



# **EVALUATION OF UNICEF ROMA HEALTH MEDIATORS PROGRAMME 2013 – 2015**

**EVALUATION REPORT**

**February, 2017**



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## ACRONYMS

<b>EU</b>	European Union
<b>FGD</b>	Focus Group Discussion
<b>HERA</b>	Health Education and Research Association
<b>HRB</b>	Human Rights Based
<b>IPH</b>	Institute of Public Health
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
<b>OECD/ DAC</b>	Organization for Economic Co-operation and Development/ Development Assistance Committee
<b>RHM</b>	Roma Health Mediator
<b>ToC</b>	Theory of Change
<b>ToR</b>	Terms of Reference
<b>UNEG</b>	United Nations Evaluation Group
<b>UNICEF CO</b>	UNICEF Country Office

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## EXECUTIVE SUMMARY

### Background

The object of the evaluation was the UNICEF supported Roma Health Mediators Program 2013-2015. The Roma Health Mediators program was initiated with a goal to improve health conditions of Roma people and their health care access, acting as a link in the chain for improving communication between the Roma population and the health system in order to ease access to health care, establish trust between patients and health care providers, and develop habits regarding self-care and care of others, which is also a constitutional obligation of all citizens.

Roma suffer from a lower health status due to different reasons. The number of self-declared Roma, according to the 2002 population census, is 53,879, i.e. 2.6% of the total population. Estimates of the Roma population provided by the authorities, researchers and NGOs vary from 80,000 to 260,000, i.e. 4%-13% of the total population. Their living conditions, often sub-standard, make them susceptible to health hazards. Those without personal documents have difficulties accessing medical and gynecological services. Data on the health status of Roma is worrying. Life expectancy of Roma is ten years shorter than the national average. Infant mortality rate is almost double that of the general population.

UNICEF supported Roma Health Mediators program in all three main components. One component is related to development of policy framework, the second component focused on capacity building of RHM and the third component focused on monitoring and evaluation of the program.

### Evaluation rationale and methodology

**Evaluation Rationale:** This formative evaluation was commissioned after three years of UNICEF support to the RHM program. In this context the evaluation offers an opportunity to critically assess and generate knowledge on the RHM program implementation in general, and on specific UNICEF contribution to the program.

**Evaluation Objectives:** The main objectives of the evaluation are to: i) assess the relevance, efficiency, effectiveness, sustainability and to the extent possible impact of RHM work; ii) identify and document lessons learned and the contribution of UNICEF to these systems or impact changes; and iii) provide recommendations to guide the RHM program for the next program cycle.

**Evaluation Target Audience:** The key purpose of the evaluation report is to be used in planning and budgeting future activities within the RHM program, and wider in the domain of Roma health. Main audience of the evaluation is the Ministry of health, UNICEF, as well as other international and national partners in the field of Roma health.

**Evaluation Scope:** The evaluation covers the period from January 2013 to December 2015 focused on UNICEF contribution to the RHM program. The geographical scope included both national and sub-national level. The evaluation was carried out by an evaluation team consisted of two national consultants and was implemented in the period of September 2016 – January 2017.

**Evaluation Methodology:** To achieve the evaluation objectives, the evaluation framework was developed which identifies indicators for each question. It also identifies the sources of information, evaluation methods, the range of documents reviewed and the key informants interviewed for each question. The methodology comprised a mix of face-to-face semi structured interviews, focus group discussions, desk-based research and review of existing reports, documents and available secondary data. An extensive desk review summarized available documents and data collected through the field work, aimed at provision of a concise but thorough synthesis of activities completed over the past 5 years. In-depth interviews with key informants qualitatively informed implementation successes, problems with program management and co-ordination, and options for change in future. The purpose of FGDs with beneficiaries was to gauge the extent to which project might have contributed to improvement in quality of services and healthy behaviors, as well as utilization of services. Furthermore, FGDs identified key bottlenecks/challenges in access to health and social protection services. The principal topics to pursue as part of these FGDs included: i) degree of accesses to services; ii) their perception on the service quality; iii) bottlenecks, challenges.

Evaluation limitations: The evaluation faced certain limitations. One of the limitations was the high staff turn-over. Some of the RHM staff members who were in place at the beginning of the evaluation reference period were not available to inform the evaluation. Additional limitation was the lack of baseline and quantitative data in general.

## Key Findings

**Relevance:** The RHM program has been aligned with the relevant national development strategies and policies. It has also been harmonized with the main International human rights treaties (CRC, CEDAW, CPRD) and addresses priorities of the main stakeholders in the country. The program has been aligned with the Ministry of Education prescribed curricula and the capacity building activities were relevant for Roma Health Mediators. Data collection and monitoring activities developed with UNICEF support were to a large extent relevant for the country context.

**Effectiveness:** The program planned results were partially achieved. As specified in the 2011 Strategic Framework, the main goal of the RHM program was to provide services to 75% of Roma population living in 16 municipalities with highest proportion of Roma. This goal is partially achieved with 12 mediators providing services in 9 municipalities. Mediator services are not provided some of the municipalities with largest Roma population – Bitola, Prilep and Veles. The program has been effective in strengthening monitoring and reporting capacities in RHM and MoH. Still, majority of interviewed stakeholders and mediators expressed an opinion that additional training is needed in this field for in order to achieve high level of skills required in practice. The program was successful in developing separate elements of a RHM continuous professional development system. Additional work is needed, however, in order to make the capacity development a sustainable, institutional and systematic process.

**Efficiency:** The program has achieved the results with optimal efficiency, with resources invested in capacity building being used in efficient manner. The activities were coordinated and conducted in close cooperation with all stakeholders ensuring efficient implemen-

tation. Coordination was efficiently ensured at different levels during the program implementation. Advocacy efforts in the period 2013-2015 did not result in the Government's shifting towards a robust financial commitment securing the continuation of the program.

**Impact:** The program was successful in improving practice and quality of services provided by RHM and the practices and quality of services provided to Roma in general.

**Sustainability:** The program contributed to improvement in allocation and use of resources in the RHM program. It also promoted ownership by Government partners over different program activities. However, the Government has limited capacity to sustain the RHM program components established with UNICEF support. One option for strengthening the Government capacities is through diversifying budget allocations by the Ministry of Health budget to capacity building and monitoring and evaluation components of the program. It makes the budget realization less sensitive to turn over of mediators and cumbersome procedure for their replacement and better budget management by altering the use of resources between different program components.

## Conclusions

**Conclusion #1:** The program was developed in complete accordance with the government priorities, endorsed by the Government, and reflects commitments of the Government, international donors and civil sector in the country. The program is fully relevant to the current situation of Roma population in terms of access to health and social services.

**Conclusion #2:** The most important contribution of the RHM is in reducing the knowledge and power imbalance that exist between Roma citizens and service providers. As pointed in the interviews and FGDs, Roma people have insufficient knowledge related to their rights, to the relevant legislation and are, in general, less able to recognize violation of their rights. Such lack of knowledge creates situations of knowledge and power imbalance, preventing Roma individuals from claiming their rights effectively. RHM were successful in mitigating such imbalance by pointing that specific action, or lack of action, is not permitted by law or presents a violation of human rights.

**Conclusion #3:** Capacity building activities consist of both pre-service and in-service training. Pre-service training was developed as an official program, in line with the MoE 2010 Post-secondary Education Conception. In-service training was included in the program as an effort to establish continuous capacity development system for RHM. The training plan and topics are being developed and agreed among the program stakeholders, in consultation with RHM, taking into account their training needs. However, the occupation Roma Health Mediator is not included in the new 2015 National Classification of Occupations, which may present an obstacle for finding a model for systematic regulation of their status and for establishment of continuous capacity building system.

**Conclusion #4:** Although seen by some stakeholders as a temporary solution, the RHM program addresses barriers in access to health services caused by low level of education and living conditions of Roma population and as such, should exist as long as these conditions exist, with no a priori time limitations.

**Conclusion #5:** Mentoring is seen by all stakeholders as one of the most successful practices within the RHM program. All interviewed mediators stated that mentoring was highly beneficial for them and that this practice should continue in future. A common notion

among the interviewees was that the success of the mentoring process was in large part result of personal qualities, skills and motivation of the most experienced mediator, rather than an outcome of a systematic approach in implementing the program.

**Conclusion #6:** Data collection system was developed primarily as a tool for monitoring the work of the mediators, by collecting data on number of visits they have made per month and annually. It was updated later to collect data on the health and living conditions and socio-economic status of the visited households. However, being an “one direction” process, data collection is seen by mediators largely as time consuming and a burden.

## Recommendations

**Recommendation #1:** Identify optimal model and institutionalize the RHM. After over five years as a project activity, some serious decisions on the future of the program need to be made. It is highly recommended for the RHM program to continue, not as a project activity but as an institutional program within MoH.

**Recommendation #2:** Increase the number of RHM, to cover large Roma communities in the country. Expanding the RHM network is one of priorities for all stakeholders. This is particularly important for Prilep, Bitola, Kicevo and Veles, municipalities with some of the largest Roma communities in the country.

**Recommendation #3:** Extend the RHM coverage to the tertiary level health institutions. Tertiary health institutions are located primarily in Skopje. In order to assist these people in the process of receiving tertiary health services, it is recommended for two of the RHMs working in municipalities in Skopje to be additionally responsible for covering the University Clinical Center.

**Recommendation #4:** Revise RHM job description and mandate. The RHM job description should clearly state that the RHMs mandate is to identify and provide services to the most marginalized households and individuals within Roma communities. Being an outreach type of service, the mediators will be most successful by targeting the most disadvantaged and difficult to reach groups.

**Recommendation #5:** Continue with mentoring support in more structured and systematic manner. Mentoring support needs to be included as an element of the RHM continuous in-service capacity building process as it has powerful effect on motivation, quality of work and achievements of less experienced mediators.

**Recommendation #6:** Upgrade the data collection system by making it more user friendly and useful for RHMs. Data collection system needs to be developed to provide useful information for RHMs, while keeping time and efforts for data entry at the minimum possible. Situation of recording same data twice is highly demotivating and it is strongly recommended to avoid such an approach.

**Recommendation #7:** Increase visibility of RHM program and the achieved results. Positive results and achievement of the program need to be communicated with general public, with local level institutions, academia, and international organizations and with potential donors. Results published in the 2015 IPH report present RHM in very positive light and should be utilized for promotion of the program.

## Best practices

**Practice #1:** Mentoring was one of most successful activities within the RHM program. Low cost, flexible and highly effective, this capacity development method should be continued and sufficient funding should be provided.

**Practice #2:** Training and networking activities organizing jointly with other profiles is a good model for bringing two professional group closer, for better mutual understanding and collaboration in practice. Such a practice should continue, and a possibility of inclusion of other profiles – social workers, teachers and police will be even better model for strengthening the RHM position in the local communities.

## PART 1. INTRODUCTION

The objective of the evaluation of RHM program is to provide evidence of the work and results achieved by RHM, identify bottlenecks and barriers in implementation of activities and provide recommendations for shaping future activities.

The purpose is to:

- » Assess the relevance, efficiency, effectiveness, sustainability and to the extent possible impact of RHM work;
- » Identify and document lessons learned and the contribution of UNICEF to these systems or impact changes; and
- » Provide recommendations to guide the RHM program for the next program cycle.

The key purpose of the evaluation report is to be used in planning and budgeting future activities within the RHM program, and wider in the domain of Roma health. Main audience of the evaluation is the Ministry of Health, UNICEF, as well as other international and national partners in the field of Roma health.

This report is organized in three parts, structured as follows:

Part 1 describes the country context in which the program operates and in which the evaluation has been conducted. It provides information on the current country situation, the health system and the position of Roma population in relation to the health services. It also provides a description of the program being evaluated as well as an introduction to the evaluation, describing the rationale, objectives, scope and target audience, the approach and methodology used in evaluation as well as the evaluation limitations.

Part 2 presents the evaluation findings in relation to five OECD/DAC evaluation criteria, as required in the TOR. Additionally, at the end of part 2, separate sections summarize the lessons learned and best practices.

Evaluation conclusions and recommendations are provided in the Part 3.

## 1.1. Country Context

### The Country Background

The former Yugoslav Republic of Macedonia covers an area of 25,713 km<sup>2</sup>, belonging to the group of relatively small countries in Europe. According to population estimations from the end of 2015, the country has 2,071,278 inhabitants<sup>1</sup>. The population density is 81 inhabitants per km<sup>2</sup>.

There is a trend towards an aging population in recent years. In 2015, 16.7% of the population were under the age of 14, while 12.87% were above the age of 65<sup>2</sup>. According to the latest World Health Organization data published in 2015 life expectancy in the country is: male 73.5, female 77.9 and total life expectancy is 75.7<sup>3</sup>. The number of infant deaths per 1,000 live births in 2015 was 8.6<sup>4</sup>.

The number of self-declared Roma, according to the 2002 population census, is 53,879, i.e. 2.6% of the total population<sup>5</sup>. Estimates of the Roma population provided by the authorities, researchers and NGOs vary from 80,000 to 260,000, i.e. 4%-13% of the total population.<sup>6</sup>

Roma population is not concentrated in a particular region of the country but is instead spread all over the territory. According to the 2002 population census, 27 municipalities have a share of Roma exceeding 1% of the population, with 10 of them having a share of Roma exceeding 4%.

### Health and Health System Overview

The Constitution guarantees universal access to healthcare for all citizens. The Law on Health Care laid the groundwork for the current health system. This Law defines the foundation of the health insurance system, the rights and responsibilities of the health care providers, the health system's organizational structure, and the use of health care resources.

Health care in the country is provided through a network of health care organizations, organized on three levels: primary, secondary and tertiary. The health facilities range from health care stations and centers at primary health care level and specialty-consultative and inpatient departments at secondary level, to university clinics and institutes at tertiary level.

<sup>1</sup> State Statistical Office, 06.07.2016, *Estimations of the Population by Sex and Age, by Municipalities and by Statistical Regions, 30.06.2015 and 31.12.2015*

<sup>2</sup> Ibid

<sup>3</sup> <http://www.worldlifeexpectancy.com/macedonia-life-expectancy>

<sup>4</sup> State Statistical Office, July 2016, *Natural Population Change 2015*

<sup>5</sup> State Statistical Office, May 2005, *Census of Population, Households and Dwellings in The Republic of Macedonia, 2002 - Book XIII*

<sup>6</sup> State Statistical Office, July 2016, *Natural Population Change 2015*

Primary health care is organized and carried out at municipal level. It consists of five specialties: General medicine, Occupational medicine, Children's health care (pediatricians) for children 0-6 years, School medicine for school children and youths 7-18 years, Women's health care (obstetrics and gynecology).

According to the State Statistical Office data, there were 20,461 deaths in the country in 2015, which represents an increase of 3.8% compared to the previous year. The structure by sex shows higher male participation, 10,562 or 51.6% of the total number of deaths. The average age of death was 70.4 years for males and 75.1 years for females. Most deaths were due to circulatory diseases, making up 58.4% of the total number of deaths, followed by neoplasms with 18.3%, while 4.3% were deaths due to endocrine, nutritional and metabolic diseases, while 3.7% were cases where death occurred due to respiratory system diseases<sup>7</sup>.

The country has very liberal conditions for obtaining health insurance. As stated in the Law on Health Insurance,<sup>8</sup> there are 15 categories of health insurance receivers. If not possible to be insured under any of the points from the first 14 categories, a person will have health insurance as being a citizen of the country. The only obstacle for a person to be insured is absence of citizenship or personal documents.

## Roma Health

Data on the health status of Roma in the country is worrying. Life expectancy of Roma is ten years shorter than the national average. Infant mortality rate is almost double that of the general population<sup>9</sup>.

Roma suffer from a lower health status due to different reasons. Their living conditions, often sub-standard, make them susceptible to health hazards. Those without personal documents have difficulties accessing medical and gynecological services.

According to the analysis conducted by UNICEF in 2015<sup>10</sup> in eight municipalities with highest percentage of Roma population, as many as 8% of Roma population have no health insurance. This percentage is higher for male respondents, 12% compared to 7% for Roma women. Percentage of Roma with no health insurance is highest in Stip and Suto Orizari and lowest in Kocani (Figure 1). Lack of personal documents is the main reason for not having medical insurance.

