SARDE Consultants Ltd

Final Evaluation of the IFRC EU4Health Project:

Provision of Quality and Timely Psychological First Aid to People Affected by Ukraine Crisis in Impacted Countries

Final Report

October 2025

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IFRC

Funded by the European Union

SARDE
Sustainable And Resilient Development for Everyone

IFRC EU4Health MHPSS Project: Final Evaluation Report: October 2025

Written by: SARDE Consultants Kieran Birtill and Jonah Rudlin, with research support by Ayesha Khalil and Marta Siciarek.

Steered by: IFRC Evaluation Management Team

Commissioned by: International Federation of Red Cross and Red Crescent Societies (IFRC)

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Abbreviations

CBMHPSS	Community Based Mental Health and Psychosocial Support
CfSV	Caring for Staff and Volunteers
DG	Directorate-General
HSP	Humanitarian Service Points
IFRC	International Federation Red Cross Red Crescent Societies
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MHPSS Hub	Red Cross Red Crescent (RCRC) Movement MHPSS Hub
NS	National Societies
PDU	People displaced from and within Ukraine
PFA	Psychological First Aid
PMER	Planning, monitoring, evaluation, and reporting
PS Centre	Psychosocial Support Centre (now known as the MHPSS Hub)
RCRC	Red Cross Red Crescent
RoE	Regional Office for Europe
SG	Secretary General (Chief Executive)
TGLF	The Geneva Learning Foundation
Tdh	Terre des Hommes

Executive Summary

This report presents the final evaluation of the IFRC EU4Health project, funded by DG Sante, to provide Mental Health and Psychosocial Support (MHPSS) to people affected by the escalation of conflict in Ukraine since February 2022. The project ran up until 31 December 2025 with a total budget of 31.9 million euros across 28 National Societies (NS).

The evaluation assessed the EU4Health project across four core activity areas, and cross-cutting sustainability, documenting best practices and lessons learned for wider dissemination:

- **Direct MHPSS activities** - Impact of PFA and PSS for people affected by the conflict, both in Ukraine and those people displaced from Ukraine
- **MHPSS Capacity strengthening**/training of staff, volunteers, other professionals
- **Caring for Staff and Volunteers** - Support systems for responder wellbeing
- **Coordination** - Effectiveness of internal and external stakeholder coordination across the project
- **Sustainability -** Long-term of MHPSS interventions, funding, organizational integration, retention.

1) Direct MHPSS for people displaced from and within Ukraine: EU4Health demonstrated the IFRC's capacity to rapidly scale MHPSS, providing 643,000 instances of MHPSS support across 28 countries up until May 25. The project demonstrated adaptability as NS reallocated budgets, shifted from emergency to community-based MHPSS approaches. While this showed the project's relevance, the emergency-focused design could have transitioned to longer-term programming earlier. Coverage varied internally, with some branches hesitating due to capacity or restrictions on serving only Ukrainian-displaced populations, though many NSs found success through flexible MHPSS delivery models. Outreach to displaced groups improved through Ukrainian staff recruitment and cultural adaptation but coverage gaps existed across branches and with more isolated persons and groups. Key indicators proved inadequate for evaluating services as the crisis evolved from mobile to more settled populations.

Recommendations focus on adaptive programming frameworks responding to evolving displacement patterns. Key elements: pre-approved crisis modifiers for emergency-to-integration pivots, proportional resource allocation between displaced/host populations, and early diaspora engagement. Impact measurement needs qualitative monitoring and clear theories of change, with flexible budgeting bridging emergency and longer-term funding. Essential enablers: systematic vulnerability mapping, early branch engagement, and implementer involvement in proposal design.

2) MHPSS Capacity strengthening: Activities exceeded its target of 38,000, training 50,052 individuals in MHPSS including PFA, with several organizations transforming from almost zero MHPSS provision to establishing dedicated units with institutionalized structures. The Training of Trainers model cascaded knowledge cost-effectively, while partnerships with TGLF and TdH expanded reach to an additional 6,300 practitioners. Implementation however faced challenges including uneven capacity assessments (6/22 later-joining societies conducted in-depth MHPSS needs assessments), trainer turnover requiring frequent retraining and limited engagement with Ukrainian/Russian speakers (80% concentrated in 5 NS). Sustainability concerns left some focal points overburdened yet hesitant to hire temporary staff.

Recommendations - establishing full capacity assessments and tiered training approaches before implementation, integrating MHPSS roles into existing organizational structures with formal trainer retention agreements, flexible staffing frameworks and monetization pathways for sustainability, streamlining resource sharing with rapid translation protocols, and dedicated PMER capacity with refined indicators that measure training quality and skill application rather than just participants.

3) Caring for Staff and Volunteers (CfSV): Exceeded targets by 53%, reaching 35,301 participants, with 79-89% reporting improved stress recognition and help-seeking abilities. Successful low-cost interventions included supportive supervision, peer support groups, and wellbeing modules in mandatory onboarding, with several NS establishing policies and wellbeing centres. However, implementation delays due to humanitarian response priorities concentrated most activities in the final year. Key barriers included HR partnership challenges, fragmented staff/volunteer management systems, inconsistent senior management buy-in, and coverage gaps for contractors and interpreters. Internal peer support systems proved more sustainable than external psychological services.

Recommendations: Implement manageable wellbeing activities with structured supportive supervision systems while building long-term institutional foundations. Integrate comprehensive wellbeing and PFA training into mandatory onboarding. Secure early NS management and HR buy-in, through systematic CfSV indicator tracking and M&E frameworks that demonstrate effectiveness to senior leadership.

4) EU4Health coordination: While EU4Health coordination was designed as a supportive partnership from the outset, early implementation naturally emphasized compliance requirements before evolving into the trust-based relationships that enabled expansion from 5 to 28 NS. Exchange visits spread innovations like health mediator models, early Ukrainian community engagement was transformative, and the 2024 paired coordinator-advisor model enhanced technical support. However, CBMHPSS approval took a year despite field evidence, and indicator definitions lacked consensus until 2024. Often, internal NS coordination suffered from isolated MHPSS focal points and staff absorbing extra responsibilities atop full workloads. Decentralized NS governance allowed some autonomous branches to refuse participation, while weak auxiliary status in some NS required extensive groundwork.

Coordination recommendations centre on structured learning phases in donor agreements enabling rapid field-driven adaptations and fast-tracked recruitment through dedicated HR support. Essential foundations include pre-proposal NS capacity assessments, differentiated support models based on MHPSS expertise, and early exchange programs. Internal coordination requires mapping organizational structures for optimal project placement, senior leadership mandates, and funded MHPSS focal points. External partnerships need early stakeholder mapping, Ukrainian organization engagement in design, formal MOUs with clear referral pathways, and quality-based indicators.

5) EU4Health sustainability: Achieved strongest results in capacity strengthening with multiple NS securing permanent training integration, and in some cases ministry accreditation, and pursual of revenue generation through commercialized training beyond the project framework and period. Some NS embedded CfSV buddy systems and supervision structures, while others secured continuation funding and integrated services into existing structures. However, outcomes varied across NS: many face service termination by October 2025, high staff turnover and capacity loss, and cannot retain EU4Health focal points. Direct MHPSS activities face funding gaps, and only 4 of 20 surveyed NS have MHPSS policies despite capacity gains.

Recommendations focus on sustainability planning from project inception rather than later**.** Position MHPSS as cross-cutting priority within existing programs, establish paid positions replacing volunteer focal points, and institutionalize knowledge through systematic documentation. Build multi-level wellbeing systems with HR and senior management buy-in, dedicated focal points with protected time, and PFA training in mandatory onboarding of NS staff & volunteers. Long-term viability needs diversified funding across public-funder-private sources while embedding MHPSS in national policy frameworks, recognizing that strengthening existing capacities outperforms standalone funder-visible initiatives.

1. Introduction

1.1 Project Background

The IFRC EU4Health project was a comprehensive initiative funded by DG Sante that provided MHPSS to people displaced from and within Ukraine following the conflict escalation in February 2022.

Project Overview

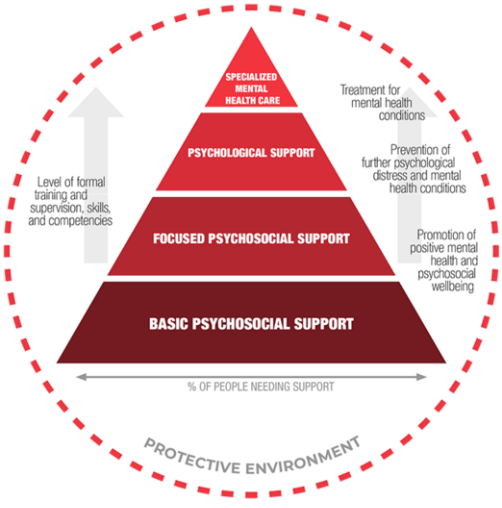
EU4Health launched in May 2022 across 5 countries (Czech Republic, Hungary, Poland, Romania, Slovakia), joined by Ukraine in September 2022 before expanding to 26 countries in January 2023, and 28[1] in 2024. It concluded 31st December 2025 with a total budget of €31.9 million.

