.

Recommendation 2. *For UNICEF Regional and Country-level health/protection staff, technically*, deepen work on R/M health at the regional and national levels by (i) Further strengthening capacities to prevent, respond, and refer cases of GBV against girls and boys, given the high number of male UASCs in the region; (ii) based on Project experience, adapting the SOPs and protocols, ensuring access to mental health and psychosocial services, and integrating health and gender components into national health systems for women and children on the move in the region; (iii) developing preventative programmes targeting R/M children and design approaches that increase integration with the host community; (iv) strengthening multi-sectoral coordination and information-sharing within UNICEF programmes and among external stakeholders (with governments, UN agencies, research institutions, IPs) within countries; (v) with UNHCR and IOM, developing protocols for dealing with fluctuating numbers of R/M and corresponding staffing needs; (vi) with WHO, establishing an IT system for cross border cooperation and tracking of R/M vaccine status; and (vii) include SADD information in the Project's final report.

Recommendation 3. For ECARO Health Division, institutionally, establish Knowledge Management and Learning, capturing the lessons learnt and experiences gained through this Project by (i) documenting and sharing unique experience on R/M population in Europe by developing four-page briefs on issues (e.g., working in informal settlements, addressing mental health and substance abuse, addressing threats to IP staff, reaching transient R/M population, working with UASCs, etc.); (ii) establishing and disseminating an e-library which includes Project outputs (e.g., SOPs, health literacy packages, etc. which is accessible to all UNICEF CO staff, especially those in countries with high R/M populations; and (iii) COVID-19 permitting, organise a regional workshop including relevant stakeholders (EU, governments, UN agencies, and Implementing Partners) to present results and lessons

[6] UNICEF, in partnership with the European Commission, is implementing the Child Guarantee programme and is working with national and sub-national authorities and select civil society organisations, children and young people to design and implement services and interventions that reduce the effects of poverty and social exclusion on children in need of support and protection. https://www.unicef.org/greece/en/child-guarantee

learnt which can be an opportunity to (i) share experiences; (ii) advocate with decision-makers; and (iii) mobilise additional resources.

Recommendation 4: For DG Health, technically, deepen knowledge and coherence on R/M child health programming in the region through (i) organizing a regional workshop bringing together key UN agencies working with the R/M population, including WHO, IOM, UNHCR, UNFPA and UNICEF to share experiences and lessons learned in terms of supporting refugee and migrant children's health in the region and (ii) drawing on lessons learned from the Project and other agencies' interventions, to strengthen coordinated R/M child health responses in the region, and in other middle- and high-income countries.

Recommendation 5: For DG Health, strategically, target funds for the continued support of R/M Child Health interventions in the region through: (i) continuing to provide support for R/M child health interventions where there is a clear demand such as GBV services, mother and baby corners and health awareness raising; (ii) strengthening partnerships with UNICEF to bolster resiliency of health systems to ensure access and respond to the needs of R/M affected by conflict in the region, particularly women and children on the move; (iii) considering investment in mental health and psychosocial support services for the R/M population in the context of the humanitarian response; (iv) enhancing synergies between complementary activities (e.g. funding for PPE) in order to increase the interventions' effectiveness and provide a more comprehensive health package to end users (beneficiaries).

1. Context and Object

1.1 Background

1. Since 2014, over 1.5 million children have sought international protection in Europe, fleeing conflict, insecurity, and lack of opportunities in Syria, Afghanistan, Iraq, and in countries in Sub-Saharan Africa.[7] This population includes over 250,000 unaccompanied and separated children, the majority of whom are adolescent boys (15-17 years old), as well as an estimated 500,000 infants and children under the age of five.[8]

2. As of mid-2019, there were approximately 42,000 refugee and migrant children in reception facilities throughout Greece, Italy, and the Balkans[9] and by the end of the year this figure had risen to 120,560[10] with children making up a quarter (29,000) of this population.

3. Due to fractured borders, multiple coast lines and mountainous zones in the Balkans, a 2020 UNHCR report showed a consistent year-on-year increase in migrants arriving in Southern and South-Eastern Europe since 2017.[11] Importantly, Eastern Europe in particular, but also Southern Europe are rarely seen as the 'final destination' for refugees as many try to head onwards to Western and Northern Europe. These sites will therefore experience increased levels of comings and goings; much movement ends up being circulatory as many are turned back at borders or even deported and detained.[12] In addition to the physical toll this takes on an individual, it also leads to insecurity, exhaustion, and other resultant mental health issues, including suicide attempts.[13]

4. The five project countries included in this evaluation (Bosnia and Herzegovina, Bulgaria, Greece, Italy, and Serbia) experienced a significant influx of refugees and asylum seekers in 2015 and 2016, driven primarily by the Syria crisis. Tables 1 and 2 in Annex 1 show the total numbers of registered refugee and asylum seekers in those countries in 2019, disaggregated by age and gender where data is available; and the total number of registered refugees and asylum seekers in Bosnia and Herzegovina, Bulgaria, Greece, Italy, and Serbia from 2015-2020. These reflect the number of people who have sought and received asylum in the project countries. It does not include the number of unregistered migrants, including those who are yet to register for asylum or may form part of other migration flows including but not limited to human trafficking or labour migration, nor those who are transiting the countries without making an asylum application.

[7] These groups of people are considered the target population of the Project and are further referred to in this document as the refugee and migrant population.
[8] UNICEF (2021). Terms of Reference for an Evaluation of the UNICEF Project - Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe (RMChild-Health Project), p.2
[9] UNICEF (2020). Project document for 'Strengthening Refugee and Migrant Children's Health Status in Southern and Southeastern Europe', p.3
[10] UNICEF (2019). Refugee and Migrant Crisis in Europe Humanitarian Situation Report No.34, p.1
[11] UNHCR (2020). Western Balkans - Refugees, Asylum-Seekers and other Mixed Movements, p.4
[12] De Vries, L.A., and Torre, L.D. (2019). Lost (in) Time on the Balkan Route: Ambiguous Migration Policies in Serbia (online). Available from: https://www.opendemocracy.net/en/can-europe-make-it/lost-time-balkan-route-ambiguous-asylum-reforms-serbia/
[13] *Ibid*

5. Greece and Italy have experienced steadily growing numbers of registered refugees and asylum seekers between 2015 and 2019, particularly as the central-Mediterranean route from North Africa to Italy grew in popularity. While Serbia, Bulgaria and Bosnia and Herzegovina experienced a decline in the numbers of refugees and asylum seekers following the closure of the Balkan Route, the last three years have shown an increase in new arrivals who seek asylum in these countries. Further information on the specific contexts for each of the five focal countries is provided in Annex 2.

1.2 Refugee and Migrant Health

6. Refugee children are likely to experience severe health stressors during the pre-migratory, migratory, and post-migratory periods. Pre-migration, war-exposed children may witness or experience war atrocities, be deprived of food and water, and be separated from family members.[14] During migration, crowded and unhygienic living conditions in transit and at destination further increase their risks of acquiring **bacterial, viral, and parasitic infections**.[15] Skin and eye infections (e.g., scabies and conjunctivitis) and upper respiratory tract infections are often identified among refugee and migrant children rescued at sea. Testimonies from unaccompanied boys and girls on the move, especially through the Central Mediterranean route, recall arbitrary detention, extortion, exploitation, and violence during the migration process, and evidence shows that these risks are exacerbated when combined with lower levels of education, longer journeys and limited resources.[16]

7. Refugee and migrant women are at higher risks of poorer pregnancy outcomes compared to women from the host community, and consequently issues around **maternal and child health** also prevail. In many cases traditional gender roles and unfamiliarity with available services prevent pregnant women and mothers of young children accessing specialised public health care in host communities, therefore presenting higher rates of pre-and perinatal events such as induced abortions and substandard feeding practices. In relation to the latter, mothers of infants may be unable to breastfeed due to stress, lack of support and privacy, thus resorting to breastmilk substitutes[17] which, in the context of inadequate hygiene, pose significant risks to infants and young children's health, including diarrhea, dehydration and malnutrition. They also deprive infants and young children of antibodies contained in breastmilk that are invaluable for their immune system.[18] Support to breastfeeding and infant and young child feeding (IYCF) for mothers on the move is therefore a critical, and often lifesaving, intervention.

8. Experiencing a traumatic event pre-migration or during migration is more likely to lead to mental health issues such as depression, anxiety, and post-traumatic stress disorder (PTSD).[19] Unaccompanied minors suffer the most extreme difficulties compared to other refugee and migrant groups. During and post-migration refugee and asylum seeker children may live under uncertain conditions for an indefinite amount of time, either in reception centres or in regularly changing housing. This uncertainty can drive stress and isolation.[20]

[14] Soppit, R. (2016). Acculturation, Multilingualism, and Migration. In Peer and Reid (Eds), Multilingualism, Literacy and Dyslexia: Breaking down Barriers for Educator, p.218
[15] WHO, (2018). Report on the Health of Refugees and Migrants in the WHO European Region, p.48
[16] UNICEF and IOM (2017). Harrowing Journeys, p.8
[17] UNICEF (2017). Croatia-RODA, Support to breastfeeding and young child feeding in emergencies: Experiences gained during the migrant and refugee crisis in Croatia in 2015 and 2016.
[18] WHO (2016). Breastfeeding in emergencies: a question of survival, 2016
[19] Hajak et al, (2021). A Systematic Review of Factors Affecting Mental Health and Well-Being of Asylum Seekers and Refugees in Germany, p.2
[20] WHO (2018). Health of Refugee and Migration Children: Technical Guidance, p. 7

9. Refugee and migrant children also face numerous barriers to accessing basic health care in their host communities. In 2018, WHO identified 'unfamiliarity with rights, entitlements and the overall health system; gaps in health literacy; social exclusion; and direct and indirect discrimination' as the primary barriers refugee and migrant children face when attempting to access basic health care.[21] Cultural mediators and interpreters are also essential in enabling access to local health services.[22] Access can be a particular issue for children living with disabilities.

1.2.1 Immunization Rates and COVID-19

10. Within countries of origin, the widespread breakdown of health systems and health services often results in children being inadequately protected from vaccine-preventable diseases. Tables 1-3 show the immunization rates, where available, for the countries of focus within the RM Health project. Specifically, Bosnia and Herzegovina, Greece, Italy, and Serbia, already lag on national routine immunization rates[23] according to WHO/UNICEF estimates. There is an increased risk of outbreaks of diseases such as measles and diphtheria in camps within these host countries, where immunization coverage is likely to be even lower than the national averages for refugee and migrant populations.

Table 1: Measles 1st Immunisation Rates per Country in 2019 and 2020

Measles 1st Dose[24]			
Country	**2020**	**2019**	**% Point Change 2019-2020**
Bulgaria	88%	95%	-7%
Bosnia & Herzegovina	N/A	68%	N/A
Greece	97%	97%	0%
Italy	92%	94%	-2%
Serbia	N/A	87%	N/A
Spain	98%	98%	0%

Table 2: Measles 2nd Immunisation Rates per Country in 2019 and 2020

Measles 2nd Dose[25]			
Country	**2020**	**2019**	**% Point Change 2019-2020**
Bulgaria	84%	95%	-11%
Bosnia & Herzegovina	N/A	69%	N/A
Greece	83%	83%	0%
Italy	86%	88%	-2%
Serbia	N/A	91%	N/A
Spain	94%	94%	0%

[21] WHO (2018). Health of Refugee and Migration Children: Technical Guidance, p. 12
[22] Ibid
[23] WHO (2018). Report on the Health of Refugees and Migrants in the WHO European Region, p. 25
[24] WHO (2020). Measles vaccination coverage (who.int) [last accessed 18/10/2021]
[25] *Ibid*

Table 3: DTP3 Immunisation Rate per Country in 2019 and 2020

DTP3[26]			
Country	**2020**	**2019**	**% Point Change 2019-2020**
Bulgaria	94%	96%	-2%
Bosnia & Herzegovina	N/A	89%	N/A
Greece	99%	99%	0%
Italy	94%	98%	-4%
Serbia	N/A	99%	N/A
Spain	98%	98%	0%

11. Immunisation coverage has also been affected by the COVID-19 pandemic. The European Centre for Disease Prevention and Control found that COVID-19 hit migrants the worst, and their vaccination rates fell behind.[27] In Greece, 25 COVID-19 clusters were found in facilities for refugees and asylum seekers and the risk of infection for those people compared with the rest of the Greek population was two and a half to three times higher. The Fundamental Rights Agency warns that migrants in the EU are at risk of being left behind in the EU vaccination race.[28]

1.2.2 Gender, GBV, and Protection

12. Children on the move, unaccompanied and separated children face significant risks and are highly vulnerable to exploitation and abuse, gender-based violence, and trafficking. A study for the International Federation of the Red Cross and Red Crescent Societies (IFRC) shows that both unaccompanied boys and girls are vulnerable to kidnapping, Sexual and Gender Based Violence (SGBV) and exploitation when travelling alone.[29] These abuses take place across their migration journey; they are driving forces for migration, are experienced during transit, and also take place within camps and reception facilities once children reach their destination.[30] Living conditions in camps and reception centres, and conditions such as overcrowding and co-habiting with adults leaves children vulnerable to abuse.[31]

13. Refugee and migrant girls are at particular risk of **gender-based violence (GBV)** and abuse[32] which is a prevalent human rights violation, both globally and at the European level.[33] UNICEF found that “a lack of security and privacy, mixed-sex reception facilities, and poor access to critical services” leave girls vulnerable to GBV[34] while IFRC found that sexual assault experienced by boys in detention facilities is under-reported.[35]

14. Those who have passed through Libya and entered Europe via the Central Mediterranean route have particularly high exposure risk.[36] GBV takes various forms

[26] WHO (2020). Diphtheria tetanus toxoid and pertussis (DTP) vaccination coverage (who.int) [last accessed 18/10/2021]
[27] European Centre for Disease Prevention and Control (2020). Guidance on Infection Prevention and Control of COVID-19 in Migrant and Refugee Reception and Detention Centres in the EU/EEA and the UK, p.3-4
[28] *Ibid*
[29] IFRC (2018). Alone and Unsafe: Children, Migration and Sexual and Gender-Based Violence, p. 14
[30] *Ibid*, pp. 0-16
[31] IFRC (2018). Alone and Unsafe: Children, Migration and Sexual and Gender-Based Violence pg. 15
[32] IOM (2020). PROTECT: Preventing Sexual and gender-based violence against migrants and strengthening support to victims. p. 11.https://italy.iom.int/sites/italy/files/news-documents/PROTECT-project-mapping-legal-framework-SGBV.pdf [last accessed 18/10/2021
[33] *Ibid,* p. 6
[34] UNICEF (2020) Making the Invisible Visible: The Identification of Unaccompanied and Separated Girls in Bulgaria, Greece and Serbia, p. 12
[35] IFRC (2018). Alone and Unsafe: Children, Migration and Sexual and Gender-Based Violence, p. 14
[36] UNICEF (2020) Making the Invisible Visible: The Identification of Unaccompanied and Separated Girls in Bulgaria, Greece and Serbia, p. 4

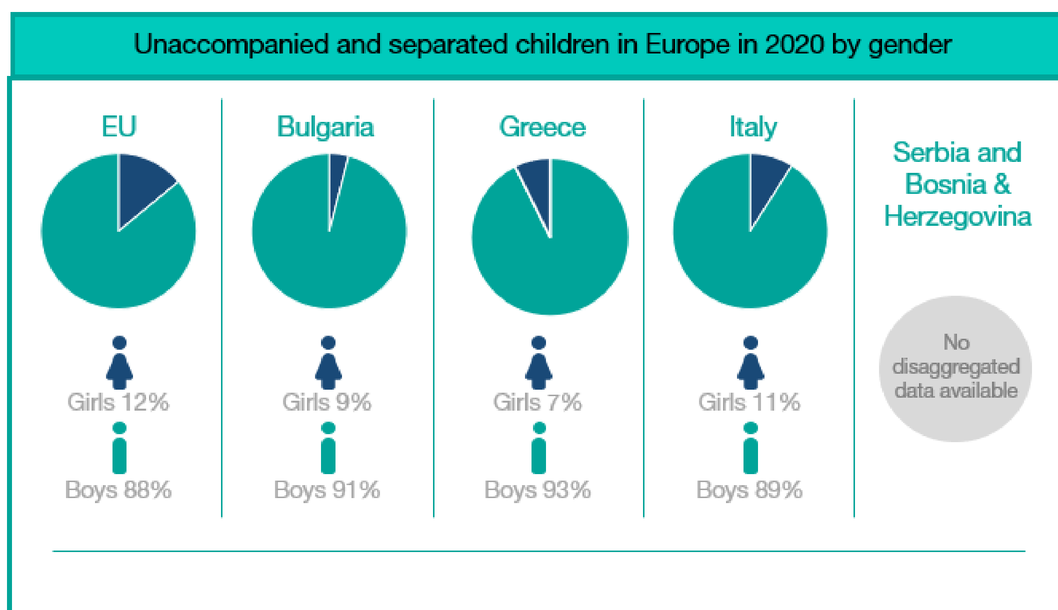
including child marriage, domestic violence, female genital mutilation, sexual abuse and exploitation, the latter of which is the most reported form of trafficking in the European Union.

15. It can be difficult for migrant and refugee girls to access their rights and services as they can be a hidden population. Women and girls are often missing from migration statistics as they can go unreported by families or when travelling alone, can self-identify, or be identified by authorities as adults.[37] While the latter can be self-protection, girls may also identify as adults under pressure from those exploiting or trafficking them. Authorities can incorrectly register married or pregnant girls as adults. This has a detrimental effect on girls' access to their rights.[38] 34 percent of unaccompanied girls in Europe are under the age of 15.[39]

16. The vast majority of unaccompanied and separated children are boys, as illustrated in Figure 1 and Figure 2[40]. While refugee and migrant girls may be under-reported in data, unaccompanied and separated boys are nonetheless a highly vulnerable group. In 2018, across the EU, 86 percent of unaccompanied children were boys.[41] The population of unaccompanied boys tends to be older than the unaccompanied female population. Only 22 percent of unaccompanied boys are under the age of 15, highlighting their need for age and vulnerability appropriate programming. Boys and young men are also at risk of sexual violence and accompanying health consequences, particularly along the central Mediterranean route. According to IFRC, in Greece, boys living in informal encampments were exploited and sexually exploited by men for money.[42] However they are even less likely to seek support compared to their female counterparts.[43]

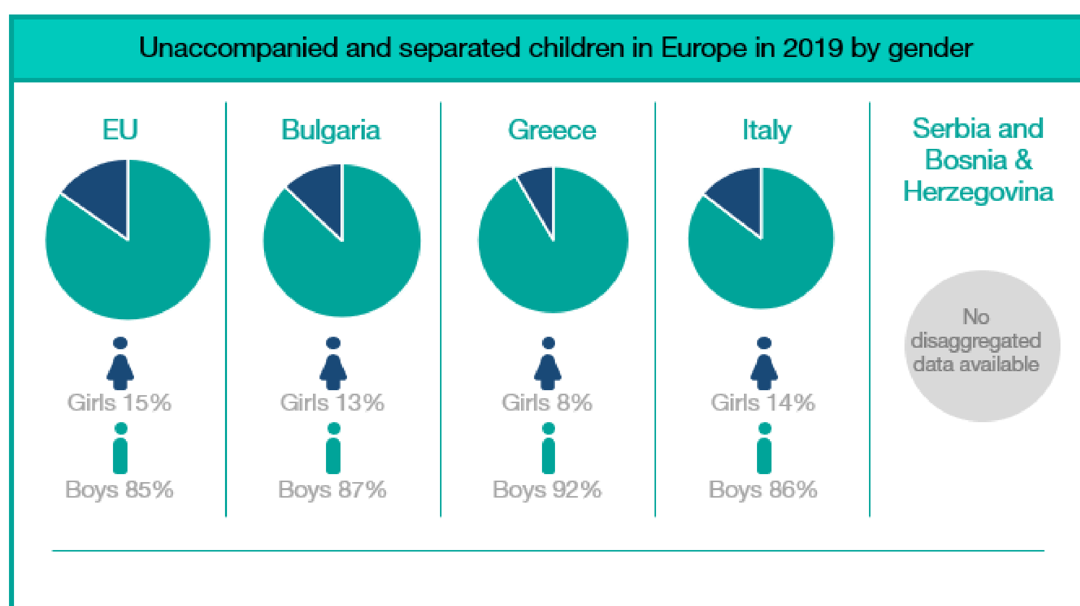
[37] *Ibid*, p. 3
[38] *Ibid*, p.12
[39] *Ibid*, p. 7
[40] UNICEF (2020) Making the Invisible Visible: The Identification of Unaccompanied and Separated Girls in Bulgaria, Greece and Serbia, p. 7
[41] UNICEF (2020) Making the Invisible Visible: The Identification of Unaccompanied and Separated Girls in Bulgaria, Greece and Serbia, p. 7
[42] IFRC (2018) Alone and Unsafe: Children, Migration and Sexual and Gender-Based Violence pg. 29
[43] https://italy.iom.int/sites/italy/files/news-documents/PROTECT-project-mapping-legal-framework-SGBV.pdf

Figure 1: Unaccompanied and Separated Children in Europe in 2020 by Sex



Source: Eurostat (2021). [Statistics | Eurostat (europa.eu)] [Last accessed on 19/10/2021]

Figure 2: Unaccompanied and Separated Children in Europe in 2019 by Sex



Source: Eurostat (2021). [Statistics | Eurostat (europa.eu)] [Last accessed on 19/10/2021]

1.3 Project Description

1.3.1 RMChild-Health Project

17. UNICEF has been commissioned by the Health Programme of the European Union, to "strengthen the health status of refugee and migrant girls and boys of all ages in Bosnia and Herzegovina, Bulgaria, Greece, Italy, Serbia and to the extent possible in Spain without discrimination based on nationality, age, sex, or migratory status." The "Strengthening Refugee and Migrant Children's Health Status in Southern and South-

Eastern Europe" hereafter referred to as the "RMChild Health Project" is being delivered by UNICEF's Europe and Central Asia Regional Office (ECARO) with implementing partners. It is co-funded by the Health Programme of the European Union and aims to strengthen the health status of refugee and migrant girls and boys of all ages in the aforementioned countries, through the improvement of access to quality primary and specialised health care provided by national authorities, and the mitigation of health risks posed to this vulnerable population and host communities.[44]

1.3.2 Project Objectives

18. The Project targeted four specific areas: (i) primary health care including immunization; (ii) mental health and psychosocial support; (iii) GBV; and (iv) maternal and child health, including infant and young child feeding (nutrition).

The specific objectives are outlined as:

- Strengthen national authorities' capacity to provide healthcare to refugee and migrant children
- Increase health literacy among refugee and migrant children and their parents
- Strengthen implementation of national health policies

1.3.3 Project Target Groups

19. Per the Project Document,[45] the Project focused on the following target groups:

- **Refugee and migrant children** (under the age of 18 years), with no sex discrimination, were targeted through interventions aiming to strengthen national authorities'[46] capacity to provide healthcare (including preventive healthcare, psychosocial and mental health support,[47] GBV prevention[48] and response services and mother and childcare). Children were also reached with health literacy interventions on related topics
- **Refugee and migrant parents** were also targeted with health literacy interventions. Mothers benefitted through interventions aiming to support national efforts to improve mother and childcare, including pre- and post-natal care, immunization, and counselling on infant and young child feeding

20. In parallel, UNICEF worked with national health authorities and practitioners to remove the main barriers to refugee and migrant children's access to the provision of care as part of a broader effort towards social inclusion, including with:

- **Health care and other relevant frontline practitioners** (e.g., child protection, education, asylum service, etc.) from both public services and civil society organisations in charge of health care provision and/or referral
- **National and local authorities** in charge of health, migration, asylum, child protection and education

[44] UNICEF (2020). Project Document for 'Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe', p.13
[45] ProDoc, p. 8
[46] For the purposes of this Project, national authorities should be understood as a broad notion, which includes national, regional and local authorities and other stakeholders, including municipalities, public professional entities, public health services providers, etc.
[47] Taking a whole-family approach towards the improvement of children's health status, parents may also be targeted with psychosocial support interventions, where needed
[48] GBV prevention and response services also targeted, without discrimination, youth up to 24 years old, as well as women more broadly (ProDoc, p. 7)

1.3.4 Implementing Partners (IP)

21. Project activities were delivered by a range of UNICEF implementing partners in each project country, presented in the table below. The health and protection services provided by each IP are detailed in Annex 11.