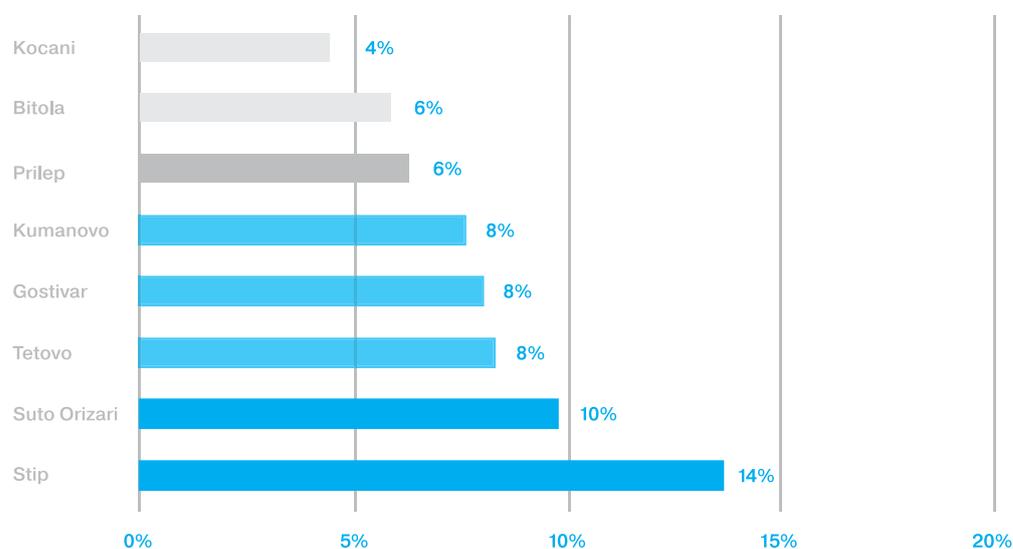
<sup>7</sup> State Statistical Office, 08.06.2016, *Mortality in the Republic of Macedonia, 2015*

<sup>8</sup> Law on Health Insurance – Internal cleaned text, (Official Gazette, 65/2012, 16/2013, 91/2013)

<sup>9</sup> Strategic Policy Framework "Improving the health and social status of the Roma population in Republic of Macedonia by introducing RHM 2011-2013

<sup>10</sup> UNICEF, March 2016, *Assessment of Barriers to Health Insurance Access for Roma Families in the former Yugoslav Republic of Macedonia*

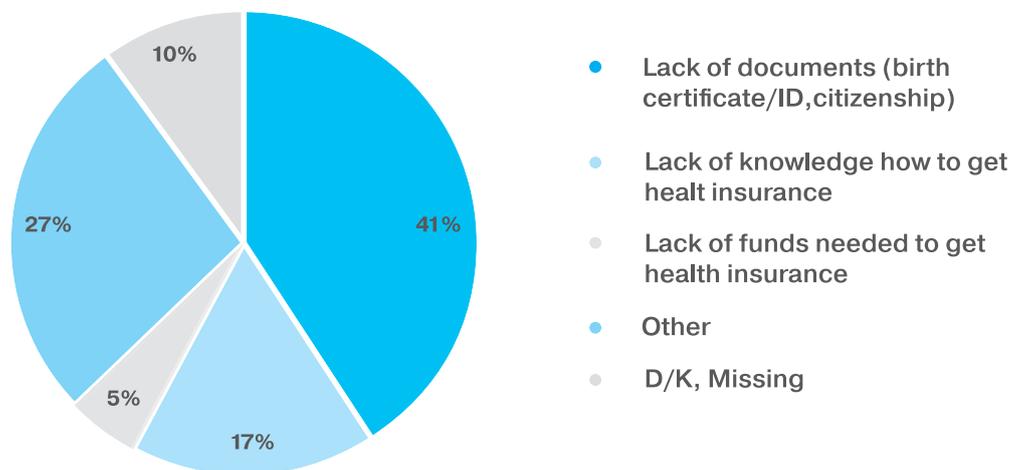
Figure 1: Percentage of Roma population with no health insurance, by municipality



Source: UNICEF, 2015

The main reason for not having medical insurance is lack of personal documents (Figure 2).

Figure 2: Reasons for lack of health insurance



Source: UNICEF, 2015

Comparing the National strategy for Roma from 2004 and the one from 2014, it can be noticed that the Roma population continues to face the same problems: lack of health insurance, unequal treatment of Roma when they access and use health services, lower level of immunization of Roma children, limited access to gynecological services and insufficient engagement of the health workers from Roma nationality. These are the priority areas where action is needed.

## 1.2. Program Description

### Program Background and Key Information

The Roma Health Mediators program was initiated with a goal to improve health conditions of Roma people and their health care access, acting as a link in the chain for improving communication between the Roma population and the health system<sup>11</sup>. The link should ease access to health care, establish trust between patients and health care providers, and develop habits regarding self-care and care of others (which is also a constitutional obligation of all citizens). In addition, the RHM was established to play an important role in referring individuals to the appropriate place in the system, in the case of unregistered individuals, individuals in need of being introduced to the health care system, children with lack of mandatory immunization, and to ease the process of integration of Roma health needs into the entire health system.

The RHM program was introduced in 2011. The Government demonstrated its political commitment by adopting the Strategic Framework “Improving the health and social status of the Roma population in Republic of Macedonia by introducing Roma Health Mediators”. Ministry of Health took the responsibility for program and financial operation of the program while local primary health care centers were assigned to provide premises and in-field support for the mediators. The Centre for Vocational Education developed training curricula for the health mediators and the medical High School “Pance Karagjov” was nominated by the Ministry of Education for delivering pre-service training and accreditation of the health mediators.

In the period of January-October 2015, a total of 19.047 services were provided by the mediators compared to 2013 when 6 RHMs provided a total of 7.280 services<sup>12</sup>. Roma health mediators provide services in 10 municipalities - Kumanovo, Suto Orizari, Gazi Baba, Karpos, Gjorce Petrov, Delcevo, Stip, Kocani, Tetovo and Gostivar, through activities such as health promotion, referrals to health centers and hospitals, accompanying Roma for issuing health insurance and immunization, assisting Roma to choose family physicians and/or family gynecologist.

As of 2009, NGO HERA and Foundation Open Society Institute Macedonia were the leading advocates and initiators of the RHM model. The core financial resources are allocated from the MoH's Roma Decade budget and Government health preventive programs and cover mainly the salaries of the RHMs. Other sources of funding are coming from UN agencies (UNICEF, UNFPA) and FOSIM, aimed at the institutional sustainability of the RHM, functional monitoring and policy advocacy activities.

UNICEF supported Roma Health Mediators program in all three main components as of 2013. The first component, related to the development of policy framework, addressed issues on institutionalization of RHM and included the activities focused on development of a Health Action Plan embedded in the Roma Strategy 2014-2020, an establishment of a National Steering Committee and development of a New Strategic Framework (2014-2017) for RHM. The second component focused on capacity building of RHM, including revision of pre-service curriculum, accreditation of RHM, in-service training and mentoring support.

<sup>11</sup> Improving the health and social status of the Roma population in Republic of Macedonia by introducing Roma Health Mediators – Strategic Policy Framework, 2011

<sup>12</sup> 2015 HERA Progress Report;

The third component focused on the program monitoring, by the development of annual reporting forms on Roma health, as well as attempts to incorporate RHM reporting system into the national electronic recording and reporting system. Global Fund to fight HIV and Tuberculosis has also contributed in the RHM program by providing financial support for mobile TB screening services.

## Program stakeholders

The activities were coordinated and conducted in close cooperation with all stakeholders ensuring efficient implementation. The core part of activities was managed by NGO HERA. The stakeholders, their role in the program, their respective contributions and collaboration with the program are described below:

**Ministry of Health (MoH):** The core financial resources are allocated from the MoH's Roma Decade budget and Government health preventive programs and cover mainly the salaries of the RHMs.

**Foundation Open Society Institute Macedonia (FOSIM):** The first initiative for introduction of the RHM program came from FOSIM, an organization which, together with NGO HERA, was the leading advocate and initiator of the RHM model at the beginning of the program. In later stage of the program, FOSIM continued on dealing in provision of technical support to the Ministry of Health in both program monitoring and mediators' capacity building. FOSIM has cooperated with the program through appointing their representative in the National Steering Committee. The purpose of the National Steering Committee is to establish a functional coordination mechanism that will be responsible for improving the RHM program and budget operation but also advocating for institutional sustainability.

**The United Nations Population Fund (UNFPA):** UNFPA has cooperated with the program mainly through direct involvement in the advocacy process by both program and financial support. One of the key activities under the advocacy was organizing the National Advocacy Conference with aim to increase visibility of the RHM program among key stakeholders, particularly decision makers, as a best practice model for improving Roma access to health services. Also, UNFPA has appointed their representative in the National Steering Committee of the program.

**The United Children's Fund (UNICEF):** Apart from Ministry of Health that provides major part of finances to cover RHM salaries, UNICEF is seen as main program and financial contributor by NGO HERA representative. UNICEF has cooperated with the program by providing program and financial support in activities related to policy framework, national coordination, capacity building and monitoring and reporting. UNICEF representative has also been a member of the National Steering Committee.

**NGO HERA:** HERA was responsible for program implementation and coordination.

## Program Theory of Change

No proper theory of change was developed for the RHM program, before or during the program implementation. Various result chain elements (inputs, activities, outputs, outcomes, impacts) can be found in different documents, developed in separate stages of the program by different stakeholders.

Due to absence of a consistent ToC, the evaluation team has constructed, for the purpose of the evaluation, a simplified version of a theory of change, based on results and activities described in documents related to the program. The ToC is presented in Figure 3.

It was not possible to construct a ToC with a complete correspondence between the levels of results. An evident inconsistency in the formulation and level of results, goals and objectives is present in the documents available to the evaluators. Such an inconsistency resulted in a ToC in which the contribution of the lower levels to the higher level results is not always obvious and logically related. However, we believe that the post-facto constructed ToC can be used for the evaluation in spite of the imperfections in the linkages between the levels of results.

The higher level results – impact and outcomes were incorporated from the *2011 Strategic Policy Framework on Improving the health and social status of the Roma population in Republic of Macedonia by introducing Roma Health Mediators* (hereinafter: **2011 Strategic Framework**). This is a strategic document, developed as a basis for the program and sets the results at the program level. Outputs, activities and inputs were selected from the program working documents – project proposals and progress reports.

Figure 3: Roma Health Mediators Program Theory of Change



## 1.3 Evaluation Purpose and Methodology

### Evaluation Rationale, Objectives and Scope

The evaluation, formative in its nature, is being commissioned after three years of UNICEF support to the RHM program. The evaluation presents evidence and generates knowledge on the RHM program implementation in general, and on specific UNICEF contribution to the program.

The main objectives of the evaluation are the following:

- » Assess the relevance, effectiveness, efficiency, sustainability and, to the extent possible, the impact of the RHM program;
- » Identify and document successes, challenges and lessons learned;
- » Provide recommendations to guide planning, budgeting and implementation of the RHM program in the future.

The evaluation is focused on UNICEF contribution to the RHM program, covering the period from January 2013 to December 2015. The geographical scope includes both national and sub-national level.

### Target Audience for the Evaluation Report

The key purpose of the evaluation report is to be used in planning and budgeting future activities within the RHM program, and wider in the domain of Roma health. The main audience of the evaluation is the Ministry of Health, UNICEF, as well as other international and national partners in the field of Roma health.

The key conclusions and recommendations of the evaluation were presented at the National Advocacy Conference held in December 2016, aimed at increasing the visibility of the RHM program among key stakeholders.

The evaluation findings and recommendations can be used as a basis for advocacy and planning between the relevant stakeholders. By reaching an agreement on specific findings, lessons learned and recommendations, UNICEF, the national authorities, international and national partners will be in a position to plan the future activities based on the current achievements and to address specific challenges.

## Evaluation Criteria and Framework

The assignment is a formative evaluation directed towards collecting evidence-based learnings from the implementation of the RHM program and to inform the planning and implementation of the program in the following period.

The evaluation assesses UNICEF contribution to the RHM program in terms of its relevance to the child rights and equity agenda, effectiveness, efficiency and sustainability (as defined by OECD/DAC). Related to these criteria, the evaluation ToR stated 22 evaluation questions. After reviewing the questions with UNICEF team, the evaluation team has developed measurable indicators for each evaluation question. The evaluation framework, containing the evaluation questions, along with corresponding indicators, descriptors as well as the data collecting tools and data sources are presented in the Annex 3 of this Report.

## Evaluation Process

The evaluation was conducted in three phases: Inception phase, Data collection phase and Reporting phase.

During the Inception phase, the evaluation team conducted desk review and prepared detailed evaluation plan, including evaluation framework, stakeholder list, interview and focus group discussion protocols, survey instrument and data collecting plan. Evaluation framework, methodology and tools were shared with UNICEF for review and approval.

The key deliverable from the Inception phase was the Inception report containing the elements listed above.

Desk review continued through the data collection phase, along with other data collection activities. Interviews with the representatives of main stakeholders at national level and of RHM staff, as well as focus group discussions with the program beneficiaries, were organized and conducted in this stage. Specific deliverable from this phase was not required in the ToR. A detailed schedule of data collection activities and transcripts from interviews and focus group discussion sessions was provided to the UNICEF CO.

In the Reporting phase, the evaluation team conducted an in-depth analysis of the collected quantitative and qualitative data. These, examined in relation to the key issues, enabled the evaluators to summarize the findings and to answer the evaluation questions. Based on the findings, draft conclusions and recommendations were developed, the evaluation report drafted, answering the evaluation questions based on data collected.

## Methodology

As required by the ToR, the evaluation is based primarily on qualitative methodology. The used methodology was a combination of face-to-face semi-structured interviews, focus group discussions (FGD), desk-based research and review of existing reports, documents and available secondary data.

An extensive Desk Review summarized available documents and data collected through the field work, aimed at provision of a concise but thorough synthesis of activities completed over the past 5 years.

All program stakeholders participated in the evaluation through interviews, discussions, consultations, they provided comments on draft recommendations and some of them will be responsible for follow-up to the recommendations.

In-depth interviews with key informants provided qualitative information on implementation successes, bottlenecks, problems with program management and coordination, and options for change in the future.

The purpose of FGDs with beneficiaries was to gauge the extent to which project might have contributed to the improvement in the quality of services and healthy behaviors, as well as the utilization of services. Furthermore, FGDs provided indications of the key bottlenecks/challenges in access to health and social protection services. The principal topics covered as part of the FGDs were: i) degree of access and quality of health and social services; ii) respondents' perception of the quality of services provided by RHM; iii) bottlenecks and challenges.

## Quality Assurance

To ensure impartiality and lack of biases, the methodology included a cross-section of information sources (stakeholder groups, including beneficiaries) which, through triangulation of information, improves data quality.

Triangulation was used to address the issue of internal validity by using more than one method of data collection to answer proposed evaluation questions, when available.

In order to account for the data quality and assess the strength of the evaluation conclusions the “robustness scoring” approach was used for each finding. Consequently, four scores (A to D) were used in this process. Assignment of the score depended on an assessment of the combination of the following two criteria: a) the extent to which qualitative and/or quantitative evidence generated from different sources point to the same conclusion and b) what is the quality of the individual data and/or source of evidence (e.g., as determined by reliability and completeness of data).

A detailed description of the “robustness score” assignment is presented in the Table 1 below.

*Table 1: Robustness Ranking for Evaluation Findings*

RANKING	DESCRIPTION
<b>A</b>	The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (i.e., there is very good triangulation); and/ or the evidence source(s) is/are of relatively high quality and reliable to draw a conclusion (e.g., there are no major data quality or reliability issues).
<b>B</b>	There is a good degree of triangulation across evidence, but there is less or ‘less good’ quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence are present.
<b>C</b>	Limited triangulation, and/ or only one evidence source that is not regarded as being of a good quality.
<b>D</b>	There is no triangulation and/ or evidence is limited to a single source and is relatively weak; or the quality of supporting data/ information for that evidence source is incomplete or unreliable

## Evaluation Limitations

One of the limitations was the high staff turn-over. Some of the RHM staff members who were in place at the beginning of the evaluation reference period were not available to inform the evaluation.

It is clearly stated in the ToR that the evaluation should be focused on UNICEF's contribution to the program. Bearing in mind that the program was initiated in 2011 with support from other stakeholders, with UNICEF support starting in 2013, some key informers that participated in interviews and focus group discussions were not clearly aware of UNICEF contribution and able to differentiate between UNICEF and other stakeholders and donors.

Additional limitation was the lack of baseline and of quantitative data in general. This shortcoming was foreseen in the preparation period, and the appropriate evaluation methodology was developed based primarily on qualitative data. Consequently, the evaluation questions were answered predominantly based on information obtained through interviews, FGDs as well as on information gathered during the desk review phase.

## Ethical Considerations

Ethical considerations were taken into account in the evaluation process. As stipulated in UNEG Norms and Standards, the evaluators have been "sensitive to beliefs, manners and customs and acted with integrity and honesty in their relationships with all stakeholders", have "ensured that their contacts with individuals were characterized by respect" and have "protected the anonymity and confidentiality of individual information".

During the evaluation process the evaluation team ensured the impartiality and independence at all stages of the evaluation process, which contributes to the credibility of the evaluation and the avoidance of bias in findings, analyses and conclusions.

The process of identifying stakeholders from different institutional levels has followed a standard procedure in order to ensure an informed consent to participate in the evaluation (letter of introduction presenting the evaluation process, protection of privacy and information confidentiality, followed by a verbal communication regarding the interview/focus group details). Participation in the evaluation was on voluntary basis.

The group discussions were facilitated sensitively, meaning that before starting the focus group the evaluators were aware about the context, the relationships between individuals and groups, the power dynamics, and how the different individuals and groups represented in the group discussion were affected by human rights and gender issues. During facilitation, the evaluators have used this knowledge to guarantee an adequate interaction between participants.

The evaluation did not involve the participation of children in the data collection process.

## PART 2. EVALUATION FINDINGS

This part presents the evaluation findings in relation to five OECD/DAC evaluation criteria, as required in the TOR. Additionally, at the end of this part, separate sections summarize the lessons learned and best practices.