The project aimed to support '580,017 people over three years'[2] through (a) provision of Psychological First Aid (PFA) within Mental Health and Psychosocial Support (MHPSS) services delivered in person, via helplines and other service platforms, and (b) by building/strengthening capacities and capabilities of the Red Cross Red Crescent (RCRC) National Societies' staff and volunteers, frontline responders and other professionals. Target groups included:

- Caregivers, children, older persons, people with disabilities
- Host communities and Red Cross staff/volunteers
- Frontline responders, healthcare professionals, teachers
- Ukrainian/Russian-speaking health professionals

At the Council of Delegates in 2017, the Movement adopted a resolution on Addressing Mental Health and Psychosocial Needs, which recognized the urgency to strengthen the Movement's collective response to mental health and psychosocial needs and requested the formulation of a Movement Policy on Addressing Mental Health and Psychosocial Needs. Building upon this work, the project employed a continuum of care approach through a four-level pyramid model, surrounded by a protective environment, in accordance with the International Red Cross and Red Crescent Movement's MHPSS Framework.

- **Level 1** - Psychological First Aid (PFA) delivered through local helplines and direct interaction at service points by trained staff and volunteers.
- **Level 2** - Targeted support for at-risk groups, delivered by trained Ukrainian health workers, frontline responders, and healthcare professionals with Ukrainian/Russian language capabilities.
- **Levels 3-4** - Established referral pathways to specialist mental health services and crisis response procedures.



The approach integrated PFA provision with capacity building for Red Cross National Societies' staff and volunteers, utilizing both in-person delivery and digital platforms to ensure comprehensive coverage across participating countries.

[1] The other NS are Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Moldova, Montenegro, Norway, Portugal, Slovakia, Slovenia, Spain, and Sweden
[2] 69,800 Ukrainian people living inside Ukraine 510,217 people displaced from Ukraine

1.2 Evaluation Purpose and Scope

The evaluation objectives, as detailed in the terms of reference were as follows:

Primary Objectives:

1. Evaluate the impact of MHPSS activities provided to people affected by the conflict within Ukraine and those displaced to countries covered by the project. This includes
    a) Provision of Psychological First Aid in different modalities - as direct in person PFA provision; via helplines, via other service platform (including digital MHPSS), PFA assessed as a set of skills, and as a MHPSS intervention for displaced populations
    b) Community based MHPSS activities. e.g., MHPSS in integration activities (e.g., sport), Social and cultural activities to enhance social connectedness and a sense of belonging in host country (e.g., cultural exchange events) and Psychoeducation and awareness-raising activities (e.g., educational theatre).
2. Assess MHPSS capacity strengthening initiatives for National Societies, RCRC National Societies' staff and volunteers, frontline responders and other professionals.
3. Review enhanced institutional frameworks and policies including MHPSS strategies, policies, framework, caring for staff and volunteers frameworks.
4. Evaluate support provided for mental health and well-being of first responders, RCRC staff and volunteers, in particular, how the National Societies were supported to meet the MHPSS needs of their staff & volunteers and frontline responders in effective response.
5. Assess coordination effectiveness among stakeholders.
6. Identify implementation challenges and mitigation strategies.

Secondary Objectives:

1. Assess IFRC technical support, through EU4Health, to National Societies' institutional capabilities including 1) IFRC Regional Office of Europe project coordination and management; and 2) MHPSS Hub (previously IFRC Psychosocial Centre PSC) technical support
2. Document best practices and lessons learned for wider dissemination

The evaluation will explore each of these points and will provide recommendations for future MHPSS initiatives. It will also seek to identify any lessons which can be applied more broadly, to other IFRC projects, projects by RC National Societies, or projects of interested partners.

The audience of this evaluation will primarily be the IFRC regional office delivery team; the wider IFRC, National Society EU4Health project teams, National Society leaders, EU DG SANTE and other IFRC funders; and other IFRC partners that IFRC which to distribute lessons to.

1.3 Methodology

Desktop analysis involved reviewing 170 documents, with 73 receiving detailed review across 28 participating National Societies.

Interview activities informed by the evaluation objectives and desktop findings - encompassed 20 National Society representatives and 11 wider project staff members conducted either in person or via MS Teams.

A National Society survey yielded 12 additional responses providing both new data and elaboration on existing findings. Project surveys were also analysed, including both the baseline and endline surveys for the Organisational Capacity Assessment and the Caring for Staff and Volunteer survey.

Field research was undertaken through 3-day visits to four National Society countries – Bulgaria, Spain, Lithuania and Czech Republic, incorporating in-person interviews, focus groups, and site visits to MHPSS service delivery locations. These case studies generated approximately 50 additional interviews. A structured sampling strategy (detailed in Appendix A) was applied to ensure representative engagement across project countries while maintaining research feasibility.

Throughout the data collection process, rigorous **safeguarding measures** were implemented, particularly when engaging service recipients displaced from Ukraine. These included applying dignity and impartiality principles aligned with the IFRC Code of Conduct, ensuring anonymity and confidentiality through anonymisation techniques, obtaining informed consent from all participants, and employing sensitive data collection approaches that recognized the vulnerable nature of the target populations.

All data collected through these engagements (totalling 1,068 data points) was **systematically analysed** and tagged according to the four evaluation areas and their respective sub-criteria. Each data point was categorized as either a challenge/weakness, strength/success, opportunity/ recommendation, or contextual background information. Following this initial coding process, common themes and findings were grouped within these categories to identify patterns and develop comprehensive insights across the evaluation framework.

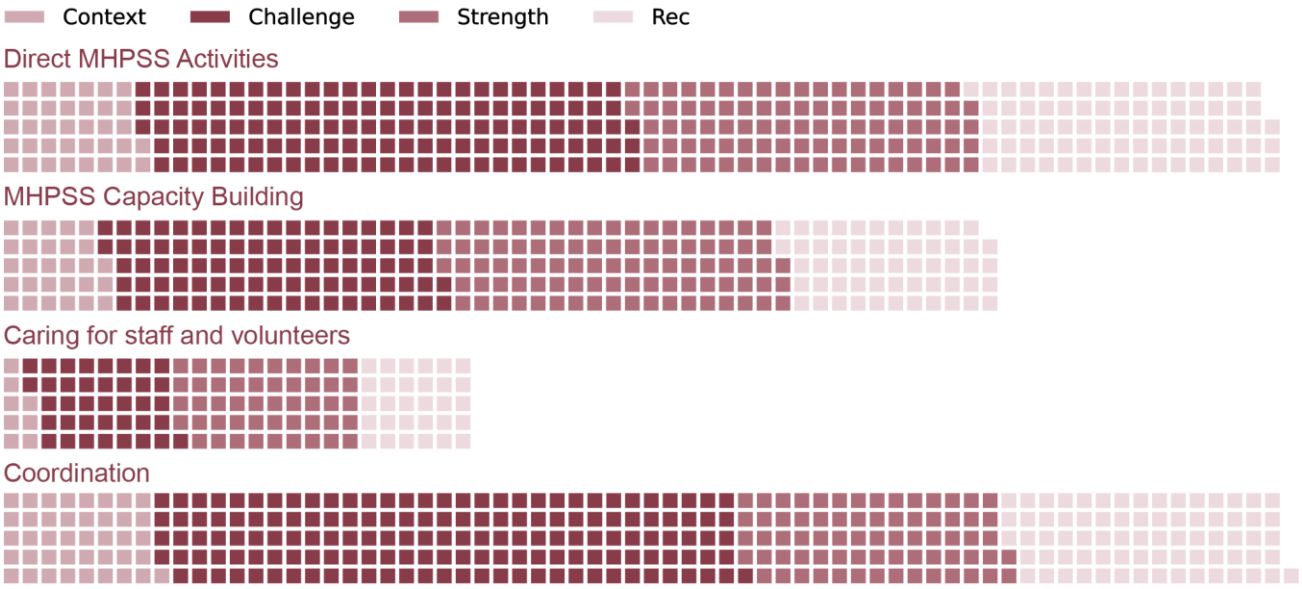
Findings and recommendations from the analysis were then presented and discussed in a **validation workshop** with NS and project coordinators.

Figure 1 – Workshop Confidence icon

The level of agreement from the workshop (out of 5), is displayed beneath each recommendation in section 2. The connection between the 1068 data points and the key findings in section 2 are also displayed through [superscript] references. This demonstrates the systematic utilisation of evidence while persevering the anonymity of those who participated in the evaluation.

Figure 2 – Number of data points by evaluation area

Figure 3 – Number of data points by evaluation area



Several **limitations** affected the data collection process.

- Given the scale of 28 participating National Societies, comprehensive engagement with all partners was not feasible, necessitating a sampling approach (Appendix A).
- Survey response rates varied, with only some NS providing complete responses to the structured questionnaires.
- A significant proportion of NS respondents were not involved in the project from its inception. Some respondents, particularly those who joined late, may not have had full visibility of earlier project phases
- Translation support differed across case studies. These variations have been documented within the respective case studies.