Table 4: Implementing Partners Per Country

Country	Implementing Partners
Bosnia and Herzegovina	Danish Refugee Council, Fenix, Medicins du Monde, World Vision
Bulgaria	Council of Refugee Women in Bulgaria (CRWB), Mission Wings Foundation, Caritas, State Agency for Refugees (SAR), Ministry of Health, Child Psychiatric Unit – Aleksandrovska Hospital
Greece	Caritas, Diotima, ELIX, Iliaktida, The Melissa Network, Metadrasi, Solidarity Now
Italy	Centro Penc, INTERSOS, Medicins du Monde, Save the Children
Serbia	ADRA, Institute of Public Health, The Association for Child and Adolescent Psychiatry and Allied Professions of Serbia (DEAPS), Danish Refugee Council, Faculty of Political Science at the University of Belgrade, Info Park, Republic Institute for Social Protection

1.3.5 Project's (implicit) Theory of Change (ToC)

22. The Project does not have an explicit Theory of Change (ToC). However, based on several project documents, including the five countries' implementation plans, and validation with UNICEF regional and country staff, its implicit ToC can be described as follows: **If national authorities' capacity to provide healthcare to refugee and migrant children is strengthened; and If health literacy among refugee and migrant children and parents is increased; and If implementation of national health policies is strengthened; Then, refugee and migrant children's health status in Southern and South-Eastern Europe is strengthened.** Annex 7 includes the reconstructed ToC.

23. There are several underlying and implicit assumptions associated with this ToC including the following: (i) government cooperation and commitment to inclusion of refugees and migrants in national services/frameworks; (ii) public opinion remains supportive of the inclusion of refugees and migrants in public services; (iii) supply (of services) matches demand (needs of migrants); (iv) services are able to continue functioning during the COVID-19 pandemic; (v) refugees and migrants are able to access services; (vi) availability/capacity of project partners to deliver services; and (vii) trust of migrant population.

24. The intended outcomes can be summarized as follows. By the end of the Project, targeted refugee, and migrant children (girls and boys) and parents/caregivers in selected locations will benefit from improved access to quality healthcare provided by national authorities, that responds to their needs and helps mitigate health risks for both refugee and migrant, and host communities. Refugee and migrant children and parents will have increased health literacy and will be empowered to adopt positive health practices and build their confidence and self-efficacy. National health and allied systems will be strengthened to respond to the increased health needs of the

refugee/migrant population, both in terms of volume and scope of health issues. Health practitioners and other relevant frontline workers will be equipped with knowledge, skills and tools for effective early detection, referral and response to refugee and migrant health cases. Structured coordination between health workers and other frontline professionals (e.g., immigration/asylum authorities and education and child protection) in the public and private sectors will be in place to address major bottlenecks in the implementation of national health policies.

25. While the outputs under Outcome 1 and Outcome 2 are similar across all the five countries, each of the five countries, and the overall regional level have country specific 'policy packages' as outlined in Annex 3.

1.3.6 Project Budget and Expenditures

26. The Project's total budget for 2020-2021 is 4.3 million Euros, (equivalent to US Dollars 4,694, 323), with a contribution from the EU of 2.5 million euros and co-funding from UNICEF of 1.8 million euros.[49] Of the EU contribution and as of 31 August 2021, the Project had spent a total of US Dollars 1,906,150 (see Table 4) and had a remaining unspent balance of US Dollars 814,447, of which US Dollars 195,755 have been committed.

Table 5: Detailed Expenditures against EU Contribution (as of 31 August 2021 in US Dollars)

	Incurred Expense		**Cash Advances and Prepayments**	**Cumulative Expenditure**
Description	**2020**	**2021**		
Staff and Other Personnel Costs	121,921	15,477	0.00	137,397
Contractual Services	129,186	113,159	0.00	242,346
Travel	499	3,047	0.00	3,546
Transfers and Grants to Counterparts	327,943	679,892	317,536	1,325,371
General Operating and Other Direct Costs	27,348	45,440	0.00	72,788
Total Programmable Cost	**606,897**	**857,015**	**317,536**	**1,781,448**
Indirect Support Cost 7%	42,483	59,991	22,228	124,702
Total	**649,380**	**917,006**	**339,764**	**1,906,150**

27. Table 5 provides expenditures by regional/country office. It is important to note that UNICEF's office in Italy is an outpost of the Regional Office and as such the expenditures of the ECARO include both the expenditures at the regional level as well as those incurred by the office in Italy.

Table 6: Summary of Expenditures against EU Contribution by Recipient Office (as of 31 August 2021 in US Dollars)

Country/Regional Office	**Incurred Expense**		**Cash Advances/ Prepayments**	**Cumulative Expenditure**	**Commitments**
	2020	**2021**			
ECA Regional Office	294,622	274,712	0	569,334	155,983
Bosnia and Herzegovina	174,089	159,955	108,674	442,719	0
Bulgaria	53,411	144,297	51,718	249,426	0

[49] Conversion rate 1.09170306

Greece	115,475	156,639	114,316	386,430	10,023
Serbia	11,783	181,403	65,055	258,241	29,749
Total	**649,380**	**917,006**	**339,763**	**1,906,150**	**195,755**

2. Evaluation Purpose, Objectives, and Scope

2.1 Purpose and Objectives

28. This is a summative evaluation of UNICEF's RMChild-Health Project to support **accountability** and **learning.**

29. To meet the **accountability** requirements of UNICEF's funding partner set forth in the Project proposal, it seeks to demonstrate and understand the Project's performance and delivery of results including how they were achieved, as well as assess the supporting and constraining factors. It also considers how UNICEF can **learn** from both the Project's weaknesses and best practices by documenting cases of these to support future planning and decision making, providing a basis for informed advocacy for children in the countries of focus and beyond.

30. The three specific objectives of the evaluation, as per the Terms of Reference (ToR) are to:

    - Provide an independent **assessment of the performance** of the RMChild-Health Project in relation to expected results towards the strengthening of migrant and refugee children's health status
    - Provide **actionable recommendations** for UNICEF on improving its work at country level and on supporting the sustainability of the results, including those related to longer-term changes
    - Identify **good practices and innovative approaches,** and provide lessons learned and forward-looking guidance for actors involved in the refugee and migrant response in the region

2.2 Object and Scope

31. The object of the evaluation is the RMChild-Health project. The evaluation focuses on the period January 2020 to October/November 2021 and covers all five of the Project's implementation countries highlighted in Figure 3: Bosnia and Herzegovina, Bulgaria, Greece, Italy, and Serbia. In addition, per the EU request, the evaluation assesses the reasons why no activities were implemented in Spain as was originally envisaged included in the Project Document.[50] Finally, and as per the ToRs, the evaluation assesses the *potential* for achieving the results of the activities which are planned for Quarter 4 of 2021 and beyond[51] (including the planned regional event to review national health policies on Refugee Migrant Health and discuss promising practices

[50] The ProDoc (p. 13) mentions "to the extent possible, in Spain" with a footnote explaining that "Due to the absence of UNICEF international programmatic presence in Spain, it would not be possible to implement fully the Project in Spain. Interventions would therefore be limited primarily to Work Package 6"
[51] The evaluation team learnt that the Project has been granted a three-month cost extension

and policy recommendations). However, it does not assess whether any results were achieved beyond the end of November 2021.

Figure 3: Map of In-Scope Countries in Southern and South-East Europe

2.3 Intended Users

32. This evaluation is expected to be widely used by stakeholders who have been involved in the Project's implementation as per the Terms of Reference (ToR, see Annex 4).

33. The primary audience of this evaluation is UNICEF staff in the Regional Office (RO) and the UNICEF Offices in the five countries covered by this evaluation. In particular, the Health, Child Protection, and Gender Specialists will be able to use the evaluation's findings and recommendations as a basis to assess their interventions and as an opportunity to integrate some of its recommendations during the no-cost extension period as well as in any future health interventions targeting refugee and migrant populations. The EU – as a funding partner – is also a key primary user of this evaluation from both an accountability and learning perspective.

34. A secondary audience is UNICEF staff in other COs, ROs or in HQ that can have an interest in the findings of the evaluation to feed into their programming and learn from ECARO's experiences that could eventually be replicated or adapted to their own contexts.

35. National governments where the interventions are being implemented will also benefit from the evaluation findings and recommendations which can be used for learning purposes and eventually to adapt their own programmes in line with the findings. Other UN Agencies, Non-Governmental Organisations (NGOs) in the field of gender-based violence and child protection may also have an interest in learning from UNICEF's experiences and may eventually lead to future collaborations.

36. Finally, this evaluation could be of interest to a broader group of donors and implementing partners, both governmental and non-governmental, as well as beneficiaries and communities, as a mechanism to strengthen transparency and share experiences and identify lessons learned.

3. Evaluation Framework

3.1 Evaluation Questions

37. The evaluation addresses five OECD DAC criteria of Relevance, Coherence, Effectiveness, Efficiency, and Sustainability. We note that gender equality is considered under Effectiveness in the proposed Evaluation Questions. Table 6 includes the Evaluation Questions.

38. As proposed in the Inception Report, the evaluation team introduced minor adjustments to some of the Evaluation Questions (EQs). EQ 9 was modified to read as follows: "To what extent was gender equality and social inclusion integrated and effectively addressed by the Project?" The proposed change was to capture the work that targeted vulnerable host communities and Roma minorities. The evaluation team assessed the supply side of "net benefits" in EQ 12 since insufficient information was available to adequately analyse the demand side. Finally, for EQ 13, the evaluation team focused on the specific aspects that improve systems' capacities to respond to shocks (to the extent this information was available), noting that "building resilience" was not a Project's objective and that the word "resilience" is not mentioned in the Project Document.

Table 7: Evaluation Questions

Evaluation Criteria	Evaluation Questions
Relevance	1. To what extent did the Project design respond to the needs and priorities of rights-holders, and continue to do so as circumstances changed? (Especially within the context of COVID-19)? 2. To what extent did the Project design align to and/or leverage health and protection (GBV) global and country policies?
Coherence	3. To what extent has UNICEF demonstrated its added value as a partner and implementer? (Especially in operating contexts of middle to high income countries with supportive institutional capacity)? 4. To what extent has the Project leveraged other interventions carried out by UNICEF? (Or carried out by other organisations/governments at country level)? 5. To what extent has duplication of activities been avoided in the context of the Project?
Effectiveness	6. To what extent has the Project achieved, or is expected to achieve, its objectives and planned results? 7. What were the enabling and constraining factors (and mitigating strategies) that supported the achievement of Project results? 8. Were there any unintended results (positive or negative) from Project implementation? 9. To what extent was gender equality and social inclusion integrated and effectively addressed by the Project?
Efficiency	10. To what extent has the Project made the best use of resources to deliver results for refugee and migrant children? 11. To what extent has the Project been able to deliver in a timely fashion?
Sustainability	12. To what extent are the net benefits of the intervention continuing, or are likely to continue? 13. To what extent did the Project contribute to building resilient health services for migrant and refugee children in the countries it operated in?

4. Approach and Methodology

4.1 Approach

4.1.1 Theory-Based Contribution Analysis

39. The evaluation used a theory-based approach. This is a significant component of the evaluation given the in-depth inquiry needed to understand the three programme areas across the five different country contexts. A theory-based approach allowed for exploration of the causal pathways between 'what' has been achieved, 'how' it has been achieved, and 'why' it has been achieved. Conversely, it also supports understanding of the reasons for delayed or limited results. In the context of COVID-19, this is important because the pandemic has created significant challenges to delivering activities but more so because it has impacted on and exacerbated any existing weaknesses and gaps in effective delivery.

4.1.2 Gender and Human Rights-Sensitivity

40. Throughout the evaluation, the Evaluation Team ensured that a human rights-based approach and gender sensitivity were followed:

- **Human Rights-Based Approach (HRBA)**: The ET followed a human rights-based approach which puts people at the centre of the evaluation as rights holders, highlighting the importance of empowerment and advocacy towards the securing of those rights. Furthermore, the evaluation assessed the extent to which the needs of vulnerable and marginalised populations (e.g., Roma, persons with disabilities, and vulnerable host communities) have been included to ensure the principle of Leave No One Behind in accordance with the 2030 Agenda. Finally, the ET adhered to the United Nations Evaluation Group (UNEG) guidance on integrating human rights and gender equality in evaluations, by looking at the extent to which both the results as well as the processes took into consideration human rights and gender equality
- **Gender Sensitivity:** Throughout the evaluation, the team used a gender-sensitive approach. This approach entailed examining how gender has been incorporated into UNICEF's actions (design, implementation, and M&E), and the extent of girls and boys, women, and men's participation at all levels. The team endeavoured to collect sex and age disaggregated data (SADD) to allow gender-sensitive analysis and identification of gaps and recommendations specific to girls and boys

4.1.3 Quality Assurance

41. IOD PARC has well established approaches to Quality Assurance (QA), which provide tools and processes to document and maintain a high standard throughout the evaluation cycle. The essential QA mechanisms include:

- A progress review at key points with clients to confirm progress and document changes, decisions, and client feedback during the assignment
- Agreed reporting standards and assessment criteria for clients to assess the standard and quality of reports, including the use of UNICEF report templates and checklists. For this assignment, IOD PARC has applied UNICEF's reporting standards and QA processes

- Transparent and systematic responses to client feedback on outputs through a comments tracker for document product (report) commentary processes
- An internal post-project review process to further interrogate the use of QA

4.2 Methodology

4.2.1 Theory of Change Construction

42. Given that the Project did not have an explicit Theory of Change (ToC), the Evaluation Team, using the Country's Implementation Plans, developed retrospective ToCs for each country (see Annex 6) which were presented during the scoping meetings to ensure joint understanding of the ToC (and accompanying hypotheses of the intervention logic or causal pathways identified). To assess the constructed ToC, a mapping of the Evaluation Questions onto the overall Theory of Change was carried out and is included in Annex 7.

4.2.2 Development of Evaluation Matrix

43. A detailed evaluation matrix was developed (see Annex 8) to map the 13 evaluation questions against evaluation criteria, evaluation sub-questions, data sources, and data collection methods. Furthermore, a data analysis framework was developed (including a coding structure) to organise and record evidence from document reviews and KIIs on an on-going basis.

4.2.3 Mixed Methods

44. The evaluation used a mixed methods approach, to establish a robust evidence base. This combined in-depth document review as well as key informant interviews (KIIs).

45. **A Document Review and Content Analysis** was carried out during the Inception Phase of the evaluation as the main form of secondary data collection which included (i) a literature review of grey and published literature relating to migrant and refugee health in the five countries: and (ii) a desk review of background documents and secondary, quantitative data. Annex 9 includes an inventory of all documents and knowledge products that were reviewed.

46. To compensate for the scarcity of monitoring reports, the evaluation team reviewed the monthly progress reports of UNICEF's Implementing Partners in the five countries. Financial and budget information tables were compiled to assist the evaluation team to analyse the EQ on Efficiency. Furthermore, and to respond to the EQ on Effectiveness, the evaluation team prepared several tables based on the document review, including a table which maps the different communication products (Annex 10), one that includes the main characteristics of health service delivery in each country (Annex 11) and a third which provides output level information (target versus outputs in year 2020 and 2021) in Annex 12.

47. **A Stakeholder Mapping Tool** was developed as part of the inception, to understand the different institutions/organisations working with UNICEF in the five countries as well as the regional level (see Annex 13). The stakeholder mapping supported the design of the evaluation questions and was one of the methods to ensure the triangulation of findings. The ET identified the key UNICEF staff, Government officials, funding partner and UN agencies' representatives, academia, and civil society organisations who have collaborated with UNICEF on the Project. The list of

stakeholders included a cross-section of organisations – public, private, and non-governmental – to capture a variety of perspectives.

48. A total of 98 **Key Informant Interviews (KIIs)** were conducted using a multi-stakeholder approach to hold in-depth discussions with people who could shed light onto the evaluation's specific areas of inquiry. Annex 14 includes the list of stakeholders interviewed and Annex 15 the evaluation sub-questions per category of stakeholder. Table 7 captures the number and type of stakeholder interviewed. When necessary, and to ensure greater participation in the KIIs and capture a wider perspective, the evaluation team used the services of local interpreters to hold interviews with non-English speaking stakeholders in the five countries. Furthermore, a KII protocol was developed to ensure that the evaluation team adhered to UNEG Norms and Principles and ethical standards (see Annex 16). Both the KII Protocol and the interview questions were shared ahead of time with trusted interpreters to ensure that they are familiar with the subject and terminology of the evaluation. Written notes were taken during interviews which were coded to reference them. Finally, the evaluation team ensured that there was no "interview fatigue" by limiting the KIIs to around one hour long.

Table 8*: Number and* Type of Stakeholder who Participated in KIIs, Sex-Disaggregated

Type of Stakeholder	Women	Men	Total	% Women
UNICEF	15	6	21	71
IP	42	9	51	82
Government	8	5	13	62
UN	7	4	11	64
EU	2	0	2	100
Total	74	24	98	76%

49. Finally, the ET held a **debriefing workshop with the Evaluation Reference Group (ERG)** following the data collection phase which allowed the team to share with UNICEF regional and country staff their preliminary findings and tentative conclusions and receive feedback. Annex 17 includes the Evaluation Reference Group's ToRs.

4.3 Ethical Approach

50. The evaluation observed the ethical principles and standards set by both UNICEF[52] and IOD PARC. Throughout the evaluation, ethical considerations were considered, and specific safeguards were put in place to protect the safety (both physical and psychological) of both the consultant team and anyone with whom they come into contact.

51. The evaluation adhered to UNEG Norms and Standards, and its overall approach was grounded based on being impartial, credible, responsible, honest, and demonstrating integrity at all stages to foster an independent evaluation of the highest quality standards. The evaluation team respected the following principles[53] throughout its engagement with UNICEF ECARO: (i) Respect for dignity and diversity; (ii) Fair

[52] Including the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System, 2016; UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis, 2021 and UNEG Ethical Guidelines for Evaluation, 2020

[53] As per UNEG Ethical Guidelines for Evaluation (2008)

representation; (iii) Compliance with codes for vulnerable groups (e.g., ethics of research involving young children or vulnerable groups); (iv) Redress; (v) Confidentiality; and (vi) Avoidance of harm. Annex 18 states and explains how different elements of the approach taken to ethical considerations relate to these ethical principles.

52. Furthermore, the Evaluation Team's ethical approach was informed by UNICEF's Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis and in accordance with the UNICEF Strategic Guidance Note on Institutionalizing Ethical Practice for UNICEF Research and UNICEF's Child Safeguarding Policy. For external ethical protocols, the Evaluation Team abided by UNICEF's guidance on ethical principles and requirements. The evaluation followed a standard level ethical review as the evaluation did not engage directly with rights-holders under 18 years of age.

53. Finally, the Evaluation Team also abided by IOD PARC's Ethical Code of Conduct (updated June 2020) which is a comprehensive document which sets a standard to which all IOD PARC staff, consultants and partners adhere when working on IOD PARC-managed evaluations. The Code of Conduct can be found in Annex 19. Furthermore, IOD PARC adheres to the following within all contexts:

- UNEG Ethical Guidelines for Evaluation, UNEG, March 2008
- UNEG Code of Conduct for Evaluation in the UN System 2007
- Department of International Development (DFID) Ethics Principles for Research and Evaluation 2011
- Economic and Social Research Council Framework for Research Ethics principles 2012

4.4 Methodological Limitations and Mitigation Measures

54. In addition to the risks associated with COVID-19 which were identified in the Inception Report, the evaluation faced a few challenges and constraints. To the extent possible, the ET was able to mitigate or reduce the negative effects of most of these, without affecting the overall quality of the evaluation. Table 8 below summarizes the challenges the evaluation faced as well as the mitigation measures put into place to minimize their impact on quality and timeliness of the evaluation.

Table 9: Challenges Faced and Mitigation Measures Undertaken

Challenges	Mitigation Measures
Inability to meet primary rights-holders (children and adolescents) or their parents/caregivers or carry out field visits due to COVID-19 restrictions	The Evaluation Team had already pointed out in the Inception Report this limitation. To mitigate it to the extent possible, the ET decide not to sample the IPs but instead held KIIs with all of UNICEF's IPs. In addition, the ET reviewed all the monthly reports of implementing partners to glean any additional information that was not captured by UNICEF's reports.
Limited time of key UNICEF staff	The data collection phase was planned to take place in November 2021 a busy time for the COs who are preparing the 2022 workplans.

Challenges	Mitigation Measures
	The ET extended the data collection phase by two weeks to ensure greater participation of key stakeholders.
Unavailability of key informants	The ET was unable to meet with key government stakeholders in Bosnia and Herzegovina, Bulgaria, and Italy. The ET requested that reminder emails be sent and when, possible, shared the EQs and requested written responses which it received in a few instances.
Unavailability of information/M&E reports regarding outcome level achievements	The ET followed up extensively to receive activity/output/financial information and spent substantial time with country and regional level UNICEF staff to ensure that it was accurate.
Logistical challenges related to technology use	Logging on to video conferencing platforms challenged some participants of the KIIs and at times the quality of the call was impacted by connectivity issues.
Language barriers	Interpretation services were sought for KIIs that required them, and a mixture of simultaneous and consecutive translation was provided during interviews. Interpretation of KIIs ran smoothly in Greece, Serbia, and Bulgaria, however it was more challenging in Bosnia and Herzegovina due to the limited capacity of the CO in liaising with translator/interpreters for sending out initial emails and scheduling with KIIs that required such a service. This meant there were some delays in scheduling KIIs scheduled for Bosnia and Herzegovina and not all were able to be conducted within evaluation's timeframe.

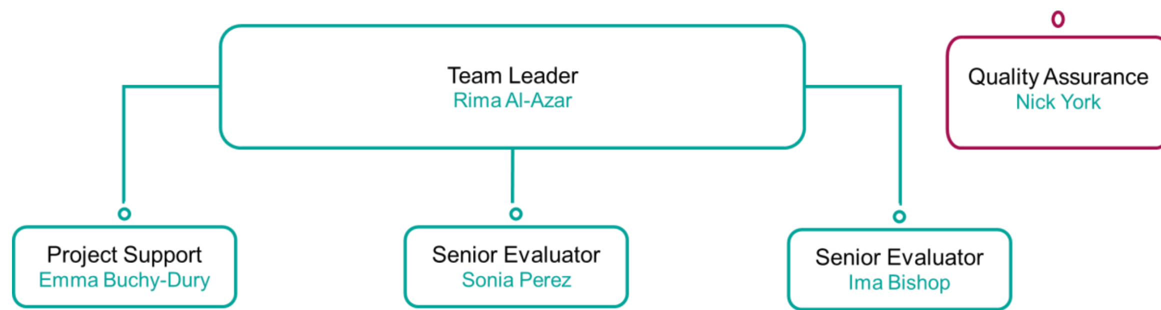
5. Evaluation Phases and Timeline

55. The evaluation was undertaken during the period from August 2021 to March 2022 and was implemented in three phases: (i) Inception, (ii) Data Collection, and (iii) Analysis and Reporting. Annexes 20 and 21 include further details regarding the three phases and timeline.