### 2.1. Relevance

*Q1. Has the program been aligned to governments and partners' priorities/policies/reform agendas?*

**The program has been aligned with the goals and objectives of the national development strategy and policies.** The RHM program was initiated within the 2005-2015 Decade of Roma Inclusion by developing the Strategic Policy Framework "Improving the health and social status of the Roma population in Republic of Macedonia by introducing RHM 2011-2013" in accordance with National Operational Health Plan for the Decade of Roma Inclusion.

The overall objective of the program is also harmonized with the goals and objectives of the national policies and legislation:

- Strategy for the Roma - covering the major pole in which there are concerns for community as health, schooling, employment and housing;
- The Declaration to enhance the status and rights of Roma - for further improvement of the social and economic situation of the Roma and the Roma community in the country;
- Law on promotion and protection of the rights of communities that are less than 20% of the population;
- Law on Prevention and Protection from Discrimination;
- Law on child protection;
- Law on protection of patient's rights;
- Law on health care;
- Law on Employment and Insurance in Case of Unemployment;

The National Health Action Plan 2015-2020 also envisaged the employment of the Roma Health Mediators, this document, however is still not adopted by the Government.

**The program addressed priorities of the main stakeholders in the country.** The first initiative for introduction of the RHM program came from the civil sector – from the NGO HERA and the Foundation Open Society Institute Macedonia (FOSIM). It followed the positive experiences of the RHM programs in the neighboring countries, primarily in Bulgaria and Romania.

As stated in the FOSIM Strategy 2014-2017, Roma integration should be kept high on the list of priorities of the national agenda to accelerate the attainment of the objectives envisaged under the National Strategy for Roma Integration. Aiming at reducing the gap between policies and practices, as a prerequisite for Roma integration, FOSIM will empower Roma to fully enjoy their health rights<sup>13</sup>.

**The RHM program also exhibits its relevance to United Nations Country Team mandate, program, principles and strategies.** An important aspect of the United Nations Country Team work has been dedicated to the capacity development of social care and protection institutions to introduce innovative and alternative approaches in delivering reproductive health and HIV/AIDS prevention services for the socially excluded and for Roma and young people in particular<sup>14</sup>.

**The UNICEF country program 2016-2020 confirmed that Roma health remains a priority for the country.** In this context, poor access to quality services by Roma children will be addressed through the integration of the Roma Health Mediator's program into national and local planning and budgeting processes. This component aims at enabling children and their families in the seven municipalities with the highest density of Roma population to benefit from an integrated model of health, social and ECD services<sup>15</sup>.

**The RHM program has also been harmonized with the main International human rights treaties (CRC, CEDAW, CPRD).**

*Q2. To what extent are the policies, strategies and other documents that regulate the education, work and placement of RHM developed with UNICEF support, relevant for the reform process?*

**The policies, strategies and other documents that regulate education, work and placement of RHM developed with UNICEF support were relevant for the reform process.**

With support of UNICEF, the **revision of the 2011 Strategic Framework** was undertaken. The revision of the Strategic Framework was done by establishing an expert group with representatives of relevant Government and NGOs representatives<sup>16</sup>, through an analysis of Roma health activities in order to ensure improved integration and acknowledgment of the RHM program into the public health policies.

**The revision of pre-service training curricula** was undertaken in order to ensure recognition of the profile of RHM into the National Classification of Occupations as a first step to their systematization and permanent employment<sup>17</sup>.

**Health Action Plan as part of Roma Strategy 2014-2020** was developed with strategic goal for continuous development of the Roma health status. The Health Action Plan included recommendation for full employment of RHM, increasing the human resources capacity of MOH with regard to RHM program and exemption of vulnerable Roma families and social assistance beneficiaries from paying taxes for determination of disability level.

<sup>13</sup> [http://soros.org.mk/dokumenti/MAK\\_Strategy-2014-2017.pdf](http://soros.org.mk/dokumenti/MAK_Strategy-2014-2017.pdf)

<sup>14</sup> United Nations Development Assistance Framework 2010-2015

<sup>15</sup> UNICEF Country Program 2016-2020

<sup>16</sup> Interview with HERA representative

<sup>17</sup> Interview with National VET Center representative

*Q3. Has the program (content and delivery) been aligned with the Ministry of Education prescribed curricula?*

**The program (content and delivery) has been aligned with the Ministry of Education prescribed curricula.** The training program has been developed in alignment with the Ministry of Education documents regulating the post-secondary education. More specifically, the RHM pre-service training program was developed in accordance with the 2010 Conception on Post-Secondary Education created by the Vocational and Educational Training Centre<sup>18</sup>. In 2012, the Centre developed training curricula for the health mediators and the medical High School “Pance Karagjozov” was nominated by the Ministry of Education for delivering pre-service training and accreditation of the health mediators. After completion of the pre-service training the Roma Health Mediators received a certificate<sup>19</sup>.

Based on the Conception, a revision of the pre-service curricula took place in 2015, and it was done in order for Roma Health Mediators to receive V-B educational level – a specialization level which is one level higher than secondary education level as a precondition for introducing of the profile of RHM into the National Classification of Occupations. However, the RHM profile was not introduced in the National Classification of Occupations<sup>20</sup>. The official introduction into the National Classification of Occupations remains to be further achieved as the process of introduction is stalled at the level of Ministry of Education<sup>21</sup>.

*Q4. How relevant are the capacity building activities for RHM?*

**The capacity building activities were relevant for Roma Health Mediators.**

The RHM capacity building activities were designed to address the existent differences in the pattern of diseases between Roma and the general population (implying different health needs) or earlier emergence of chronic diseases compared to the general population (implying shorter life expectancy). This was confirmed by all interviewed stakeholders and mediators. All trainings received during the period subject of the evaluation were evaluated as highly relevant by the interviewed mediators for their daily job, and their content and delivery were developed in a consultative process which involved all stakeholders. For example, as a result of such consultative process, the training **on tuberculosis prevention** was designed and organized with the goal of providing RHM with required knowledge and skills for providing family counseling services to Roma people.

*“Based on what we were seeing on the field we recognize that certain diseases as tuberculosis or hepatitis were present in Roma families, especially among those families living in substandard conditions, and therefore we emphasize the need for training on this issue and it was organized by HERA”.*

**Interview with RHM**

As rapidly growing population with the highest birth rate and natural growth rate in the country, the training of the Roma Health Mediators on **reproductive health and family planning** of Roma was also highly relevant.

<sup>18</sup> Ibid

<sup>19</sup> Interview with Medical High School “Dr. Pance Karagjozov” representative;

<sup>20</sup> State Statistical Office, National Classification of Occupations 2015

<sup>21</sup> Interview with HERA representative

The training of RHM on **early detection and proper referral of children with developmental difficulties** was also relevant, taking into consideration that the awareness about the issue is not at the adequate level among Roma community.

*“Most of the parents who have children with disabilities are not well educated to recognize the disability and they definitely needed our support in this respect”.*

### Interview with RHM

The RHM Program capacity building activities were developed in close collaboration with all involved partners. For example, the trainings on tuberculosis and reproductive health and family planning were complementary or additional to the trainings funded by the Global Fund and UNFPA to increase capacities of service providers that are dealing on Roma health.

Similarly, the training on early detection and proper referral of children with developmental difficulties was in line with UNICEF broader program on early detection and was complemented with other projects supported by UNICEF with regard to access to quality health-care including early detection and intervention for children with developmental difficulties. As stated in the UNICEF CPD 2016-2020, *all program components will include a disability component to promote an inclusive approach, with special attention given to the children’s development, learning and participation, as well as child-centered services*<sup>22</sup>.

**Mentoring support** was evaluated as highly relevant by RHMs since the mentoring support was customized based on specific requirements and needs of each mediator. The purpose of this activity was to ensure that the mediators can easily manage outreach activities through the mentor support provided by the most experienced mediators. The mentor support was introduced in 2014. The task of the mentor was to evaluate RHM’s work, to present the mentor’s own experience and provide assistance with performing outreach activities.

*Q5. To what extent are the data collecting and monitoring activities developed with UNICEF support relevant for the country context in Roma access to 1) health services, 2) social protection sector and 3) other services?*

**Data collection and monitoring activities developed with UNICEF support were to a large extent relevant for the country context.**

Accurate data on the number of Roma with no health insurance is difficult to obtain in the country and all calculations are based on estimates, often with sporadic estimates available by NGOs, which show that health insurance coverage among Roma population varies between municipalities.<sup>23</sup> There is also lack of disaggregated data by ethnicity on access to health services, since such disaggregated data is not collected by public health institutes<sup>24</sup>.

**With UNICEF support a functional RHM service statistic system was designed to facilitate the data collection and analysis and provide information about the realities of Roma health.** The Institute of Public Health developed forms for evidence that RHM use during their visits to Roma families for collecting required information. The RHM then enter data in the specialized software and send it to IPH and MOH on a monthly basis.

<sup>22</sup> UNICEF 2016-2020 Country Program Document

<sup>23</sup> Analysis of Barriers to Health Insurance of Roma Families in Macedonia, 2016

<sup>24</sup> Interview with National IPH representative

The software has a possibility to generate quarterly, semi-annual and annual reports. UNICEF also supported trainings for RHM on collecting and entering data into the database software. The trainings aimed: to present the database software, to instruct Roma Health Mediators on how to import data in excel files, to determine problems that RHM face during collecting data and reporting, to share the experience of the Institute for Public Health regarding the results from received reports from RHM, to share information and experience among RHM.

The data collected by RHM contains information on a) socio-economic status of families; b) housing conditions and c) provided services by RHM, thus providing information on Roma access to health services, social protection sector and other services. The institute for Public Health prepares an annual report on RHM’s work containing the information on level of services provided and the efficiency of utilization of resources and institutional organization as well as evaluation of socio-economic and living conditions of Roma community provided with mediation services. Based on the information, IPH can propose concrete interventions and budget to MoH and the Government to improve the quality of the work of RHM and services they provide.

## SUMMARY AND ROBUSTNESS OF FINDINGS ON PROJECT RELEVANCE

Evaluation question	Findings	Rank	Justification
Q1. Has the program been aligned to governments and partners’ priorities/policies/reform agendas?	The program has been aligned with the goals and objectives of the national development strategy and policies and with the partners priorities.	A	Findings are substantiated through review of national policies and strategy documents and supported by key program documents of relevant partners
Q2. To what extent are the policies, strategies and other documents that regulate the education, work and placement of RHM developed with UNICEF support, relevant for the reform process?	The policies, strategies and other documents that regulate education, work and placement of RHM developed with UNICEF support were relevant for the reform process.	A	Findings are substantiated through review of national policies and strategy documents and supported by qualitative data
Q3. Has the program (content and delivery) been aligned with the Ministry of Education prescribed curricula?	The program has been aligned with the Ministry of Education prescribed curricula.	A	Findings are substantiated through qualitative data obtained from different sources and supported by review of national strategic documents
Q4. How relevant are the capacity building activities for RHM?	The capacity building activities were relevant for Roma Health Mediators.	A	Findings are substantiated through qualitative data obtained from different sources and supported by review of UNICEF strategic document
Q5. To what extent are the data collecting and monitoring activities developed with UNICEF support relevant for the country context in Roma access to 1) health services, 2) social protection sector and 3) other services?	Data collection and monitoring activities developed with UNICEF support were to a large extent relevant for the country context.	A	Findings are substantiated by qualitative and quantitative data

## 2.2. Effectiveness

### *Q1. Have the planned results been achieved (quantitative and qualitative)?*

**The planned results were partially achieved.** The main goal of the RHM Program, specified in the 2011 Strategic Framework<sup>25</sup> is to provide services to 75% of Roma population by covering 16 municipalities with highest proportion of Roma. It was planned to hire 32 RHMs to cover these 16 municipalities. With a total of 12 mediators, providing services in 9 municipalities at the time the evaluation was conducted, this goal is partially achieved. Mediators are not present in some of the municipalities with largest Roma population – Bitola, Prilep and Veles.

Such an outcome is a result of different factors, most prominent of them are briefly described below:

- High turnover rate of RHM staff was mentioned by all interviewed stakeholders, this is one of the major obstacles preventing the RHM program to achieve higher success. High turnover is a result of different causes: family reasons (marriage, pregnancy), moving to another city or to another country or finding another job.
- Uncertain professional status was emphasized by all interviewed mediators as an important shortcoming of the Program. Lack of professional security and benefits, lack of pension and health insurance have a negative effect on the RHM motivation and reduce the quality of their services.
- Administrative and financial delays affect both quality of services and the number of RHM active in the field. Prolonged procedure for signing the contracts and delayed receiving of their salary result in reduced motivation and quality of work. Furthermore, although twelve RHM were trained in 2015, due to the lack of funds for their salaries, none of them was offered a contract.

These factors affect program implementation in various ways:

- By depriving Roma communities of services and assistance provided by mediators;
- By requiring additional funds for training new mediators and interruption of continuous capacity building process;
- By increasing administrative work for appointing new mediators (which can be time consuming);
- By disrupting proper budget utilization. Unspent balance results in decreased budget for the following year.

Aside from the relatively low coverage, it was clearly confirmed by the stakeholders and the beneficiaries that the RHM services, when provided, do bring significant advantage to the Roma community members.

Figure 4 presents the key results of the RHM program as defined in the 2011 Strategic Framework<sup>26</sup>.

<sup>25</sup> 2011 Strategic-Framework-for-Roma-Health-Mediators-in-Macedonia;

<sup>26</sup> 2011 Strategic-Framework-for-Roma-Health-Mediators-in-Macedonia, pp. 8;

Figure 4: Key benefits of the RHM program

#### 4) What are the benefits of the RHMs? Expected results

The implementation of RHM in the health and social care systems will contribute to:

1. Increased awareness among the Roma in RM to take better care for their health and the health of their loved ones;
2. Improved information of the Roma regarding the opportunities and access to health care;
3. Eased health care access;
4. Eased access to social rights achievement;
5. Eased access to civil rights achievement;
6. Increased trust by the Roma in the health care and social institutions;
7. Improved levels of information and stimulation of the community for a proactive approach toward the rights and obligations in the context of existing mechanisms for social protection.

The quality of services provided by RHMs was assessed through focus group discussions with members of Roma community. They shared their experience and expressed very positive opinion on the quality of services they received. Following conclusions on the quality of RHM services, related to different results presented in the Figure 4, can be drawn based on the focus group discussions:

Most recognized and appreciated by beneficiaries was the support in obtaining legal documents, such as birth certificates and citizenship, required for health insurance. Majority of participants stated that they did not have personal identification documents or health insurance until the RHM assisted in acquiring them, which corresponds to the result 4 and 5 from Figure 4.

Similarly, the participants acknowledged the valuable support provided by mediators in improving access to health services, by accompanying them to the health care providers, assisting in administrative procedures and by ensuring that adequate services were provided as needed (result 3).

*When we go alone, they can tell us what they want: 'come another day, go to other place...' When the RHM come with us, he knows the laws and they change their behavior, because he tells them they have to provide the service to us.*

#### Focus group participant from Delcevo

The support provided by the RHMs was specifically targeted towards women and children, which was also confirmed during the FGDs, affirming the gender-sensitive approach in their work.

FGD participants also stated the important role of RHMs in providing advices and guidance on which health institution to visit and to pay more attention on health issues in their family in general (result 2 and 1).

Based on these conclusions, we can say that out of seven qualitative results, five were recognized by the beneficiaries of RHM services.

Furthermore, as clearly explained by the MoH representative<sup>27</sup>, the mandate of RHM was extended during the first year of the program. While the initial role of mediators was to inform the beneficiaries about the availability of services and provide directions on how to achieve them, it was realized shortly after the program initialization that informing alone was not sufficient and that the visited families rarely followed-up the instructions received from mediators. It was not only lack of knowledge and information that prevented them from accessing the services, but also lack of skills to actually go to the relevant institutions and receive the needed service.

*I have to go with them, because if he goes alone, he does not know what to do, where to give the health card, does not know where to ask, what to look for and will never go there alone.*

### Interview with RHM

It was agreed by the program stakeholders that the mediators will in future not only provide information and advice, but will physically accompany the beneficiaries to relevant institutions and assist in claiming their rights and receiving services. This change had an impact on the quantity of work, by reducing the number of families that a mediator can visit, but had a positive effect on the quality of work and actual number of Roma people receiving the services they needed.

*Q2. To what extent the program on RHM contributed to creating or improving the regulatory framework needed for reform of the system?*

**All preconditions for initializing and maintaining the RHM Program were already in place when UNICEF joined the Program.** One of the funding documents for implementation of the program – the 2011 Strategic Framework, was revised in 2014 with UNICEF support. The revision was conducted by an expert group with representatives of relevant Government institutions and NGOs.

The main goal of the revision was to ensure continuation, acknowledgment and inclusion of the RHM program into the public health policies. The revised Strategic Framework acknowledged the achievements of the program in the 2011-2014 period, provided suggestions for continuing the program in the period 2015-2020 and recommendations for strengthening the institutional position of mediators.