Table 1– Evaluation framework

The below framework presents evaluation criteria and questions mapped to overall evaluation objectives (1-4). Section 2 will be structured by the evaluation objectives and criteria.

	Relevance	Effectiveness	Efficiency	Coverage	Impact	Coherence	Sustainability	Accountability
1. Evaluation of MHPSS activities provided to the affected population	*- Was project designed to meet the needs of affected population?* *- Were the activities and outputs consistent with goals and objectives?* *- How did the project ensure that it was meeting evolving needs as crisis progressed?*	*- Did the project achieve intended goals, outcomes & outputs regarding provision of MHPSS to the affected population?*	*- Was project design & delivery including resources used efficiently to reach impacted?* *- Could the same results be reached with fewer resources?*	*- Were the most vulnerable people / groups reached? Were there any gaps in this respect?*	*- How did the activities impact the wellbeing of the affected population?*	Covered under objective 4 (coherence across project components)	*- Are the benefits likely to continue after the project?* *- What plans are in place for continuity beyond the end of project funding?*	*- Were affected populations consulted & was delivery transparent?* *- How robust was project management, reporting, & M&E of MHPSS service provision?*
2. Evaluation of MHPSS / broader capacity strengthening initiatives on NS capacities	*- Was project designed to support NS capacity building?* *- Were the activities and outputs consistent with goals and objectives?*	*- Did the project achieve intended goal, outcomes & outputs regarding NS and broader MHPSS capacity strengthening in the project countries?*	*- Was project design & delivery including use of training & technical support efficient?* *- Could same results be reached fewer resources?*	*- How was this capacity strengthening distributed across the NS and its branches?*	*- What was the impact on NS's ability to provide MHPSS services?* *- What was the impact on broader MHPSS including non-RC professionals?*		*- Will NS built capacity be sustained beyond project?* *- What policies, strategies, frameworks are now in place to improve NS capacity (generally/for MHPSS)?*	*- To what extent were NS involved in planning, implementation, and monitoring of the project?* *- How robust was project management, reporting, & M&E of MHPSS capacity initiatives?*
3. Evaluation of MHPSS initiatives on Red Cross staff and volunteers	*- Was project designed to support the needs of staff & volunteers?* *- Were the activities and outputs consistent with goals and objectives?*	*- Did the project achieve intended goal, outcomes & outputs regarding MHPSS for staff & volunteers?*	*- Was project design & delivery including use of resources efficient for this theme?* *- Could same results be reached fewer resources?*	*- Were all RC and volunteer MHPSS personnel engaged? Were there any gaps in this respect?*	*- What impact did the project have on mental health & wellbeing of RC staff and volunteers?*		*- Are there plans, policies, frameworks in place to continue support for staff wellbeing after the project ends?*	*- Were staff & volunteers involved in decisions related to CfSV initiatives?* *- How robust was project mgmt., reporting, & M&E of MHPSS for RC staff and volunteers?*
4. Evaluation of coordination mechanisms among stakeholders	*- Was the project designed for effective coordination (internally, in NS and externally?) What plans / mechanisms were put in place?* *- How did these evolve as crisis evolved?*	*- Did the project achieve its aims regarding coordination? (internally, in NS and externally?) and were mechanisms fit for this purpose?*	*- Could coordination among actors have been more efficient? (internally, in NS and externally?)*	*- Were the right actors engaged in coordination activities? (internally, in NS and externally?) Were there any notable omissions?*	*What has been the impact to date from coordination activities? (internally, in NS and externally?)* *Did coordination lead to improved project impact?*	*- Were project components coherent and coordinated?* *- To what extent did the project complement other NS projects?* *- To what extent did the project complement non-RC interventions?*	*- What plans are in place for continued coordination across engaged MHPSS actors post-project?*	- How did coordination contribute to collective accountability among actors delivering MHPSS services? (e.g. transparent info sharing? Recording and monitoring commitments)

2. Findings

2.1 Evaluation of MHPSS with People Displaced from and within Ukraine

2.1.1 Overview

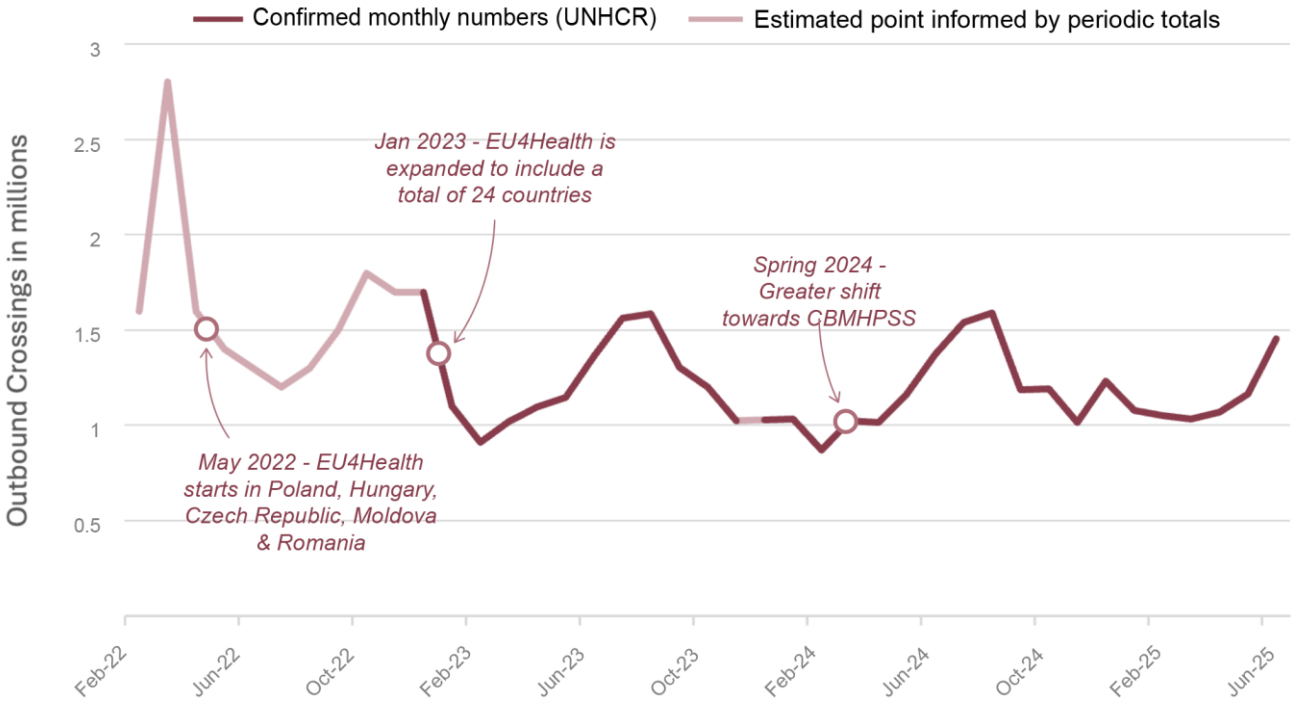
This section focuses on the direct MHPSS provision to the People Displaced from and within Ukraine (PDUs). It examines to what extent the project was designed and delivered to meet the needs of PDUs – including the most vulnerable and explores the impact on PDU wellbeing. The section will look at the underlying process including project management, monitoring and accountability.

2.1.2 Relevance of the project design to be able to provide MHPSS for displaced

In terms of overall relevance, the EU4Health project addressed a clearly identified need for MHPSS among people displaced from and within Ukraine. A 2023 study estimated that 62% of externally displaced individuals and 55% of those internally displaced in Ukraine met criteria for post-traumatic stress disorder, underscoring the significant mental health burden created by the conflict.

The project adopted a continuum-of-care approach: providing Psychological First Aid (PFA) and focused psychosocial support at the base of the Movement MHPSS pyramid, while mapping referral pathways to national actors more specialised care at higher levels. Two phases were planned: an initial preparatory phase (assessments and capacity strengthening) in the first 3-4 months, followed by full implementation of MHPSS services in person, online, and via other platforms, adapted to national contexts.

Figure 4 –Ukrainian Western Border Outbound Crossings –Feb 22 – June 25 (UNHCR, IOM)[3]



[3] Note: Data represents border crossing movements from Ukraine to European countries (excluding Russia/Belarus). The graph illustrates crossings rather than unique individuals, as many refugees crossed borders multiple times. Sources UNHCR, IOM,

In terms of timing of the project, as Figure 4 shows, border-crossing data indicate that peak demand for immediate psychological first aid (PFA) occurred before EU4Health became fully operational. When the project expanded to Phase 2, border movements had declined and often reflected repeat crossings rather than new displacement. As the crisis became more protracted, needs shifted toward longer-term recovery and integration support in host countries.

Although National Societies identified the need for CBMHPSS early and IFRC raised this with the funder during the revised proposal discussions in January 2023, the inclusion of these activities was not supported at that time since the focus of the preferred interventions was still on the emergency response.