5.1 Evaluation Team Roles and Responsibilities

56. The evaluation was carried out by a core team of three experts in addition to a dedicated Quality Assurance and Research Assistant as shown in Figure 5. Please see Annex 22 for the evaluation team's biographies.

Figure 4: Evaluation Team



6. Evaluation Findings

6.1 Relevance

Key Findings:

Finding 1: The Project is aligned with UNICEF's country strategies where they exist - in Bosnia and Herzegovina, Bulgaria, and Serbia, specifically to their outcomes focusing on health and protection. In Greece and Italy, UNICEF did not have Country Programme Documents at the time of the Project.

Finding 2: The Project is aligned with several global and regional strategies and policies that address migration, health, and children's rights, including UN Conventions and UNHCR, UNICEF, WHO and EU policies and guidance.

Finding 3: The Project is aligned with several SDGs including SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), SDG 16 (Peace and Justice Strong Institutions) and SDG 17 (Partnerships to achieve the Goal) and several of their targets.

Finding 4: Several consultative processes were used to ensure continued relevance as well as to design new activities or to fine-tune existing ones to respond to R/M needs. These included (i) holding regular meetings with government institutions; (ii) carrying out satisfaction surveys; (iii) using results of U-Report poll; (iv) integrating information from field reports of project field coordinators and IP staff; (v) organizing Focus Group Discussions; and (vi) assessing training needs prior to designing training activities.

Finding 5: Three main reasons prevented the R/M population from being effectively reached: (i) in some countries, the Project's design targeted R/M in camps or centres (e.g., R/M outside Temporary Refugee Centres (TRCs) in Bosnia and Herzegovina were excluded); (ii) specific government rules which created obstacles (e.g., registration of R/Ms with GPs in Bulgaria); and (iii) lockdowns due to the COVID-19 pandemic (in most countries).

Finding 6: The Project demonstrated a high-level of agility in responding to the COVID-19 pandemic by (i) changing its modalities of delivery; (ii) adapting the type of services offered to address new needs; (iii) modifying training content; (iv) greater targeting of vulnerable groups; and (v) dealing with logistical challenges. In addition, in Greece, the Project also had to adapt to the fire that destroyed Moria camp in Lesbos.

6.1.1 Alignment with UNICEF Country Strategies

57. **The Project is aligned with UNICEF's country strategies in Bosnia and Herzegovina, Bulgaria, and Serbia.**[54] Annex 23 includes a table which demonstrates the alignment with specific outcomes included in the three countries' Country Programme Documents (CPD) related to health and protection. Furthermore, the Project responds to health sector weaknesses in the five countries and addresses identified "systems" failure which include: (i) understaffing of public health systems; (ii) a focus predominantly on tertiary care (and not on prevention); and (iii) no services for R/M providing psychosocial and mental health support.

6.1.2 Alignment with Global/Regional Policies

58. The Project is aligned with several global and regional strategies and policies that address migration, health, and children's rights. Specifically, the Project is in line with the three UN international agreements related to refugees and migrants: (i) the 1951

[54] At the time of the Project's design, UNICEF did not have a Country Programme Document in Greece and Italy. Currently, UNICEF is developing a CPD for Greece. In Italy, health programming was included in the office work plan.

Convention Relating to the Status of Refugees and its 1967 Protocol, which the five countries included in the Project have ratified (see Table 9); (ii) the 2018 Global Compact on Refugees, in particular with its two objectives to ease the pressures on host countries and to enhance refugee self-reliance; and (iii) the 2018 Global Compact for Safe, Orderly and Regular Migration which addresses all aspects of international migration, including the humanitarian, developmental, and human rights-related ones. Furthermore, the Project is aligned with UNICEF's Global Programme Framework on Children on the Move (2017) and with the European Union's (EU) recommended actions to be taken/better implemented by the EU and its Member States as outlined in the "Communication from the Commission to the European Parliament and the Council: The Protection of Children in Migration".

Table 10: Ratification of the 1951 Convention relating to the Status of Refugees and the 1967 Protocol

Country	1951 Refugee Convention	1967 Protocol	Reservations
Bosnia and Herzegovina	01/09/1993	01/09/1993	N/A
Bulgaria	12/05/1993	12/05/1992	N/A
Greece	05/04/1960	07/08/1968	Reservation on the 1951 Refugee Convention - "In cases or circumstances which, in its opinion, would justify exceptional procedure for reasons of national security or public order, the Hellenic Government reserves the right to derogate from the obligations imposed by the provisions of article 26."[55]
Italy	15/11/1954	26/01/1972	Retracted its reservations on the 1951 Refugee Convention.[56]
Serbia	12/03/2001	12/03/2001	N/A

Source: https://www.unhcr.org/1951-refugee-convention.html

59. In addition, the Project is also **aligned with several health strategies and guidance documents** addressing health issues, and in particular the health of refugees and migrants. These include UNHCR's Regional Public Health and Nutrition Strategy for Emergency Refugee Response in Europe (2015), UNICEF's Health Strategy (2016-2030), and the WHO-UNHCR-UNICEF joint technical guidance regarding the general principles of vaccination of refugees, asylum-seekers, and migrants in the WHO European Region. Finally, the Project espouses the **Convention on the Rights of the Child** and contributes to the implementation of UNICEF's Strategic Plan (2018 – 2021) and the fulfilment of UNICEF's Core Commitments for Children (CCC). Annex 24 provides detailed information regarding the alignment of the Project to the above-mentioned strategies and policies.

6.1.3 Alignment with SDGs

60. The Project is aligned with several SDGs including SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), SDG 16 (Peace and Justice

[55] UNHCR (2021). State Parties, Including Reservations and Declarations, to the 1951 Refugee Convention, p. 8

[56] "In a communication received on 20 October 1964, the Government of Italy has notified the Secretary-General that "it withdraws the reservations made at the time of signature, and confirmed at the time of ratification, to articles 6, 7, 8, 19, 22, 23, 25 and 34 of the Convention [see United Nations, Treaty Series, vol.189, p. 192]. The above-mentioned reservations are inconsistent with the internal provisions issued by the Italian Government since the ratification of the Convention. The Italian Government also adopted in December 1963 provisions which implement the contents of paragraph 2 of article 17". Source: UNHCR (2021). State Parties, Including Reservations and Declarations, to the 1951 Refugee Convention, p. 18

Strong Institutions) and SDG 17 (Partnerships to achieve the Goal) and several of their targets (see Table 10).

Table 11: Alignment with Select SDGs and Targets[57]

SDG	Target	Relevant Project Outcome/Activity (Regional ToC)
SDG 2: Zero Hunger	2.1 End hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious, and sufficient food all year round 2.2 End all forms of malnutrition, including achieving the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	Outcome 1: National authorities' capacity to provide healthcare to refugee and migrant children is strengthened • Activity 3 Outcome 2: Refugee and migrant parents have improved access to relevant health information for knowledge development • Activity 5
SDG 3: Good Health and Well-being	3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Outcome 1: National authorities' capacity to provide healthcare to refugee and migrant children is strengthened • Activity 1 • Output 2 Outcome 3: Implementation of national health policies is strengthened • Activities 6-8 • Outputs 4-5
SDG 5: Gender Equality	5.1 End all forms of discrimination against all women and girls everywhere 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	Outcome 1: National authorities' capacity to provide healthcare to refugee and migrant children is strengthened • Activity 1 • Output 1 Outcome 2: Health literacy among refugee and migrant children • Activity 5 • Output 3 Outcome 3: Implementation of national health policies is strengthened • Activities 6-8 • Output 4-5

[57] Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 Agenda for Sustainable Development. Available at: https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202021%20refinement_Eng.pdf

SDG 16: Peace and Justice Strong Institutions	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children 16.b Promote and enforce non-discriminatory laws and policies for sustainable development	Outcome 3: Implementation of national health policies is strengthened • Activities 6-8 • Output 4-5
SDG 17: Partnerships to achieve the Goal	17.9 Enhance international support for implementing effective and targeted capacity-building in developing countries to support national plans to implement all the Sustainable Development Goals, including through North-South, South-South and triangular cooperation 17.15 Respect each country's policy space and leadership to establish and implement policies for poverty eradication and sustainable development	Outcome 3: Implementation of national health policies is strengthened • Activities 6-8 • Output 4-5

6.1.4 Responds to Needs and Priorities of Rights Holders

61. UNICEF designed and implemented the Project in a manner to respond to the needs and priorities of rights holders. To ensure continued relevance, UNICEF used several methods to integrate the needs of R/M children, their parents, and caregivers as well as of those of service provider staff. These included holding consultations with government and R/M population, conducting satisfaction surveys, using online polling, integrating information from UNICEF and IP field staff, and carrying out training needs assessments.

62. In order to ensure relevance and appropriate design, UNICEF ECARO held several brainstorming sessions (remotely) with UNICEF in the five countries in order to make sure that the Project (i) built on and complemented existing programmes; (ii) responded to R/M needs on the ground; and (iii) corresponded to EU requirements.[58] In addition, and in order to address the needs of rights' holders, the Project used gender assessments which had been carried out previously by the BPRM-funded Action Against Gender-Based Violence Affecting Refugees and Migrants in Europe Project (hereinafter referred to as the "regional GBV project")[59]. Furthermore, during implementation, UNICEF consulted with government and implementing partners, with young refugees and migrants and their caregivers on the ground to identify information gaps – which, in turn, guided the development of health literacy packages across all five countries on a range of crucial health issues, from immunization and nutrition to sexual and reproductive health (SRH) and gender-based violence (GBV).[60]

63. Some common priorities were identified by refugees and migrants across all five countries, including access to immunization and other primary health care services, breastfeeding and young child feeding, and the prevention of GBV. They also flagged the pressing need for more mental health and psychological services. Other issues emerged as priorities in specific countries, including cyberbullying and online safety in Italy, and substance abuse among young people in Serbia – which led to the

[58] UNICEF ECARO staff
[59] UNICEF ECARO staff
[60] UNICEF (n.d.). Improving health literacy among refugee and migrant children, by Angela Hawke, https://www.unicef.org/eca/stories-region/improving-health-literacy-among-refugee-and-migrant-children

production of an in-depth UNICEF study on that issue.[61] Finally, in some instances such as in Greece, funding from DG Health was critical and particularly relevant to R/M needs because it was the only donor which supported Mother and Baby Corners in Athens and Thessaloniki.[62]

64. The Project used different methods to continuously assess the needs and priorities of the R/M population. Following are some examples:

- **Regular meetings with government institutions**: In Serbia, UNICEF held regular meetings with state institutions (e.g., ministries of interior, social affairs, health, refugee agencies) to ensure that it had the most up-to-date figures[63]
- **Satisfaction surveys**: In Bosnia and Herzegovina, UNICEF's implementing partners carried out satisfaction surveys with both parents[64] and service providers in the TRCs[65] which demonstrated that the activities responded to the R/M needs and that the beneficiaries were highly satisfied with both the pediatric services provided as well as the awareness raising/training delivered. In Serbia, satisfaction surveys were also used by IPs delivering GBV services.
- **U-Report poll**: In Italy, to ensure relevance, UNICEF held online consultations with R/M through the U-platform which revealed major gaps in their knowledge about sexual and reproductive health. This allowed UNICEF to produce appropriate material to reach young refugees and migrants.
- **Field reports of project field coordinators and IP staff**: In all five countries, UNICEF continuously monitored evolving needs on the ground through its field coordinators and its implementing partners and adjusted implementation accordingly to address those needs.[66,67] For example, in Bosnia and Herzegovina, activities designed were based on identified needs of children (e.g., dental, and ophthalmological care) and of single fathers (on nutrition).[68,69]
- **Focus Group Discussions**: In Greece, Metadrasi, UNICEF's IP, developed health awareness material based on women's needs which were identified during conversations with women who attended the Mother Baby Corners (inside the asylum centres). In Serbia, at the Centre for Refugees and Migrants near Bela Palanka, the needs of refugee and migrant women shaped the development of the Community Centre in Belgrade run by ADRA which offered women the possibility to attend language classes, participate in sports activities and attend workshops about their own health and rights.[70]
- **Assessment of training needs**: In Greece, UNICEF followed a detailed methodology to design relevant training sessions which responded to participants' needs as well as to the changing context due to COVID-19 (see Box 1). In Serbia, needs assessments were also conducted to support the training of case workers and other staff in the protection sector.

[61] Pejović Milovančević, M. Vasić, J. Grujičić, R. Tošković, O. (Ed.). (2021). The Prevalence of Alcohol and Substance Use Among Young Refugees and Migrants in Serbia and Psychological Correlates; A Helping Hand for Young Refugees and Migrants Transiting Serbia: Preventing Alcohol and Substance Use
[62] UNICEF CO staff
[63] UNICEF CO staff
[64] IP staff
[65] IP staff
[66] UNICEF CO staff
[67] UNICEF CO staff
[68] UNICEF CO staff
[69] The Project initially provided nutrition information to mothers; however, based on feedback from the field, it modified its approach to include single fathers as well
[70] UNICEF (2021). Strengthening the implementation of health policies, by Angela Hawke, 1 February 2021. https://www.unicef.org/eca/stories/strengthening-implementation-health-policies

Box 1: Relevance in Designing and Delivering Training in Greece

In Greece, UNICEF's IPs took several steps to ensure that training was designed and delivered in such a way that it was relevant to participants and responded to their needs. Following are the steps undertaken:

- Built sense of ownership and participant engagement by integrating national knowledge and experience
- Added modality on improving skills for delivering online training due to COVID-19
- Carried out an assessment of training needs of participants to make sure the training responded to what they needed content-wise
- Organized meetings with representatives of the communities participating in the training – in-person and online – to assess what kind of support they needed the most
- Designed a questionnaire to collect information to assess what training participants had already attended, the problems encountered most often, and their skills gaps
- Ensured that the webinars contained new content that had not been included in previous trainings
- Identified challenging areas which were added to the training: (i) working with vulnerable children within the R/M population; (ii) professional stress and burnout amongst frontline workers; (iii) better cross-sectoral cooperation to establish a better integrated response when working with migrant population

Source: KIIs with Government and IP staff

6.1.5 Difficulties/Obstacles in Reaching Target Population

65. The evaluation found that there were three main reasons why R/M population were prevented from being effectively reached: (i) in some countries, the Project's design targeted R/M in camps or centres (e.g., in Bosnia and Herzegovina R/M outside the TRCs were excluded and in Greece the Project only included populations in camps and RICs); (ii) specific government rules which created obstacles (e.g., registration of R/Ms with GPs in Bulgaria); and (iii) lockdowns due to the COVID-19 pandemic (in most countries).

66. In Bosnia and Herzegovina, the Project – by design – targeted only R/M in the TRCs. The challenge is that many migrant children and families stay outside of reception centres because they want to stay close to the border, especially during the warmer months.[71] As a result, those that were present in informal settlements or were not in the TRCs did not always receive the same services, although in some critical situations UNICEF through its IP - the Danish Refugee Council (DRC) - did provide outreach and pediatric support but this was funded directly by UNICEF and DRC rather than through this Project.[72]

67. Similarly, UNICEF in Bulgaria faced challenges in providing medical assistance to refugees and migrants living outside the state reception centres and facilities, who are required to organise their own health care provision including paying for their own health insurance. These groups often cannot afford to do so themselves or are unaware of the administrative requirements involved in accessing healthcare. Consequently, many were left with untreated health problems or remained untracked over time in terms of their health.[73] Furthermore, in Bulgaria, general practitioners

[71] IP staff
[72] UNICEF CO staff
[73] Mission Wings Progress Report December 2020-March 2021

(GPs) have a certain quota of R/M they can sign up and treat. If a R/M leaves the country without deregistering – which happens frequently – the health system does not allow the GP to deregister the R/M which prevents other R/Ms from being included in the GP's quota and to be treated.[74]

68. Finally, the COVID-19 pandemic had a major impact on both R/Ms' access to services but also on IPs outreach to R/M targeted populations. In some countries, public services were shut down or severely decreased, thus preventing R/M from accessing them. In others, COVID-19-related rules limited the movement of R/M and did not permit them from leaving the refugee camps (e.g., Greece). In most countries, strict lockdowns, albeit short term, also prevented IP staff from carrying out extensive outreach to R/M populations.

69. Additional factors also had an impact on R/M access which are discussed in Section 6.3 (constraining factors).

6.1.6 Adaptation to Changing Contexts and Needs

70. The Project was designed prior to the start of the COVID-19 pandemic and in a period when the R/M situation was different (e.g., lower numbers of R/M in Bosnia and Herzegovina and no surge in migration in Italy). Furthermore, there was a delay between the Project's design and its final approval and, by the time activities started being implemented, the context had changed significantly.[75] The pandemic created unprecedented upheavals and disruptions as well as new needs – both physical and psychosocial. The Project demonstrated great adaptability to the changing context and needs and used the initial three months of Project to design detailed implementation to re-programme some of its activities accordingly and to respond to the COVID-19 pandemic.[76] Following are the changes introduced to respond to the COVID-19 pandemic:

71. **Changing the modality of delivery**: The IPs used a variety of ways to continue providing services. For example, in Greece, IPs during COVID-19 did not have access to R/M in open accommodations so they piloted community-based activities in four sites. In addition, all service provision was adapted to remote programming via telephone and internet. IPs also complemented remote delivery with tent-to-tent visits, setting up pop tents (when weather permitted), co-sharing space with other organisations, and setting up mobile teams. In Greece, IPs used hybrid ways (inside/outside camps) to meet with R/M.[77] When R/M were not allowed to leave their camps and asylum centres were closed for several months, preventing R/M to access services, IPs used social media allowing women to access PSS services.[78] Likewise, in Bulgaria, some IPs faced limited access to registration and reception centre of the State Agency for Refugees (SAR) which disrupted provision of face-to-face services and the identification of health related issues, making it necessary to develop various online materials, webinars and trainings.

72. In Bosnia and Herzegovina, when COVID-19 restrictions permitted to deliver in-person training/awareness-raising, the IPs resorted to holding more frequent meetings with fewer participants. In addition, procedures to join activities were established, such as measurement of temperature, use of disinfection and face masks.[79] In several countries, the IPs used mobile teams to reach R/M populations in order not to interrupt

[74] UN and IP staff
[75] EU and UNICEF ECARO staff
[76] UNICEF CO staff
[77] UNICEF CO staff
[78] UNICEF CO staff
[79] IP staff

service provision during lockdowns. For example, in Bosnia and Herzegovina, when R/M did not have access to MBCs, IP staff went to the mothers and held one-on-one meetings and/or organized meetings in smaller groups. Similarly, in Italy, a mobile outreach team in Rome was able to reach R/M children throughout the COVID-19 pandemic and the resulting lockdown[80] and in Bulgaria, some IPs (Mission Wings and Caritas) also used mobile teams to reach people.[81]

73. **Adapting the type of services offered to respond to new needs**: Three countries added activities to their implementation plan to respond to emerging needs (see Box 2). In Italy and in Serbia, UNICEF prioritised the distribution of hygiene kits[82] and COVID-19 awareness materials.[83] In Bosnia and Herzegovina, nutrition information was added based on R/M request as was psychosocial support.[84] Furthermore, in Greece[85] and Italy, UNICEF IPs provided phone or internet data top-ups to log onto the internet in order to ensure R/M continued access to services.[86][87] Finally, IPs in Greece and Serbia established several WhatsApp social groups for different age groups and provided them with ideas for coping during lockdowns.[88] In Serbia, WhatsApp and Viber groups also provided information on health concerns, mental health, protection services and asylum procedure.[89] In addition, an IP in Bulgaria (Council of Refugee Women) established a Vulnerability Fund to provide direct support to those in need, such as cash to cover treatment and examinations not covered within the state budget.[90]

Box 2: Adding Activities to Respond to Needs

Following are the activities that some countries added to respond to needs and which were not originally conceived as part of the Project design:

- UNICEF in Bosnia and Herzegovina provided information on health risks, entitlements, and services available related to MHPSS
- UNICEF in Bulgaria and Serbia provided information on health risks, entitlements, and services available related to maternal and childcare, including breastfeeding
- UNICEF in Italy supported access to health checks and referrals to public healthcare services, including to immunization

74. **Adapting of content**: In Italy and Serbia, training material was adapted to be delivered through distance learning. Similarly, in Bosnia and Herzegovina, information and training material was modified to reflect the COVID-19 pandemic.[91] In Bulgaria and Serbia, there was an increased demand for printed health literacy materials which were amended to include COVID-19 related issues.[92] In Bulgaria, specific COVID-19 related health information was also provided online, via the Council of Refugee Women in Bulgaria's (CRWB) Facebook page.[93]

75. **Greater targeting of vulnerable groups**: Realising the greater difficulties that vulnerable and/or at-risk R/M faced in accessing services due to lockdowns, UNICEF's

[80] UNICEF (2021) RM Child-Health Newsletter 1, January 2020, p. 4
[81] UNICEF CO staff
[82] Funded from another project
[83] UNICEF CO staff
[84] UNICEF CO staff
[85] Refugee camps in Greece did not have access to Wi-Fi
[86] IP staff
[87] UNICEF CO staff
[88] UNICEF CO staff
[89] UNICEF CO staff
[90] UNICEF CO staff
[91] UNICEF CO staff
[92] UNICEF CO staff
[93] Presentation Health project meeting of Bulgaria team coordination meeting 7 October 2020 final

IPs in Italy continued to deliver remote and in person health screenings and online psychological support and case management to the most vulnerable migrants and refugees.[94,95]

76. **Dealing with logistical challenges**: In Bosnia and Herzegovina, UNICEF addressed logistical challenges due to health workers getting sick with COVID-19. It organized transportation from one canton to another and dealt with obtaining official approvals allowing health workers to work in another canton than the one they were assigned to.[96] In addition, containers which were used as Mother and Baby Corners were transformed into isolation rooms for COVID-19 patients.[97]

77. Finally, in Greece and Bosnia and Herzegovina, the Project was forced to adapt to disasters in addition to the COVID-19 pandemic. In Greece, the Moria Reception, and Identification Centre (RIC) in Lesbos were destroyed by fire in 2020. As a result, UNICEF's Child and Family Support Hub (CFSH) where several project activities were implemented was turned into an emergency shelter for the most vulnerable members of the Moria camp, specifically for UASCs and single mothers. The CFSH acted as emergency centre and space for psychosocial support for single-headed household women and their children.[98] The loss of the CFSH space and changing needs of beneficiaries meant that UNICEF had to pivot activities to better respond to the needs of women and children in the temporary shelter through case management, outreach, non-formal education, child protection (including PSS), and prevention and response activities for GBV.[99] In Bosnia and Herzegovina, an earthquake destroyed most of the health centre so COVID-19 testing was provided in a container.[100]

According to one IP, "achieving the Project's objectives was possible only due to UNICEF's understanding and flexibility. Other donors insisted on continuing services in the same pre-pandemic way or even stopped funds, but UNICEF was different. The trust we were given was crucial."[101]

6.2 Coherence

Key Findings:

Finding 7: According to the different stakeholders interviewed, UNICEF's credibility, neutrality, technical expertise, convening power, agility, and ability to work in a multi-sectoral manner are its added value which it has been able to demonstrate both as a partner and implementer in High-Income Countries (Greece and Italy) or Upper Middle-Income Countries (Bosnia and Herzegovina, Bulgaria, and Serbia).