*Q3. To what extent the program contributed to strengthening monitoring and reporting capacities in 1) RHM program and 2) MoH?*

**The program interventions have been effective in strengthening monitoring and reporting capacities in RHM and MoH.** Development of monitoring and reporting capacities was one of focus areas in capacity development of RHMs supported by UNICEF. Still, this is the field for which majority of interviewed stakeholders and mediators expressed an opinion that additional training is needed in order to achieve high level of skills required in practice.

UNICEF supported development at both institutional and individual level in this regard.

<sup>27</sup> Interview with MoH representative;

At institutional level, support was provided for development of software for data collection and reporting by mediators. The database containing information generated through the software is located and maintained by IPH. It is utilized for production of annual analytical reports on work and achievements of RHMs. The database provides valuable data on households, as well as on number and type of services provided by RHMs<sup>28</sup>. Being initially developed as a management tool for monitoring the amount of work and number of visits by mediators, the software and the database were not designed to collect information on living conditions and health status of Roma population. As the need for such information grew, the software was later upgraded and expanded to collect that information too. It was accomplished by designing new forms for recording additional information and by increasing the workload for mediators in recording and entering the newly added data into the database. However, data collection process is organized as one-way flow of data, with mediators collecting and sharing data with MoH and IPH but not receiving feedback or analysis useful for planning or for improving their work. In addition, recording is paper-based, with consequent data entry in the software, usually after the working hours, causing additional and unnecessary workload for RHM.

In regard to individual level, UNICEF supported three training sessions related to data collection and reporting. Training sessions in this area reflected the changes in tools used for recording data from the field. After the initial software was developed, the mediators received instructions in 2013 on completion of the forms on number of visits and entering data into the software. With upgrading the software and addition of new forms for recording the social and health status, a second training was organized in 2014, providing information on completion of household and personal forms. The same training was repeated in 2015, as the quality of data the mediators shared with MoH and with IPH was not at an acceptable level. The quality of data and reports submitted to the MoH and IPH by the mediators was improved as a result of the third training. Such a conclusion was confirmed by mediators<sup>29</sup> and IPH representative<sup>30</sup>.

#### *Q4. How successful was the program in establishing and developing the national level mechanism for continuous professional development of RHM?*

**The RHM Program was successful in developing separate elements of a RHM continuous professional development system.** The three elements – pre-service training, in-service training, and mentoring are currently at different stages of development and are not integrated into a comprehensive system.

Pre-service training program was developed in 2010 and revised in 2015 with UNICEF support. The program, prior to the 2015 revision, was implemented as integral qualification and the participants received a certificate upon completion of the training. That was not an official qualification and did not provide a ground for RHM permanent employment. Through the 2015 revision, the training program was upgraded to a full qualification, providing a diploma for post-secondary education level<sup>31</sup>. The pre-service training program was developed by the National Vocational Education and Training Center and is being delivered by the Medical High School “Dr. Pance Karagjovov”, accredited to provide this type of post-secondary training. It consists of 8 modules and a corresponding exam. The training manual was developed with UNICEF support<sup>32</sup>. The training has been organized in three rounds since 2011. A total of 26 candidates have completed the training.

<sup>28</sup> Interview with National IPH representative;

<sup>29</sup> Interview with Roma health mediators;

<sup>30</sup> Interview with National IPH representative;

<sup>31</sup> Interview with National VET Center representative;

<sup>32</sup> Interview with Medical High School “Dr. Pance Karagjovov” representative;

In-service training, completely supported by donors, has continuously been provided to the RHMs throughout the program implementation. The training was planned annually, based on coordination among stakeholders, taking into account the needs expressed by the RHMs. The planning process was led by HERA, through consultations with the mediators, MoH and donors<sup>33</sup>. Topics covered by the training reflected the needs and interests of both RHMs and donors. Among other topics, RHMs received training on tuberculosis prevention, family planning, early detection of children with developmental difficulties, and data collection and reporting. As stated by the interviewed RHMs, the trainings were useful in improving the services they provided to their clients and worked as additional motivators for the mediators<sup>34</sup>.

Mentoring process, covered in detail under the Q8 in this section, is the third element of the capacity development mechanism. Mentoring provides individualized support, targeting specific needs of different mediators.

With these elements developed and implemented in practice, the groundwork for establishing continuous capacity development mechanism has been accomplished. Additional work is needed, however, in order to make the capacity development a sustainable, institutional and systematic process. Integrating the elements into one system, developing tools for managing and monitoring the process and defining conditions and criteria for advancing in career or licensing are some of activities needed for finalization of this process.

#### *Q5. To what extent the program contributed to building the capacities of the RHM?*

**The program contribution in building the RHM capacities was recognized and appreciated by all involved parties.** Capacity development was one of the key areas of the support provided by UNICEF and other donors. Effects of capacity development activities were positively assessed by main stakeholders, by mediators as well as by the FGD participants who also noted an improvement in practice and quality of RHM services.

Representative of HERA expressed her positive opinion on usefulness of capacity building activities and particularly of mentoring for improving the quality of services provided by RHMs<sup>35</sup>. Careful selection of training topics for the in-service training, covering relevant areas and taking mediators' opinion and experience into consideration when planning, resulted in capacity development process that provides valuable practical skills needed for effective work with Roma community. Training events were, in her opinion, useful opportunities for networking and strengthening the internal cohesion in the group and had motivational effect in addition to expanding their skills and knowledge.

Training in data collection and reporting had a positive effect on mediators' skills in recording data from their visits and on their adherence to the schedule for sharing data with IPH. As stated by IPH representative<sup>36</sup>, an improvement in quality of data received from mediators as well as in the compliance of their reports with the schedule was noted after the training. There was also a difference in this regard between the more experienced mediators and the newly employed, which may be a result of their participation in capacity building activities.

<sup>33</sup> Interview with HERA representative;

<sup>34</sup> Interview with Roma health mediators;

<sup>35</sup> Interview with HERA representative;

<sup>36</sup> Interview with IPH representative;

All interviewed mediators expressed positive opinion about the relevance and usefulness of received trainings. They all agreed that the selected topics – family planning, tuberculosis prevention and early detection of children with developmental difficulties, are highly applicable in their work with Roma population and that skills they have developed contribute to higher quality of their services. Training in data collection, recording and reporting was described by the interviewed mediators as useful in their practice, although some mentioned that completing the forms and entering data into the software is still a challenge. Mentoring was also appreciated as a highly valuable practice that provided additional skills and experiences.

*We have already identified few children with developmental difficulties after the training. After our suggestion, parents have taken children to relevant institution and in some cases it was confirmed that the child has an impairment or disability.*

### Interview with Roma health mediator

Positive change in RHM knowledge and skill was recognized by beneficiaries and expressed during focus group discussions. As stated by the FGD participants, mediators were better informed about the relevant legislation and services that should be provided by health professionals and institutions. Improved communication skills were also mentioned, as well as technical skills in completing administrative procedures.

Another useful practice implemented in the capacity development process, was involvement of patronage nurses in some RHM trainings. Such an approach has strengthened the RHM position in the health system, by establishing stronger connection between the two profiles. Simultaneously, a clear distinction between the mandate of patronage nurses and RHM reduced the potential overlapping, contributing to better collaboration between them<sup>37</sup>. Participation in the training on early detection of children with developmental difficulties provided ground for future consistent approach between patronage nurses and RHM when providing services to this vulnerable category of children.

*Q6. Has the program provided any additional (not directly planned) significant contribution or outcome in Roma access to 1) health services, 2) social protection sector and 3) other services?*

**The program has exceeded the planned achievements in regard to improvement of attitudes and treatment of Roma by health professionals.** While prior to RHM program implementation, health professionals had had predominantly negative attitude towards Roma population, and in some cases Roma individuals received even discriminatory treatment, that situation is changed at the time of evaluation. This change can be attributed to the RHM activities, possibly to increased presence of mediators in the health institutions and familiarity with health workers, or to increased frequency of Roma patients as a result of RHM activities. One argument to support this assumption is the fact that such change has mainly taken place, according to the FGD participants and key informants, at primary health care level, whilst negative treatment is still present at secondary and tertiary level.

<sup>37</sup> Interview with HERA representative;

*Q7. How effective UNICEF supported model for mentoring has been and what are the options or possibilities for expanding and scaling?*

**Mentoring is one of the most successful practices within the RHM program<sup>38</sup>.** Mentoring was introduced in 2014 and continued in 2015 as a mode of support to the new and less experienced RHMs. It was carried out through field visits by the most experienced mediator. UNICEF played a key role in supporting the mentoring practice. The main tasks of the mentor were to evaluate RHMs' work and working conditions, to share with them practical experience and to provide assistance with performing outreach activities.

Total of 18 mentoring visits were conducted in these two years – 10 in 2014<sup>39</sup> and 8 in 2015<sup>40</sup>. Mentoring was introduced with an idea to become a principal element of the national mechanism for RHM continuous professional development<sup>41</sup>.

All interviewed mediators stated that mentoring was an excellent learning opportunity, highly beneficial to them and that this practice should continue in future<sup>42</sup>. In addition to mentoring visits, they communicate regularly with the mentor asking for advice for specific issues.

However, a common notion among the interviewees was that the success of the mentoring process was in large part result of personal qualities, skills and enthusiasm of the most experienced mediator, rather than an outcome of a systematic approach in implementing the program.

With a limited number of recipients of mentoring support, as is the case with RHMs, it is expected for all to be covered by mentoring. Expanding and scaling up this practice is possible and recommended, in terms of increasing the number of mentoring visits, the time each mediator spends with the mentor, and in terms of developing a systematic mentoring program. Mentoring newly appointed mediators should include more basic skills, while the more experienced mediators should receive specific support, developed to maximize their skills.

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<sup>38</sup> Ibid.

<sup>39</sup> 2014 HERA Progress Report;

<sup>40</sup> 2015 HERA Progress Report;

<sup>41</sup> Interview with UNICEF representative;

<sup>42</sup> Interview with Roma health mediators.

## SUMMARY AND ROBUSTNESS OF FINDINGS ON PROJECT EFFECTIVENESS

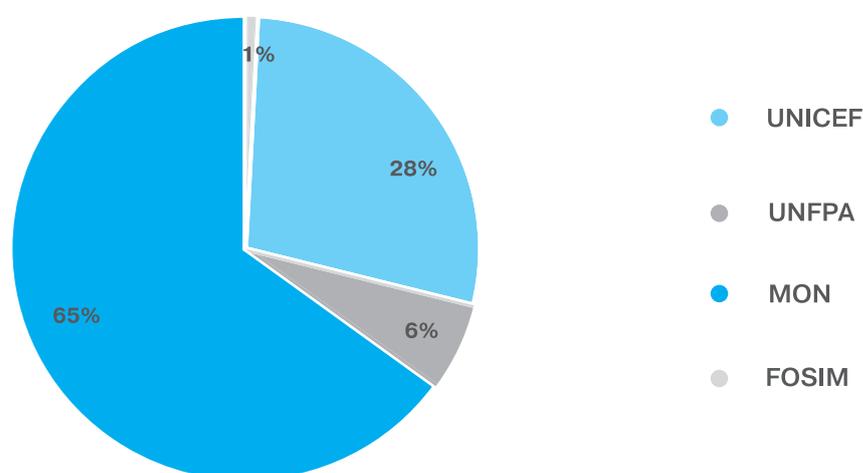
Evaluation question	Findings	Rank	Justification
Q1. Have the planned results been achieved (quantitative and qualitative)?	The planned results were partially achieved.	A	Findings are substantiated by documentary review and supported by qualitative data
Q2. To what extent the program on RHM contributed to creating or improving the regulatory framework needed for reform of the system?	All preconditions for initializing and maintaining the RHM Program were already in place when UNICEF joined the Program. The only document revised with UNICEF support was 2011 Strategic Framework.	B	Findings are substantiated by documentary review
Q3. To what extent the program contributed to strengthening monitoring and reporting capacities in 1) RHM program and 2) MoH?	The program interventions have been effective in strengthening monitoring and reporting capacities in RHM and MoH.	A	Findings are substantiated by documentary review and supported by qualitative data
Q4. How successful was the program in establishing and developing the national level mechanism for continuous professional development of RHM?	The program was successful in developing separate elements of a RHM continuous professional development system. Additional work is needed, however, in order to make the capacity development a sustainable, institutional and systematic process.	A	Findings are substantiated by documentary review and supported by qualitative data
Q5. To what extent the program contributed to building the capacities of the RHM?	The program contribution in building the RHM capacities was recognized and appreciated by all involved parties	A	Findings are substantiated by documentary review and supported by qualitative data
Q6. Has the program provided any additional (not directly planned) significant contribution or outcome in Roma access to 1) health services, 2) social protection sector and 3) other services?	The program has exceeded the planned achievements in regard to improvement of attitudes and treatment of Roma by health professionals	B	Findings are substantiated by qualitative data
Q7. How effective UNICEF supported model for mentoring has been and what are the options or possibilities for expanding and scaling?	Mentoring is one of the most successful practices within the RHM program	A	Findings are substantiated by qualitative data and supported by documentary review

## 2.3. Efficiency

*Q1. Have UNICEF's resources invested in capacity building of RHM been used in the most efficient manner?*

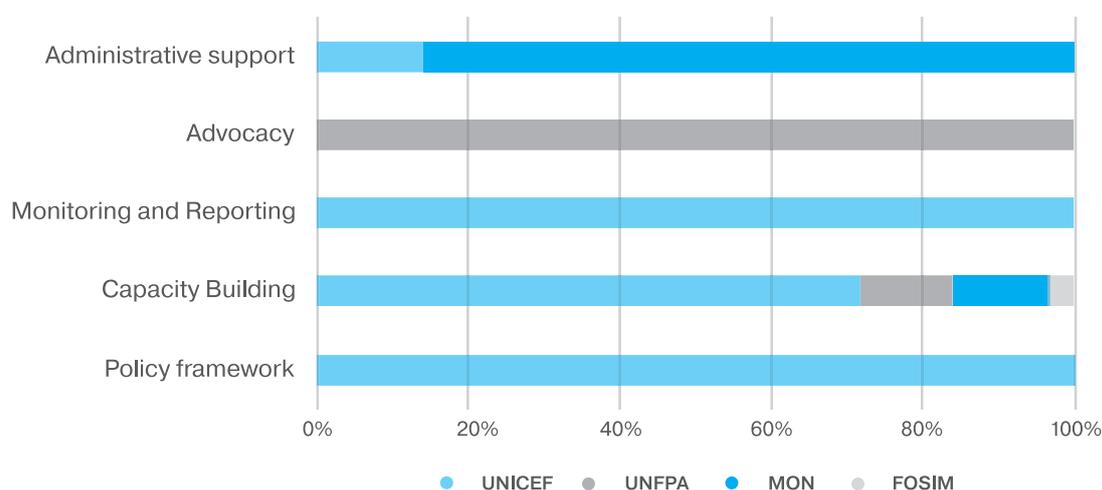
**UNICEF resources invested in capacity building have been used in efficient manner.** According to the revised budget in 2015, UNICEF contributed with financial resources to the program with 28% (Figure 5).

Figure 5: Project expenditure by donor



Nearly two third of these funds were used for capacity building activities of the RHM program and one third contributed to activities related to monitoring and evaluation and policy framework component, as well as for the administrative support of the program (Figure 6).

Figure 6: Program expenditure by activity and donor



The annual financial reports of HERA submitted to UNICEF indicate no report on extra charges compared to budget, meaning that resources were adequate to meet project objectives indicating a high level of efficiency and capacity to use resources in accordance with the planned ones. UNICEF resources were efficiently used in scaling up activities such as trainings on data collection and upgrading the existing data base in terms of facilitating the administrative work, with no extra resources but rather using remaining funds from the activity preparation of annual health statistics reporting<sup>43</sup>.

*Q2. Would there have been a more cost-effective way to achieve the expected results?*

Often understood as a low-cost intervention, an efficient model is rather one that both costs little and elicits high results. Focusing exclusively on low-cost interventions or initiatives can in reality bring about poor results. In order to achieve efficiency, initiatives must undertake evaluative activities to foster the best results from available resources. Table 2 presents the optimal model for efficient initiatives.

Table 2: Efficiency matrix

	High cost	Low cost
High impact	Expensive	***Efficient***
Low impact	Ineffective	Inexpensive

One good example demonstrating the efforts of UNICEF staff to achieve planned results with reduced costs is related to production of the RHM database:

In 2015, during preparations for development of the new RHM database, UNICEF staff was engaged in advocacy with MoH with intention to make the existing MoH database available for use by RHMs. The agreement was reached, resulting in a higher quality of the final product at a lower cost. The cost for production of the software was reduced significantly, as with use of the existing database all that was needed was a module to be added to the software running the database, as opposed to fully fledged, independent software solution. Simultaneously, this solution was expected to reduce the RHM workload and to improve the quality of collected data, as the basic demographic data for all citizens was already included in the existing MoH database, eliminating the need to enter it again and the chance of making errors in that process. In addition, a further reduction of costs was achieved when the MoH agreed for their IT staff to develop a technical specification for the RHM module, saving the funds planned for the consultancy fee<sup>44</sup>.