Table 2 – CBMHPSS activities – adapted from MHPSS Hub

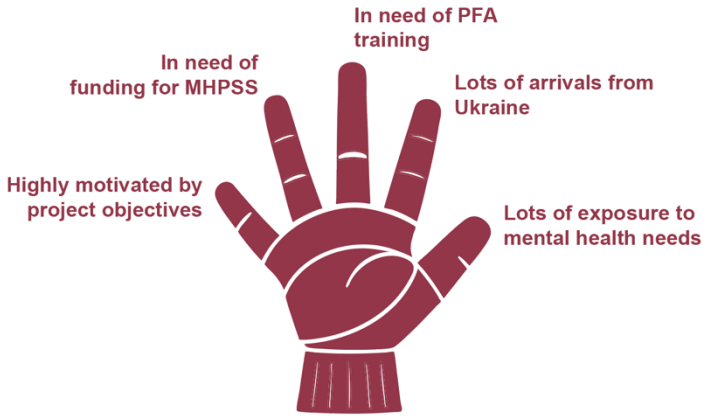
Integration (Children): Sport, play, theatre, camps	**Integration (Adults):** Support groups, PFA training, yoga	**Access Facilitation:** Health mediators, help to access local services	**Social & Cultural:** Festivals, gatherings, events to celebrate culture	**Psycho - education:** Theatre, art, wellbeing sessions	**Life Skills:** Conflict resolution, communication, coping mechanisms	**Self-Care Promotion:** Wellbeing guides, relaxation / stress relief techniques,

Following further evidence presented during the February 2024 lessons learned event and in light of recent developments, the justification was accepted and the amendment was subsequently submitted and approved in May 2024. Both qualitative and quantitative data suggest that this **shift to CBMHPSS could have taken place earlier, with the 2023 country expansion perhaps offering the best opportunity for this adjustment. That is not to say that PSS lower down the MHPSS pyramid was no longer relevant, but for many, needs had changed.**

A project that involves 28 NS will have variance in its relevance. For countries close to Ukraine with high numbers of arrivals – especially those engaged from the beginning – the scope and approach was often seen as highly relevant.

Figure 5 - Five characteristics of National Societies which made the design of the EU4Health project a 'perfect fitting glove'

"For us, it was a perfect (fitting) glove…The countries that were complaining about the community-based activities were not hit by the refugee wave as we were… I understood their concerns" – National Society Focal point



Planning a project that responds to an uncertain situation is also difficult, with no indication when the conflict will end. Still, the methodology appeared to remain largely consistent across phases, despite the wider range of contexts the later cohort. **The remaining 22 countries operated under relatively different circumstances to the initial five national societies for which the project was designed for, both in terms of their geographic and cultural distance, as well as their economic and operational environments.**

The original PFA-focused proposal was framed as counting support to unique individuals, aiming to serve – '*a total of 580,017 people*'. This was appropriate for one-off PFA provision but became less practical as movement slowed and longer-term support became a priority.

The need to count individual services, became more apparent, allowing continuous support to be appropriately recorded. Although, the agreement was eventually made, it was only formally agreed in early 2024 and **delay in this clarity was a longstanding point of confusion across National Societies** (351, 460, 842, 277)

Another challenge for the NS was the project's exclusive focus on people displaced from Ukraine which led to some branches declining to be involved. While the proposal mentions 'host communities' as one of the groups that the project aims to support, only MHPSS support provided to displaced Ukrainians counted towards the corresponding project indicator target. Several NS reported that this conflicted with RCRC movement Fundamental Principle of impartiality and commitment to inclusivity. While some NS creatively served broader communities by using combined funding streams and/or low-cost programming and only counting Ukrainian members of these activities (557, 156, 728, 816), it frequently presented an obstacle for many, particularly with respect to integration with host communities as the needs evolved to longer-term integration. The data also noted anecdotal evidence of resentment from other displaced groups in a number of NS countries.

> *"People (non-Ukrainian displaced groups) saw…Ukrainians can receive therapy and go on trips, and others cannot"* – National Society

With these findings in mind, the evaluation makes the following recommendations for this section:

1. Build adaptive frameworks with pre-approved crisis modifiers into initial donor agreements, enabling rapid adjustments to respond to geographic and temporal variations without extensive negotiation (465, 301; 732, 941)

4.2

2. Design future programming with proportional approach; prioritise the main displaced population while reserving a defined share of resources and indicators for host communities and other displaced groups. Use early field data to refine this balance, as noted in the first recommendation.

4.5

2.1.3 Effectiveness achieving MHPSS for displaced

EU4Health had an original target of providing emergency MHPSS to 568,017 individuals (69,800 within Ukraine and 510,217 leaving for EU4Health countries). According to UNHCR, 6.168 million Ukrainian refugees were registered across Europe by the end of July 2024, so the project aimed to support approximately 8% of those externally displaced. As noted in the first section, indicator 4 changed from individuals to services in early 2024 but the overall target remained at 568,017. At the time of writing, almost 700,000 MHPSS service occasions had been recorded. However, because NS varied in how they reported data, it is not possible to determine how many of these service occasions represented unique individuals. This limited the ability to assess actual coverage and continuity of care.

The proposal outlined two (process-orientated) targets to support MHPSS provision:

1. That PFA helpline and other service platforms would be made available for all Ukrainians in need, as well as for host communities, with a total target of 51 platforms, subsequently increased to 61.
2. To train 21,077 RCRC staff and volunteers, frontline responders and other professionals – incl. Ukrainian/Russian-speaking health professionals to provide MHPSS including PFA. This was subsequently increased to 38,000.

Quantitively, NS collectively surpassed these targets, although the indicators are not particularly revealing of effectiveness in providing MHPSS to PDUs.

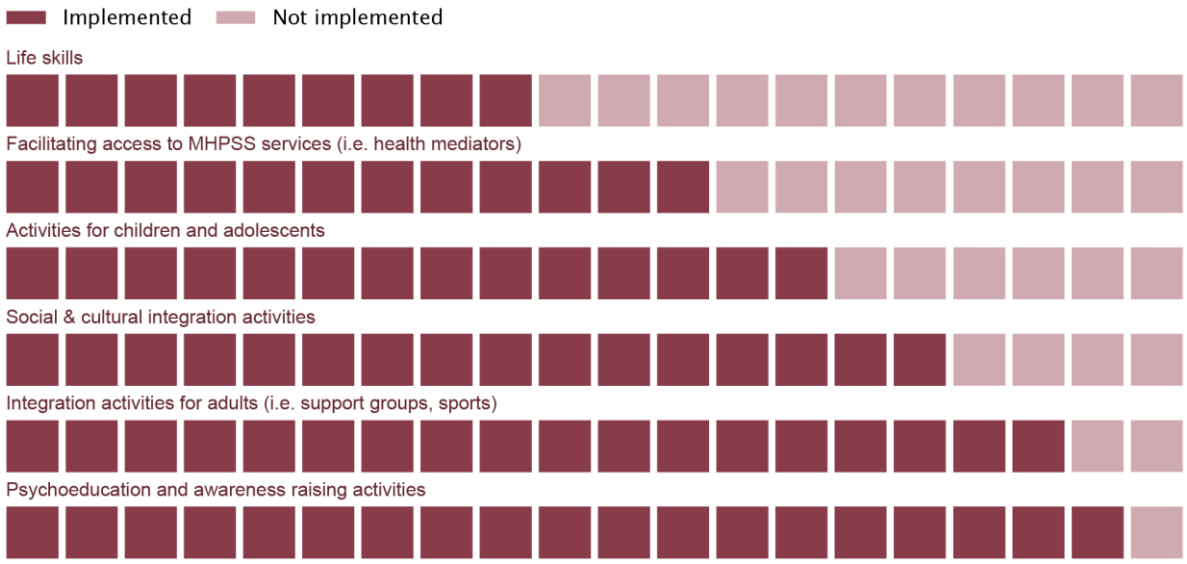
- The total number of PFA and other service platforms currently stands at 97 (nearly double the target). However, **the number of platforms does not reveal their success.**
- The total number of persons trained currently stands at just over 50,000, surpassing the original and revised targets. However, much of this training took place after peak PFA demand.

Figure 6 - Number trained in PFA & MHPSS (indicator 1) versus outbound crossings from Ukraine (see figure 3 for source)

By May 2023, when training started to gather pace (Figure 6), there had been approximately 21.5M outbound crossings from Ukraine. While new arrivals certainly continued after this point, it can be assumed that most first time crossings happened pre-May 23. Therefore, **there was no way that PFA training could be rolled out in time to meet peak demand. It will have helped new arrivals after this point, but in terms of pre-positioned capacity, it is perhaps more relevant for the next crisis.**

Looking beyond the numbers, **earlier CBMHPSS transition would inevitably have had an impact on the effectiveness of MHPSS activities** [42, 626, 564, 726]. While 2025 OCA data outlined which activities they had implemented, there was generally an absence of consistent qualitative indicator measurement to conclude the effectiveness of support [85, 254, 376]. This will be explored in the impact analysis section.