Finding 8: Within the Project, there were a few examples of collaboration among the different countries; however, the Project missed an opportunity to achieve greater coherence by not jointly producing health literacy materials and insufficient sharing of information and lessons learned among the five countries. With the fine-tuning of the Project to be more relevant within each country and insufficient regional coordination, the Project evolved into a multi-country project rather than a regional one.

[94] IP staff
[95] Italy: detailed Implementation Plan, revised 01062020
[96] UNICEF ECARO staff
[97] UNICEF ECARO staff
[98] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[99] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021*i*
[100] Government Representative
[101] IP staff

Finding 9: Between the Project and other UNICEF programmes, coherence was greatest with the other regional GBV Project which contributed significantly to the R/M Project in staffing, funding, common IPs, and integrated work on GBV. There was coherence between the Project and other UNICEF programmes, especially Child Protection (in Bulgaria, Greece, Italy and Serbia). In Bosnia and Herzegovina, there was close collaboration between the project and most other UNICEF programmes (health, early childhood development, social inclusion) and in Italy with UNICEF Office of Research - Innocenti.

Finding 10: UNICEF achieved external coherence by collaborating with other UN agencies such as IOM (in both Bulgaria and Bosnia and Herzegovina), UNFPA (in Italy), UNHCR (in Bulgaria) and WHO and UNHCR (in Serbia), which could be replicated in the other countries.

Finding 11: Different coordination mechanisms exist in each country and the degree of coordination differs from one country to another. Notwithstanding these different coordination bodies, different stakeholders (government, UN agencies and IPs) noted that there were instances of overlapping and/or duplication of activities (e.g., training of same service providers by the different UN agencies) which could have been avoided with more timely and more efficient information exchange. Finally, there was no evidence that regional level coordination with key UN and NGO partners – as stipulated in the Project Document – took place.

6.2.1 UNICEF's Added Value

78. UNICEF has been able to demonstrate its added value both as a partner and implementer in the five countries which are classified either as High-Income Countries (Greece and Italy) or Middle-Income Countries (Bosnia and Herzegovina, Bulgaria, and Serbia). The different stakeholders interviewed underlined UNICEF's credibility, neutrality, technical expertise, convening power, agility, and ability to work in a multi-sectoral manner. These advantages correspond to some of the change strategies as identified in UNICEF's Strategic Plan (2018-2021),[102] in particular: Gender-responsive programming; Winning support for the cause of children from decision-makers; Developing and leveraging resources and partnerships for children; United Nations working together; and fostering innovation in programming and advocacy for children. Annex 25 captures the perceptions of UNICEF's added value per category of stakeholder.

In their own words: for government UNICEF is a "Window to the world". According to its Implementing Partners, it is a "partner not a donor" and they "feel that they are listened to". For other UN agencies and the EU, it is a "trusted partner".

79. Finally, several stakeholders noted that while it is true that the five countries included in this Project are classified as either HICs or UMICs, there are large differences within the countries due to their diverse regions which have varying levels of poverty. In areas with higher poverty levels, provision of services tends to be more limited and capacity to respond to R/M needs is often weaker. UNICEF adds value in those under-served regions where R/M tend to be more present.

6.2.2 Internal Coherence

80. Within the Project, there were a few examples of collaboration among the different countries; however, the Project missed an opportunity to achieve greater coherence

[102] The UNICEF Strategic Plan identifies eight change strategies: (1) Programming excellence for at-scale results for children; (2) Gender-responsive programming; (3) Winning support for the cause of children from decision-makers and the wider public; (4) Developing and leveraging resources and partnerships for children; (5) Leveraging the power of business and markets for children; (6) United Nations working together; (7) Fostering innovation in programming and advocacy for children; and (8) Using the power of evidence to drive change for children. It also lists four organisational enablers to drive results: (1) Responsive, transparent, and accountable internal governance; (2) Results-oriented, efficient and effective management; (3) Staff capacity to drive change for children; and (4) Versatile, safe and secure knowledge and information systems. Source: UNICEF Strategic Plan (2018–2021) Available at: https://www.unicef.org/media/48126/file/UNICEF_Strategic_Plan_2018-2021-ENG.pdf

by not jointly producing health literacy materials and insufficiently sharing information and lessons learned among the five countries. For example, Bosnia and Herzegovina and Serbia shared health-related information material.[103] UNICEF's Regional Office distributed the DG Health training curriculum which was developed in different languages, and which was used and/or adapted by the countries included in this Project.[104] However, as most UNICEF staff noted, there was a missed opportunity for greater collaboration and coherence among the five countries. This would have allowed a greater sharing of experiences and lessons learnt as well as achieving greater efficiencies (e.g., by jointly producing the health packages).[105] With the fine-tuning of the Project to be more relevant within each country and insufficient regional coordination, the Project evolved into a multi-country project rather than a regional one.[106]

81. There are some examples of coherence with other UNICEF programmes, the most prominent one is with the Regional GBV Programme.[107] The Project achieved this coherence through several ways: (i) co-funding of activities; (ii) having the same Project Coordinator for both Projects (in the case of Greece, Italy, Serbia, and Bulgaria); (iii) working mostly with the same IPs in both projects; and (iv) addressing GBV in both projects. At the same time, this almost complete integration between the two projects created challenges for the evaluation team to identify which activities were implemented under which project.

82. In addition to the close integration between the two regional programmes on Health and GBV, in Bosnia and Herzegovina, there was close collaboration and coherence between different UNICEF country programmes and the Project, such as with the health programme (on immunization and R/M population), the Early Child Development (ECD) programme (on nutritional guidance for R/M children), and the social inclusion programme (addressing R/M with disabilities).[108] In both Greece and Italy, there was close collaboration between this Project and the Child Protection Programme, and in Greece with the non-formal education programme. Finally, in Italy, the Project collaborated closely with UNICEF Office of Research - Innocenti to produce research and knowledge products.[109]

6.2.3 External Coherence

83. UNICEF achieved external coherence by collaborating with other UN agencies such as IOM (in Bosnia and Herzegovina, Bulgaria, and Italy), UNHCR (in Bulgaria and Italy), UNFPA (in Italy), and WHO and UNHCR (in Serbia).

84. In Bosnia and Herzegovina, a close **collaboration between UNICEF and IOM** resulted in improving nutritional outcomes for infants. UNICEF had noted that baby formula milk was being widely distributed by IOM to R/M children. As a result, UNICEF developed nutritional guidelines, which were shared with IOM and which led to IOM

[103] UNICEF CO staff
[104] UNICEF CO staff
[105] UNICEF CO staff
[106] The Project is considered a regional one because it had the following characteristics: (i) Its title specified the region: Southern and South-Eastern Europe. (ii) The funding was channelled from the donor to the regional office and not directly to the countries involved. (iii) The reporting was done on a regional level. (iv) It had one M&E framework (the three outcomes applied to all the countries). (v) It had a Regional Project Manager (at least during the first year). As implementation progressed and to maintain the relevance of the Project, each country fine-tuned their activities to reflect both R/M needs as well as UNICEF staff capacities. As a result, some services were offered in one country but not others. Furthermore, and as indicated in Section 6.4 (Efficiency), information sharing among the countries was not optimal and there was a missed opportunity to jointly produce some deliverables (such as the health packages or information material)
[107] UNICEF ECARO and UNICEF CO staff
[108] UNICEF CO staff
[109] UNICEF CO staff

changing its practices.[110,111] In Bulgaria, the two organisations delivered joint training on rights and responsibilities of unaccompanied minors and GBV.[112]

85. **UNICEF and UNFPA** jointly produced GBV information material in Italy, successfully combining their respective comparative advantage (UNFPA's technical expertise and UNICEF's extensive in-country network to design and implement the tools). They adapted the "Boys on the Move" tool to the Italian context and jointly trained UNICEF's IPs. The two organisations have also produced 12 Q&A on sexual violence and sexual and reproductive health targeting young adults (female and male). They implemented a participatory process in designing these tools and held consultations with adolescents to better understand the issues that needed to be addressed.

86. In Serbia, **UNICEF and WHO closely collaborated and coordinated** their immunization-related activities. For example, UNICEF organized meetings with partners and WHO participated in these meetings and shared the guidelines it had developed at the regional level thus ensuring that all partners received the same technical information. These meetings included not only WHO, but also representatives from the Ministry of Health, the National Institute of Public Health and the Commissariat for Refugee and Migration.[113]

87. Also, in Serbia, the Project to ensure greater coherence with **UNHCR**, worked with the official guardianship system specifically set up to cover UASCs and which was established by UNHCR and the Ministry of Labour, Employment, Veterans and Social Affairs and supported by another EU-funded project.[114]

88. In Italy, UNICEF, in collaboration with **IOM and UNHCR**, has carried out advocacy efforts and is implementing research activities.

89. Finally, there were some examples of coherence among the different IPs. For example, in **Bosnia and Herzegovina**, Centar Fenix collaborated with a partner organisation to ensure fast transport to the hospital for pregnant women and, with another, to guarantee that, four times a week, new-born babies and children (0-5 years) were able to access pediatric examinations.[115] World Vision International (WVI) collaborated closely with Danish Refugee Council's (DRC) pediatrician to ensure that formula milk could be provided only to babies that had a medical prescription.[116] Mission Wings, in **Bulgaria**, reported using appropriate printed materials from another IP, the Council of Refugee Women in Bulgaria (CRWB),[117] rather than printing their own. Due to resourcing constraints, CRWB printed and disseminated these materials for all IPs to use.[118] Similarly, in **Italy**, Medici del Mondo (MdM) collaborated with Caritas by providing medical consultations in Caritas-run health clinics.[119]

6.2.4 Coordination

90. Different coordination mechanisms exist in each country and the degree of coordination differs from one country to another. Notwithstanding these different coordination bodies, various stakeholders (government, UN agencies and IPs) noted that there were instances of overlapping and/or duplication of activities (e.g., training

[110] UNICEF CO staff
[111] IP staff
[112] UN representative
[113] UN representative
[114] Government representative
[115] IP staff
[116] IP staff
[117] Mission Wings Progress Reports December 2020-March 2021 and April-June 2021
[118] UNICEF CO staff
[119] MdM Progress report September 2020

of same service providers by the different UN agencies) which could have been avoided with more timely and more efficient information exchange.[120]

91. In Bosnia and Herzegovina and Serbia, coordination is primarily led by the government. In Bosnia and Herzegovina, the Ministry of Health (MoH) coordinates activities regarding health care activities for the migrant population. Bilateral meetings took place between UNICEF and MoH to ensure information sharing.[121] Monthly meetings were also organized and attended by the various implementing partners and representatives of government at federal, cantonal and local levels; however, according to some IPs, there remains poor coordination which results in duplication of services in some instances.[122] Of the five countries, Serbia had the most effective coordination mechanisms which included a number of government institutions (e.g., Institute for Public Health, Commissariat and camp/centre managers, NGOs[123]). Indeed, in Serbia, coordination is driven through the national working group for migrant health. UNICEF participates in its meetings alongside UNFPA, WHO, and UNHCR. This working group is led by MoH and includes other government partners and national NGOs.[124] The group held intensive meetings during the state of emergency in the pandemic. This has enabled better coordination among all NGOs and the Government of Serbia as well as improved access and referrals.[125] In addition, UNICEF also co-chairs the Child Protection Sub-Working Group with the Ministry of Labour, Employment, Veteran and Social Affairs, which has met regularly since 2016.

92. Elsewhere, UNICEF is a participant in wider refugee and migrant response coordination mechanisms that are led by other UN agencies in addition to governmental coordination mechanisms. In Bulgaria, UNHCR leads two sub-working groups on integration[126] and protection.[127] UNICEF, together with leading NGOs and representatives of stage agencies participate in these sub-working groups.[128] The State Agency for Refugees (SAR) organizes monthly coordination meetings for all actors working with asylum seekers.[129] Health coordination in Greece, revolves around the national health working group which currently focuses on COVID-19.[130] On the national level, UNICEF has participated in the Child Protection Sub-Group led by UNHCR since 2016. However, in the last year, UNICEF has not attended all the meetings. This was assumed by other actors to be due to staffing constraints at UNICEF while UNICEF stated that as Greece is no longer in a state of emergency, such coordination mechanisms are used less regularly.[131] In Lesbos, UNICEF also leads the WASH and Education working groups however as the refugee response in Greece is no longer an emergency, these groups are not convened regularly. Nevertheless, UNICEF, IOM and UNHCR meet a couple of times per year to ensure that there is no duplication and in Lesbos continue regular humanitarian coordination. Overall, UNICEF has a good working relationship with the Government of Greece.[132]

93. Italy has mixed forms of coordination. Here, UNICEF, IOM and UNHCR meet monthly. UNICEF also participates in the national MHPSS Technical Working Group which is led by the Ministry of Health, and which is planning to establish a sub-working group

[120] Government and UN Representatives
[121] Government representative
[122] IP staff
[123] Government representative
[124] UN representative
[125] Government representative
[126] The integration group is focused on those who have already obtained international protection and need assistance
[127] The protection working group is focused on people who are in process of obtaining international protection in the country
[128] UNICEF CO staff
[129] UN representative
[130] UNICEF CO staff
[131] KII with UN Agency, KII with UNICEF staff
[132] UNICEF CO staff

to address R/M mental health.[133] In addition, UNICEF is also a member of the Vulnerability Working Group, which is the main forum to discuss protection related issues and is led by the Ministry of Interior (MoI) and MoH. To avoid duplication – which had been observed in the past - UNICEF and UNHCR are currently developing a joint work plan and are carrying out joint field missions (also with IOM) and joint research on transition to adulthood. However, UNICEF does not hold coordination meetings with its IPs but rather meets with them on a one-on-one basis.[134] Based on an agreement reached between the NGOs and the UN agencies, at the national level, Save the Children organizes coordination meetings with several the NGOs working on child protection in Italy and, of the UN agencies, only UNHCR attends these meetings as an observer. Furthermore, at the decentralised level, and during the summer months which see an increase in migrant influx in Sicily, UNHCR steps up its coordination efforts and holds them on a more regular basis. In addition to UNICEF's participation, representatives from NGOs and prefectures attend these meetings. Furthermore, Save the Children reported that it, too, increased the frequency of its coordination meetings during the summer in the Agrigento prefecture. [135]

94. Finally, at the regional level, the Project was supposed to "coordinate with key UN and NGO partners, including UNHCR, IOM, UNFPA, WHO and OHCHR and other members of the Global Migration Network as appropriate towards the implementation of the Global Compact for Safe, Orderly and Regular Migration (GCM)."[136] However, there was no evidence that such regional coordination took place.

6.3 Effectiveness

Key Findings:

Finding 12: To a large extent, the Project has succeeded in meeting its planned targets in the five countries. Proxy outcome level indicators reveal that the Project has succeeded in (i) strengthening national authorities' capacity to provide healthcare to R/M children; (ii) increasing R/M health literacy; and (iii) strengthening implementation of national health policies. However, since the M&E system did not envisage Outcome level monitoring, the evaluation was unable to determine the extent to which the outcomes were achieved.

Finding 13: IPs monthly monitoring reports were produced in in a timely fashion, SADD were provided, however this was not reflected in the Interim Report. As a result, the Project was unable to compile SADD data across the five countries.

Finding 14: By not setting up a dashboard at the beginning of implementation, the Project missed an opportunity to properly and regularly monitor both output level and financial information.

Finding 15: The M&E framework was inadequate which was reflected in (i) the Project's title which did not capture what the Project was designed to achieve, (ii) the logic and coherence of the framework, and (iii) the definition of output and outcome indicators.

Finding 16: Several factors enabled the achievement of outcomes in the five countries. Most prominently was UNICEF's agility and flexibility followed closely using other grants to complement this Project. In addition, the use of cultural mediators and multiple means of communication, physical outreach to R/M population (mobile units, asylum centres), capacities and long presence of IPs on the ground, and cutting-edge research were all aspects that allowed to achieve its objectives.

Finding 17: COVID-19 was a major constraining factor which affected both the supply side (provision of services) as well as the demand side (inability of R/M to access services because of lockdowns and movement restrictions). It also created several operational challenges. In addition, there were

[133] UNICEF CO staff
[134] IP staff
[135] Save the Children, Progress Report August 2021
[136] ProDoc, p. 19

other limiting aspects which affected both service provision (supply side) as well as access to services (demand side).

Finding 18: The Project has led to several unintended consequences. Mostly they were positive and led to increased active participation in online webinars, lower number of school dropouts and better learning opportunities, improved social cohesion, greater demand for safe spaces, and greater capacity to use digital devices.

Finding 19: One serious unintended consequence are the increased threats that IP staff have received from both smugglers as well as perpetrators of violence, which are ongoing despite IPs strengthening their risk management systems.

Finding 20: UNICEF and its IPs have endeavoured to address both the needs of boys, especially UASC boys (which are substantively larger in number) while also providing services to girls and women who face greater risks. However, ensuring gender equality and social inclusion is not uniform across the five countries, partly because of the prevailing political discourse regarding gender equality in some countries.

Finding 21: UNICEF's approach to GBV Is in line with its Theory of Change and with the definition of GBV in the IASC's guidelines which focus on girls' and women's safety (and also the gendered dimensions of certain forms of violence against men and boys). The Project document specific that GBV prevention and response services should be provided to 'youth up to 24 years old, without discrimination, as well as women more broadly. The evaluation found limited evidence as to how male children and adolescents benefitted from GBV services but recognise that work on sexual violence against boys occurred as part of Child Protection Programming rather than as part of GBV services through this Project.'

6.3.1 Achievement of Results

95. To a large extent, the Project has succeeded in meeting its planned targets in the five countries. It has exceeded the number of children, parents/caregivers who received health-related information and services as well as the number of health officials who participated in capacity building activities. With the no cost extension, it is also on track in delivering the remaining outputs associated with Outcome 3. Annex 11 provides detailed information regarding the health services provided, in which languages health literacy materials were produced, and the venues where R/M were targeted, and Annex 12 provides detailed information per country and year for each output.

96. There were several reasons that led to the over-achievement of the originally set targets. They include the following: (i) due to COVID-19, the needs of the R/M population increased significantly and, as a result, the number of beneficiaries also increased; (ii) in some cases, the target numbers had been underestimated during the Project's design, so it was relatively easy to reach and surpass the planned number of beneficiaries;[137] (iii) a change in the number of R/M population which significantly increased in the last two years (e.g., in Bosnia and Herzegovina);[138] (iv) a larger number of participants in online training; and (v) a greater demand for the flyers which were widely distributed to all categories of refugee/migrants – parents and children (see Box 3).

Box 3: High Demand for Certain Type of Brochures

In Bulgaria, one of the most sought-after brochures was the one which provided emergency contact information (phone number 112). It was used preventively during health consultations, but also in cases of emergencies and for handling of cases of gender-based violence. [139]

97. In a few instances, the Project was unable to reach the set targets which was due to (i) a significant decrease in the number of R/M (e.g., in Greece R/M decreased by 90

[137] UNICEF ECARO staff
[138] UNICEF CO staff
[139] Mission Wings Progress Report December 2020-March 2021

percent in last two years);[140] and (ii) changes in the demographics of the population on the move, such as a decrease in the number of families transiting with children 0 to 2 years old which led to lower numbers of beneficiaries in the MBCs (e.g., in Serbia).

98. The Project did not set up a system to monitor outcome indicators. As such, the following section provides examples of changes the Project was able to achieve based on KIIs with multiple stakeholders.[141] The evaluation was unable to determine the extent to which these changes took place (i.e., the number of R/M and health officials who – because of the awareness-raising and training delivered – have changed behaviour).

Strengthened national authorities' capacity to provide healthcare to refugee and migrant children

99. The Project succeeded in strengthening national capacities[142] to provide healthcare to the R/M population – and, in some cases, in introducing services that had not been offered before to R/M children - by (i) delivering MHPSS services to R/M population in the five countries, especially children (e.g., in Bosnia and Herzegovina, prior to Project focus of mental health services was on adults and not children;[143] (ii) ensuring that R/M children were immunized (in Bosnia and Herzegovina prior to the Project, R/M were not being vaccinated);[144] (iii) providing dental and ophthalmological medical services for children (Bosnia and Herzegovina);[145] (iv) improving quality of maternal health services, including nutrition;[146] (v) providing additional capacity where the systems were over-stretched (e.g., in Lesbos, Greece, the human resources in state run facilities were significantly constrained making service provision with RICs crucial);[147] (vi) providing complete physical check-ups to children (in Bosnia and Herzegovina and Bulgaria);[148] (vii) offering GBV prevention and referral services to women and girls; and (viii) having cultural mediators to accompany women and children which increased their access to public social and health services and improved the quality of the services delivered.[149]

Increased health literacy among refugee and migrant children and their parents

100. UNICEF supported the production of appropriate health literacy materials in several languages to increase R/M's health-related awareness (see Box 4).

Box 4: Age and Language Appropriate Health Literacy Material in Serbia

> During the last year, in partnership with UNICEF, the government developed six booklets/leaflets that have been translated into several languages spoken by R/M population. In addition to the brochure that provided general information regarding healthcare services, several others were produced for a specific target group. For example, mothers received one on the importance of breastfeeding. Parents and caregivers were provided one on early childhood development. Some materials were intended for youth on topics such as anger, stress management and substance abuse.

Source: KII Government

---

[140] UNICEF CO staff
[141] However, as mentioned in the Limitations section, the evaluation team was unable to interview rights holders (children, parents, caregivers) nor health staff who participated in the trainings
[142] Outcome 2 would have been more accurate if it had been worded as "Strengthened provision of health care to refugee and migrant children" since, often, the provision of services was made predominantly by IPs and not by national institutions. Furthermore, activities which strengthened national capacity (such as training of health staff and developing procedures) were implemented under Outcome 3
[143] UNICEF CO staff
[144] UNICEF CO staff
[145] Government representative
[146] IP staff
[147] UNICEF CO and IP staff
[148] IP staff
[149] IP staff and Government representative

101. In most cases, the R/M were targeted in reception centres, hotspots, refugee camps, asylum offices. Furthermore, in Italy, UNICEF's IPs worked with R/M living in informal settlements as well as those along border areas (see Box 5).

Box 5: Innovation in Italy – Establishing a Viber Group for R/M "on the move"

In Italy, UNICEF targeted R/M not only in migrant centres or camps but also those "on the move" and along border areas. UNICEF and its IP set up Viber groups to protect R/M when they realised that R/M were vulnerable to "criminal groups" and cyber-bullying.

Source: UNICEF ECARO, UNICEF Italy

102. In the five countries, IPs implemented several activities to increase the health literacy of R/M children and their caregivers covering various topics that were wide ranging.[150] This was evidenced by stakeholders mentioning the following proxy indicators: (i) continued breast-feeding (and not switching to baby formula).[151] In one camp in Greece, the requests for baby formula milk completely ceased which was a significant achievement;[152] (ii) an increase in number of R/M immunized children (proxy for health literacy and improved access to services) since prior to the Project, some parents were reluctant to immunize their children;[153] (iii) greater demand by women and girls to access physical and mental health support;[154] and (iv) an increase in the number of mothers frequenting Mother Baby Corners.