In the current settings, a single change that will have strong effect on increasing efficiency, in terms of cost, time and human resources, is to reduce the high turn-over rate of RHMs. Bearing in mind that for each RHM a period of at least three years is needed to achieve full potential, during which a set of trainings should take place, it is clear that each preventable RHM resignation increases unnecessarily the total cost of the program.

<sup>43</sup> HERA Progress report 2014

<sup>44</sup> Interview with UNICEF representative;

*Q3. Has the program been successful in leveraging governments' political will and financial resources to address Roma equity issues in terms of Roma access to 1) health services, 2) social protection sector and 3) other services?*

The changes in the budgeting of the program to include the Government contribution were completed in the period 2011-2012, when the Government, represented by the MoH, committed to cover the half and the full amount of the RHM salaries in 2011 and 2012 respectively. Therefore, all advocacy in this regard was done by HERA and FOSIM, prior to UNICEF involvement in the program. As of 2012, the financial support to the program remains unchanged, with RHM salaries being covered by MoH, and other costs, including capacity development, policy development and monitoring and reporting funded by the donors. Advocacy efforts in the period 2013-2015 did not result in the Government's shifting towards a robust financial commitment securing the continuation of the program.

On the other hand, as confirmed by the MoH representative<sup>45</sup>, all the funds that MoH has currently budgeted for Roma health are being allocated to the RHM program, demonstrating the importance of the program for the Ministry.

*Q4. How well the implementation of activities has been managed? What management and monitoring tools have been used and what tools could have been used?*

**The activities were coordinated and conducted in close cooperation with all stakeholders ensuring efficient implementation.** The core part of activities was managed by NGO HERA and their management was highly appreciated by partners<sup>46</sup>. The partnership of the stakeholders was manifested through establishing a working group (Steering Committee) consisted of representatives of HERA, relevant ministries, partners and Roma non-governmental organizations to ensure efficient monitoring of the implementation of program activities. The role of the working group was to monitor the overall implementation of the program and to endorse the eventual changes, as appropriate. At their quarterly meetings, the working group assesses the program progress and monitors the overall implementation process discusses any critical points or bottlenecks for further project implementation, and proposes actions to improve the program<sup>47</sup>. The activities of the representatives of the working group also included regular field visits to RHMs, attendance at the training workshops and other program activities. The monitoring field visits were perceived as useful and beneficial by the mediators as they also provide on-site assistance on how to solve certain issues they face in their daily routine<sup>48</sup>.

**The functional RHM service statistic system is in use as a part of monitoring and evaluation of the program.** The statistic system containing indicators and statistics ensured monitoring of RHM activities and was upgraded in several occasions in order to improve and facilitate the administrative work of mediators and to increase precision of the statistics generated by the software<sup>49</sup>. An attempt to integrate the statistic system into National Health Electronic System "Moj termin" was also made, but due to staff turnover at UNICEF, this activity is still not completed.

<sup>45</sup> Interview with MoH representative;

<sup>46</sup> Interview with UNICEF representative;

<sup>47</sup> Interview with MOH representative;

<sup>48</sup> Interview with Roma Health Mediator;

<sup>49</sup> Interview with IPH representative;

*Q5. Did the RHM program ensure coordination with other similar program interventions to encourage synergies and avoid overlap?*

**Coordination was efficiently ensured at different levels during the program implementation.**

**At UNICEF level, the intervention was managed by the program officer, head of health and nutrition sector.** Coordination with other sectors and the country program objectives was conducted through consultations with other officers and the CO management. UNICEF CO focus on most vulnerable groups was reflected in the RHM program through conducting training on early detection of children with developmental difficulties, proper referral and coordination with patronage nurses. UNICEF CO monitoring and evaluation officer was included in the program, providing technical support in developing the RHM database and monitoring tools needed by the program<sup>50</sup>.

**Internal coordination between RHM program stakeholders was successfully managed by HERA<sup>51</sup>.** Coordination was critical during the period of annual planning and budgeting of activities. Being aware of the big picture and keeping all needed elements in mind, HERA was able to meet the program interests of different stakeholders and to provide funds for implementation of the key activities. Budgeting was transparent, with donors complementing each other's budget allocations. Having the Ministry of Health, the main donors and local NGOs interested in supporting RHM program on board working together toward achieving program goals was a crucial precondition for ensuring synergy and avoiding overlapping.

**Coordination with other similar interventions has been carried on by RHMs and program stakeholders on a daily basis.** Two interventions which RHM collaborated regularly with were the Project for Providing Para-legal assistance to Roma and the Roma Information Centers. The three interventions were focused on Roma population, but were sufficiently different from each other that the possibilities for overlapping were minimal. Still, as stated by the interviewed RHMs<sup>52</sup> and HERA representative<sup>53</sup>, there were cases when a Roma person would go to one of these programs asking for services that were not provided by the specific program. That person would have been referred to the program capable to provide the required service.

<sup>50</sup> Interview with UNICEF representative;

<sup>51</sup> Ibid.

<sup>52</sup> Interview with Roma Health Mediator;

<sup>53</sup> Interview with HERA representative;

## SUMMARY AND ROBUSTNESS OF FINDINGS ON PROJECT EFFICIENCY

Evaluation question	Findings	Rank	Justification
Q1. Have UNICEF's resources invested in capacity building of RHM been used in the most efficient manner?	UNICEF resources invested in capacity building have been used in efficient manner	B	Findings are substantiated by documentary review
Q2. Would there have been a more cost-efficient way to achieve the expected results?	The program has achieved the results with optimal efficiency	B	Findings are substantiated by qualitative data
Q3. Has the program been successful in leveraging governments' political will and financial resources to address Roma equity issues in terms of Roma access to 1) health services, 2) social protection sector and 3) other services?	The program has been partially successful. Advocacy efforts in the period 2013-2015 did not result in the Government's shifting towards a robust financial commitment securing the continuation of the program.	A	Findings are substantiated by documentary review and supported by qualitative data
Q4. How well the implementation of activities has been managed? What management and monitoring tools have been used and what tools could have been used?	The activities were coordinated and conducted in close cooperation with all stakeholders ensuring efficient implementation	A	Findings are substantiated by qualitative data and supported by documentary review
Q5. Did the RHM program ensure coordination with other similar program interventions to encourage synergies and avoid overlap?	Coordination was efficiently ensured at different levels during the program implementation.	A	Findings are substantiated by qualitative data and supported by documentary review

## 2.4. Impact

*Q1. How successful was the program in improving the practice and quality of services provided to Roma population?*

**Presence of RHM had a positive impact on the practices and quality of services provided to Roma.** As mentioned under Q6 in Effectiveness section, this change was noticed by program stakeholders, by mediators and by representatives of Roma population. Two factors limited these effects and prevented the program from achieving wider impact, as presented in the program Theory of change, page 8. First limiting factor is the low number of mediators present in the field and a number of municipalities not covered by RHM. Second, the mediators work predominantly to provide access to primary health protection, which is the level where changes in practice and the quality of services is evident. As indicated by the mediators and beneficiaries, the situation at secondary and tertiary level is still not changed.

*Q2. How successful was the program in improving the practice and quality of services provided by RHM?*

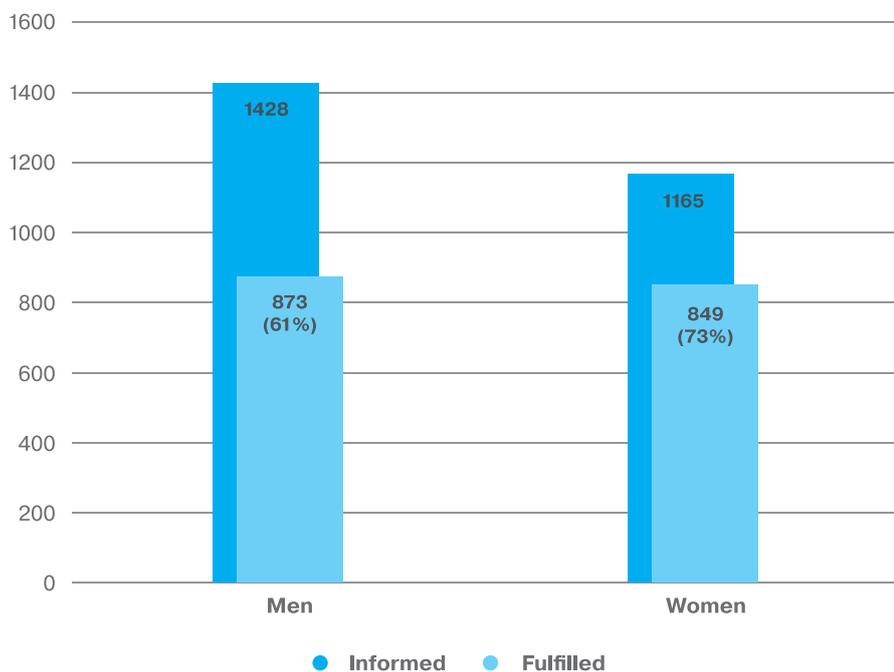
To answer this question properly, we need comparable data, describing practice and quality of RHM services provided in 2013 and 2015. The only available set of data that can be used for this purpose is published in the 2015 IPH Report on the Work of Roma Health Mediators (Table 3).

*Table 3: Number of services provided by RHMs in 2013 and 2015, total and per RHM*

Type of service	Total number of services		Number of services per RHM	
	2013	2015	2013	2015
Health services	6300	18340	1050	1411
Social benefits	280	1234	47	95
Personal ID	700	1399	117	108
<b>Total</b>	<b>7280</b>	<b>20973</b>	<b>1213</b>	<b>1613</b>
<b>Number of RHM</b>	<b>6</b>	<b>13</b>	<b>6</b>	<b>13</b>

It presents data on the number of services provided by the RHMs in 2013 and 2015. Based on this limited data, we can make some conclusions on the quantity of work accomplished by the RHMs. First, it is important to note that the numbers for 2013 are based on the work of six mediators, while that number in 2015 was 13. We can see that the mediators have provided more service on average in 2015 – 1613 services per RHM, as opposed to 1213 services per RHM in 2013. Largest increase is present for the services related to the social benefits with the number per RHM in 2015 being twice as high compared to 2013.

Figure 7: Right to health insurance – informed and fulfilled, by gender

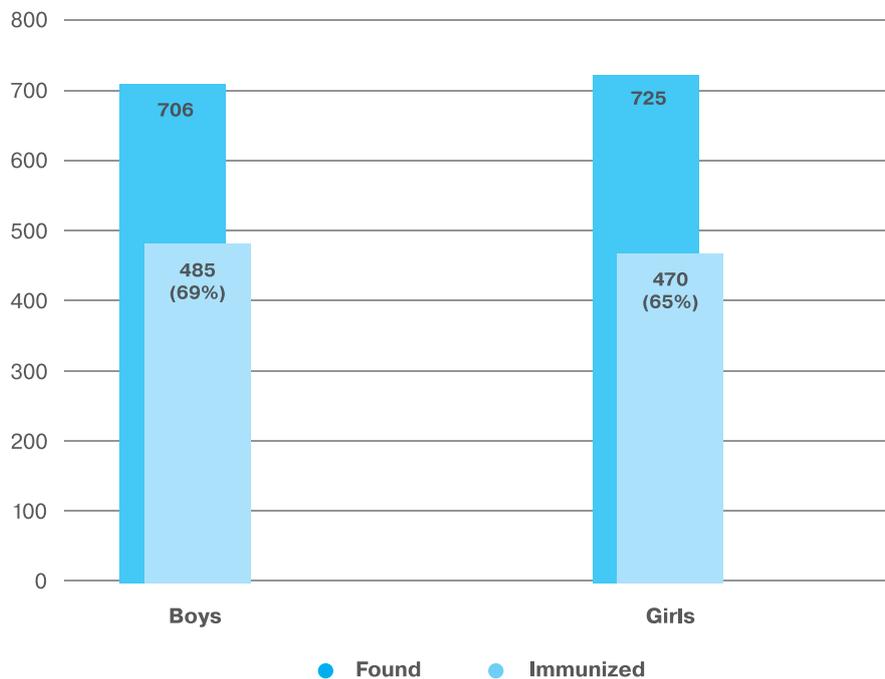


The report provides more detailed data for the year 2015, that can be used to describe the RHM work related to different rights and the difference between the number of beneficiaries informed on their rights and those that have fulfilled the specific right.

The number of people informed about their right to health protection in 2015 was 2593, while the number of those that were able to actually have that right fulfilled is 1722 or 66% of the informed (Figure 7).

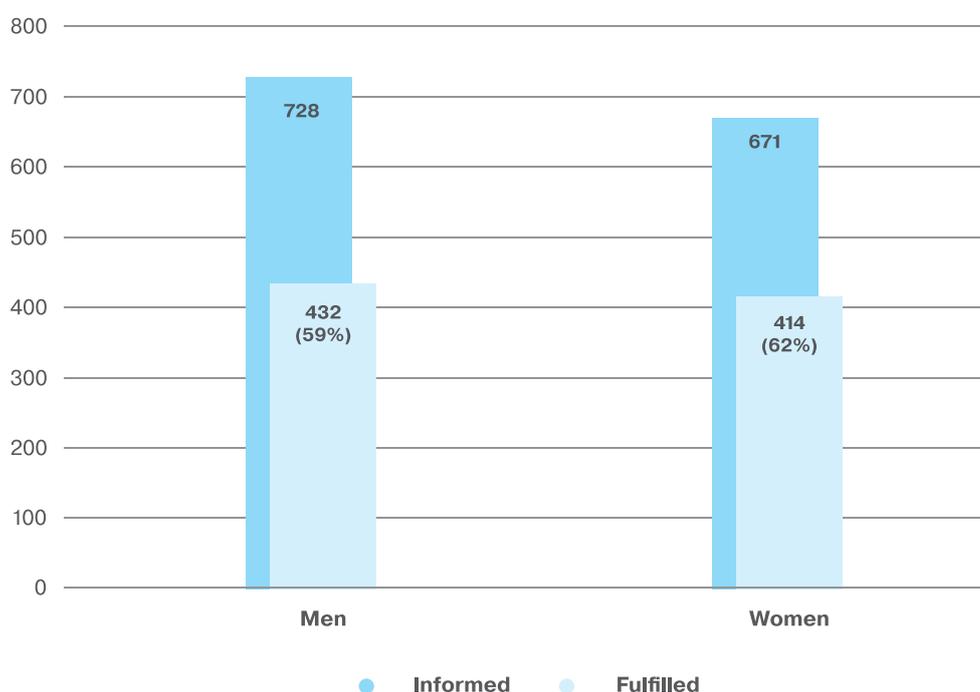
It would be interesting to do a follow-up visit to the households whose members had not achieved the right, to understand the reason for such an outcome. Knowing the reasons for not claiming or not be able to achieve some right would provide information for better addressing the bottlenecks and may inform the program on the potential capacity building needs. What should also be noted for the data presented in the Figure 7, is the gender difference in the number of informed people and those that have actually achieved the right. While the number of informed is higher for males, the percent of females that have achieved the right to health protection is higher. Reasons behind that situation can also be useful topic to be analyzed in more details, and can provide valuable information on the situation in Roma communities or in RHMs approach in their work.

Figure 8: Children without immunization – found and immunized, by gender



Mediators were able to find 1431 children without or with incomplete immunization in 2015, as shown in the Figure 8. After the RHM visit, 955 children or 67% were fully immunized. The remaining 436 children were not immunized even with RHM support. No gender differences are present in this case. More detailed analysis of this data is needed in order to answer some important questions, like what is the percentage of unimmunized, compared to official data and some NGO claims; are some patterns recognizable, based on geographical distribution, socio-economic status, living conditions; reasons for being unimmunized, before the RHM visit and after the support was provided. It would be useful to compare this data with the situation in the previous years, to identify any changes and trends in this regard. Also, it will be valuable to analyze the reasons for not immunizing children after RHM visit.