Figure 7 – Community-Based MHPSS activities undertaken by National Societies (OCA, 2025, N=20)



Regarding platforms, in some contexts helplines often underperformed, while reception centres and social media channels proved far more effective entry points. **Several NS noted reception centres provided crucial initial contact and Red Cross brand recognition facilitated trust, while some NS found greater success with informal Ukrainian language social media channels.**

Language barriers and cultural differences fundamentally shaped how NS could reach PDUs. Focus groups found that displaced Ukrainian psychologists, especially from occupied territories, uniquely understood compatriots who had lived through distressing or disruptive events. Limited study confirmed Ukrainians often preferred Ukrainian-speaking MHPSS providers[4], while local social workers served different roles in practical integration. Ukrainian-speaking staff proved indispensable (cited as essential 27 times across 8 NS interviews), particularly for psychological sessions and crisis helplines.

Despite a clear need, recruitment remained difficult. Only 14 Ukrainian speakers attended the June 2023 Training of Trainers in PFA across 23 NS, despite millions of Ukrainians in the region. While some NS recruited impressive numbers (125-299 staff/volunteers), most struggled to find qualified Ukrainian MHPSS professionals. **Successful NS used creative approaches:** Czech RC partnered early with diaspora organizations like the Association of Ukrainian Psychologists; Bulgaria RC

[4] EthnoMed (2024). Ukrainian Refugee Mental Health Profile. University of Washington.
Dickson, K. et al. (2024). Assessing MHPSS interventions for Ukrainian refugees. Cambridge Prisms: Global Mental Health, 11, e81.
Toczyski, P. (2025). MHPSS training for Ukrainian refugees in Poland. Intervention Journal.

transformed recipients into call centre volunteers with MHPSS referral pathways. Countries with Slavic languages had advantages, though younger Ukrainians engaged more readily than elderly. Where Ukrainian staff weren't available, translators helped, especially when MHPSS-trained. Ukrainian or Ukrainian-heritage staff consistently served as vital bridges, translating not just language but culture.

The quality of MHPSS services including PFA varied widely by NS experience. Some NS only provided basic PFA support as they were relatively inexperienced in MHPSS while others such as the Czech RC delivered a broader spectrum including crisis interventions and stabilization techniques. with more specialist methods delivered less frequently, but by specialists with extra training.

Table - Case Study Insight – Types of emergency PSS delivered by CZRC

Basic PFA	Emotion Aid basics	Crisis intervention	Assyst method
Basic emotional support you can give someone right after a crisis. It focuses on making them feel safe, listened to, and connected to help - not therapy, just compassion & practical help: *1. Look - Check what's happening and if it's safe* *2. Listen - hear their needs* *3. Link - Connect them to help and support*	*5-step method to help people calm down quickly. Based on based on methods such as Somatic Experiencing (using body awareness to release stress), EMDR (to help process traumatic memories), and polyvagal theory (grounding techniques to help calm the nervous system).*	*Teaches how to calmly and safely help someone who's having a mental health crisis or behavioural emergency, focusing on de-escalation rather than force. Includes identifying signs of distress, verbal de-escalation techniques, and active listening skills. 150 hrs training.*	*Stabilization technique used right after trauma to reduce severe distress before longer-term therapy. Uses scripted process and techniques such as specific tapping and eye and body movement to calm the nervous system and help the brain process trauma.*

level of complexity →

Beyond PFA, many NS developed introduced activities tailored to identified needs, e.g., adaptation of art therapy by Slovak and Bulgarian NS. While the project framework set certain restrictions, it also allowed flexibility allowing the NS to determine appropriate activities, leading to innovation and beneficiary acceptance. However, the monitoring framework could not adequately distinguish between PFA, PSS, and CBMHPSS interventions. These limitations are discussed in detail in the next section

With these findings in mind, the evaluation makes the following recommendations for this section:

3. **Recruit native speakers and diaspora speakers using diaspora networks from project initiation to ensure culturally and linguistically relevant services.** Future programming should prioritize early identification and engagement of staff and volunteers who share language and cultural background with displaced populations through established diaspora communities [145, 180, 741]. National Societies should implement comprehensive registration systems capturing language skills, cultural background, and professional expertise beyond basic contact information, enabling rapid deployment and culturally appropriate matching in future emergencies.

4.6

4. Utilize **community-preferred communication channels from the start.** (e.g. social media or word of mouth) rather than defaulting to only helplines. [147, 208, 230, 744]. **Establish partnerships with diaspora communities early for co-creation and community entry points.** Engage diaspora organisations not only as beneficiaries but as partners, as trusted entry points and for co-design of services that are relevant, accessible, and aligned with how communities seek support. [208, 230, 744].

4.4

2.1.4 Impact of activities on displaced wellbeing

While evaluation encountered numerous examples of EU4Health's positive impact (discussed hereafter), **the absence of consistent qualitative measurement prevented the evaluation from making definitive conclusions about impact across all NS**. As discussed in 2.1.2. the indicators measure how many services have been provided, but not the quality of these services or the impact that these services had on PDUs. While most NS underwent some sort of initial needs assessment, this was typically to inform programming rather than to create a baseline for ongoing measurement. While some NS collected feedback on activities such as CBMHPSS, there was a lack of regular and systematic qualitative monitoring.

Box 1– Proposed Methodology for robustly measuring area 1 – Direct MHPSS support

Actual indicator	Alternative EU4H area 1 indicators
Number of people including Ukrainian displaced people requesting support via helplines and other service platforms established	*1.a. Number of instances of PFA provided in person or via helplines or other platforms* *1.b. % of service users who report a positive experience with the MHPSS/PFA received through Red Cross helplines or other service platforms (Annex X for full description)* *2.a. Number of instances of psychosocial support provided* *2.b. Number of individuals provided psychosocial support* *3.a. Number of instances of psychological Support* *3.b. Number of individuals provided psychological support*

Interventions classified under indicator 4 varied dramatically, both within individual NS and across the network. At one end of the spectrum, some programs in several NS delivered crucial crisis intervention for PDU dealing stressful or traumatic events, loss, anxiety and suicidal ideation through sustained psychological and psychosocial support for adults and children based on need. At the other end MHPSS, including PFA instances were limited to brief conversations that only superficially addressed mental health needs. This wide variation reflected key differences in how NS approached service delivery, different stages of organizational MHPSS development, and overall project capacities.

Headline service numbers do not capture the depth of support provided: in some contexts, they risk overstating the significance of light-touch interventions, while in others they may understate substantial contributions. The case study insight on the next page illustrates a stark contrast in focus group findings from two locations within the same country, with one demonstrating high impact and the other showing limited success.

Impact varied significantly depending on NS' starting capacity. NS building MHPSS from scratch often achieved different outcomes than those with existing frameworks. Some despite starting with a single inexperienced staff member and recruitment delays, still managed to establish functioning MHPSS units, representing important organizational transformation. However, these capacity constraints limited the depth and consistency of impact achievable within the project timeframe.

Some NS provided integrated services while others remained constrained by their interpretation of funding rules. One experienced NS leveraged its MHPSS capacity to partially fill national system gaps, delivering holistic support from the outset including in-depth psychological care when needed. By contrast, another NS recruited psychologists, but limited support to three sessions per client for funding compliance, restricting interventions non-specialized services which are 2nd and 3rd level of

RCRC MHPSS pyramid. Although cases needing more specialized services (provided by psychiatrists and psychologist) were meant to be referred to national healthcare, extensive waiting lists left many PDU without timely continued care, with risk of regression in mental health.

Case Study Insight: Contrasting testimonies from two locations within the same country

Location A – participant testimonies

- Participant 1 – female, 70s from Kyiv. She came when her husband died. The Ukrainian psychologist at the centre helped a lot when she came. Now she needs that support less but still comes to the centre. She likes that the centre responded to her individual needs. She now volunteers and plays the piano there too. She liked the mutual support aspect.
- Participant 2 – female, 60s from west Ukraine. When she came to the centre, she wasn't looking to talk to someone, but for community. She became a volunteer as she couldn't handle just sitting around crying. Older son cannot leave Ukraine – she is always thinking about this. At the start, the centre was a source of basic needs, but now she is starting to share. She met (Ukrainian psychologist from RC). The support was important help to proactively prevent depression.
- Participant 3 – female 70s from Kherson - Her son died in the conflict; she lost her house in Ukraine and is here alone. She has cancer. When she arrived, she didn't even know how to use the app for receiving allowances. She made a mistake at the start and lost support for first month. The coordinator helped her navigate this and helped her in the short-term when she saw how empty her fridge was. The centre and the coordinator have been key sources of support for her.

Discussing together:

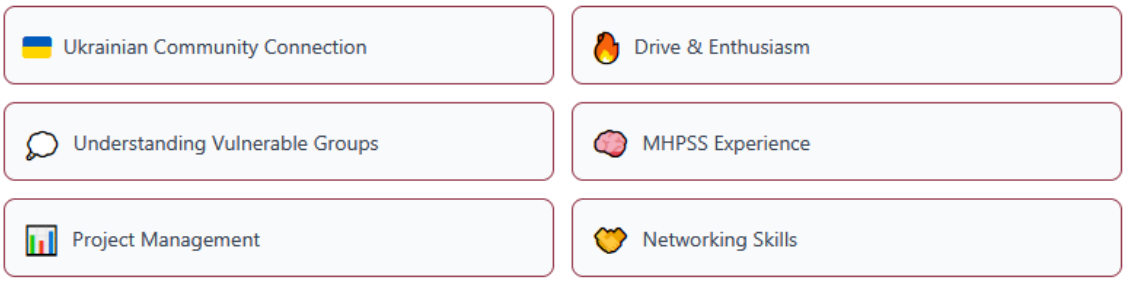
- Around 100pl a day come to the centre. We know each other thanks to the centre.
- 'No one misses out' as (the psychologist that helps them) 'won't give them the chance to miss out'. The coordinator says there are a few that isolate, but not many.
- All the ladies felt 'closed' at first but then felt able to open more over time.