103. In addition, IPs covered several other health-related topics based on their field observations. These included (i) nutritional awareness (e.g., malnourishment/obesity in children)[155] and the consumption of energy/soft drinks;[156] (vi) substance abuse in Bosnia and Herzegovina,[157] Bulgaria,[158] and Serbia; (vii) prevention of tuberculosis, (viii) spine deformities[159][160] in school children and improvement of posture;[161] (ix) information regarding COVID-19 prevention and protection measures;[162] (x) daily routines (e.g., the importance of sleep for children and the side effects of playing videogames late at night);[163] (xi) general hygiene issues;[164] and (xii) a special session to deal with child tantrums.[165]

104. IPs reported that the target R/M population provided positive feedback regarding the training and capacity building and parents started requesting specific topics they wanted to be included in future sessions.[166] The IPs were also successful in building trust among the R/M population, which is a key factor especially regarding GBV issues (see Box 6).

Box 6: Using Health Consultations for Establishing Trust to Address GBV

According to one IP in Greece, due to the holistic model it used, they witnessed the highest percentage of self-disclosures. The combination of information awareness sessions/pregnancy

[150] Since the evaluation was unable to meet with the direct beneficiaries, it was not possible to assess the extent to which these activities resulted in behaviour change
[151] UNICEF ECARO staff
[152] IP staff
[153] UNICEF CO staff and Government representative
[154] IP staff
[155] IP staff
[156] IP staff
[157] IP staff
[158] IP staff
[159] One IP noticed - when doing the medical examination necessary for children to enroll in primary schools – that several had a problem with their body posture of their bodies and decided to raise awareness regarding this issue
[160] IP staff
[161] IP staff
[162] IP staff
[163] IP staff
[164] IP staff
[165] IP staff
[166] IP staff

cycle/young girl awareness raising, led to establishing trust and to a high self-disclosure rate because women felt they could share their experiences and receive appropriate support. A key point was that the IP had established a system through which it could quickly refer women without subjecting them to questioning. Unlike other organisations, they did not use extensive questionnaires. Instead, the IP had a team of highly skilled psychologists and therapists who were able to pre-identify survivors of GBV and follow up more closely.[167]

105. It is important to note that behaviour change is easier to observe in R/M in camps than those on the move.[168] Behaviour change was mostly noted in the feedback received from women and girls who participated in multiple workshops over the course of several months. IP staff observed a change in how the R/M addressed certain topics, such as parenting style, gender and sex issues, and child marriages.

Strengthened implementation of national health policies

106. The Project – given its short duration - focused more on developing tools (SOPs, Code of Conducts, etc.) and not on reviewing/developing policies.[169] Public health officials and frontline workers participated in several trainings. In some instances, IPs did pre/post training tests and found that knowledge had improved.[170] The Project also contributed to increasing the knowledge of public health institutions. For example, in Bosnia and Herzegovina, cantonal health institutes are better informed regarding the R/M health conditions – which was not the case prior to the Project.[171] In Serbia, the workshops were offered to a wide range of professionals, including educators, training of trainers, people working directly with RM (e.g., guardians from centres for social work, Commissariat staff, and frontline health staff including doctors and psychologists).[172] Similarly, in Italy, UNICEF offered online accredited continuous education for medical professionals and in Greece, training targeted a variety of stakeholders (see Box 7).

Box 7: Capacity Building in R/M Camp in Lesbos, Greece

Training was underpinned by a needs assessment and field observation that kits contained the wrong food for babies

Targeted a wide range of participants, including NGO staff, employees of the state-run health provider EOYD, employees of site management organisations who deliver food kits, volunteer movements based around camps, other professionals working in Lesbos (e.g., teachers)

Produced set of training materials, including posters for beneficiaries that contained distilled information, a truth or myth game that can be used by any facilitator with or lactating women. Made sure that the material was aesthetically pleasing and applicable, because a lot of existing material is a little bit dated and is more applicable to other contexts

Results achieved: (i) Most of the people who participated in the post-training survey stated that they had changed their mind and think the topic is more important than it was before. (ii) It created a network of people who have kept in touch, and some have come back to ask for more information, how to deal with specific cases. IP staff noticed that the participants in the training have started collaborating in the camps (e.g., midwives and volunteers are working together).

Challenges faced: Training was delivered at a time when many staff were being made redundant because of budget cuts and there were layoffs so many were not interested in participating in capacity building activities. The targets were based on the staff that were present in the camps, however, since their number was reduced, they had a fewer number of participants than initially planned.

[167] IP staff
[168] IP staff
[169] UNICEF-ECARO staff
[170] IP staff
[171] Government representative
[172] Government representative

Source: IP

107. The Project was able to strengthen national capacities to provide healthcare to R/M children in several ways by: (i) including a "prevention" element without which there would have been a greater number of high-risk cases;[173] (ii) training government officials and IP staff which resulted in a noticeable behaviour change in health service providers and the manner they deliver services;[174] iii) developing coping mechanisms of public health workers to better be able to cope with feelings of helplessness and to reduce professional burnout;[175] (iv) mapping of services and developing SOPs for improved and more effective referral services that connect children and their caregivers to specialised health care (e.g., in Bulgaria and Italy, UNICEF conducted such mapping of services; and in Bosnia and Herzegovina the mapping exercise was done at the cantonal level);[176;177] (vi) learning about the importance of cultural mediators, since for most public health officials it was the first time they had interacted with cultural mediators; (vii) increasing understanding and visibility of substance abuse and immunization amongst health professionals;[178] (viii) understanding the importance of mental health issues;[179] (ix) building capacities of partners (e.g., in Bosnia and Herzegovina, IOM now follows UNICEF's protocol regarding provision of baby formula milk[180] and in Italy, UNICEF built partners' capacity regarding Protection Against Sexual Exploitation and Abuse - PSEA);[181] and (x) dissemination of indicators, tools and protocols to work with UASC which has strengthened the capacity of frontline staff to work with these children.[182]

108. At the regional level and at the time of the evaluation, the Project had produced a draft "dashboard" and five draft country "policy" briefs capturing "key promising practices and recommendations for improving refugee and migrant children's health status" and which are supposed to feed into the regional policy brief that will be produced by the end of the Project.[183] There was a lack of clarity regarding the type of information and the timing of establishing this dashboard.[184] As a result, a "draft dashboard" was produced in November 2021 which was a graphic representation of the information provided in the Interim Report (a snapshot of what was achieved by end of March 2021). Similarly, the draft country-level "policy briefs", which were shared with the evaluation team, compile good practices and are not an analysis of existing R/M-related policies/gaps in the five countries. There is still an opportunity to include in the final version a policy/legislative analysis which identifies gaps regarding R/M access to health services and which could guide current/future advocacy efforts.[185] Finally, also at the regional level, several visibility products were developed which include a Project webpage, two regional Project newsletters, and serval human-interest web stories.

[173] Government representative and UNICEF ECARO staff
[174] IP staff, Government representative, UNICEF CO staff
[175] Government representative
[176] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[177] UNICEF (2021). Strengthening national health capacity for refugee and migrant children, by Angela Hawke, 29 January 2021. https://www.unicef.org/eca/stories/strengthening-national-health-capacity-refugee-and-migrant-children
[178] UN representative
[179] Government representative, UNICEF-CO staff
[180] UNICEF CO staff
[181] IP staff
[182] Government representative
[183] TORs "Consultancy to support strengthening the implementation of national health policies for the 'Refugee and Migrant Children's Health Status in Southern and South-East Europe' Project"
[184] UNICEF ECARO staff
[185] UNICEF ECARO staff

6.3.2 Monitoring, Reporting, and M&E Framework

109. **IPs monthly monitoring reports were produced in a timely fashion**. Per the agreement with DG Health/CHAFEA, UNICEF was expected to report on all beneficiaries disaggregated by sex and age, in order to ensure that the Project focused on children while at the same time offering GBV services to women.[186] However, the Regional Office did not provide a standardized reporting form meaning that COs produced their own standardized reporting forms that were issued to IPs in each country. As a result, the way in which IPs reported on sex and age-disaggregated data (SADD) was not standardized across all five Project countries. Furthermore, the IPs ranged from large international NGOs to smaller local organisations and not all had the same capacity to provide adequate reporting (see Box 8). Interestingly, in some cases, IPs such as Intersos and Save the Children in Italy, tracked the type of referral that was made (e.g., medical, mental, education, police, employment, GBV, shelter, etc.)[187] which could be a basis for a future case management system.

Box 8: Reporting by Local NGO in Serbia

One challenge is related to the reporting requirements and how a small NGO partner is expected to feed into a UNICEF regional project. There were some constraints regarding some of UNICEF M&E requirements and the push to have the identical (or almost) indicators/services/log frames as the other countries. It was a challenge to adjust the Project's log frame to the local context since every NGO was implementing different activities. This was a particular challenge in cases where IPs used the UNICEF funding to expand on existing activities which were not specifically tailored to the Project since they were designed prior to its start. Furthermore, according to the local NGO, compiling and reporting had more steps than necessary and presented a burden for them as a small NGO with limited resources.[188]

110. Furthermore, as mentioned previously, the Project had envisaged the setting up of a "dashboard".[189] The understanding of UNICEF – which it confirmed with the EU – was that the dashboard would be a graphic representation – a snapshot - of achievements during two points in time: at the Interim Report and the Final Report. **By not setting up a dashboard at the beginning of implementation, the Project missed an opportunity to properly and regularly monitor both output level and financial information.**

111. UNICEF was required to produce an Interim (15 months after start of Project) and a Final report to the EU. The draft Interim report was produced in a timely fashion and was finalized based on feedback from the EU in July 2021.

112. The M&E framework was inadequate which was reflected in (i) the Project's title which did not capture what the Project was designed to achieve, (ii) the logic and coherence of the framework, and (iii) the definition of output and outcome indicators. The Project's title "Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe" focused on strengthening the "health status" of R/M and did not reflect what the Project aimed to achieve.[190] It reflected the EU's preference for the use of "development" language whereas the activities focused mostly on humanitarian interventions (supply side). Furthermore, it would not have been possible for UNICEF to measure the "improved health status" since there was no baseline information

[186] ProDoc (p.8) footnote: Data on results will be disaggregated by age and sex to provide details on number of children and adults reached in interim and final assessment reports and relevant dashboards.
[187] Monthly reports of Intersos and Save the Children
[188] IP staff
[189] A dashboard is a type of graphical user interface which often provides at-a-glance views of key performance indicators (KPIs) relevant to a particular objective or business process. The "dashboard" is often accessible by a web browser and is usually linked to regularly updating data sources.
[190] UNICEF ECARO staff

neither on the supply side nor on the demand side which would have been difficult – if not impossible – to have such a baseline for a transient population.[191]

113. In addition, the output indicators included in the Project's logical framework "(#1) Partnership agreements with implementing partners signed by Month 3; (#2) Country-specific health literacy packages developed by Month 8; (#3) Interim regional assessment report submitted by Month15; and (#4) Final regional assessment report submitted by Month 30" - with the exception of #2 - were not "output indicators" as such but rather project management ones.

114. At the country level, there was a lack of clarity regarding the indicators (e.g., some countries reported number of posters produced and not number of beneficiaries reached with awareness-raising material, other countries had difficulty with reporting of beneficiaries receiving GBV services since this activity was also part of the regional GBV project). Furthermore, and as a result, the outcome indicators in the M&E framework were in effect "output" level indicators, meaning that in reality the Project measured the number of people whose awareness was raised and number of people who were referred to health services[192] but did not measure actual access to health services (e.g., number of people vaccinated),[193] and even less so, improved health status (see Annex 26 for the Project's Logical Framework and Indicators).[194]

6.3.3 Enabling Factors

115. **Several factors enabled the achievement of outcomes in the five countries. Most prominently was UNICEF's agility and flexibility followed closely using other grants to complement this Project.** In addition, the use of cultural mediators and multiple means of communication, physical outreach to R/M population (mobile units, asylum centres), capacities and long presence of IPs on the ground, longer contracts with IPs, and cutting-edge research were all aspects that allowed the Project to achieve its objectives.

116. **Agility and innovations of UNICEF and its partners on the ground.** All of UNICEF's IPs - without exception – pointed out UNICEF's agility and flexibility which allowed the Project to respond to changing contexts and needs, as already discussed above (see Box 9). For example, in Serbia, UNICEF allowed its IPs to (i) introduce new services (e.g., an online communication platform and a GBV phone line during the COVID-19 pandemic); (ii) changed the location where services were provided to follow families when they moved from one camp to another; and (iii) strengthened their teams with a protection stream.[195] In Italy, one IP - by creating "My Playlist" - used music as an innovative coping strategy during the COVID-19 lockdown and to ease the emotional aspects during the isolation period.[196]

Box 9: Agility and Flexibility of IP in Bosnia and Herzegovina

IPs in Bosnia and Herzegovina had to find creative solutions to the different challenges they faced, especially since the Project did not allow for the procurement of certain essential items. In one camp, the IP used a container to establish an MBC. It also used a container as a space to deliver different services (training and advisory). In another camp, the conditions were even worse: the space available was a small room. These spaces did not have electricity nor heating. The IPs had to be

[191] UNICEF ECARO staff
[192] For example, the indicator that measured # of children who received dental services was the # of children who were referred to dentists and not necessarily the # of children who received effective dental treatment
[193] UNICEF ECARO staff
[194] UNICEF ECARO staff
[195] IP staff
[196] MdM Progress Report June 2020

creative to deliver services that meet minimum standards, especially when it concerned infants who need a specific temperature, clean surfaces, and hot water.[197]

Also, in Bosnia and Herzegovina, there were cases where R/M pregnant women and mothers were in isolation because of COVID-19. During this time, the women must be treated differently from the rest of the R/M population. To respond to those new needs, the IP had to re-organise its activities and procure additional items, including protective equipment and gear.[198]

117. **Mobilizing funds from other resources to complement this Project**. Since the HaDEA procurement rules did not allow the procurement of goods nor the funding of health service delivery, UNICEF and its partners succeeded in using other grants to purchase essential items (e.g., hygiene supplies, drugs, PPE for IP staff, snacks to offer during awareness-raising sessions[199]) and were able to fund the delivery of services to support R/M through other Projects (see Box 10).[200] It is important to highlight this aspect because it played a big role in ensuring the effectiveness of the Project. Otherwise, the Project may have been able to raise health-related awareness and refer R/M beneficiaries to service providers; however, the R/M beneficiaries would not have been able to actually *receive* the health services because either the necessary supplies were not available and/or the cost of the service was not covered.

Box 10: Use of Other Grants to Complement this Project in Greece

Melissa, a UNICEF IP in Greece, delivered MHPSS through group therapy because it found that it built trust, is more culturally acceptable, and helps to replace a disrupted social network. This group therapy model was very valuable in the pandemic because it could be smoothly transferred to online delivery. Even if the rates of attendance may decrease, the level of engagement could be maintained. A separate grant was secured to provide participants with tablets, so it was easy for them to access the services. They often heard that women referred to the tablet as 'Melissa's eye in their house' and used it to feel safer (e.g., could threaten husbands with recording domestic violence). The IP also developed a code word system which could be used by women to ask for help/protection. This played a big part in creating an online safe space but only worked because the IP had already established the women's trust by initiating the sessions in-person and in a physical environment which could be later transferred to online service provision.

118. **Multidisciplinary approach integrating health, GBV and child protection**. Following a multidisciplinary approach allowed UNICEF and its partners to address physical and mental health, as well as GBV and protection issues which increased the effectiveness of the services delivered because the IPs were able to refer R/M to the relevant services. A strong example of this is the IRC Consortium in Greece. Here, several IPs under the leadership of IRC worked together to implement project activities in Lesbos. Each partner brought a specialty to the consortium (e.g., child protection, GBV, case management) and the tight coordination within the consortium meant that partners could quickly make referrals to each other and leverage each other's expertise to provide holistic support to beneficiaries. This allowed them to circumvent long referral processes to external partners and coordinate their response to ensure if remained relevant to emerging needs. Furthermore, the **COVID-19 pandemic was an opportunity to tackle more sensitive issues related to GBV and protection. T**eams used the delivery of COVID-19 related information as an entry point to link children and their families to other services.[201]

119. **Prior close working relationships with key ministries.** Delivering services to R/M population is a sensitive issue. UNICEF's long-term cooperation with ministries of health and social protection, especially in Bosnia and Herzegovina, Bulgaria, and

[197] IP staff
[198] IP staff
[199] Snacks are often offered during awareness-raising sessions to ensure their effectiveness
[200] UNICEF CO staff
[201] UNICEF (2021). RMChild-Health Newsletter 1, January 2021, p.4

Serbia, allowed it to build on the already established collaboration mechanisms to work with R/M.[202]

120. **Multiple means of culturally and age-appropriate communication and information sharing.** UNICEF and its IPs used a wide range of tools to reach out to R/M, such as Facebook pages, WhatsApp/Viber groups, emails, websites to communicate with R/M in several languages. For example, in Italy, UNICEF and its IPs in Sicily established relationships with local public service providers, private sector who managed reception centres, lawyers (who handled cases of GBV), President of Cultural Associations and relied on word of mouth as ways of communicating and sharing information with R/M population.[203] UNICEF also produced culturally appropriate material to address GBV and other sensitive issues (see Box 11). In Greece, simple and engaging visuals on COVID-19 prevention and on how to maintain good nutrition during the pandemic were developed and shared. Child-friendly information posters and stickers on COVID-19 prevention are now on display wherever refugees and migrants congregate.

Box 11: Culturally Appropriate Information Material to Tackle Sensitive Topics in Italy

In Italy, a whole range of materials has been developed and is now available specifically for linguistic and cultural mediators, health workers, social workers, and others. These include Q&As on subjects that are often particularly sensitive and difficult for young refugees and migrants – and even frontline workers themselves – to discuss, such as gender-based violence and sexual and reproductive health. They provide clear, concise, user-friendly information that helps to dispel the many myths and misconceptions around such issues.

Source: UNICEF (2021). Strengthening the implementation of health policies, by Angela Hawke, 1 February 2021. https://www.unicef.org/eca/stories/strengthening-implementation-health-policies

121. **Removing barriers and facilitating access.** IPs ensured that all potential barriers were removed by (i) providing services without requesting for documentation; (ii) being open during different times of the day (e.g., both in morning and afternoon)[204] and some after working hours;[205] (iii) setting up an emergency phone number in 11 languages with a doctor and cultural mediator which allowed the provision of prevention information and a first aid medical consultation remotely;[206] (iv) recruiting a joint medical/cultural mediator team to better understand cultural barriers and how to better address them and provide appropriate services; and (v) using mobile teams in Serbia, Italy and Bulgaria[207] to cover neighbourhoods with high migrant population.[208,209] The Project paid special attention in addressing language barriers and produced information material in R/M native languages.[210] For example, in Bulgaria, UNICEF and the Council of Refugee Women of Bulgaria (CRWB) provided materials in Arabic and Bulgarian on COVID-19 prevention. In Italy, UNICEF and its partners developed and disseminated key messages on how to prevent COVID-19 infection once lockdowns end and when living with someone. A short video was also developed and disseminated in Italian, English, and French.[211] In some cases, special attention

[202] Government representative
[203] IP staff
[204] IP staff
[205] IP staff
[206] IP staff
[207] IP staff
[208] IP staff
[209] UNICEF (2020). In Pictures: UNICEF continues support for critical frontline care during COVID-19 pandemic in Italy Health team targets vulnerable refugee and migrant children and families with limited access to services, 21 April 2020 https://www.unicef.org/eca/stories/pictures-unicef-continues-support-critical-frontline-care-during-covid-19-pandemic-italy
[210] IP staff
[211] UNICEF (2021). Safeguarding the health of refugee and migrant children during the COVID-19 pandemic, by Angela Hawke, 1 February 2021. https://www.unicef.org/eca/stories/safeguarding-health-refugee-and-migrant-children-during-covid-19-pandemic

was paid to illiterate children (see Box 12) and to persons with disability (see Section 6.3.6).

Box 12: Conducting Surveys with Illiterate R/M Children in Serbia

When, in Serbia, researchers discovered several children that were illiterate in their mother tongue, they recorded all the questions being read in their native language and played the recording to the children, thus removing a barrier and ensuring social inclusion.

Source: KII Government

122. **Capacities and long presence of IPs on the ground.** The fact that the team has worked on the topic for several years meant that they were familiar with the issues and context regarding migration, women in the migrant community, working in a refugee camp. That goes for simple things like adjusting language and behaviour to more over-arching matters like designing activities (e.g., appropriate remote channels).[212]

123. **Longer contracts with IPs**. In humanitarian settings, IPs usually have short-term contracts (on average 3-6 months). UNICEF's longer funding window was crucial for IPs to innovate and suggest adjustments. Staff were assured of having greater job security and access to R/M camps and were able to run safe spaces and mobile units for a longer and more continuous time which was critical for building trust, and effectively delivering services.[213]

124. **Cutting edge research in some of the countries to inform the development of information material, training, and referral mechanisms.** For example, in Serbia, UNICEF established a partnership with the Institute of Mental Health to carry out research beyond the provision of basic health care to assess the scale and nature of substance abuse among refugee and migrant communities. This cutting-edge field research guided the development of materials and capacity building specifically for health and community workers who are in regular contact with young refugees and migrants, helping these workers to identify and tackle substance abuse by connecting children and youth to support services.[214] Similarly, in Bulgaria, ground-breaking research was undertaken on refugees' experiences of health services in their countries of origin, and how this has shaped their expectations and uptake of health services in Europe.[215] Finally, UNICEF in Italy has partnered with the Office of Research - Innocenti to carry out several research products some of which were funded through this Project (e.g., mapping of MHPSS good practices).

125. **Physical location of services.** The location where services were provided also played a role in ensuring that a greater number of beneficiaries were reached in an effective way. For example, in Bulgaria, the IP located its office within a 10-minute walk from the refugee camp which encouraged the R/M population to seek help and advice from its health professionals.[216] In Italy, health promotion was delivered in quarantine centres (which was not initially envisaged by the Project) and which proved to be an

[212] IP staff
[213] IP staff
[214] UNICEF (2021). Strengthening the implementation of health policies, by Angela Hawke, 1 February 2021. https://www.unicef.org/eca/stories/strengthening-implementation-health-policies
[215] The analysis on access to health services, delivered by the Council of Refugee Women in Bulgaria (CRWB) as part of the 'RMChild-Health' initiative, surveyed more than 130 beneficiaries from Afghanistan, Iran, Iraq, Palestine, Russia and Syria, as well as 24 health specialists in September 2020. The analysis had two main goals. First, to assess the health needs of migrants, asylum-seekers and refugees and their access to state-led health services in Bulgaria and compare this to their previous experience in their countries of origin. And second, to develop training modules and practical recommendations for beneficiaries and health specialists that would strengthen their mutual understanding and cooperation and, therefore, enhance access to strong health services. Source: UNICEF (2021). Strengthening national health capacity for refugee and migrant children, by Angela Hawke, 29 January 2021. https://www.unicef.org/eca/stories/strengthening-national-health-capacity-refugee-and-migrant-children
[216] Mission Wings Progress Report December 2020 – March 2021

effective way to increase awareness of R/M population on various health aspects.[217] Similarly, in Greece, health promotion was also carried out in classrooms with educators.[218] Finally, also in Greece, IPs targeted R/M at asylum services – where usually there is a long wait – and is an effective way to reach a greater number of beneficiaries for a longer period of time and deliver health literacy awareness messages (see Box 13).[219]

Box 13: Mother Baby Corners (MBCs) in Asylum Centres in Greece – A Good Practice

The MBCs were originally established because of an individual initiative of a government employee who noticed that women were queuing for several hours outside the asylum service in Athens and that women needed a private space to feed their babies. In addition, they were receiving a lot of unwanted attention from men which made them uncomfortable. In collaboration with Metadrasi who was already offering interpretation services at the asylum centre, UNICEF also recognised the necessity for such MBCs and supported Metadrasi to ensure the availability of such services. Though some government employees were initially suspicious of the idea, over time they became convinced of the MBC's importance and how it created a win-win situation: women are not allowed to bring their children into the interview and MBCs provided a safe space where they could be left. This helped both the case worker and the asylum-seeker.