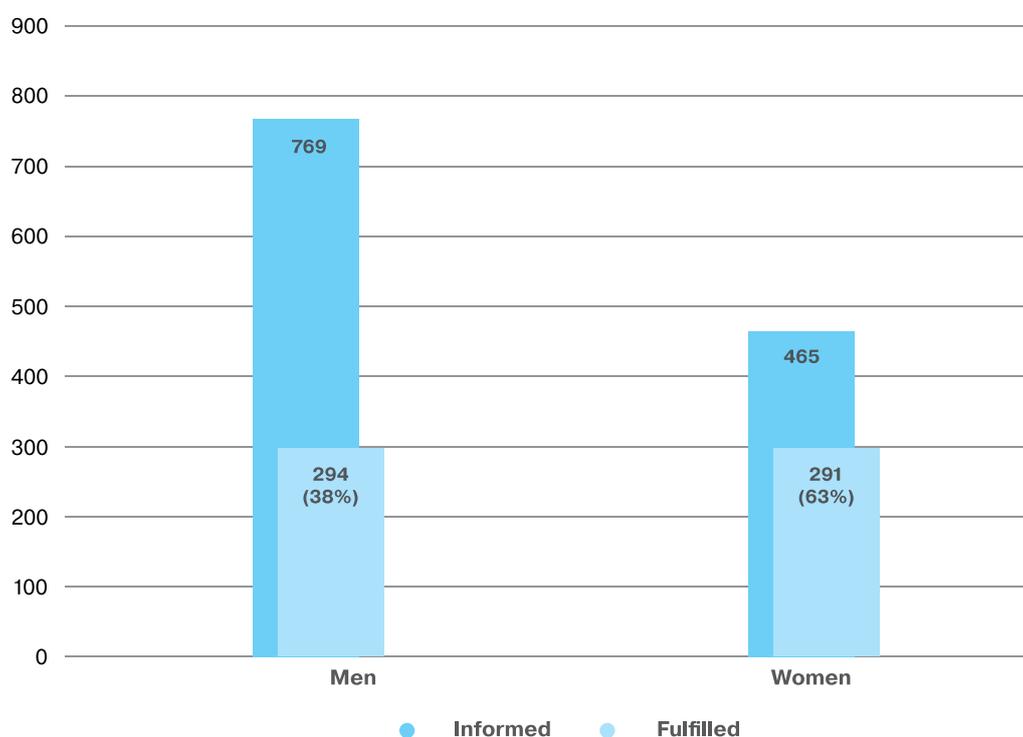
Figure 9: Right to personal documents – informed and fulfilled, by gender



Another important role of RHMs is to provide services to people without registration or personal documents. The importance of this function and the positive impact of their work is even clearer when the data is presented on the number of people whose right to identity and personal documents had been violated and the number of them that have successfully claimed that right with RHM support. In 2015, thirteen RHMs, working in nine municipalities have found 1399 people with no personal documents (Figure 9). After RHM had informed them on their rights and provided support, 846 of them have received their ID documents. Again, a detailed analysis of this data would be useful to provide information on the structure and distribution of this group and reasons for not being able to obtain personal ID documents. Furthermore, these findings should be made more visible and used for promotional and fundraising purposes. Gender difference, although with same pattern as in Figure 7, is not substantial in this case.

Finally, RHMs provided services to people in need of financial support. Number of people informed about options and possibilities of receiving social benefits in 2015 was 1234. Out of this number, 585 or 47% have successfully applied and achieved some type of financial assistance (Figure 10). The gender difference pattern present in 2 of the figures above is in this case much more distinct. Similar questions can be asked in this case too, and will be useful to have them answered.

Figure 10: Right to social protection – informed and fulfilled, by gender



Q3. What was/is the impact of RHM program on policy makers and ministerial stakeholders to provide resources for sustainability of the RHM program?

This question overlaps with the Q3 in Efficiency section and was addressed there.

### SUMMARY AND ROBUSTNESS OF FINDINGS ON PROJECT IMPACT

Evaluation question	Findings	Rank	Justification
Q1. How successful was the program in improving the practice and quality of services provided to Roma population?	Presence of RHM had a positive impact on the practices and quality of services provided to Roma.	B	The findings are substantiated by qualitative data
Q2. How successful was the program in improving the practice and quality of services provided by RHM?	The program was successful in improving practice and quality of services provided by RHM	B	The findings are substantiated by quantitative data

## 2.5. Sustainability

*Q1. To what extent the Government involved in project implementation have the capacity to sustain the RHM program components established with UNICEF support?*

### **The Government has limited capacity to sustain the RHM program components established with UNICEF support**

The Government demonstrated its commitment to the sustainability of the program by taking over financing the biggest part of the program, that is, budget for the salaries of mediators. Starting from 2012 the Ministry of Health first together with FOSIM contributed for the salaries of RHM and as of 2013 the budget from Ministry of Health covers the salaries for RHM without providing funds for pension and health insurance. Furthermore, the MOH financing of the RHM salaries is influenced by administrative barriers in case of replacements of the Roma Health Mediators who abandon the program. According to MOH representative hiring a new health mediator requires permission from Ministry of Finance and that process is cumbersome and could take months. Although, as stated by the MoH representative, the commitment of the Ministry to continue the financial support to the Program is guaranteed<sup>54</sup>, the internal mechanisms between the MoF and MoH still curb the program sustainability. That is why, no new RHM was hired from the cohort of RHM who completed the pre-service training in 2015. In addition, as a consequence of unused budget resources, during the rebalance of the MOH budget, RHM program budget was reduced and the budget for 2016 RHM program faced even more drastic reduction to almost 35 per cent<sup>55</sup>.

Through the project for enhancing institutional sustainability of Roma Health Mediators, UNICEF supported following program components:

**Legislation and regulatory framework.** While the program through UNICEF support invested in the revision of the Strategic framework 2014-2017 that should ensure continuation of services provided by Roma Health Mediators and in developing Roma Health Action Plan that needs to be embedded in the Strategy for Roma, still the official adoption of both documents by the Government was still pending<sup>56</sup>. A lack of political commitment of the Government to ensure better institutional framework for Roma health was noted in the program progress report.

**Capacity building and data collection and monitoring.** To promote the educational qualification of Roma Health Mediators and provide possibility for their institutionalization and systematization, a revision of the pre-service training curricula was done in 2015 and adopted officially by the Ministry of Education thus making the initial education process sustainable. UNICEF supported in-service training activities and efforts were invested in building continuous training program and for the first time in 2015, HERA and UNICEF signed a two-year contract for cooperation on RHM program which enable more sustainable planning of program activities<sup>57</sup>.

Recognizing the importance of reliable data in improving the quality of the services provided by RHM, agreed template for data collection for RHM program was designed and each mediator has been responsible to collect and send data on a monthly basis to the Ministry of Health and the Institute for Public Health.

<sup>54</sup> Interview with MOH representative

<sup>55</sup> HERA progress report April-December 2015

<sup>56</sup> Ibid

<sup>57</sup> Interview with UNICEF representative

Respective databases have been installed at the MOH and IPH and the specialists responsible for data analysis trained by the project have been instrumental in the Roma health information strengthening effort. The Institute for Public Health is responsible for producing comprehensive annual report on Roma health including socio-economic and living conditions used for improved monitoring of the RHM performance, whereas the Ministry of Health prepares quarterly reports to the Government on the number of services provided by RHM and their outreach activities for future service delivery planning and budgeting by the Ministry.

Risks to sustain and further improve outcomes related to program components established with UNICEF support still remain. Additional capacity development is needed, as well as reduction of the high turnover rate of the RHMs in order to enhance the program stability and possibility for continuous development of the mediators, as well as, for comparative analysis of the results achieved<sup>58</sup>.

*Q2. What specific recommendations could be given that would contribute to the sustainability of the overall program?*

**The Government commitment and contribution to the stability and success of the program is crucial.** Identifying optimal model for Roma Health Mediators institutionalization and systematization remains a priority for sustainability of the overall program. This should be done by introducing the profile of health mediator into National Classification of Occupations enabling their systematization and entitlements as for any other Government employee.

**Developing a framework for continuous in-service training activities** in a systematic way similar to other professionals in health system (patronage nurses) or social protection system (social workers) including mentoring support, which if conducted properly can have powerful effect on motivation and quality of work of the mediators.

**Diversifying budget allocations by the Ministry of Health budget into different RHM program components.** Currently, the MOH budget is only used only for one program component, that is, for coverage of Roma Health Mediators salaries. Diversifying the budget allocations to capacity building and monitoring and evaluation components of the program would make the budget realization less sensitive to turn over of mediators and cumbersome procedure for their replacement and better budget management by altering the use of resources between different program components.

**Integrating data collection system into National Health Electronic system.**

*Q3. Did the program promote ownership over different program activities? Did the relevant partners own the results of the program?*

**The program promoted ownership over different program activities.** The program demonstrated the political power of national government structures as well as funding, which has been made available for sustainability of RHM activities. The program used a participatory approach with multidisciplinary groups consisted of relevant ministries, strategic partners and civil sector for the development of the normative framework. In support of the project the Government, at the very beginning, ensured the establishment of an enabling policy environment by adopting the Strategic Policy Framework and later a revision of the framework.

<sup>58</sup> Interview with MOH representative

The Ministry of Education and the Vocational and Educational Center were involved in designing the pre-service training curricula, whereas Ministry of Health ensured funding for RHM salaries, which is the major part of program budget.

Institute for Public Health made a sustained effort to take ownership of information system consisted of data collected by RHM. The Institute for Public Health is responsible for producing annual reports from the data collected by RHM to be used for proposing concrete interventions and budget to MoH and the Government to improve the quality of the RHM.

*Q4. Did the program contribute to improvement in allocation and use of resources in the RHM program?*

**The program did contribute to improvement in allocation and use of resources in the RHM program.**

One of the outputs achieved was an improved annual reporting format on Roma health. The purpose of the report is analyzing the results of RHM’s work, the level of services provided and the efficiency of utilization of resources and institutional organization.

The introduction of monitoring framework in HERA project proposal where all planned activities and available resources were placed in one document contributed to improved allocation and use of resources – “In this project proposal by HERA we could clearly see who finances what and all program activities not just those financed by UNICEF”<sup>59</sup>.

**SUMMARY AND ROBUSTNESS OF FINDINGS ON PROJECT SUSTAINABILITY**

Evaluation question	Findings	Rank	Justification
Q1. To what extent the Government involved in project implementation have the capacity to sustain the RHM program components established with UNICEF support?	The Government has limited capacity to sustain the RHM program components established with UNICEF support	A	Findings are substantiated by qualitative data supported by documentary review.
Q2. What specific recommendations could be given that would contribute to the sustainability of the overall program?	Diversifying budget allocations by the Ministry of Health budget into different RHM program components	B	Findings are substantiated by qualitative data
Q3. Did the program promote ownership over different program activities? Did the relevant partners own the results of the program?	The program promoted ownership over different program activities	A	Findings are substantiated by qualitative data supported by documentary review.
Q4. Did the program contribute to improvement in allocation and use of resources in the RHM program?	The program did contribute to improvement in allocation and use of resources in the RHM program	A	Findings are substantiated by qualitative data supported by documentary review.

<sup>59</sup> Interview with UNICEF representative

## 2.6. Lessons learned

### Lesson #1

High turnover rate of mediators is one of the major obstacles preventing the RHM program to achieve higher success. It affects program implementation in various aspects:

- It deprives Roma communities of services and assistance provided by mediators;
- It requires additional funds for training new mediators and interrupts continuous capacity building process;
- It increases administrative work for appointing new mediators (which can be time consuming);
- It disrupts proper budget utilization. Unspent balance may result in decreased budget for the following year.

High turnover is caused by different factors, both subjective and objective in their nature.

Subjective factors include: family reasons (marriage, pregnancy), moving to another city or to another country or finding another job. Being of personal character, these factors cannot be significantly affected or modified by the project management or stakeholders.

Objective factors are those that originate in the way the system is established and managed, and can be influenced by change in the system set-up and management. These factors have an effect on motivation, satisfaction and quality of work - for example, if established as a recognized job position, with a secure salary, RHMs would be more motivated to stay, rather than look for another job. Some of the objective factors that play role in the RHM project are: administrative delays in signing the contracts, contracts that do not entitle RHM to any pension and health insurance, delays in receiving wages, lack of professional security and benefits and lack of communication means (mobile phones and computers). Eliminating one or more of these factors will result in significant improvement in quality of services provided by the RHMs.

### Lesson #2

Human rights based approach in work, knowledge of relevant laws and primary health care programs are crucial for ensuring success in the RHM work. RHM are human rights workers. Their primary mandate is protection of human rights in the health and social sector. The HRB approach is the best tool they have to assist their clients, applicable in all situation of discrimination both intentional and unintentional. When accompanied by knowledge of the legislation governing the health and social sector, it can contribute to higher rate of success in achieving relevant human rights.

*When I told the doctor that, according to the Law on health protection, she is obliged to provide service to the patient and that the right to health protection is one of the basic human rights, she had no choice but to help the patient. And she was very friendly and positive toward us after that.*

#### Interview with Roma health mediator

## 2.7. Best Practices

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### *Practice #1*

As mentioned earlier in the report, mentoring was one of most successful activities within the RHM program. Low cost, flexible and highly effective, this capacity development method should be continued and sufficient funding should be provided. More details are presented in the Recommendation #4.

### *Practice #2*

Organizing training and networking activity jointly with other profiles, in this case, with patronage nurses is a good model for bringing two professional group closer, for better mutual understanding and collaboration in practice. Such a practice should continue, and a possibility of inclusion of other profiles – social workers, teachers and police will be even better model for strengthening the RHM position in the local communities.

## PART 3. CONCLUSIONS AND RECOMMENDATIONS

### 3.1. Conclusions

#### *Conclusion #1*

The program was developed in complete accordance with the government priorities, as stated in the key documents related to Roma health. Initiated within the Decade of Roma Inclusion, the program was officially endorsed by the Government, by adopting the Strategic Framework on Roma Health Mediators. The program reflects commitments of the Government, international donors and civil sector in the country on improving the health status and access to health services of Roma people. It contributes to UNICEF equity focused approach, by reducing equity gap in access to health services between Roma and general population.

The fact that the program is highly relevant to the context and based on a main policy document related to national health priorities within the Decade of Roma Inclusion – the Strategic Framework on Roma Health Mediators built the program's strong reputation among partners and ensured high interest of stakeholders in participating in its implementation.

Furthermore, the program was and still is fully relevant to the current situation of Roma population in terms of access to health and social services.

#### *Conclusion #2*

The most important contribution of the RHM, as seen by mediators, by beneficiaries and by representatives of stakeholders is in reducing the knowledge and power imbalance that exist between Roma citizens and service providers. It has been pointed several times in the interviews and FGDs that Roma people have insufficient knowledge related to their rights, to relevant legislation and are, in general, less able to recognize violation of their rights. Such lack of knowledge creates situations of knowledge and power imbalance, preventing Roma individuals from claiming their rights effectively. RHM were successful in mitigating such imbalance by pointing that specific action, or lack of action, is not permitted by law or presents a violation of human rights.

In spite of this achievement, Roma still face obstacles claiming their rights in the tertiary health. While mediators from other cities can provide support or even accompany a Roma person when visiting primary health institution, such support is not possible when the patient is in need of tertiary level health services. Being primarily located in Skopje, tertiary health institutions are not within range of the RHM from other cities. Several cases of Roma experiencing violation of their rights by health staff in tertiary health services were documented. Although some of those cases were resolved successfully, it was mainly done sporadically by using informal links that mediators from other cities had with their colleagues in Skopje.

### *Conclusion #3*

Capacity building activities cover both pre-service and in-service training. Pre-service training was developed as an official program, in line with the MoE 2010 Post-secondary Education Conception. It was developed by experts from the Vocational Education and Training Center and the training was provided by the Secondary Medical School in Skopje. After finishing the training, the participants receive a diploma for completed post-secondary level of education. However, the occupation Roma Health Mediator is not included in the new 2015 National Classification of Occupations, which may present an obstacle for finding a model for systematic regulation of their status and for establishment of continuous capacity building system. A formal recognition of RHM as an occupation, could possibly contribute to the perception of their work among other professionals.

In-service training was included in the program as an effort to establish continuous capacity development system for RHM. The training plan and topics are being developed and agreed among the program stakeholders, in consultation with RHM, taking into account their training needs. However, a national-level mechanism for continuous professional development of RHM has not been set up and the plan for in-service trainings is still being prepared annually on an ad-hoc basis. The set-up of the mechanism will be possible only after the occupation is included in National Classification of Occupations.

Both pre-service and in-service training were financially supported by UNICEF and other donors, the latter being developed in accordance with UNICEF mandate and in synergy with other UNICEF program activities, like early detection of children at developmental risk.

### *Conclusion #4*

Roma Health Mediators are seen by some of the interviewed stakeholders as a temporary solution. They should be present in the field with a mission to ease the access of Roma population to health services, until these services become available to all, including the Roma population. However, as it was clearly stated by the MoH representative, according to the current legislation, health services are already available to everyone and no population or group is excluded. Furthermore, it was not possible to attain the information on meaning of the term “temporary”. Temporary is a relative term and can have different meaning for different actors. The mandate of RHM is not to change the health system and to make it available to Roma population, as it is already available. RHM program addresses barriers in access to health services caused by low level of education and living conditions of Roma population and as such, should exist as long as these conditions exist, with no a priori time limitations.

Limitations of different nature, however, should be introduced in the work of the RHMs, as described in recommendation #3.

### *Conclusion #5*

Mentoring is seen by all stakeholders as one of the most successful practices within the RHM program, with UNICEF playing a key role in supporting the mentoring practice. Mentoring was introduced in 2014. It continued in 2015 with all RHMs received mentor support at least once in that year. Mentoring visits were conducted by most experienced mediator. During these visits the mentor shared her experience and assisted the host mediator in providing services to Roma population. All interviewed mediators stated that mentoring was highly beneficial for them and that this practice should continue in future. However, it was a common notion among the interviewees that the success of the mentoring process was in large part result of personal qualities, skills and motivation of the most experienced mediator, rather than an outcome of a systematic approach in implementing the program.