Location B – participant testimonies

- They don't have it (PSS) here in this location, they have it in other cities or online, but not here. They feel alone, like they have no-one, cannot talk to their families. They don't want to do online.
- It would be nice if they had a group like this language group, but with psychologists.
- Language support helped, but the host community are closed. She doesn't feel much better.
- There's a lack of mental health support. Group & professional individual support would help.
- A lot of people have stress inside them, but they don't know where to go.
- It would be easier if people were consulted and the activities happened here. There are groups for kids, but the groups are oversubscribed.

In decentralized NS, the quality and success of regional delivery was often significantly influenced by local coordinator capabilities. Field visits identified key characteristics within individuals or across local project teams:

Box 2 - key identified characteristics of project coordinators



Case Study: Zlín's Integrated MHPSS Model in Czech Red Cross

Serving 50 families through an estimated 5,000 annual interventions with just 13 staff, Zlín Red Cross branch operates at full capacity. The project coordinator's networking efforts activated crucial partnerships with schools, government offices, and medical services. Her half-Ukrainian heritage combined with deep Zlín roots created an ideal bridge between communities. Strategic co-location with the Regional Pedagogical Centre enabled daily collaboration, Ukrainian RC psychologists and specialized support complemented the Pedagogical Centre colleagues' services for the broader Zlín population, creating mutual benefit. The local RC coordinator provided essential organizational support, ensuring smooth operations across all levels.

Impact was profound: families in a 20-person focus group described support as "crucial," with several calling it "lifesaving." The collaborative team helped Ukrainian families navigate Czech healthcare, education, and social services, addressing issues such as bullying and school integration, and providing psychological support.

Key insight: The Zlín model demonstrates how, with strong leadership, RC branches can amplify impact by embedding within existing service ecosystems, with committed teams from multiple organizations adding specialized capacity that benefits both displaced populations and host institutions.

Beyond direct services, MHPSS programming catalysed unexpected transformation and gradual reduction of mental health stigma. For example, in some NS, Ukrainian caregivers insisted *"we are okay, please care for our children"*, but as programs matured adult needs became apparent and many sought help, with primary data collection revealing numerous examples of important MHPSS interventions that provided people with required support and aided recovery and resilience. NS discovered that emotional support created ripple effects: *"thanks to support directly addressing the emotional sphere, positive effects were observed in the community's level of integration*." In many cases, programs that shifted to community-based approaches achieved deeper change by *"structurally incorporating integration work between host and refugee communities*."

Case Study: Plovdiv's Community-Centred Approach

Bulgarian Red Cross activity in Plovdiv transformed from humanitarian service provider to community anchor for Ukrainians, demonstrating how trust-building can create lasting impact.

Operating with a team including Ukrainian-speaking staff and volunteers, Plovdiv became what municipal authorities called "a big heart for the Ukrainians." The branch's success stemmed from combining immediate crisis response, offering PFA and warm welcome at border crossings, with sustained community integration support. Their helpline showed increasing call lengths and repeat callers, while children's progress was visible through increased verbalization during activities.

Word-of-mouth became Plovdiv's primary growth engine. Satisfied beneficiaries drew others into services, creating organic expansion that served as a proxy for impact in a context where MHPSS outcomes proved difficult to measure. This peer recommendation system built trust faster than any formal outreach.

The branch fostered unexpected empowerment through volunteering opportunities that gave youth agency, with some Ukrainian participants emerging as community leaders. These unintended outcomes complemented planned interventions, creating multiple pathways for healing and integration.

Recipient-to-provider transitions often created powerful multiplier effects. NS that hired Ukrainians early sparked virtuous cycles where those seeking help became helpers, healing through service. Testimonies of volunteers who were former recipients revealed depth of transformation:

"At the border we received so much support I wanted to give back"

"I feel proud transitioning from recipient to volunteer...now I feel victorious helping others"

These individual transformations rippled outward as some empowered Ukrainians became cultural bridges, enhanced service quality, and modelled resilience for their communities.

With these findings in mind, the evaluation makes the following recommendations for this section:

5. **Develop impact-focused theories of change** at inception that explicitly link MHPSS activities to community integration and individual transformation outcomes, not just service numbers [1038, 857]

3.9

6. **Implement systematic qualitative monitoring** from project start, including longitudinal tracking of recipient journeys and community-level changes to capture transformational impacts [857, 280]

4.1

7. **Strengthen referral mechanisms** & map pathways between MHPSS layers from inception [1031, 295]

4.6

2.1.5 Efficiency of MHPSS for the displaced

While many NS demonstrated creative use of resources and often achieved quantitative targets within budget, critical timing issues limited overall program efficiency. The project began after peak displacement crisis, with further delays from both coordination challenges and variable NS mobilization capacity. This created pressure for rushed implementation without adequate preparation, reducing cost-effectiveness, while delayed strategic pivots meant resources remained locked in less efficient delivery models longer than necessary.

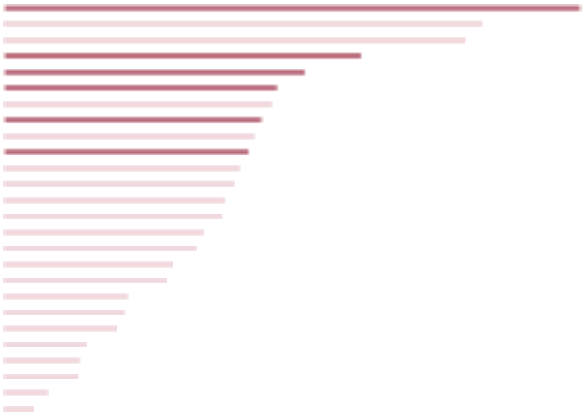
Critical timing gaps and delayed adaptations undermined momentum. The gap between initial emergency response and EU4Health funding caused branches to lose contact with beneficiaries [42]. The shift to community-based MHPSS was delayed despite numerous project actors requesting this earlier [727, 582]. With National Societies entering across three contractual extensions at different starting points, implementation experiences varied considerably - some early participants faced rushed beginnings without proper inception phases [939].

Service delivery models showed mixed alignment with displaced population needs. While context assessments informed implementation activities, the proposal's emphasis on helplines proved ineffective in many contexts, with numerous helplines going largely unused. NS discovered that displaced populations preferred informal communication channels, Ukrainian language social media and word-of-mouth networks proved far more effective than traditional outreach: *"we produced a lot of posters and leaflets about our helpline...we only waste our time and the money"* [11]. Reception centres and face-to-face services generated some of the best engagement through Red Cross brand recognition and trust-building. **The disconnect between planned platforms and community preferences exemplified broader challenges in adapting standard approaches to specific crisis contexts.**

Budget planning and execution revealed complex dynamics between estimated and actual costs. While most NS achieved or exceeded targets, significant underspend remained common [403]. The budget process required multiple revisions [466, 589, 637], with some NS unable to fully utilize allocations while others significantly underspent, suggesting misalignment between budget design and operational realities. This pattern reflects multiple factors: overestimated initial costs, cost-effective delivery methods discovered during implementation, or conservative spending practices limiting fund utilization and therefore potential reach and quality.

Budget allocation methodology produced unexpected geographic distributions. NS-submitted requests based on assessed needs, activities, and country-specific costs (HR rates, volunteer compensation, cost of living). While proposals considered displaced populations and technical capacity, two top-five recipients were neither border countries nor major displacement hosts. Their substantial funding - reflecting strong implementation capacity and high operational costs - highlights how demand-driven allocation can favour institutional readiness over geographic proximity and caseload pressures.

Figure 8 - budget proportions of NS (original 5 plus Ukraine in darker colour)



Funding delays until March-April 2023 compressed implementation time [463], while complex cost allocation rules for activities crossing funding sources added administrative burden [533]. Despite these challenges, budget flexibility proved valuable for NS accustomed to rigid European funding, enabling crucial adaptations as needs evolved from emergency response to community-based programming [79]. However, the standardized budgeting approach failed to accommodate the vastly different contexts and absorption capacities across 28 NS [326, 74].

Case Study: Spanish Red Cross - When Volunteer Culture Meets Project Funding

SpRC's conservative spending approach reflected culturally embedded practices around voluntary service and frugal operations. The organization maintained its volunteer tradition, but this created a dilemma: paying for traditionally free services risked establishing precedents unsustainable after EU4H. While funds were ultimately spent, this caution slowed implementation and potentially reduced reach.