126. **Institutional collaboration at different levels.** In Bosnia and Herzegovina, UNICEF was able to work with the central authorities as well as those at the decentralised level. Here the Project collaborated with both the central Ministry of Health as well as with the cantonal ones.[220] Similarly, in Italy collaboration took place with the Ministry of Interior (which is a centralized ministry) as well as with the regional and local level public health institutions which are managed at the decentralised level.

127. **Flexibility of the EU in widening the target group.** The EU accepted to include GBV though, initially, it was not a priority since it preferred that the Project focus on children, adolescents, and pregnant women. It also approved UNICEF's approach to work with caregivers – and not only parents – regardless of their sex.

6.3.4 Constraining Factors

128. COVID-19 was a major constraining factor which affected both the supply side (provision of services) as well as the demand side (inability of R/M to access services because of lockdowns and movement restrictions). It also created several operational challenges. As noted in the Interim Report, COVID-19 also led to a mismatch between the supply/access to services and the increased needs (health-related, GBV and psychosocial) created by the pandemic.[221] COVID-19 also overstretched the national public health systems as well as UNICEF Health staff.[222] In addition, the pandemic had a direct impact on government and NGO staff who contracted the virus and were unable to work and, in some cases, led to office closures because all the staff had to be placed in quarantine.[223] COVID-19 also forced most services to be delivered remotely and created new challenges, such as (i) difficulty in building relationships of trust with children - particularly adolescent girls; (ii) difficulty in coordinating online relationships with reception centres; (iii) inequality of access to digital devices (in particular for children); (iv) lack of private places for GBV survivors to talk freely; (v) an

[217] UNICEF CO staff
[218] UNICEF CO staff
[219] UNICEF-CO staff
[220] UNICEF CO staff
[221] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[222] UNICEF-ECARO staff
[223] Mission Wings Progress Report December 2020 –March 2021

increased sense of isolation among R/M;[224] and (vi) technical problems related to online training delivery (e.g., not all participants had equally good connectivity and, in Serbia, a third training was delivered on a new platform which had some technological problems and had to be addressed on the go).[225]

129. The constraining factors related to the R/M themselves (demand side) which affected access to health services included lack of trust in public services, lack of key documentation, and their transient nature.

130. **Lack of trust**: R/M tend to distrust public services. According to research conducted by UNICEF in Bulgaria, this lack of trust was also compounded by negative attitudes from health providers, cumbersome and bureaucratic systems, unavoidable financial costs (for services that fall outside the state-covered health budget), and over-crowded accommodation that heightened health risks.[226] Furthermore, in some cases, R/M were unwilling to take the one-shot vaccine, however no other vaccine was available at the time.[227] In the five countries, several IPs addressed this issue by making available cultural mediators which contributed to building trust with refugees and migrants.[228]

131. **Lack of key documentation**. R/M children often lack the proper documentation which proves their age (to determine whether the person is a minor or not) and their health history, including vaccination status (see Box 14). Without such documents, IPs faced difficulties in convincing authorities to place R/M children in childcare facilities[229] and noted that there were cases where UASC were mis-identified as adults.[230] COVID-19 brought about a further complication. When the strict lockdowns were lifted, R/M increased their attempts to cross the borders and destroyed their documents (including health-related ones) so they could not be tracked. During this period, organizing immunization campaigns was quite challenging, and all efforts by public health institutions to vaccinate R/M children were quite ad hoc.[231]

Box 14: Challenges Identified by Social Service Providers in Bulgaria

Absence of complete information about the date and year of birth

Absence of data and information about the current health status and health history concerning chronic, hereditary, and past diseases

No information regarding COVID-19 status

No information about the child's development – both physical and mental

No information about past mental and physical traumas

Unaccompanied immigrant children cannot gain access to health care due to absence of documents and issues with legal representation.

Language and cultural barriers

Source: Social Assistance Agency of Bulgaria

[224] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[225] Government representative
[226] UNICEF (2021). Strengthening national health capacity for refugee and migrant children, by Angela Hawke, 29 January 2021. https://www.unicef.org/eca/stories/strengthening-national-health-capacity-refugee-and-migrant-children
[227] UNICEF CO staff
[228] Mission Wings Progress Report December 2020 – March 2021
[229] IP staff
[230] UNICEF CO staff
[231] Government representative

132. **Transient nature of R/M:** R/M in the five countries included in this Project are more transient than refugees and migrants in other countries. This created challenges both in awareness raising, skills building and provision of health services. In Serbia, skills building activities for R/M children faced obstacles in implementation due to the dynamics of their transit through Serbia. The trainings required continuous presence, but since unaccompanied and separated adolescents are one of the most mobile categories of R/M, prioritizing attempts to cross borders, it was difficult to motivate them to participate regularly. Adjustments to the training dynamics and flexibility of the teaching staff were thus required.[232] Furthermore, the high turnover of beneficiaries rendered following up the child from the beginning to the end of the treatment quite challenging.[233] Finally, the fluctuating migrant population meant that children often left the country before getting their booster shot.[234]

133. **The Project also faced difficulties related to the supply side of service delivery. Below are some examples.**

134. **Lack of willingness of public health staff**: In Bulgaria, IP staff noted the lack of desire at local level for cooperation and coordination among the different stakeholders relevant to R/M health.[235] Often, staff from one structure did not provide the needed service but instead referred R/M to another, which negatively affected the trust of those in need of assistance.[236] This was also partly due to the public health system being already over-stretched and work with R/M is not a priority.[237]

135. **General public attitude towards migrants**: In several countries included in this evaluation, the general attitude towards R/M has deteriorated in recent years. In some cases, prejudice has increased due to misperceptions leading people to think that COVID-19 was brought by migrants from other countries.[238] In the case of Greece, although overall the host population has been welcoming, a major financial crisis combined with a large influx of R/M has created several challenges. Furthermore, the lack of a common language and cultural understanding has added to the lack of acceptance of R/M.[239] In Serbia, a government official noted that the pandemic is preventing them from addressing integration with the host community to lessen stigma.[240]

136. **Lack of ownership due to institutional turnover**: In Bulgaria, the government changed twice during the life of the Project. As a result, UNICEF was unable to "sell" the project to the Ministry of Health due to the institutional turnover.[241]

137. **Discriminatory or lengthy legislation and procedures**: In some countries, there were some discriminatory laws and procedures which impeded R/M's access to health services/or for example, in Bulgaria, pregnant refugee and migrant women are not currently covered by state health insurance. In addition, the law requires that UASCs are accompanied by a legal guardian when they are being examined and treated, particularly when such children need a life-saving intervention.[242] In Greece, administrative delays posed a problem. Many refugee and migrant families did not

[232] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[233] IP staff
[234] Government representative
[235] Mission Wings Progress Report December 2020 – March 2021
[236] Mission Wings Progress Report April-June 2021
[237] UNICEF CO staff
[238] IP staff
[239] UNICEF CO staff
[240] Government representative
[241] UNICEF CO staff
[242] CHAFEA - UNICEF RM Child-Health project Kick-off meeting, 29 April 2020

receive the Temporary Aliens Provisional Insurance and Health Care Number (PAAYPA)[243] in time due to lengthy bureaucratic procedures exacerbated by COVID-19, thus preventing them from accessing public health care services.[244] To respond to this challenge, UNICEF and its partners supported with increased case management and referrals.[245]

138. **Lack of specialized care for GBV survivors and insufficient capacities at local level:** In all the countries in this evaluation, IPs remarked that there is a lack of dedicated professionals to support GBV survivors which limits the availability and effectiveness of service provision.[246] Furthermore, at the local level, where refugees and migrants first arrive, authorities do not have adequate tools and proper training to identify the most vulnerable R/M.[247]

139. **Finally, there were project-related, operational factors that created additional constraints.**

140. **Short project duration.** The Project was designed to be implemented within two years which is too short of a time and insufficient resources to build national capacities and achieve behaviour change.[248]

141. **Unavailability of interpreters and materials in R/M languages.** In the five countries, UNICEF and its IPs made a great effort to ensure that interpreters and information material were available in the appropriate languages. Nevertheless, there were instances where IPs identified some challenges. They noted that the timing was also an issue: information material was produced after the health literacy activities had taken place.[249] In Bosnia and Herzegovina, one IP reported that there was only one Interpreter-Cultural Mediator assigned in two reception centres (TRC Borici and TRC Sedra). As a result, in a beneficiary satisfaction survey, some parents responded that they did not have an interpreting assistance during the pediatric examination of their child/children.[250]

142. **Ineligibility of certain expenditures (goods and services). The Project's rules followed those of CHAFEA/HaDEA which did not approve the procurement of several goods and services that were necessary to ensure the Project's effectiveness.** DG Health is used to working with highly structured ministries of health and are not familiar with the practice of providing snacks during awareness-raising sessions or providing mental health support to frontline service providers (see Box 15).[251,252] In addition, according to the EU rules, personal protective equipment (PPE), medication, personal hygiene kits, cold chain equipment, etc. were all ineligible expenditures. Consequently, the Project funded awareness raising activities and referral services but not the procurement of supplies nor the actual provision of the service (such as immunization and deployment of medical teams to support health

[243] In the past, R/M population used to receive a National Insurance Number (AMKA) which entitled them to access the public health system. This changed in in 2019.
[244] UNICEF CO staff
[245] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[246] Save the Children Progress Report August 2021
[247] Save the Children, Progress Report August 2021
[248] IP staff, UNICEF CO staff
[249] UNICEF CO staff
[250] Results of the Satisfaction Survey on Pediatric Activities in Temporary Reception Centres Sedra, Borići and Ušivak in BiH & Upcoming Project Activities
[251] Mission Wings Progress Report December 2020 – March 2021
[252] UNICEF ECARO staff

services for children who are squatting with their families).[253,254] Whereas some IPs were able to mobilise resources from other donors to fund these items, others found it more challenging (this was especially the case in Bosnia and Herzegovina).[255,256]

Box 15: The Importance of Addressing Mental Health of Service Providers

Working with R/M is often overwhelming, when addressing mental health, GBV and other trauma. This puts severe pressures on frontline workers who can develop feelings of helplessness and burnout. In this Project, this was compounded with the pandemic. Partners on the ground had to work tirelessly, often risking their own lives to protect the health and well-being of R/M children during the COVID-19 pandemic. There is a need to create a support system for service providers to help them deal with increased mental distress and health risks, and, at the same time to respond to increased needs (e.g., at some point, daily cases doubled from 30 to 60 cases per day in Bulgaria), thereby increasing the pressure on UNICEF staff and their partners.[257] Unfortunately, the EU requested that the psychological care of health workers would not be covered within this Project (in Bulgaria proposal).[258]

6.3.5 Unintended Results

143. The Project has led to several unintended results. Mostly they were positive and led to increased active participation in online webinars, lower number of school dropouts and better learning opportunities, improved social cohesion, greater demand for safe spaces, and greater capacity to use digital devices. One serious unintended consequence are the increased threats that IP staff have received from both smugglers as well as perpetrators of violence. Finally, in Serbia, research on R/M children had some unexpected findings, which could be attributed to several factors

144. **Greater than expected active participation in online webinars.** As already mentioned above (see Section 6.3.1), shifting training and awareness-raising to online delivery due to COVID-19 allowed for a higher than planned number of participants. Furthermore, in some cases (see Figure 14 on Melissa), online delivery allowed participants to view problems from a different perspective than in-person training would have. In Serbia, trainers had extensive experience in delivering in-person training but not with remote modalities. Fearing that participants would be too passive, they focused strongly on participatory methods to encourage active participation and sharing of experiences which resulted in effective training.[259]

145. **Increased R/M women and children's capacities to use digital devices.** In Bulgaria (and probably elsewhere), due to COVID-19 lockdowns and to shifting services to online, an IP noticed a greater ease of women and children to use digital devices due to their need to access support remotely.

146. **Improved social cohesion.** In Bulgaria, one IP realised that the state-run centres were under – financed and were receiving less than one euro/day to provide R/M with food. The IP started supporting the women to cook their traditional dishes and brought together women from different nationalities to cook together which created a good atmosphere and improved social cohesion within the Crisis Centres and Mother and Baby Units.[260]

[253] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[254] UNICEF CO staff
[255] Mission Wings Progress Report December 2020 – March 2021
[256] UNICEF CO staff, IP staff
[257] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[258] CHAFEA - UNICEF RM Child-Health project Kick-off meeting, 29 April 2020
[259] Government representative
[260] IP staff

147. **Increased demand for Safe Spaces.** In Italy, responding to a request from women and girls, a UNICEF IP opened a Safe Space on a pilot basis expecting to accommodate around five women. The number of girls and women who sought support was unexpected and much larger than anticipated reaching around 100 cumulatively.[261] As a result, the IP, with technical assistance from UNICEF, developed a protocol on COVID-19 safety measures (e.g., social distancing) in safe spaces which was not originally envisaged as a project output.

148. **Scaling up of guidelines developed for R/M population**. In Serbia, guidelines to address concerns about substance abuse and immunization among the R/M population are planned to be used as a basis to cover all the population of Serbia since the recommendations and principles, according to a government representative, contain transferable learning.[262]

149. **Improved school attendance and learning opportunities**. In Bosnia and Herzegovina, by providing R/M children with ophthalmological services, the Project also contributed to improving learning outcomes (not only health ones).[263] UNICEF's IPs in Bulgaria, by providing immunization and medical check-up certificates[264] to young children, allowed R/M children to attend kindergarten which required such certificates. Similarly, in Italy, one IP noted that because of its support with COVID-19 documentation, a greater number of R/M children were able to attend school and there was a decrease in dropouts.[265]

150. **Increased threats from smugglers.** IPs in both Greece and Italy have reported threats from human smugglers because of their presence on the ground and for the protection information they were providing R/M. As a result, some IPs in Italy developed protocols on risk management to protect their own staff.[266] The IP also noted that being supported by UNICEF and DG Health lent it greater credibility.[267]

151. **Direct threats from perpetrators of violence**. In Greece, one IP described the threats its staff received from perpetrators of violence against women. The IP removed the survivors of such violence from the environment and in some instances, it had to refer the case to the police and seek legal support. However, its staff who continued to work in the same venue received threats. The IP was labelled as the 'divorce organisation'. This has led to a positive intended consequence (removing and protecting women and children from the cycle of violence) and a negative unintended one (IP staff receiving threats).[268] Similarly, in Bulgaria, an IP staff received repeated threats from GBV perpetrators which made it necessary to seek support from security staff.[269]

152. **Unexpected research results**. In Serbia, while it was not an unexpected consequence, research on R/M children resulted in unexpected findings, such as (i) the number of children attending school was lower than expected;[270] (ii) the number of children reporting neglect was much higher than originally envisaged (45 percent); (iii) a lower number of children reported substance abuse; and (iv) a large number spoke positively about the camp conditions. According to the institute that carried out the

[261] IP staff
[262] Government representative
[263] UNICEF CO staff
[264] IP staff
[265] IP staff
[266] IP staff, UNICEF CO staff
[267] IP staff
[268] IP staff
[269] Mission Wings Progress Report, December 2020-March 2021
[270] Official data showed that a higher of children were in school however, children thought that remote education was not school and were not accessing it.

research, the two last findings were probably due to cultural, religious and/or legal issues which led the children to either lie or under-report.[271]

6.3.6 Gender and Social Inclusion

Gender and Social Inclusion in Design

153. According to UNICEF staff, the Project relied on previous gender assessments implemented by the regional GBV Project to inform its design.[272] There was no evidence that it carried out a separate gender assessment during the design phase.

Gender and Social Inclusion in Implementation

154. UNICEF and its IPs have endeavoured to address both the needs of boys, especially UASC boys (which are substantively larger in number) while also providing services to girls and women who face greater risks. However, ensuring gender equality and social inclusion is not uniform across the five countries,[273] partly because of the prevailing political discourse regarding gender equality in some countries.[274] Finally, GBV services focused almost exclusively on vulnerable women and girls.[275]

155. According to UNICEF and its IPs, the Project was able to provide equal services to girls and boys and did not note any gender or sex challenges/exclusion regarding general health provisions (e.g., dental, ophthalmological, general check-up, immunization).[276] As one stakeholder noted, cultural sensitivities (e.g., issues around how the family functions) were more important in planning the interventions than differences between girls/boys.[277] In some cases, IPs also endeavoured to recruit female service providers and doctors to reach out to UASC girls.[278]

Box 16: A Gender-Informed and Multi-Stakeholder Approach to Working with UASCs in Serbia

In Serbia, the government, UNICEF, and IPs worked together to target UASC girls and boys separately, recognising the different needs and interventions required for these groups. Firstly, they focused on improving identification of UASC girls as they see them as the most vulnerable of the vulnerable. They carried out these activities in several ways – visits to centres, joint roundtable discussions etc. on how to address the issues that girls face. The Commissariat for Refugees and Migration participated actively in these consultations which contributed to the development of indicators and tools for unaccompanied girl identification, an initiative led by ECARO. Regarding unaccompanied boys, they also focused on their identification but looked not only at minors but also boys who have just come of age and are no longer protected by the guardianship system. The UASCs face many risks and hazards on the road.

The approach to supporting and protecting them had to be coordinated between UNICEF and several national counterpart institutions. In addition to UNICEF and the Commissariat other institutions took part in these discussions – social protection system (Ministry of Labour, Employment, Veteran and Social Affairs). Sometimes the Commissariat and the local centre for social work identify a child in need of social protection. If the social protection system assesses the child should be placed in a government-controlled social protection institution for UASC, they are allocated a space. However, as spaces are very limited, the most vulnerable and younger children tend to be placed in these institutions. Due to the limited spaces, other children are placed in Commissariat's facilities. The involvement of NGOs is crucial due to their direct contact with the population. UASCs are often invisible to public institutions because children do not want to be registered and held up in facilities

[271] Government representative
[272] These gender assessments were carried out in Bulgaria, Greece, Italy, and Serbia. Bosnia and Herzegovina was not included in the regional GBV project. The evaluation team did not have access to these gender assessments.
[273] UNICEF ECARO staff
[274] IP staff
[275] Government representative
[276] This information is based on KIIs and not on M&E data (see section below on Gender and Social Inclusion in M&E)
[277] Government representative
[278] IP staff

since they want to proceed with their journey. That said, other actors in Serbia also play a key role in this process with Commissariat representatives, centres for social work and UNHCR all contributing to identification efforts.

Source: KII Government

156. Regarding addressing sexual violence and GBV,[279] both the Balkan and southern Mediterranean routes reflect the global trend of GBV increasing in humanitarian crisis settings. Most of the population are young single men and there is insufficient attention given to male victims of sexual violence (witnessed, experienced, or forced to perpetrate).[280] There has been a coordinated effort of UNICEF regionally to develop a manual for addressing this issue.[281] It is a taboo topic, and the volume of boys is an issue that needs to be considered.[282] Some IPs in Serbia did demonstrate a strong effort to tailor GBV awareness raising sessions to boys, recognising that male UASC account for most of their beneficiaries. At the same time, there are also R/M families and women and girls and, even if fewer in number, they have different and sometimes larger needs.[283] Furthermore, due to their lower numbers, women and girls have greater difficulty in integrating, finding relevant information and support from compatriots (see Box 17).

Box 17: Women and Girls Safe Spaces and GBV Support Services in Italy

In Italy, UNICEF's implementing partners have noted that – due to their low number, and the compounded discrimination that women and girls face (including isolation, violence and care burdens) - female R/M have a greater difficulty in integrating and accessing relevant information. They are more isolated than male R/M who have a larger network. Safe spaces and GBV support services - which are open to both new arrivals as well as to R/M who have been in Italy for a longer time - allow the new R/M to meet compatriots who speak their language, socialize and feel less isolated. Furthermore, women and girls face risks due to the ongoing pandemic. This includes pregnant women not knowing if they should, or can, access health care. During public health emergencies women and girls are also at higher risk of domestic violence because they must spend more time confined at home and are socially isolated. The IP's Outreach Team provided relevant information on how to access violence response services, including information on the national help line which functions 24 hours a day in five languages. Women and girls played a pivotal role in organizing and facilitating the Outreach Team's visits. [284] Another IP, because of an increase of an influx of trafficked women and girls from Côte d'Ivoire, included GBV activities (which were not previously part of their portfolio of interventions).[285]

Source: KII with UNICEF IP in Italy

157. Several IPs noted that since they had to switch their services to online delivery, this meant victims of violence were unable to discuss issues such as GBV with women/girls and/or sexual violence with boys since the perpetrator was physically present in the

[279] The term 'GBV' is most used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls… The term 'gender-based violence' is also increasingly used by some actors to highlight the gendered dimensions of certain forms of violence against men and boys—particularly some forms of sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity (e.g., sexual violence committed in armed conflict aimed at emasculating or feminizing the enemy) … The term 'gender-based violence' is also used by some actors to describe violence perpetrated against lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons that is, according to OHCHR, "driven by a desire to punish those seen as defying gender norms". Source: Inter-Agency Standing Committee (2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, pp. 5-6
[280] UNICEF ECARO staff
[281] These efforts were not part of the Project and therefore outside the scope of the evaluation
[282] IP staff
[283] IP staff
[284] UNICEF (2020). In Pictures: UNICEF continues support for critical frontline care during COVID-19 pandemic in Italy Health team targets vulnerable refugee and migrant children and families with limited access to services, 21 April 2020 https://www.unicef.org/eca/stories/pictures-unicef-continues-support-critical-frontline-care-during-covid-19-pandemic-italy
[285] IP staff

same room.[286] Some services were designed/delivered with sex differences in mind. For example, IPs in Bosnia and Herzegovina noticing that some children are accompanied by single fathers, decided to include fathers into MBC/nutrition service provision, rather than just mothers. In this case a special attention was paid to the specific needs of mothers (women) and fathers (men) in ensuring their rights are fulfilled equally within the services. Save the Children, in Italy, distributed different kits[287] for girls, boys, women with small children and R/M on the street.[288]

158. In Serbia, work on substance abuse focused mostly on male migrants as boys make up the majority of the UASC amongst which substance abuse is most prevalent.[289] Furthermore, in Serbia, to ensure greater female participation, IPs chose to use phone lines and the Viber platform (and not WhatsApp) because it was a safer digital space since it does not allow all participants to send messages or contact each other/see each other's photos. This reduced the chances of digital harassment. There were always specific times when they shared information for women and girls (e.g., on the importance of education, safety advice, reproductive health, MHPSS, and parenting skills).[290]

159. Finally, there are a few examples of how the Project has included R/M with disabilities. In Italy, mobile units allow services to be provided to R/M who have difficulty in accessing services due to physical disabilities. UNICEF has produced a video on putting on a mask for COVID-19 in sign language to ensure that those how have hearing impairments can also be reached.[291] Government officials in Serbia have noted that the number of R/M with special needs is increasing and greater effort needs to be exerted to ensure that they are not left out.[292] As mentioned above, extra attention was given to include illiterate children in the research being conducted in Serbia. Finally, in Bosnia and Herzegovina, UNICEF has succeeded in integrating Roma and host communities in the awareness-raising efforts it delivered to the R/M population.

Gender and Social Inclusion in M&E

160. As mentioned above, sex and age disaggregated data were not compiled consistently by the UNICEF offices in the five countries included in this evaluation. As a result, the Project was unable to compile SADD data across the five countries.[293] In Italy – and understandably – UNICEF faced a challenge in collecting such information through its online platform an issue that it is currently addressing (see Box 18).