### *Conclusion #6*

Data collection system is an important component of the RHM program. It was developed primarily as a tool for monitoring the work of the mediators, by collecting data on number of visits they have made per month and annually. It was updated in the later stages of the program to collect data on the health and living conditions and socio-economic status of the visited households. UNICEF supported the development of the database and software, as well as three training sessions related to data collecting and reporting. However, data collection and reporting are “one direction” only, while availability of information related to their activities should have positive effect on the work of mediators. . As stated by the interviewed mediators, the process is time consuming and affects their motivation. It is not surprising, knowing that they have to record the information on paper during the household visits, to fill it in the software and share with IPH on a monthly basis, and to prepare narrative reports to submit to the MoH. With data flowing in one direction, from mediators to the IPH and MoH, with mediators having no benefit from the information they provide, and with a system requiring them to do double entry, this process is seen largely as a burden.

## 3.2. Recommendations

The recommendations were developed based on the findings and conclusions of the evaluation and they are in line with the consultation with the stakeholders interviewed during the field phase concerning the priorities related to Roma health. The early draft recommendations were validated by UNICEF together with other stakeholders during the National Advocacy Conference “Improvement of the Roma Population Status Through Achieving the Sustainable Development Goals” held in December 2016. The recommendations in the final evaluation report reflect these multiple perspectives and the interest for future implementation.

### *Recommendation #1*

**Identify optimal model and institutionalize the RHM.** After over five years as a project activity, some serious decisions on the future of the program need to be made. It is highly recommended for the RHM program to continue, not as a project activity but as an institutional program within MoH.

The following aspects should be taken into consideration:

Inclusion in national classification of occupation as a prerequisite for RHM systematization in the health centers (or other institution as per agreed model).

The program should further investigate the local solutions and should seek greater support by local self-governments (by financing part of the costs).

The program should ensure greater involvement of local NGO in order to get even greater visibility and recognition at local level.

The program should explore possibilities of collaboration with other programs targeting Roma population such as Roma Information Centers and Program on Paralegal Support for Roma.

UNICEF, other donors and national NGOs should continue supporting the program by focusing on continuous capacity building, establishing mentoring in systematic way and on coverage of tertiary level health institutions.

### *Recommendation #2*

**Increase the number of RHM, to cover large Roma communities in the country.** Expanding the RHM network is one of priorities for all stakeholders. This is particularly important for Prilep, Bitola, Kicevo and Veles, municipalities with some of the largest Roma communities in the country.

### *Recommendation #3*

**Extend the RHM coverage to the tertiary level health institutions.** Tertiary health institutions are located primarily in Skopje. Receiving health service at this level involves scheduling an appointment in advance, traveling to Skopje on a scheduled date and finding a way, both physically and administratively, to receive needed services, with a possibility of facing unfavorable or discriminatory attitudes along the way. That can be a challenging task for people who needed RHM assistance at primary health level in first place!

In order to assist these people in the process of receiving tertiary health services, it is recommended for two of the RHMs working in municipalities in Skopje to be additionally responsible for covering the University Clinical Center. Doing it in a systematic way will require this responsibility to be officially assigned to the selected RHMs and included in their job description; their current workload to be reduced; they will need to receive training and to familiarize themselves with the tertiary level health services and institutions; and an official model of communication will need to be established between RHMs to inform the newly appointed RHMs when their support is needed.

This assignment can be combined with mentor position, discussed in the Recommendation #5.

#### *Recommendation #4*

**Revise RHM job description and mandate.** It should be clearly stated in the RHM job description that they will work on identifying and providing services to the most marginalized households and individuals within Roma communities. Being an outreach type of service, the mediators will be most successful by targeting the most disadvantaged and difficult to reach groups. Such an approach will be highly beneficial for the members of Roma population and will, at the same time, produce better results and generate strong arguments for supporting the continuation of their work.

This type of assistance can easily cause negative consequences by making users of RHM services exceedingly dependent on RHM assistance, resulting in certain members of Roma community being even more excluded and unable to protect their rights without RHM assistance. To prevent such unwanted outcome, RHM need to approach their clients primarily as educators, enabling them to claim their rights, rather than to offer solutions to problems. It is strongly recommended this mandate to be communicated with RHMs and included in the future capacity building activities.

#### *Recommendation #5*

**Continue with mentoring support in more structured and systematic manner.** Mentoring, if conducted properly, can have powerful effect on motivation, quality of work and achievements of less experienced mediators. Mentoring support needs to be included as an element of the RHM continuous in-service capacity building process. Developing criteria for selection of RHM mentors; appointing mentors officially and reflecting mentoring tasks and responsibilities in their job description and contracts; developing additional training for mentors, as well as mentoring program and monitoring tools. Mentoring program should give general directions on areas and topic to be covered, on number of visits per year and should include tools to be used for monitoring and management of the process. The program should be clear but flexible, as mentoring often depends on the personal needs and develops spontaneously.

#### *Recommendation #6*

**Upgrade the data collection system by making it more user friendly and useful for RHMs.** Data collection system needs to be developed to provide useful information for RHMs, while keeping time and efforts for data entry at the minimum possible. Situation of recording same data twice – once on paper while in the field and re-entering same information in electronic form later is highly demotivating and it is strongly recommended to avoid such an approach. Similarly, the quantity of data collected by the mediators should be kept at minimum, by reducing the number of indicators to the essential set necessary for advancing and

improving quality of RHM services. Data collection can be conducted through independent application, developed for this purpose, or can be integrated in the existing databases within health sector. Important moment is to ensure that recorded data is available to the RHMs in useful form, by prompting them when specific household should be visited or by providing inputs for weekly or monthly planning, based on a defined set of criteria.

In the absence of health statistics about Roma population, since IPH does not collect statistics on ethnicity, the information on key indicators related to health, housing conditions and socio-economic status of Roma population collected by RHM can help in creating the so called 'health profile' of Roma population, which could be used for improved RHM and other health/social policy related programs planning.

#### *Recommendation #7*

**Increase visibility of RHM program and the achieved results.** Positive results and achievement of the program need to be communicated with general public, with local level institutions, academia, international organizations and with potential donors. Results published in the 2015 IPH report present RHM in very positive light and should be utilized for promotion of the program.

## Annexes

### Annex 1: List of Documents Reviewed

1. Assessment of Barriers to Health Insurance Access for Roma Families, UNICEF, 2015;
2. Census of Population, Households and Dwellings in The Republic of Macedonia, 2002 - Book XIII, State Statistical Office, May 2005;
3. Enhancing Institutional Sustainability of Roma Health Mediators in Macedonia – Final Report, HERA, 2016;
4. Estimations of the Population by Sex and Age, by Municipalities and by Statistical Regions, 30.06.2015 and 31.12.2015, State Statistical Office, 06.07.2016;
5. HERA progress report 2015;
6. HERA progress report 2014;
7. HERA progress report 2013;
8. Scaling up Roma health mediators program in Macedonia - Concept Note, HERA, 2014;
9. Strategic Policy Framework “Improving the health and social status of the Roma population in Republic of Macedonia by introducing RHM 2011-2013;
10. Strategy for the Roma in Republic of Macedonia 2014 – 2020, Ministry of Labor and Social Policy, 2014;
11. Supporting and Scaling Up Roma Health Mediators Program in Macedonia – Final Report, HERA, 2014;
12. Извештај за работата на Ромските здравствени медијатори во Република Македонија во 2015 Година, Institute for public health, March 2016

## Annex 2: List of Key Informants

Mr. Senad Memedi, Ministry of Health;

Mrs. Elena Kosevska, Institute for Public Health;

Mrs. Liduska Vasilevska, Vocational Education Center;

Mrs. Sonja Slavkovic, Medical High School Pance Karagjozov;

Mrs. Ljatifa Sikovska, Roma Health Mediator, Municipality of Suto Orizari;

Mrs. Bezit Bezitovski, Roma Health Mediator, Municipality of Delcevo;

Mrs. Turkjan Limani, Roma Health Mediator, Municipality of Tetovo;

Mrs. Dance Gudeva Nikovska, UNICEF Office, Skopje;

Mr. Igor Veljkovic, former UNICEF Officer;

Mrs. Sonja Taneska UNFPA Office, Skopje;

Mrs. Afrodita Shalja-Plavjanska UNFPA Office, Skopje;

Mrs. Suzana Velkovska, Foundation Open Society Institute Macedonia, Skopje;

Mrs. Neda Mllevska-Kostova, NGO Studiorum, Skopje;

Mrs. Kristina Plecic, NGO HERA, Skopje;

Mr. Zoran Bikovski, NGO Kham, Delcevo;

## Annex 3: Evaluation Framework

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Relevance</b>					
<b>Q1</b>	Has the program been aligned to governments and partners' priorities/policies/reform agendas?	<p><b>1.1.</b> RHM program was in line with national strategies and took these into account</p> <p><b>1.2.</b> RHM program was complementary and did not overlap with partners' strategies</p>	<p><b>1.1.1.</b> Documented elements on the alignment of RHM program with the national Roma Health strategies</p> <p><b>1.1.2</b> References made by relevant stakeholders that the RHM program addressed priorities in the national Roma Health agenda</p> <p><b>1.2.1</b> Documented elements in UNICEF documents and in key partners' strategies on the relation between UNICEF's approach and key partners' strategies</p> <p><b>1.2.2</b> References made by UNICEF key partners that their strategic interventions were mutually taken into account</p>	Desk review Interview	<p>Roma Health Strategy</p> <p>Partners' strategic documents</p> <p>UNICEF CO staff</p> <p>HERA staff</p> <p>Key National partners</p> <p>Key strategic partners</p>
<b>Q2</b>	To what extent are the policies, strategies and other documents that regulate the education, work and placement of RHM developed with UNICEF support, relevant for the reform process?	<p><b>2.1.</b> Changes in RHM related policies and strategies correspond to the objectives of the reform</p>	<p><b>2.1.1.</b> Documented elements on the consistency between the changes in the RHM related policies and strategies and the objectives of the reform</p> <p><b>2.1.2.</b> References made by UNICEF staff on the consistency between the changes in the RHM related policies and strategies and the objectives of the reform</p> <p><b>2.1.3.</b> References made by decision makers on the consistency between the changes in the RHM related policies and strategies and the objectives of the reform</p>	Desk review Interview	<p>Relevant policies and strategic documents</p> <p>UNICEF CO staff</p> <p>HERA staff</p> <p>Key national partners</p> <p>Key strategic partners</p>

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
Q3	Has the program (content and delivery) been aligned with the Ministry of Education prescribed curricula?	3.1. Capacity building activities developed by HERA with UNICEF support have been developed in line with the MoE curricula for RHM training developed in 2012	3.1.1. Documented elements of alignment between the capacity building activities developed by HERA and the 2012 RHM training curricula 3.1.2. References made by relevant informants on consistency between the capacity building activities developed by HERA and the 2012 RHM training curricula	Desk review Interview	HERA training programs UNICEF CO staff HERA staff Key national partners Key strategic partners Center for Vocational education representative Medical High School Pance Karagjozov representatives
Q4	How relevant are the capacity building activities for RHM?	4.1. Adequacy of the capacity building activities to the professional needs of RHM staff	4.1.1. Opinions expressed by RHM staff about their satisfaction on the appropriateness of the capacity building activities supported by UNICEF to increase their knowledge and skills to deliver quality services to Roma population 4.1.2. References made by the relevant informants on the appropriateness of the capacity building activities supported by UNICEF to increase RHM staff's knowledge and skills to deliver quality services to Roma population	Survey Interview	HERA training programs UNICEF CO staff HERA staff Key national partners Key strategic partners RHM staff Center for Vocational education representative Medical High School Pance Karagjozov representatives

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Q5</b>	To what extent are the data collecting and monitoring activities developed with UNICEF support relevant for the country context in Roma access to 1) health services, 2) social protection sector and 3) other services?	<p><b>5.1.</b> UNICEF support for the development of data collection and monitoring capacity was designed and implemented in line with the needs related to Roma access to health services</p> <p><b>5.2.</b> UNICEF support for the development of data collection and monitoring capacity was designed and implemented in line with the needs related to Roma access to social protection services</p>	<p><b>5.1.1.</b> Documented elements on the appropriateness of UNICEF support for the development of data collection and monitoring capacity to the needs related to Roma access to health and social protection services</p> <p><b>5.1.2.</b> References made by the relevant informants on the appropriateness of UNICEF support for the development of national data collection and monitoring capacity to the needs related to Roma access to health and social protection services</p>	<p>Desk review</p> <p>Interviews</p>	<p>RHM strategy</p> <p>UNICEF CO staff</p> <p>HERA staff</p> <p>Key national partners</p> <p>Key strategic partners</p> <p>RHM staff</p>
<b>Efficiency</b>					
<b>Q6</b>	Have UNICEF's resources invested in capacity building of RHM been used in the most efficient manner?	<b>6.1.</b> Cost-efficiency of UNICEF investment in RHM Program	<p><b>6.1.1.</b> Factual elements on UNICEF allocated budget's correspondence to the national market prices (e.g. costs per trained person or level of consultants' fees compared to the market prices)</p> <p><b>6.1.2.</b> References made on the allocation of UNICEF resources</p>	<p>Desk review</p> <p>interview</p>	<p>HERA progress reports</p> <p>Hera program budget</p> <p>UNICEF CO staff</p> <p>HERA staff</p>

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
Q7	Would there have been a more cost-effective way to achieve the expected results?	7.1. Better alternative modes for resource allocation	7.1.1. Factual elements on the existence of other of more cost-efficient alternative modes for resource allocation on the national market  7.1.2. References being made and documented on the existence of other of more cost-efficient alternative modes for resource allocation on the national market	Desk review interview	HERA progress reports  Hera RHM program budget  UNICEF CO staff  HERA staff
Q8	Has the program been successful in leveraging governments' political will and financial resources to address Roma equity issues in terms of Roma access to 1) health services, 2) social protection sector and 3) other services?	8.1. Government's resources contribution in the program made strategically	8.1.1. Factual elements on the Government efforts to gradually take over the services/activities during the implementation of the program with targeted aim to completely do so after the program cut-off date  8.1.2. References made on the Government efforts to gradually take over the services/activities during the implementation of the program with targeted aim to completely do so after the program cut-off date	Desk review interview	MoH budget  Hera RHM Program budget  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners
Q9	How well the implementation of activities has been managed? What management and monitoring tools have been used and what tools could have been used?	9.1. Strengths and weaknesses in the management of program implementation, factors that have threatened the management and opportunities which have helped the management of activities	9.1.1. Factual elements on the management of the activities  9.1.2. References of UNICEF CO management and HERA staff on the strengths and weaknesses in the management of activities, factors that have threatened the management and opportunities which have helped the management of activities	Desk review interview	HERA progress reports  UNICEF annual reports  UNICEF CO staff  HERA Staff

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Q10</b>	Did the RHM program ensure coordination with other similar program interventions to encourage synergies and avoid overlap?	<b>10.1.</b> RHM program is developed and implemented in coordination with other programs targeting Roma health	<b>10.1.1.</b> Documented elements of correspondence and coordination between different programs targeting Roma health <b>10.1.2.</b> References made by relevant informers on correspondence and coordination between different programs targeting Roma health	Desk review  Interviews	Roma Health Action Plan  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners
<b>Effectiveness</b>					
<b>Q11</b>	Have the planned results been achieved (quantitative and qualitative)?	<b>11.1.</b> Changes in the policy framework regulating the position and work of RHM staff <b>11.2.</b> Changes in the capacities of the RHM staff to provide services to Roma population <b>11.3.</b> Changes in monitoring and reporting capacities of RHM staff	<b>11.1.1.</b> Documented elements on contribution of the UNICEF-supported activities to creating or improving the policy framework regulating the position and work of RHM staff <b>11.1.2.</b> References made on contribution of the UNICEF-supported activities to creating or improving the policy framework regulating the position and work of RHM staff <b>11.2.1.</b> References and opinions made on contribution of the UNICEF-supported activities to building the capacities of the RHM staff to provide services to Roma population <b>11.3.1.</b> References and opinions made on contribution of the UNICEF-supported activities to strengthening monitoring and reporting capacities of RHM staff	Desk review  Interview  Survey	Policy documents  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners  Relevant local entities  RHM staff

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
Q12	To what extent the program on RHM contributed to creating or improving the regulatory framework needed for reform of the system?	12.1. RHM program elements incorporated in the higher level policy documents addressing the reform of Roma health system	12.1.1. Documented elements on inclusion of RHM program elements in the policy documents addressing the reform of Roma health system 12.1.2. References made on inclusion of RHM program elements in the policy documents addressing the reform of Roma health system	Desk review Interview	Roma Health Strategy (2014-2020) UNICEF CO staff HERA staff Key national partners Key strategic partners
Q13	To what extent the program contributed to strengthening monitoring and reporting capacities in 1) RHM program and 2) MoH?	13.1. Changes in monitoring and reporting capacities of RHM staff 13.2. Changes in monitoring and reporting capacities of IPH and MoH	13.1.1. Opinions on the contribution of the program for building monitoring and reporting capacities of RHM staff 13.1.2. References made by IPH representatives on the contribution of the program for building the RHM staff monitoring and reporting capacities 13.2.1. Stage of integration of the RHM monitoring system into National health electronic system	Interview Survey	RHM staff UNICEF CO staff HERA staff Key national partners Key strategic partners Relevant local entities
Q14	How successful was the program in establishing and developing the national level mechanism for continuous professional development of RHM?	14.1 Existence of a mechanism for continuous professional development of RHM	14.1.1. Factual elements provided by documents bringing evidence on the existence of a mechanism for continuous professional development of RHM 14.1.2. Opinions of the informants regarding the existence of a mechanism for continuous professional development of RHM	Desk review Interview	Relevant program documents and reports UNICEF CO staff HERA staff Key national partners
Q15	To what extent the program contributed to building the capacities of the RHM?	15.1. Changes in the capacities of the RHM staff to provide services to Roma population	15.1.1. Documented elements on contribution of the UNICEF-supported activities to building the capacities of the RHM staff to provide services to Roma population 15.1.2. References and opinions made on contribution of the UNICEF-supported activities to building the capacities of the RHM staff to provide services to Roma population	Desk review Interview	Relevant program documents and reports UNICEF CO staff HERA staff Key national partners