Through trial and error, SpRC developed responsive programming strategies. Attendance fluctuations created ongoing difficulties, sessions planned for 25 sometimes drew only 5 participants due to population mobility. Despite these frustrations, SpRC found their rhythm through co-located services and community activities that outperformed individual interventions. Regular programming eventually emerged, including activities co-developed with participants, demonstrating that persistence and community involvement could overcome initial participation barriers.

SpRC's experience highlights a common challenge for volunteer organizations: balancing immediate impact with long-term sustainability when managing project funding. Their cautious approach, while understandable given organizational culture, demonstrates both the benefits and limitations of maintaining traditional operating models during humanitarian crises - volunteer tradition/ethos can safeguard long-term capacity but reduce short-term efficiency in reaching beneficiaries.

Operational learning combined formal mechanisms with inevitable trial-and-error adaptation. While workshops, exchange visits, and monthly meetings provided valuable knowledge sharing, operational pressures combined with differing local contexts required on-the-ground discovery.

Some NS learned that traditional outreach failed, "Reaching the affected population outside the system has been one of the biggest challenges. Frequent changes in living conditions, locations, or legal status required continuous adaptation of plans and activities.[912]

Translation and resource development highlighted both innovation and coordination gaps. While translation lacked dedicated budget [749], NS found creative solutions like incorporating psychologists into emergency-funded language classes [605]. Ukrainian volunteers brought professional skills and found healing through service [293]. Yet coordination remained limited—several NS developed MHPSS apps in the project, duplicating efforts that could have been pooled for comprehensive multilingual resources from the start. This blend of systematic learning, local adaptation, and missed coordination opportunities reflected the complex reality of humanitarian response.

Evidence-based adaptation succeeded where implemented but remained inconsistent across NS. Some NS conducted annual needs assessments using consistent tools, tracking changes across respondents and enabling responsive programming [127, 148]. Centralized coordination through SharePoint helped prevent translation duplication [752]. These systematic approaches demonstrated potential for continuous improvement but weren't universally adopted.

With these findings in mind, the evaluation makes the following recommendations for this section:

8. **Design a graduated inception.** Allow time for needs assessment, recruitment and system setup, while ensuring immediate delivery of limited emergency PFA to maintain beneficiary contact [694, 939]

4.3

9. **Mandate systematic needs assessments from project start.** Require all NS to use standardized tools from the outset [127, 148]. Early, consistent assessments must produce actionable insights, with clear mechanisms to translate findings into program adaptations. Complement with continuous beneficiary feedback through community-preferred channels.
10. **Support flexible budgeting** that enables responsive programming. Allow NS to adapt service intensity based on evolving needs [639]. Base budgets on actual cost-per-service data rather than initial estimates, using realistic flexibility allowances for context-specific adaptations [403, 404, 79].
11. **Bridge funding gaps.** Establish contingency mechanisms preventing loss of beneficiary contact between emergency response and longer-term programming, [42] - including active beneficiary databases, retention of key outreach staff/volunteers, knowledge transfer systems, and effective early warning of possible programs so bridge funds can be pursued.
12. **Create guidance for balancing volunteer ethos with project funding.** When volunteers assume quasi-professional responsibilities in well-funded projects, develop frameworks for appropriate compensation models - such as stipends, or transition to temporary contracts. Include guidance on thresholds for converting high-commitment volunteer roles to paid positions, maintaining volunteer mobilization while ensuring fair treatment, and post-project sustainability.

13. **Strengthen resource development coordination mechanisms.** Establish a systematic resource mapping system where NS register planned tools (apps, websites, translations, materials) early in the project cycle and encourage early development while acknowledging that some innovations emerge from operational learning and budget reallocation. Create clear protocols for when NS should develop independent versus shared resources

2.1.6 Coverage in MHPSS reaching the most vulnerable

Coverage patterns revealed systematic gaps in reaching diverse vulnerable populations, despite some NS developing targeted approaches.

Specific vulnerable populations required tailored approaches that few NS systematically implemented. Some NS with developed Protection, Gender and Inclusion frameworks successfully prioritized vulnerable cohorts through dedicated programming [NS: 270, 881, 928], including partnerships with education departments for Ukrainian schoolchildren and parent engagement through child-focused activities [NS: 265, 880]. Most NS, however, relied on informal connections rather than systematic outreach, undermining scalability. Roma communities remained almost entirely unreached except through personal staff connections: "we provide some activities in 1 or 2 places...because of our psychologist. Personal connection" [NS: 19]. One NS noted that LGBTQI+ Ukrainians faced multiple barriers including discrimination requiring confidential support approaches [NS: 270]. Men remained notably absent from services despite rebranding efforts to reduce stigma [NS: 211].

Geographic coverage depended heavily on NS capacity and branch engagement. Some NS built effective multi-branch systems [NS: 130, 143] and established strategic presence at transit points [NS: 505, 506]. Yet decentralized structures often created gaps when branches viewed MHPSS as "extra work" beyond traditional first aid [NS: 99], with coordinators understanding the need but not "how or why" to implement it. Internal politics and debates over Ukraine-specific versus general programming created additional barriers [P: 810, 813]. Where committed branches operated, creative solutions emerged, such as integrating psychologists into language classes [605], but these innovations remained localized and were not scaled across the network, thus their impact remained limited and uneven.

The combination of unsystematic outreach and uneven geographic coverage left many vulnerable populations likely unserved. A gap between easily accessible collective centre residents and harder-to-reach populations in private housing, rural areas, or marginalized communities represents a fundamental challenge requiring more proactive, inclusive approaches in future responses.

With these findings in mind, the evaluation makes the following recommendations for this section:

14. **Map and proactively target underserved groups early. Incorporate targeted outreach through community organizations and safe spaces based on vulnerability mapping** through engagement and partnership with trusted community organizations. Undertake active outreach targeting private housing, rural areas, and mobile populations in addition to more passive forms of engagement. Establish safe spaces for discriminated groups and replace ad-hoc connections with structured protocols ensuring systematic reach to all vulnerable populations.

15. **Improve branch engagement through early intervention and HQ support** - Engage branches during emergency phase before resistance patterns solidify [51, 107, 459]. Deploy differentiated strategies and HQ support teams to address resistance. Create branch champions and escalation pathways when coverage gaps threaten vulnerable populations.

4.3

2.1.7 Accountability and PM of MHPSS for displaced

Project accountability systems evolved throughout implementation, revealing tensions between rapid emergency response and robust measurement frameworks. Design phase disconnects between proposal writers and implementers created lasting challenges, while coordination teams, though significantly stretched, worked tirelessly to support an expanding network.

Design phase coordination gaps created persistent implementation challenges. Several NS reported disconnect between proposal developers and implementers, with different departments or individuals handling each phase. This resulted in limited consultation, insufficient branch-level buy-in, and decision-making divorced from ground-level assessments. Enhanced dialogue from all parties involved in negotiations could have strengthened the process, which would have supported evidence-based programming. One implementer noted*: "The project was written basically without any involvement of me."* These disconnects persisted even during the expansion phase when more consultation time theoretically should have been available, suggesting systemic or communication challenges rather than purely time-related constraints, resulting in misaligned targets and weakened accountability.

Some NS starting from minimal MHPSS capacity faced compounded challenges. Several NS developed MHPSS components entirely from scratch within EU4Health, with single staff members lacking prior MHPSS experience managing complex programs.

One NS noted: "the MHPSS component was fully developed during this project, we had no such unit before." Recruitment delays for critical positions, project officers, promotion officers, event managers, created cascading effects, while staff redeployment to other emergencies further disrupted implementation timelines. While building capacity from scratch was an achievement, accountability suffered because inexperienced staff had to manage complex systems without prior orientation.

System gaps amplified accountability challenges. NS without dedicated monitoring software (e.g., CRM systems like Salesforce or RedRose) relied on spreadsheets and manual tracking, making consolidated reporting difficult and creating additional workload for donor reports. Some NS faced capacity challenges when rapidly scaling up for EU4Health - newly recruited project staff, including those in coordination roles, sometimes lacked familiarity with Red Cross procedures and EU project requirements. This was particularly evident in NS with limited prior experience managing large-scale donor-funded projects. These capacity gaps meant accountability systems had to be developed during implementation rather than being ready at project start, affecting consistency and transparency.

Central coordination teams managed extraordinary expansion despite static resources - IFRC coordinators oversaw a five-fold increase from 5 to 28 National Societies [478, 638, 772,]. While there was additional recruitment, it was not proportional to this increase and personal relationships and trust-

based coordination filled formal system gaps [370, 569], while biweekly meetings and bilateral engagements helped manage the expanded scope [549, 583, 975]. Staff worked through multiple project restarts, three official starts and six kick-off meetings, reflecting the evolving nature of the response [701]. When turnover occurred, remaining team members absorbed expanded portfolios while providing gradual transition support to maintain continuity [611, 487, 716, 612].

Indicator confusion compounded existing implementation challenges. Although M&E guidance and toolbox were developed early and workshops conducted (April 2023), a significant gap emerged between central guidance and field implementation. The distinction between counting individuals versus service instances - while documented in written materials - was not uniformly understood across NS teams until formal re-clarification in early 2024 [351, 460, 842, 277]. Factors including staff turnover, incomplete handovers, and uneven dissemination of guidance to implementing teams contributed to this prolonged confusion. While Kobo tools and dashboard systems enhanced data management [737, 739], the experience highlights that written guidance alone is insufficient without systematic dissemination and verification of understanding at all implementation levels [49, 91, 943].