Box 18: Addressing the Challenge of Capturing SADD through Online Platforms

UNICEF in Italy was challenged by the difficulty in acquiring sex and age-disaggregated data of individuals reached with health-related information through the U-Report on the Move. The platform currently reaches more than 6,100 subscribers who are migrants and refugees in Italy (https://onthemove.ureport.in/engagement/). UNICEF is working to address this challenge by increasing the provision of in-person information to migrant and refugee children, adolescents and

[286] IP staff
[287] Though not funded by this Project, this contributed to the effectiveness of Save the Children's work
[288] It is important to note that these kits - while necessary and improved the effectiveness of the interventions -were not funded through this project
[289] Government representative
[290] Government representative
[291] MdM Progress Report September 2020
[292] Government representative
[293] All IPs in Greece and Italy provided SADD regarding their beneficiaries. In Bulgaria, all IPs according to the detailed implementation plan, also provided SADD. In Serbia, while UNICEF Serbia stated that they collect SADD in IPs' monthly reports, the IPs' quarterly reports shared with the evaluation team did not all include SADD. While one IP included SADD in their quarterly report, the majority only provided overall figures which are not disaggregated, and a narrative that makes minimal reference to disaggregation but does not do this consistently or systematically. In Bosnia and Herzegovina, the evaluation team was only able to access the reports from one IP which included sex-disaggregated information

their parents and developing alternative strategies.[294] UNICEF carried out a survey to better understand how to modify the content to increase girls' engagement. As a result, female participation increased from around 9 percent (two years ago) to 13 percent.[295]

161. Finally, in Serbia, due to the low number of R/M girls, research which was undertaken did not include sex-disaggregated breakdown since it would not have been statistically significant to do this.[296] Also in Serbia, one IP reported that UNICEF requested that it tracks beneficiaries living with disability, which they had not previously done, and which it found useful because it made the IP consider accessibility for people living with disabilities.[297]

6.4 Efficiency

Key Findings:

Finding 22: Financial implementation as at the end of month 20 (August 2021) of the Project, stands at 88 per cent of total implementation (3,765,522 Euros).

Finding 23: Efficient use of resources and cost savings has allowed for a three-month no cost extension to complete disbursement of remaining funds.

Finding 24: At the regional level, the Project suffered from staff turnover and a change in divisional responsibility which affected (i) regional coordination, (ii) ownership of the Project by UNICEF Regional Health staff, and (iii) interaction with the EU on operational matters. At the country level, Project benefitted from highly dedicated UNICEF staff; Human resource capacities were reflected in the extent health was emphasized in country-level programming.

Finding 25: UNICEF ECARO was able to apply a One UNICEF Response approach with the UNICEF National Committees in Italy; and established a full-fledged country office in Greece in November 2020. However, this was not the case in Spain which prevented the Project from implementing activities in Spain.

Finding 26: The Project experienced delays due to three factors: (i) lack of familiarity with CHAFEA/HaDEA's rules and procedures by UNICEF and its IPs and, vice versa, insufficient awareness of HaDEA regarding UNICEF's approaches; (ii) delays in receiving responses/approvals from the EU and UNICEF regional offices; and (iii) COVID 19-related delays.

Finding 27: Most Government counterparts and IPs appreciated UNICEF's speed in responding to requests, its agility in responding to changing contexts on the ground, and its flexibility in addressing emerging needs which greatly contributed to both the Project's efficiency as well as the effectiveness.

6.4.1 Financial Resources

162. Financial resources have been used efficiently which has led to savings and a request for a three-month no cost extension from 31 December 2021 to 31 March 2022. The Project was granted a three-month no cost extension to compensate the delays in implementation mostly caused by COVID-19 and to allow more time to deliver results.

163. The Project was able to generate **substantive cost-savings due** to cancelling field visits and travel to countries because of COVID-19 travel restrictions.[298] In some cases,

[294] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021
[295] UNICEF CO. This figure fluctuates from month to month. Furthermore, it is important to note that the low female participation is also due to a lower number of R/M girls/young women compared to boys/young men
[296] Government representative
[297] IP staff
[298] UNICEF ECARO staff

there were additional savings due to a lower-than-expected number of beneficiaries (e.g., number of mothers which children under two years were lower than originally anticipated). Finally, cost savings were generated by reprogramming purchase of equipment - which was originally included in the budget - but was not approved by the EU.[299] As Table 11 demonstrates around 56 percent of the budget was allocated to grants to IPs.

Table 12: Budget Allocation/Expenditure per Line Item

Budget for the Action	Original Allocation (total in EUR))	Allocation per Amended Budget (in EUR)	Spent to 31 August 2021 (in EUR)	Remaining Funds (in EUR)	% Disbursed	% of Budget Allocated per Line Item
Budget line item	**(a)**	**(b)**	**(c)**	**(d)**	**(c/b)**	**(d/10)**
1. Staff and personnel cost	1,142,008	1,013,835	741,840	271,995	73%	24%
2. Supplies and commodities	0	0	0	0		0%
3. Equipment, vehicle, and furniture	13,410	0	0	0		0%
4. Contractual services	657,319	509,210	562,659	-53,449	110%	12%
5. Travel	94,088	15,198	9,463	5,735	62%	0%
6. Transfers and grants to counterparts	2,005,324	2,379,267	2,194,525	184,742	92%	56%
7. General operating and other direct costs	90,967	85,605	23,275	62,330	27%	2%
8. Total direct eligible costs of the Action (1-7)	4,003,115	4,003,115	3,531,762	471,353	88%	93%
9. Administrative costs (maximum 7% of total cost)	280,218	280,218	233,760	46,458	83%	7%
10. Total eligible costs of the Action (8+9)	4,283,333	4,283,333	3,765,522	517,811	88%	100%

Source: ECARO, January 2022

164. Furthermore, the Project efficiently used resources (e.g., Child and Friendly Support Hubs, Women and Girls Safe Spaces) established by other projects.[300] By partnering with the same NGOs implementing other UNICEF-funded projects, UNICEF was also able to achieve efficiency gains. By building on planned and existing activities, and working in close cooperation with its partners, UNICEF was able to expand activities to include COVID-19 related support without additional funding.[301] For example, it adapted pre-existing procedures to address the COVID-19 pandemic. SOPs and communication models previously developed by UNICEF and IOM to handle the influx of refugees in 2015 - while they were part of the early migration response and not

[299] Purchase of three cold chain equipment packages to support the regular immunisation campaign in Serbia
[300] Government representative
[301] UNICEF ECARO (2021). Interim Technical Report, CHAFEA Grant Nr: 2019 51 02, Strengthening Refugee and Migrant Children's Health Status in Southern and South-Eastern Europe, 30 May 2021

directly related to this Project - were used to improve coordination and collaboration to respond to COVID-19.[302] COVID-19 awareness-raising activities were also added to all ongoing activities, including the work of mobile health teams, which allowed UNICEF's IPs to efficiently integrate prevention messages at no additional costs.[303] Similarly, the use of protocols to work with UASCs (developed through another project) have contributed to improving the efficiency and capacity of frontline staff in centres working with these children.[304]

165. Finally, in the case of Greece, UNICEF worked through a consortium led by the International Rescue Committee (IRC) which proved to be a very efficient way of implementing activities. It placed all the protection services into one contract and ensured faster referral of cases to the specialised organisation within the consortium.[305]

166. At the end of August 2021 of the Project**, financial implementation** stood at 88 per cent of total implementation (3,765,522 Euros) and is on track for achieving all deliverables by the extended end date of the Project.

167. The **allocation of budgets** was negotiated with each country using the Humanitarian Action for Children (HAC) Appeal as a reference and taking into consideration the number of R/M, operational capacities, and availability of other sources of funding to address R/M needs. For example, even if Italy hosted a larger number of R/M than Bosnia and Herzegovina, UNICEF's Country Office in Bosnia and Herzegovina was allocated more funding through this Project because it had less resources than UNICEF in Italy to address R/M needs (see Table 12). Furthermore, Bosnia and Herzegovina had to deal with a relatively larger number of R/M than originally expected because, due to COVID-19 border closures, the R/M population increased.

Table 13: Initial Resource Allocation per Country

Countries	EU	UNICEF	Overall (EUR)	Percentage
Bulgaria	300,000	171,799	471,799	11
Greece	400,000	462,964	862,964	20
BiH	600,000	400,000	1,000,000	23
Italy	400,000	262,913	662,913	16
Serbia	350,000	219,592	569,592	13
Regional Office	450,000	266,065	716,065	17
Total	**2,500,000**	**1,783,333**	4,283,333	100

Source: UNICEF ECARO November 2021

168. Finally, and as per the agreement with the EU, **UNICEF leveraged the EU financing by co-funding at 40 percent this Project** with much of the Country Office funds coming from the Bureau of Population, Refugees and Migration (BPRM)-funded regional GBV project.

[302] Government representative
[303] UNICEF (2021). Safeguarding the health of refugee and migrant children during the COVID-19 pandemic, by Angela Hawke, 1 February 2021. https://www.unicef.org/eca/stories/safeguarding-health-refugee-and-migrant-children-during-covid-19-pandemic
[304] Government representative
[305] UNICEF CO staff

6.4.2 Human Resources

169. At the regional level, the Project suffered from staff turnover and a change in divisional responsibility which affected (i) regional coordination, (ii) ownership of the Project by UNICEF Regional Health staff, and (iii) interaction with the EU on operational matters.

170. The Project was designed by UNICEF's Refugee/Migrant Cell Unit without much involvement from the Regional Health Advisers.[306] In FY, 2020, the R/M Cell Unit intermittently engaged the Regional Gender Adviser to align the sub-regional GBV programme with the DG Health Project, following which in the subsequent implementation of the DG Health Project there was not much involvement sought from the Regional Gender section.[307] Similarly, notwithstanding the emphasis on "health literacy" and the production of information material, a regional newsletter and website, UNICEF's Regional Communications Unit was not consulted during the design phase.[308] The change from the staff who were involved in the design to those responsible for implementation was not limited to the regional level: it was also the case in Serbia and Bulgaria, where the UNICEF staff managing the Project had not been involved in the design.[309] During the first year of the Project, a Regional Project Manager was recruited as a long-term consultant; however, his contract was not renewed for the second year due to lack of funding.[310]

171. Coordination meetings among the regional office and the five countries became more regular in the second year and were organized monthly as of May 2021. In addition, one *ad hoc* meeting was held with the communications staff.[311] UNICEF country-based staff observed that in the last year, there was improved structure and coordination from UNICEF ECARO; however, some COs found that there was insufficient technical backstopping, especially in the countries which did not have health expertise among their staff.[312]

172. The divisional responsibility changes as well as the change in health staff responsible for project management which took place in the first year and half of the Project also affected the interaction with the EU on operational matters and did not allow the establishment of a relationship with the same counterpart (UNICEF staff) throughout the Project's duration. This resulted in lengthened operational discussions since with every change, EU rules and procedures had to be re-shared (e.g., regarding the no cost extension, eligibility for COVID-19 related expenses which had not been included originally in the Project).[313] This was further exacerbated by the fact that the two handovers[314] were sudden and took place without time for a proper handover.[315]

173. At the country level, the Project benefitted from highly dedicated UNICEF staff. Human resource capacities were reflected in the extent health was emphasised in country-level programming. For example, in Greece, Bulgaria and Italy, UNICEF had no health specialists on the team. The Project managers in Greece and Italy were both GBV/Protection specialists which was reflected in a greater emphasis on these themes in their programming[316] and in Bulgaria, the Project was managed by the Refugee and Migrant Children Programme Officer and relied on the CO's already established Child

[306] The Regional Gender Adviser was also the Project Manager of the BPRM GBV Regional project
[307] UNICEF ECARO staff
[308] UNICEF ECARO staff
[309] UNICEF CO staff
[310] UNICEF ECARO staff
[311] UNICEF ECARO staff
[312] UNICEF CO staff
[313] UNICEF CO staff, EU representatives
[314] From R/M Unit to Health Division and from Consultant to Project Assistant with the Health Division
[315] UNICEF ECARO staff
[316] UNICEF CO staff

Protection systems and relationships. Nevertheless, UNICEF in these countries included mental health in its activities, and in the case of Italy, as already mentioned above, was able to add COVID-19 awareness raising activities to its original design. Whereas, UNICEF Country Offices in Bosnia and Herzegovina and Serbia already had a health programme, health specialists among their staff, and pre-established close working relationships with the Ministries of Health. As a consequence, the DG Health Project in these countries had a relatively larger focus on health-related issues, including both physical and mental health.

174. Finally, at the time of Project design, UNICEF did not have country offices in Greece, Italy and Spain and had to outpost regional staff to implement projects in these countries. In Italy and Spain, there are UNICEF National Committees. UNICEF ECARO was able to apply a One UNICEF Response approach with the UNICEF National Committee in Italy and established a full-fledged country office in Greece in November 2020. However, this was not the case in Spain which prevented the Project from implementing activities in Spain. In Italy, UNICEF has succeeded in rationalizing expenses since UNICEF ECARO staff share offices with the National Committee. However, there is lack of clarity regarding the institutional roles and responsibilities between the UNICEF out-posted staff and the National Committee staff. UNICEF staff noted that they benefitted from the pre-existing networks that the national Committee had put in place. However, they also observed that there is greater clarity with ministries who deal exclusively with either the National Committee or with the UNICEF staff (e.g., the Ministry of Interior which has relations only with UNICEF).[317]

6.4.3 Timeliness

175. The Project experienced delays due to three factors: (i) lack of familiarity with the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)/HaDEA's (European Health and Digital Executive Agency)[318] rules and procedures by UNICEF and its IPs and, vice versa, insufficient awareness of CHAFEA/HaDEA regarding UNICEF's approaches; (ii) delays in receiving responses/approvals from the EU and UNICEF regional offices; and (iii) COVID 19-related delays.

176. This Project was the first experience that both HaDEA and UNICEF had in working together. There were delays in finalizing the Project agreement because both organisations had to "learn the language" of the other.[319] As a result, the context had changed significantly from when the Project had been designed to the time implementation started.[320] This also meant that the original implementation plans had to be revised during the "inception" phase to adapt to the new context.[321] As a mitigation measure, although the grant agreement was signed in March 2020, based on a request from UNICEF, it entered into force retroactively on 1 January 2020.[322] With agreement with DG Health, UNICEF HQ frontloaded funds for the initial months in order not to delay further project activities.[323] Furthermore, and to gain time, UNICEF recruited a Project Manager as a consultant which follows a faster recruitment process than hiring regular staff.[324] Despite the more expedited process, the consultant was only hired in May 2020. In some countries (e.g., Bulgaria and Italy which originally were expected to implement all activities within one and not two years), to respond in a

[317] UNICEF CO staff
[318] On 1 April 2021, CHAFEA's Health Programme was delegated to the newly created European Health and Digital Executive Agency "HaDEA"
[319] Several UNICEF staff, DG Health, HaDEA
[320] UNICEF ECARO staff
[321] UNICEF ECARO staff
[322] CHAFEA - UNICEF RM Child-Health project Kick-off Meeting Part II, 8 May 2020
[323] UNICEF ECARO staff
[324] UNICEF ECARO staff

timely manner, IP partners were deployed using other sources of funding and then financed through DG Health when funds were made available.[325]

177. **Lengthy EU and UNICEF approval processes caused some delays**. Since work on COVID-19 was not originally envisaged when the Project was designed, UNICEF had to request approval from the EU to include COVID-19 related activities which was slow in coming.[326] In addition, UNICEF staff noted that there were delays in responses from the EU which sometimes took several months.[327] Furthermore, approval for external communication material (newsletters, website) had to go through multiple layers of clearances/approvals (UNICEF Country Office, ECARO, UNICEF Brussels and in some cases EU) which was a lengthy and time-consuming process.

178. Delays **were also exacerbated by COVID-19 which further hindered implementation and several activities had to be postponed.** For example, in Bosnia and Herzegovina, activities in temporary reception centres (TRC) had to be postponed due to COVID-19 government restrictions. In Greece, distribution of COVID-19 child-friendly posters and stickers in various locations across the country met with delays due to COVID-19 lockdown and movement restrictions. In Serbia, both the research on substance abuse and the immunization programme[328] were delayed because health staff (even psychiatrists from the Institute of Public Health) were re-purposed to respond to COVID-19.[329] Since the research was a basis for guiding the design of action, it also delayed the implementation of the remaining activities.[330]

179. **Finally, and at the implementation level, most Government counterparts and IPs appreciated UNICEF's speed in responding to requests, its agility in responding to changing contexts on the ground, and its flexibility in addressing emerging needs which greatly contributed to both the Project's efficiency as well as the effectiveness.[331]**

6.5 Sustainability and Resilience

Key Findings:

Finding 28: There are "elements" of sustainability in the five countries. However, although some COs are attempting to mobilise resources to ensure continuity of services, there is no evidence that any one of the countries in this evaluation will be able to sustain, at the same level, service provision to the R/M population due to decreasing resources. The elements of sustainability that were identified were the following: (i) government ownership; (ii) existence of an exit/handover strategy; (iii) institutional arrangements; (iv) advocacy for policy/legislative changes; (v) capacity building of government and IP staff; (vi) sustainable approaches (community-based vs integration into national system); (vii) continuity of funding; and (viii) policymaking based on research.

Finding 29: The short span of the Project did not allow sufficient time to carry out effective advocacy since significant time is required to advocate for and achieve policy/legislative changes.

Finding 30: The European context is unique since R/M population in centres/camps are multinational and transient. It may be difficult to implement approaches used in different contexts (e.g., community-based approaches).

[325] UNICEF CO staff
[326] UNICEF ECARO staff
[327] UNICEF ECARO staff
[328] UN representative
[329] UN representative
[330] UNICEF letter to HaDEA on 23 November 2021
[331] IP staff and Government representative

Finding 31: Though building resilience was not a specified objective of this Project, several activities were implemented which could potentially contribute to a more resilient health system with a greater ability to respond to shocks. These include (i) producing GBV and psychosocial support packages both important in times of crisis; (ii) networking and linkages for better preparedness;(iii) working on prevention.

6.5.1 Sustainability

180. There are “elements” of sustainability in the five countries. However, there is no evidence that any one of the countries in this evaluation will be able to sustain, at the same level, service provision to the R/M population due to decreasing resources. That said, UNICEF, in particular in Greece, Italy and Serbia, is engaging in advocacy with donors for sustaining the Project’s results. Greece and Italy are also advocating for sustaining efforts and leveraging resources through the Asylum, Migration, and Integration Fund (AMIF) and the EU’s Child Guarantee initiative. The elements of sustainability that were identified were the following: (i) government ownership; (ii) existence of an exit/handover strategy; (iii) institutional arrangements; (iv) advocacy for policy/legislative changes; (v) capacity building of government and IP staff; (vi) sustainable approaches (community-based vs integration into national system); (vii) continuity of funding; and (viii) policymaking based on research.

181. Ensuring government ownership: The clearest evidence of government ownership is in Bosnia and Herzegovina and Serbia. Since the beginning of the migrant crisis, stakeholders have observed greater support from the state level in Bosnia and Herzegovina. In the past year and a half, the engagement of the Ministry of Security at state level[332] has developed a new strategy to respond to the migrant crisis.[333] In Serbia, strong ownership is demonstrated by the government-led coordination mechanism (and not by a UN agency or NGO as in the other countries). This was already noted during the Project’s kick-off meeting when Serbia was identified as having “one of the best conceived plans and is promising in terms of sustainability and replicability.”[334]

182. Implementing an exit/handover strategy: In some countries, there have been some initiatives to hand over certain activities to the government. For example, in Bosnia and Herzegovina, a TRC which was run by IOM has closed and a new one will be government-managed, reflecting increased leadership and provision of services by the government.[335] In Bulgaria, UNICEF expects that as of January 2022, the State Agency for Child Protection will take over the management of the national database for UASCs and will make the information public, thus enabling a better and more comprehensive analysis of the unaccompanied and separated children’s situation.[336] In Serbia, initially MBCs were operated by NGOs, however recently the Commissariat has taken over their management and plans to integrate their activities into the national system, in cooperation with the Ministry of Health.[337] Finally, in Greece, UNICEF had planned to transfer to the government some of the activities being implemented, however capacities to address psychosocial/GBV issues is still low and handing over has been postponed several times.[338,339]

[332] Government representative
[333] IP staff
[334] CHAFEA - UNICEF RM Child-Health project Kick-off meeting, 29 April 2020
[335] UNICEF CO staff
[336] IP staff
[337] Government representative
[338] UNICEF CO staff
[339] Unlike immunization which was successfully handed over to the Greek public health system

183. There were no indications as to whether UNICEF was contemplating any exit strategy and/or a process of handing over implementation and/or financing to the government. Furthermore, and as part of an exit strategy, some IPs noted that it would have been useful to receive timely and clear communication regarding the ending of UNICEF support and financing.[340] They noted that beneficiaries expected the services to last and that survivors of extreme GBV, child abuse, and new mothers continue to request such services which the IPs are no longer able to fulfil.[341] The IPs remarked that this has a negative effect on the trust and morale of the R/M community.[342] Finally, IPs observed that even when the government takes over service provision, there needs to be a period of hand-holding because government staff are not familiar with the mentality and customs of the beneficiary population and need to be supported – at least for a while – by UN agencies and/or NGOs such as what is being done in Bosnia and Herzegovina where IOM and some NGOs continue to provide some assistance.[343]

184. **Establishing sustainable institutional arrangements**. In Serbia, a key achievement which contributes to sustainability is establishing a course "Protection of Children affected by Mixed Migration" as part of the **University of Belgrade** programme for social work students as well as practitioners thus ensuring long term capacity building.[344] In Italy, a Memorandum of Understanding signed between UNICEF and the **National Institute for Promoting the Health of Migrant Population** (*Istituto Nazionale per la promozione della salute delle popolazioni Migranti* – INMP) formalizes a long-term institutional collaboration between the two organisations, including INMP providing training to UNICEF cultural mediators, technically reviewing UNICEF research, and jointly advocating with key governmental stakeholders about critical protection issues, such as for the endorsement of appropriate procedures to assess the age of young migrants and refugees in line with international standards.

185. **Advocating for policy change:** Although many stakeholders, including UNICEF staff, identified advocacy for children's rights as one of UNICEF's added values, there was little evidence that UNICEF advocated for policy change through this Project. The country-level policy briefs which were drafted during the evaluation period may provide further information once they are finalized. One notable exception is UNICEF in Bulgaria where – along with other organisations – it was successful in introducing several amendments to the national legislation in the field of migration, asylum and refugees, to ensure protection and legal representation of unaccompanied minors, foreign citizens and refugee children. Specifically, amendments to the Law on Asylum and Refugees, article 25 in October 2020 permitted lawyers from the legal aid bureau to represent separated children.[345]

186. Several stakeholders noted that the short span of the Project did not allow sufficient time to carry out effective advocacy since significant time is required to advocate for and achieve policy/legislative changes.[346] Nevertheless, in Greece, UNICEF has carried out advocacy with the Ministry of Migration and Asylum and the Ministry of Labour and Social Affairs on the protection of UASC in RICS and camps and established a child protection referral pathway.[347] In addition, and as a result of successful advocacy jointly carried out with other UN agencies, the Vulnerability Group was established to develop procedures for identification and referral of vulnerable

---

[340] The "no cost extension" was not granted to all of UNICEF IPs (e.g., in Bosnia and Herzegovina and Greece)
[341] IP staff
[342] IP staff
[343] IP staff
[344] In Serbia, the University of Belgrade is the only university that graduates social workers
[345] UNICEF CO staff, UN representative
[346] IP staff, UNICEF CO staff
[347] UN representative

people and new legislation regarding migration adopted by the government in Italy.[348] In countries such as Bosnia and Herzegovina which has a decentralized system, or Italy which has a hybrid system (Ministry of Interior is centralized whereas health policy is made at the regional level), advocacy efforts require even greater effort and time.