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Q16</b>	Has the program provided any additional (not directly planned) significant contribution or outcome in Roma access to 1) health services, 2) social protection sector and 3) other services?	<b>16.1.</b> Broadened program effects	<b>16.1.1.</b> Factual elements provided by documents bringing evidence on the existence of other effects of the program in addition to the planned ones <b>16.1.2.</b> Opinions of the informants regarding the existence of other effects of the program in addition to the planned ones	Desk review Interview Survey	Relevant program documents and reports  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners  Relevant local entities  RHM staff
<b>Q17</b>	What strategies/core roles of UNICEF have been most efficient in influencing improvements in Roma access to 1) health services, 2) social protection sector and 3) other services?	<b>17.1.</b> Relative strengths and weaknesses of relevant core roles in influencing improvements in the area of Roma health	<b>17.1.1.</b> Opinions of the informants regarding the effectiveness of the specific core roles in influencing improvements in the area of Roma health	Interview Survey	Relevant program documents and reports  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners  Relevant local entities  RHM staff
<b>Q18</b>	How effective UNICEF-supported model for mentoring RHM has been, and what are the options or possibilities for expanding and scaling?	<b>18.1.</b> Changes in the capacities of the RHM staff to provide services to Roma population as a result of the mentoring process	<b>18.1.1.</b> References and opinions made on contribution of the UNICEF-supported mentoring model to building the capacities of the RHM staff to provide services to Roma population	Interview Survey	RHM staff  UNICEF CO staff  HERA staff

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Sustainability</b>					
<b>Q19</b>	To what extent the Government involved in project implementation have the capacity to sustain the RHM program components established with UNICEF support?	<p><b>19.1.</b> Relative strength of factors enabling the Government to ensure continuity of the RHM program established with UNICEF support</p> <p><b>19.2.</b> Relative strength of factors that might impede on Government's capacity to sustain the RHM program established with UNICEF support</p>	<p><b>19.1.1.</b> Documented elements indicating Government's capacities to ensure continuity of the RHM program established with UNICEF support</p> <p><b>19.1.2.</b> References and opinions made by relevant informants related to the Government's capacities to ensure continuity of the RHM program established with UNICEF support</p> <p><b>19.2.1.</b> Documented elements indicating potential risks which may impede on sustaining the RHM program established with UNICEF support</p> <p><b>19.2.2.</b> References and opinions made by relevant informants related to the potential risks which may impede on sustaining the RHM program established with UNICEF support</p>	Desk review Interview Survey	<p>MoH budget</p> <p>UNICEF CO staff</p> <p>HERA staff</p> <p>Key national partners</p> <p>Key strategic partners</p> <p>Relevant local entities</p> <p>RHM staff</p>
<b>Q20</b>	Did the program promote ownership over different program activities? Did the relevant partners own the results of the program?	<p><b>20.1.</b> Ownership facilitated by the program</p> <p><b>20.2.</b> Ownership assumed by the relevant partners</p>	<p><b>20.1.1.</b> Factual elements that the program was designed and implemented in such a manner that it promoted successfully ownership over different program activities</p> <p><b>20.1.2.</b> References and opinions made by relevant informants that the program was designed and implemented in such a manner that it promoted successfully ownership over different program activities</p> <p><b>20.2.1.</b> Factual elements that the relevant partners had/have assumed specific program activities</p> <p><b>20.2.2.</b> References and opinions made by relevant informants that the relevant partners had/have assumed specific program activities</p>	Desk review Interview	<p>Relevant program documents and reports</p> <p>UNICEF CO staff</p> <p>HERA staff</p> <p>Key national partners</p> <p>Key strategic partners</p>

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Q21</b>	Did the program contribute to improvement in allocation and use of resources in the RHM program?	<b>21.1.</b> UNICEF contribution to the program made strategically	<b>21.1.1.</b> Factual elements on the UNICEF efforts to gradually phase out the services/activities during the implementation of the program with targeted aim to completely do so after the program cut-off date <b>3.1.2.</b> References made on the UNICEF efforts to gradually phase out the services/activities during the implementation of the program with targeted aim to completely do so after the program cut-off date	Desk review Interview	Relevant program documents and reports  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners
<b>Impact</b>					
<b>Q22</b>	How successful was the program in improving the practice and quality of services provided to Roma population?	<b>22.1.</b> Changes in terms of quality of services provided to Roma population	<b>23.1.1.</b> Opinions on contribution of the RHM program for improvement of practices and quality of health services provided to Roma population <b>23.1.2.</b> Opinions on contribution of the RHM program for improvement of practices and quality of social services provided to Roma population	Focus group	Beneficiaries of RHM program
<b>Q23</b>	How successful was the program in improving the practice and quality of services provided by RHM?	<b>23.1.</b> Changes in terms of quality of services provided by RHM staff	<b>23.1.1.</b> Factual elements, references and opinions on improvement of practices and quality of health services provided by RHM staff <b>23.1.2.</b> Factual elements, references and opinions on improvement of practices and quality of social services provided by RHM staff <b>23.1.3.</b> Factual elements and references on the existence of a system of registration and monitoring of services <b>23.1.4.</b> Factual elements and references on the existence of a coordination mechanism for services	Desk review Interview Survey Focus groups	Relevant program documents and reports  UNICEF CO staff  HERA staff  Key national partners  Key strategic partners  Relevant local entities  RHM staff  Beneficiaries of RHM program

Question Number	Question	Indicators	Descriptors	Data collecting methods	FGD Survey
<b>Q24</b>	What was/is the impact of RHM program on policy makers and ministerial stakeholders to provide resources for sustainability of the RHM program?	24.1. Changes in terms of position of the MoH officials related to provision of resources for sustainability of the RHM program	24.1.1. References on contribution of the RHM program for provision of resources for sustainability of the RHM program	Interview	HERA staff Key national partners Key strategic partners

## Annex 4: In-Depth Interview Guides

### INTERVIEW GUIDE

UNICEF CO; HERA; Key National and Strategic Partners;

#### **Relevance**

##### *HERA/ UNICEF*

When thinking on the program objectives, how were priorities of the Government taken into account when developing the programme? What steps have been undertaken to include Roma health strategy (and other policy documents on a national level) into the programme? In what way were different ministries/institutions involved in developing the programme? How would you describe the cooperation with ministries/institutions?

Were there any gaps in the cooperation with different Governmental Ministries/Bodies? What would be the practical improvements you would suggest in this respect?

Did UNICEF have any contribution to these changes? Did UNICEF support efforts for improvements in this domain? To what extent was UNICEF support complementary with strategic partners (i.e. donors and international organizations?)

How relevant were the capacity building activities for health mediators with regard to services for the Roma population?

##### *Key national partners*

What changes in the legislation (laws, policies, by-laws, secondary legislation) were made with support of the RHM programme? How would you characterize the overall reforming process? What/who triggered these changes? Were all measures adopted coherent along time in order to produce durable changes in Roma health? Were there any measures that contradicted previous changes?

How do you perceive UNICEF's contribution to the changes in RHM program, previously discussed? What changes would not happen without UNICEF intervention? What interventions relevant for the reform would have taken place without UNICEF intervention?

Does the training program correspond to the practical needs of RHM staff? In what way were the needs of the RHM staff being identified and by whom? How did this training contribute to capacity of the RHM staff to provide services to Roma in line with the RHM Strategic Framework?

Has the training program been aligned with the MoE curricula? What kind of changes was involved in the revision of the curricula and with support of UNICEF?

What about data collection and monitoring capacity of RHM. How did the UNICEF support the data collection and monitoring capacity related to Roma access to health and social protection services?

### *Key national partners*

What changes in the legislation (laws, policies, by-laws, secondary legislation) were made with support of the RHM programme? How would you characterize the overall reforming process? What/who triggered these changes? Were all measures adopted coherent along time in order to produce durable changes in Roma health? Were there any measures that contradicted previous changes?

How do you perceive UNICEF's contribution to the changes in RHM program, previously discussed? What changes would not happen without UNICEF intervention? What interventions relevant for the reform would have taken place without UNICEF intervention?

Does the training program correspond to the practical needs of RHM staff? In what way were the needs of the RHM staff being identified and by whom? How did this training contribute to capacity of the RHM staff to provide services to Roma in line with the RHM Strategic Framework?

Has the training program been aligned with the MoE curricula? What kind of changes was involved in the revision of the curricula and with support of UNICEF?

What about data collection and monitoring capacity of RHM. How did the UNICEF support the data collection and monitoring capacity related to Roma access to health and social protection services?

### *Strategic partners (FOSIM/UNFPA)*

What were your main interventions in the period 2013-2015 in the area of Roma health? Did you establish any partnership or collaboration with the UNICEF in the respective period? What were the main objectives of the partnership/collaboration? Who were the main national/local partners for the respective interventions? Did the respective interventions respond to their needs?

Thinking about the RHM Program, was the legal framework or the policy framework harmonized with other key sectors (MoH, MoE, MoLSP)? PROBE, IF NOT MENTIONED: Is there a body with coordination on a national level (RHM Steering Committee)?

## **Efficiency**

### *HERA/ UNICEF*

How did you allocate the resources for the interventions? Based on what criteria decisions were made to approve the budgets? Where these allocations driven by the prices on the national market, or they were driven by constraints in terms of the limited resources you had available/leveraged from other international donors? If it would be the case to do again the same projects would you make the same allocations? If not, why? Were there any market studies which guided your decision in the budget allocation?

Were there any measures which did not support the goal of the reforms? What about the timing, would you prioritize changes differently?

How well the implementation of the activities been managed by the UNICEF in consultation with national partners? What tools were developed in order to monitor the effectiveness of program activities? What tools for monitoring and evaluation of training activities were developed? Did the institutions responsible for trainings implemented these tools and reported regularly on the quality of trainings conducted? What were the main obstacles in implementation of the activities? What would be the improvements you would suggest in this respect?

### *Key National Partners*

How much time, human resources, and financial resources did your institutions/organisation invest in developing and implementing projects that contributed to RHM program? Did your institution/organisation implement any common activities/any form of collaboration with other institutions/organisation with UNICEF support? Were there any changes in state budget allocation, which were initiated by some of the activities under the programme? If yes, please describe in more detail. What else can be done in order to involve the Government's resources on a larger scale?

### *Strategic partners*

To what extent have the resources allocated to the common activities/with your support and UNICEF's involvement been used in an economic manner? Could they have been used better? Were there any other programs/projects addressing Roma health supported by your organization? If yes, were those activities coordinated with RHM program? By whom?

## **Effectiveness**

### *HERA/UNICEF*

Have the planned results been achieved (quantitative and qualitative)?

- In creating/improving regulatory framework regulating the work and position of RHM staff and at the higher level policy documents addressing the reform of Roma health system?
- In building capacities of RHM staff
- In strengthening monitoring and reporting capacities of RHM staff and MoH staff

How successful was the program in establishing and developing national level mechanism for continuous professional development of RHM?

Were there any unexpected results? What were the key factors of success? What were the main constraints/challenges from inside the organization, as well as the external factors that have influenced the attainment of the results?

How effective has UNICEF supported model for mentoring has been, and what are the options or possibilities for expanding and scaling?

What strategies/core roles have been most efficient in influencing improvements in Roma access to health and social protection services?

### *Key national partners*

Have the projects supported by UNICEF achieved their planned outcomes under the RHM program? How satisfied are you with the quality of policy documents, studies, technical tools, technical advice, capacity building and other activities delivered by the UNICEF supported activities? To what extent the UNICEF supported program contribute to building capacities of RHM? Did those interventions provided any additional (not directly planned) significant contribution to Roma access to health and social protection services? If yes, which are those? What were the most successful practices adopted and the main problems encountered?

### *Strategic partners*

To what extent have the planned results in RHM been achieved? Were there any unexpected effects? Was there a strategic coordination and collaboration between your organization (or other strategic partners i.e UN agencies, EU Delegation etc. you are aware of) and UNICEF in order to achieve planned outcomes in the reform? What were the key factors of success? What were the main constraints/challenges that have influenced the attainment of the results?

Did the programme components generated changes in other important areas influencing Roma access to health and social protection services that should be mentioned? Who are the main stakeholders contributing to changes in these areas?

## **Sustainability**

### *HERA/UNICEF*

To what extent are the results achieved sustainable? What makes them sustainable? What are the risks that the achievements would not be sustainable and what are the measures needed to improve prospects for the sustainability of results? What has been missing in the reforms and is needed in order to fully implement the desired changes?

### *Key national partners*

How stable is progress achieved so far in the Roma health reform? What more should be done to make it more stable? Are you willing and committed with achieving priorities in RHM program? Do you have the capacities to continue with achieving RHM program priorities? Is there local ownership of RHM outcomes? Which are your major concerns regarding the success of the reforms in the RHM program in the country? How can these vulnerabilities be mitigated?

### *Strategic partners*

How stable is progress achieved so far in the reform of Roma access to health and social protection services? What more should be done to improve sustainability? What has been missing in the reforms and is needed in order to fully implement the desired changes? Does your organisation have any plans to continue the collaboration with the UNICEF? What these plans for future collaboration about?

## **Impact**

### *HERA/UNICEF*

How did the UNICEF's work build the capacity of RHM to deliver on improving Roma access to health and social protection services? How did the UNICEF work in the country influence coordination among the UNICEF and its strategic partners?

### *National partners*

Did the UNICEF support influence the capacity of your organisation? In what sense? Do you think that now you have the capacity to continue implementation of the adopted strategies and initiatives to deliver on RHM priorities? What else does your organization need in order to have the capacity to deliver on RHM priorities? Was there any cooperation with other donors/organizations in achieving RHM program? If yes, how did UNICEF influence coordination with those strategic partners?

### *Strategic partners*

How did your cooperation with the UNICEF work in the country contribute to building the capacity of the RHM staff to deliver on Roma access to health and social protection services?

## INTERVIEW GUIDE

### RHM staff

#### **Relevance**

Does the training program correspond to your practical needs? In what way were the needs of the RHM staff being identified and by whom? How did this training contribute to your capacity to provide services to Roma?

What about data collection and monitoring capacity? How did the UNICEF support the data collection and monitoring capacity related to Roma access to health and social protection services?

#### **Effectiveness**

How satisfied are you with the quality of policy documents, studies, technical tools, technical advice, capacity building and other activities delivered by the UNICEF supported activities? To what extent the UNICEF supported program contribute to building your capacities? PROBE strengthening monitoring and reporting capacities? Did those interventions provided any additional (not directly planned) significant contribution to Roma access to health and social protection services? If yes, which are those? What were the most successful practices adopted and the main problems encountered?

#### **Sustainability**

How stable is progress achieved so far in the Roma health reform? What more should be done to make it more stable? Are you willing and committed with achieving priorities in RHM program? Do you have the capacities to continue with achieving RHM program priorities? Which are your major concerns regarding the success of the reforms in the RHM program in the country? How can these vulnerabilities be mitigated?

#### **Impact**

Did the UNICEF support influence your capacity as RHM? In what sense? Do you think that now you have the capacity to continue implementation of the adopted strategies and initiatives to deliver on RHM priorities? What else do you need in order to have the capacity to deliver on RHM priorities?

## Annex 5: Focus Group Discussion Guide

### Discussion Guide

#### Beneficiaries

Good afternoon and thank you for accepting our invitation to participate in this group discussion. My name is \_\_\_\_\_ and today we have gathered to discuss about the role and importance of Roma Health Mediators for your community. Your participation is totally voluntarily and we really appreciate your time and willingness to allocate your time for the discussion. We assure you that all the information you will provide during the discussion will be treated with confidentiality and only for evaluation purposes?

Now I would like to ask you to get to know each other....

- » Introduce yourself, what is your name
- » How old are you
- » What do you do
- » Place of living

How accessible are medical services to you and your family? To what extent do they respond to you and your family needs. If no, what are the problems encountered in accessing health services?

How often do you go to doctor/use medical services?

Did you ever use services of RHM? If yes, what was the reason behind?

How satisfied were you with the services provided by RHM?

IF USED FOR A LONGER PERIOD AND AT MULTIPLE OCCASION ASK

Were there any changes in the services provided by RHM? If yes, in what way. Were they improved/worsened? Why?

What do you think about your access to RHM services in your community (*Probing availability and affordability of services*).

Where do you get information about the RHM services in your community?

Do you consider the amount of these services enough? Do they meet your demand?

How often does RHM visit you after the involvement in this service?

Would you like RHM to visit you more frequently?

Do you provide feedback about your dis/satisfaction with RHM? Were your opinions taken into account?