187. **Building capacity of government and IP staff.** In the five countries, and as discussed in Section 6.3 (Effectiveness), UNICEF has invested in building the capacities of government and IP staff. Capacity of local NGOs has been developed by building their internal processes and systems (e.g., remote service delivery and guidelines).[349] Even in countries such as Greece, where the NGO staff working on R/M is decreasing, it was noted that so far this has been balanced by the Greek government (National Public Health Organisation – EODY) and the European Asylum Support Office (EASO) increasing recruitment of NGO staff to work on the R/M response. The capacity built and knowledge acquired by these NGO staff has been transferred to national institutions, thus ensuring the sustainability of such efforts. However, most stakeholders noted that the capacity of government staff to engage with R/M communities – especially on sensitive issues such as mental health and GBV – is still insufficient.[350]

188. **Implementing different approaches to ensure sustainability:** In Greece, UNICEF's IPs introduced community-based child protection mechanisms (CBCPM), an approach to engage R/M and to provide them with different tools to manage everyday life and have greater autonomy.[351] However, as the IPs noted, these methods are more successful with stable/static R/M populations and not transient ones. They noted that such techniques may be harder to implement in the European context because the turnover of R/M population is high, and it is challenging to build a sense of "community". The fact that camps are multinational, and stays are so brief means that people do not develop inter-communal bonds. Communities become fragmented into different religious/national groups, so it is hard to implement something that is fundamentally community-based.[352] However, the IPs questioned the sustainability of this activity and suggested that focusing on a more integrated model of support might be more sustainable, an approach that could be introduced more proactively in the MBC of the asylum centres.[353]

189. **Linking research with policy**: Research undertaken by the Association for Child and Adolescent Psychiatry and Allied Professions of Serbia (DEAPS) was shared with the Institute for Public Health to formulate policies and guidelines regarding substance abuse.[354] In Italy and Serbia, MHPSS technical working groups have been used as a consultation forum to help shape research design, validate findings and provide policy advice.[355] In Bulgaria, the annual research that UNHCR undertakes has included questions on the health status and needs of refugee children and provides information to address children's needs in a different way than that of adults.[356]

190. **Putting in place arrangements to ensure the continuity of a minimum level of services**. Different IPs have found a variety of ways to ensure a minimum level of service provision. One IP in Bulgaria is using volunteers and interns to provide translation services for R/M when they seek government services. While

[348] UN representative
[349] IP staff
[350] UNICEF CO staff
[351] IP staff
[352] IP staff
[353] IP staff
[354] Government representative
[355] Government representative, UNICEF CO staff
[356] IP staff

acknowledging that this is a temporary solution because volunteers and interns need to also be trained which requires resources, it minimizes the disruption of service provision due to lack of funding.[357] In Italy, one IP has signed a protocol with the Palermo municipality which provides offices free of charge and covers its fixed costs as well as administrative expenses allowing it greater sustainability.[358] In Serbia, UNICEF plans to continue supporting service provision – albeit at a lower level. It is also investing efforts in coordination to ensure better use of resources at the national level.

191. In Greece, some NGOs reported that they also receive some funding from the Government but are concerned that with the end of DG Health Project, the government funds will not allow them to deliver the same level and quality of services.[359] Other IPs – especially larger ones - are actively mobilizing resources from other sources. Yet others are well-funded and will be able to continue with most of their activities;[360] however, some services, such as GBV, which were funded through this Project will be either significantly reduced or cut.[361] Finally, some IPs indicated that once they have partnered with UNICEF, this sends a signal to other donors that they are reliable partners and have the relevant technical expertise which facilitates their resource mobilizing efforts.[362] Several IPs believe that UNICEF should have put more effort into resource mobilization to ensure the continuity of key services, such as MBCs, immunization, and child protection.[363]

192. In conclusion, whereas institutionalizing capacity building and developing processes can be sustained, continuity of service delivery to R/M population may face challenges due to its heavy dependence on donor funding – which is decreasing – and will be a function of the success of resource mobilization efforts of IPs and UNICEF in the five countries.[364]

193. **Finally, the above-mentioned elements of sustainability pertain to service provision (supply side). Regarding the sustainability of health literacy and awareness raising activities (demand side), there is no information as to the extent to which the Project has succeeded in instituting long-lasting changes in R/M health-related behaviours.**

194. **Paradoxically, COVID-19 may have contributed to the "sustainability" of behaviour change**. Due to lockdowns and border closures, R/M were unable to move to another country. The result was a greater number of steady beneficiaries (e.g., the same women attended awareness-raising sessions for months). This may contribute to sustainability and behaviour change because the participants could accumulate and consolidate their knowledge by participating in multiple sessions.[365] Similarly, due to COVID-19, the R/M population became less transitory and more static. This allowed UNICEF and its IPs to build more trust, offer more comprehensive services and develop longer relations to address sensitive issues, such as GBV and substance abuse with young R/M.[366]

[357] IP staff
[358] IP staff
[359] IP staff
[360] IP staff
[361] IP staff
[362] IP staff
[363] IP staff
[364] UNICEF CO staff
[365] IP staff
[366] UNICEF ECARO staff

6.5.2 Resilience

195. Though building resilience was not a specified objective of this Project, several activities were implemented which could potentially contribute to a more resilient health system with a greater ability to respond to shocks. These include (i) producing GBV and psychosocial support packages, both important in times of crisis; (ii) networking and linkages for better preparedness; and (iii) working on prevention.[367]

196. Availability of GBV and psychosocial support packages are important in times of crisis. In the five countries, the Project has developed (or is developing) processes (referral and coordination mechanisms and SOPs) and information (mapping of services) that are essential to respond to any future shocks. Following are the different outputs that contribute to building the resilience of national systems: (i) MHPSS referral pathways for R/M children in Una-Sana Canton (Bosnia and Herzegovina); (ii) Mapping of health and PSS services and Referral mechanism for asylum-seeking and refugee children in need of psychiatric support (Bulgaria); (iii) Mapping of GBV service providers; Referral mechanism for refugee and migrant GBV survivors to state-run shelters and counselling centres (Greece); (iv) Mapping of best practices and factors of success in MHPSS services; Referral mechanism for refugee and migrant children in need of MHPSS (Italy); and (v) Supporting the work of the R/M child protection working group (as an important coordination platform) and developing guidelines for the immunization of R/M children (Serbia). All these resources are permanent and can be utilized to respond to any future external shock.[368] As one stakeholder noted, at least for the short-term, there is "muscle memory" and both government as well as NGOs would be able to respond to an external shock.[369]

197. Establishing networks and linkages. The Project strengthened multidisciplinary work, especially linking protection, nutrition, and health[370] and established partnership networks and referral mechanisms among governmental and non-governmental actors. Such collaboration networks are essential for building capacity to respond fast to any new crisis.[371] A concrete example of how resilience has been built is in Italy which is experiencing an increase of R/M transiting through Greece and Turkey (and not through the usual North Africa route) and arriving in new locations. The "new" type of R/M has a different profile (e.g., higher education, different spoken languages, etc.) and different challenges than those arriving through Libya. Furthermore, even if Lampedusa in Sicily continues to be the main disembarkation point in Italy, a significant increase of landings has also occurred in other southern regions such as Calabria, Apulia, and Sardinia. Many migrants are landing on the shores of Roccella Jonicain, for example, a small town in Calabria (of 6,000 inhabitants) which does not have health facilities or sufficient capacities (e.g., hospital, doctors, and nurses) and is not prepared to receive a larger number of R/M. However, resilience has been demonstrated through different activities (see Box 19).

Box 19: Resilience to Respond to Influx of New Type of R/M in Southern Italy

The activities implemented by this Project have continued to build the resilience of R/M response in the following ways:

- **Mapping of existing services** at the regional level has allowed IPs to make referrals for the newly arrived R/M population
- **Setting up services at both the disembarkation point as well as at the reception facilities.** This allowed IP to make internal referrals where the team at the

[367] UNICEF ECARO staff
[368] Government representative
[369] UNICEF ECARO staff
[370] Government representative
[371] Government representative

disembarkation point informs the team at the reception centre ahead of time of the number, sex, age, condition of the UASC, allowing for more efficient and effective service provision

- **Established networks** of local authorities, service providers and other NGOs has facilitated and sped up the response
- **Experience previously gained** regarding providing psychological first aid, type of information R/M need, activities to reduce stress, etc., meant that the IPs had "ready-made" solutions to offer to newly arrived R/M
- Awareness of need to have cultural mediators present has led to the establishment of a **partnership with an association of cultural mediators,** which has a roster, and allows IPs to adapt and tap into the roster's mediators who have different language skills and knowledge of diverse cultures

Source: KII UNICEF IP (MdM and Save)

198. **Integrating prevention activities.** Working on prevention contributes to strengthening resilience of systems. For example, in Serbia, UNICEF built capacity not only to respond to substance abuse but also to create a more proactive, preventative environment. This allows service providers not only to respond to urgent cases but provides them with tools to better identify and refer R/M at risk.[372]

199. In conclusion, most stakeholders were confident that resilience has been built however the capacity to respond would also depend on the intensity of the influx and the number of new migrants. There might be challenges with accommodation capacities and financial resources especially if there were to be a large influx; but generally, the response would probably be better.[373] Even though what worked in the Project may not apply to a future shock, government institutions, UN agencies and IPs would now know how to go about finding solutions and working together to address the next crisis.[374]

7. Reflections on the ToC

200. This section focuses on the issues arising analysing the Theory of Change (ToC) and its assumptions, as constructed during the Inception Phase (see Annex 6).

201. The Project did not have an explicit ToC. However, its implicit ToC is validated from a *conceptual* point of view. By addressing both supply and demand aspects as well as the enabling environment, R/M health can be improved. As mentioned earlier, the evaluation team constructed an implicit ToC based on a review of project documents as well as discussions with UNICEF regional and country staff. This implicit ToC can be summarized as follows: **If national authorities' capacity to provide healthcare to refugee and migrant children is strengthened (supply); and If health literacy among refugee and migrant children and parents is increased (demand); and If implementation of national health policies is strengthened (enabling environment); Then, refugee and migrant children's health status in Southern and South-Eastern Europe is strengthened.**

[372] Government representative
[373] Government representative
[374] IP staff

202. However, *operationally*, **the main objective of "strengthening the health status" was quite ambitious given the Project's short duration** (Lesson 1). In addition, it was an objective that was not measurable since a **baseline study of R/M children's health status prior to the start of the Project would have been necessary** (Lesson 2), without which it would not have been possible to measure whether the Project contributed to improving it or not. Furthermore, **to increase demand and improve health literacy, a key assumption is that the R/M population is stable** for at least a minimum amount of time (Lesson 3). Furthermore, and related to the Project's duration, is the ambition to address the enabling environment by "strengthening the implementation of national policies". By focusing on "implementation" and not "review and update" of national health policies, this outcome was **less ambitious and more realistic** to achieve within the two-year duration of the Project. Finally, the Project demonstrated the necessity of having **funding from other sources to cover the essential goods and services that were ineligible under this Project** but without which the Project would have been significantly less effective (Lesson 4).

203. Furthermore, the evaluation found several assumptions which were not considered during the ToC's construction, and which proved to be essential to implement Project activities, deliver its outputs and achieve the outcomes desired. Table 13 summarizes these new assumptions.

Table 14: Additional Assumptions which are Needed to Fulfil the ToC

	Additional Assumptions
Impact level	• Baseline information is available to measure "improved health status"
Outcome level	• Existence of other sources of funding which allows the procurement of goods/services to complement the Project • Stability of R/M population
Output level	• Length of Project is sufficient to build expertise • Stability of R/M population • Capacity to deal with threats (smugglers and perpetrators of violence) • Availability/capacity of UNICEF staff to manage project and partners
Activity level	• UNICEF health expertise at the country level • Existence of other sources of funding which allows the procurement of goods/ services to complement the Project • Existing strong partnerships/ongoing activities with partners upon which to build project activities

8. Conclusions

204. **Conclusion 1:** Notwithstanding the challenges brought by COVID-19, and the severe overstretching of the national public health systems in the five countries as well as UNICEF Health staff both at country and regional level, The Project was able to deliver and over-achieve several of its planned outputs. However, the Project's aim of improving policy implementation was constrained by the short timescales for policy change to take effect. The evidencing of whether the intended outcomes were met was weak due to limitations in the M&E systems such as inadequate logic and coherence in the M&E framework and an unrealistic expectation of what the Project could achieve in two years. Furthermore, by not setting up a dashboard at the beginning of implementation, the Project missed an opportunity to properly and regularly monitor

both output level and financial information. Although the Project's duration was short, and it did not envisage carrying out a baseline study, the Project could have made greater efforts to capture outcome-level results by using qualitative/participatory methodologies, such as Most Significant Change techniques.

205. **Conclusion 2:** The Project's key drivers of success were UNICEF and implementing partners' agility, effective communications, leveraging of local contextual knowledge, and ability to reach refugee and migrant populations. UNICEF's well-regarded reputation secured successful interactions with national governments, and, in some countries, it supported high levels of national ownership. A major constraining factor was the COVID-19 pandemic which coincided with the start of the Project. This affected the supply of services as lockdowns and closures of camps made it hard for IPs to reach the R/M community. Many activities shifted to a remote modality, altering how IPs and beneficiaries interacted. Equally, COVID-19 affected the demand side as R/M were less able to access services due to lockdowns and movement restrictions. While this raised challenges, particularly in identifying new vulnerabilities and providing safe spaces for GBV and MPHSS activities, the Project adapted well and there were no insurmountable challenges.

206. **Conclusion 3**. The Project led to several unintended consequences, mostly positive, stemming from the shift to remote activities. Except for Greece, which experienced challenges with delivering activities remotely, these included increased active participation in online webinars, lower number of school dropouts and better learning opportunities, improved social cohesion, and greater capacity to use digital devices. Many IPs reported that activities (remote and in-person) were more popular than anticipated which resulted in a positive demand for more information and a greater demand for safe spaces. This highlights the need for similar services in future programming. One serious unintended consequence was increased threats that IP staff have received from both smugglers and perpetrators of violence. To respond to these threats, some of UNICEF's IPs have developed risk management protocols. Unplanned results provide an opportunity for learning and disseminating these experiences with other countries and regions with high R/M populations.

207. **Conclusion 4:** The Project's multisectoral approach and strong linkages with other UNICEF projects/programmes was a key strength. In particular, the provision of both mental/psychosocial, protection and physical health services helped build trust with the R/M population and meet their needs in a holistic and efficient manner. However, there was a missed opportunity to better link the activities and share information. Consequently, the Project evolved into five separate country projects rather than a regional one where greater information and experience could have been shared, and deliverables, such as the health literacy package, could have been jointly produced. While localization is undoubtedly essential, the Project could have benefitted from a greater balance between country-specific activities (to ensure relevance) and maintaining greater internal coherence (to ensure greater efficiencies and sharing of lessons and experiences). Finally, the Project could have been further strengthened by more consistently leveraging the expertise of and strategic partnerships with other UN agencies, with whom UNICEF already works in the Project countries. This would ensure the delivery of better services to R/M population; tap into the comparative advantages and technical expertise of the different UN agencies; and facilitate joint resource mobilization efforts.

208. **Conclusion 5:** UNICEF tried to address the needs of both girls and boys (UASC boys in particular) and women through the Project activities. However, while SADD was compiled by COs in their monthly reporting, it was not included fully in the interim report. As such, while knowledge of the number of R/M girls and boys assisted by the

Project was known at country level, it was not reflected at regional level. This is problematic for two reasons. Firstly, there are large number of male UASCs present in the five project countries, in Italy and along the Balkan route in particular, where they account for most child refugees and migrants. Secondly, UASC girls are often unreported in migration data and as such their vulnerabilities are not always understood and addressed in programming. Consequently, the Project missed an opportunity to fully report on and understand its effects on girls and boys beyond the country level and across the region; this is important given the transitory nature of the R/M population across the Project countries. Furthermore, ensuring GESI was not uniform across the five countries, partly due to the prevailing political discourse regarding gender equality in some countries, and driven by the fact that each country's intervention is shaped by different political and institutional contexts, necessitating different and flexible approaches.

209. **Conclusion 6:** Some important conditions for sustainability were met. The Project helped to build capacity amongst frontline workers and the Project's response to the COVID-19 pandemic has built more resilient networks and ways of working amongst Project stakeholders. The likelihood of intended results being sustained is rather low, due mainly to decreasing resources and an inability to handover Project activities to most national authorities however efforts are being made in some countries, advocating with donors for sustaining the Project's results. Greater resource mobilization and advocacy efforts, as well as further integrating R/M health services into national ones will be necessary to ensure that R/M needs continue to be addressed.

9. Lessons Learnt

210. The evaluation team identified the following lessons which may be useful for learning beyond this Project:

211. **Lesson 1. The importance of both vertical and horizontal coordination in a regional project.** The Project demonstrated the necessity of having strong and effective coordination between the regional office and the five countries included in the Project. The existence of such vertical coordination would have allowed for better technical backstopping, increased information sharing among the countries and the region, and ensured greater efficiencies (when jointly producing deliverables). Similarly, coordination among all stakeholders within the same country - especially when led by the government – resulted in greater national ownership, ensured complementarity of efforts, and decreased the risk of duplication.

212. **Lesson 2. The effectiveness of a multi-sectoral approach to deliver services to R/M population.** By offering basic public health services, combined with protection and psychosocial support, the IPs were able to address more sensitive issues (such as GBV). Furthermore, the pairing of cultural mediators/interpreters with the health service providers ensured the establishment of trust which allowed for better service delivery and resulted in more effective psychosocial support for the R/M population.

213. **Lesson 3. The need to establish structures and processes for ensuring better management and monitoring of both financial and programmatic information.** Setting up an M&E framework with measurable indicators that capture input, output and outcome level is essential for monitoring Project progress. Relevant indicators need to provide SADD information which should be aggregated first at the country level

and then at the Project/regional level. The M&E framework would need to include financial information (allocation and expenditures) based on source of funding. Furthermore, establishing a "live" dashboard during the Project's Inception Phase would facilitate monitoring on a quarterly basis the number of R/M receiving services. Finally, even though the Project's duration was short, and it did not envisage carrying out a baseline study, the Project could have made greater efforts to capture outcome-level results by using qualitative/participatory methodologies, such as Most Significant Change techniques.

214. **Lesson 4. The importance of involving the technical division and M&E staff during the design phase.** The Project highlighted the consequences of not involving the Regional Office's Health Division from the very start of the project design. This is essential in order to: (i) ensure that technical expertise and aspects are included in project design and implementation; (ii) develop a long-term peer-to-peer relationship with funding counterparts (DG-Health); (iii) establish and strengthen partnerships with national Ministries of Health, WHO and other health institutions where such partnerships are not already well-formed; and (iv) provide technical backstopping to country offices. Furthermore, the technical input and review of the M&E framework by technical staff at the start of the Project could have strengthened the results framework and sharpened the way the indicators were formulated.

10. Recommendations

The evaluation team developed draft recommendations based on the findings and conclusions which were further refined and finalized based on inputs from ECARO and UNICEF staff in the five countries covered by the evaluation. The consequent three, overarching recommendations are presented below with a suggestion as to who should be responsible for each, the level of priority suggested and what conclusions as per Chapter 8 that it relates to.

Recommendation 1. *Strategically*, advocate that health services for R/M are better integrated into national health systems and continue to support their provision	**Responsibility**: ECARO, COs and National Committees (where applicable) **Priority**: High **Conclusions**: 4 and 6
• Partner with strategic UN organisations both at the regional and national levels, such as WHO, IOM and UNFPA to jointly mobilise resources and implement programmes that address R/M needs • Advocate at the national and decentralised levels with Ministries of Health, Interior, and other key government institutions for ensuring that R/M children's rights are guaranteed, and their needs continue to be addressed • Integrate R/M children into the Child Guarantee Programme[375] to ensure greater sustainability and social inclusion and cohesion	

Recommendation 2. *Technically*, deepen work on R/M health at the regional and national levels	**Responsibility**: COs' Health/Protection staff with technical support from ECARO **Priority**: High **Conclusions**: 1, 4 and 5
• Further strengthen capacities to prevent, respond, and refer cases of GBV against girls and sexual violence against boys, given the high number of male UASCs in the region	

[375] UNICEF, in partnership with the European Commission, is implementing the Child Guarantee programme and is working with national and sub-national authorities and select civil society organisations, children and young people to design and implement services and interventions that reduce the effects of poverty and social exclusion on children in need of support and protection. https://www.unicef.org/greece/en/child-guarantee

- Based on Project experience, adapt the SOPs and protocols, ensure access to mental health and psychosocial services, and integrate health and gender components into health services for women and children on the move
- Develop preventative programmes targeting R/M children and design approaches that increase integration with host community
- Strengthen multi-sectoral coordination and information-sharing within UNICEF programmes and among external stakeholders (with governments, UN agencies, research institutions, IPs) within countries and at a regional level
- With UNHCR and IOM, develop protocols for dealing with fluctuating numbers of R/M and corresponding staffing needs
- With WHO, establish an IT system for cross border cooperation and tracking of R/M vaccine status
- Include SADD information in the Project's final report

Recommendation 3. *Institutionally*, establish Knowledge Management and Learning, capturing the lessons learnt and experiences gained through this Project	**Responsibility**: ECARO with support from COs **Priority**: Medium to High **Conclusions**: 1 and 3

- Document and share unique experience on R/M population in Europe by developing four-page briefs on issues (e.g., working in informal settlements, addressing mental health and substance abuse, addressing threats to IP staff, reaching transient R/M population, working with UASCs, etc.)
- Further populate and disseminate an e-library which includes Project outputs (e.g., SOPs, health literacy packages, etc. which is accessible to all UNICEF CO staff, especially those in countries with high R/M populations
- COVID-19 permitting, organise a regional workshop including relevant stakeholders (EU, governments, UN agencies, and Implementing partners) to present results and lessons learnt which can be an opportunity to (i) share experiences; (ii) advocate with decision-makers; and (iii) mobilise additional resources.

Recommendation 4. *Technically*, deepen knowledge and coherence on R/M child health programming in the region	**Responsibility**: DG Health **Priority**: Medium **Conclusions**: 5

- Organize a regional workshop bringing together key UN agencies working with the child R/M population, including WHO, IOM, UNHCR, UNFPA and UNICEF to share experiences and lessons learned in terms of supporting refugee and migrant children's health in the region
- Draw on lessons learned from the Project and other agencies' interventions to strengthen coordinated R/M child health responses in the region and other middle- and high-income countries

Recommendation 5. *Strategically*, target funds for the continued support of R/M Child Health interventions in the region	**Responsibility**: DG Health **Priority**: High **Conclusions**: 3 and 6

- Continue to provide support for R/M child health interventions where there is a clear demand, such as GBV services, mother and baby corners and health awareness raising
- Building on the results of the Project, strengthen partnerships with UNICEF to bolster resiliency of health systems to ensure access and respond to the needs of R/M affected by conflict in the region, particularly women and children on the move
- Consider investing in mental health and psychosocial support services for the R/M population in the context of the humanitarian response
- Enhance synergies between complementary activities (e.g., funding for PPE) in order to increase the interventions' effectiveness and provide a more comprehensive health package to end users (beneficiaries)