With these findings in mind, the evaluation makes the following recommendations for this section:

16. **Involve implementing PMs in NS proposal to align budgets & operational realities** – Ensure direct participation of implementing departments in target setting and activity design, with effective communication about "project requirements, expectations, coordination demands, and workload" from the outset. Where this is not possible ensure that a continuity presence is in place and that those responsible for design are available for robust handover.

4.6

17. **Strengthen PMER systems from project start** - Recruit PMER expertise dedicated specifically to the project before implementation begins, both in the IFRC project coordination team and within participating NS

4.7

18. **Establish rapid mobilization register for overall project coordination** - Develop a register of professionals who can be mobilized quickly to fill critical IFRC coordination roles - Project Managers, Coordinators, PMER officers, Finance staff, and Administrative Assistants - for at least 6 months while permanent HR structures are established. This would help speed up implementation kick-off significantly, ensuring essential central coordination and management capacity is in place from day one rather than building these functions during project delivery.

19. **Standardize M&E data collection systems from project start** with clear indicator definitions, consistent measurement guidance, support and training across all NS [279, 182, 737].

4.6

2.2 Evaluation of MHPSS Capacity Strengthening of NS and & NS partners

2.2.1 Overview

This section evaluates the project's capacity strengthening component, which aimed to train Red Cross staff, volunteers, and other professionals in PFA and MHPSS. The project exceeded its target by training over 50,000 people across 28 National Societies, with many organizations transforming from having minimum MHPSS capacity to establishing dedicated units, though challenges included uneven capacity assessments, high trainer turnover, and sustainability concerns about maintaining newly built capabilities after project funding ends.

2.2.2 Relevance of design for MHPSS capacity strengthening

To support the delivery of MHPSS including PFA to people displaced by the international armed conflict in Ukraine, **the initial project plan aimed to conduct assessments in each participating country.** These assessments were intended to identify needs, existing resources, and relevant capacities.

Based on the findings, the first phase of the project sought to target National Society (NS) staff, volunteers, frontline responders, and health professionals (including Russian- and Ukrainian-speaking personnel) to address MHPSS needs in an accessible and cost-effective manner.

The first six National Societies participating in the EU4H project conducted detailed assessment visits with the support from the MHPSS Hub. These involved qualitative engagement with displaced people from and within Ukraine as well as with key field stakeholders. The assessments revealed:

1. A significant lack of MHPSS capacity and systems in the host countries.
2. The need for capacity-strengthening through targeted training.
3. The demand for both general information and emotional support for displaced Ukrainians.

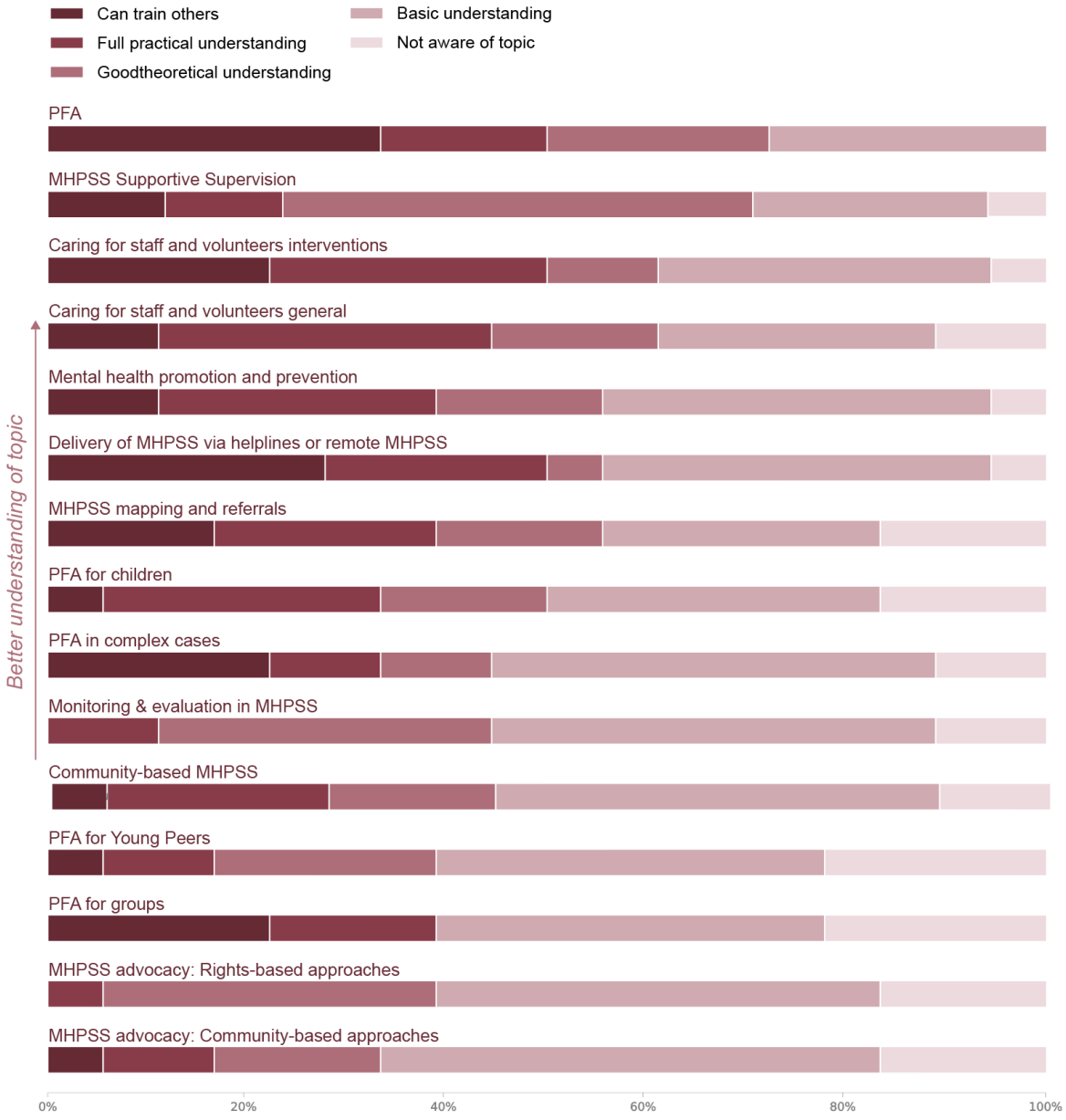
These findings informed Expected Result 1.2, which focused on the development of helplines and service platforms.

By contrast, only a few of the National Societies that joined the EU4H project later conducted similar in-depth needs assessments [719, 720]. Instead, 18 of the new members completed an Organisational Capacity Assessment (OCA) survey followed by entry interviews with the MHPSS Hub Technical advisors to provide insights into the most suitable modalities of technical support [720, 754]. While the OCA provided a useful quantitative overview of capacities across multiple National Societies, and the entry interviews supported tailoring support, it did not quite have the qualitative depth and engagement of the on-the-ground needs assessments [808]. This gap later created challenges, as some NS focal points did not have a full understanding of the project's aims or their own capacity to respond effectively [548].

> *"I think it helped definitely us to support them more efficiently knowing that their internal context. In some cases it helped them as well…we did the survey. And then we went and had meetings with everyone of them. So there was an and more in depth discussion and questions…I saw it clicking in her head so it was a learning process for them to extend" – IFRC Project team [808]*

The 2023 OCA survey further highlighted the pressing need to strengthen MHPSS capacities across National Societies. Findings showed that half of the respondents did not feel they had a practical understanding of PFA, nor the ability to train others in its application. In more specialized areas, such as PFA for Young Peers, PFA for Groups, and rights-based, community-based MHPSS advocacy, approximately 20% of National Societies reported being entirely unfamiliar with the topics. Capacity gaps were also significant in other critical areas, including Caring for Staff and Volunteers, the delivery of helplines, MHPSS mapping and referrals, PFA for children, and PFA in complex cases. In each of these domains, around 40% of National Societies reported only a basic or no level of understanding. These gaps underscored the scale of foundational training required across the network.

Figure 9 - MHPSS capacity across national societies at the beginning of the EU4Health project (OCA, 2023)



In response to these capacity gaps, the IFRC RoE team and MHPSS Hub delivered a series of trainings in the IFRC's regional office in Budapest, in Copenhagen where the MHPSS Hub is located, and in partner National Society countries. These trainings covered core MHPSS competencies, staff and volunteer wellbeing, community-based approaches, and programme management skills (see table below for full details).

Table 3 - List of trainings delivered across the EU4Health project

Training	Date
Training of Trainers in PFA	October 2022
Caring for Staff and Volunteers	November 2022
Technical Induction and M&E Workshop	April 2023
Caring for Staff and Volunteers II	May 2023
PFA Training of Trainers (English)	June 2023
PFA Training of Trainers (Ukrainian/Russian)	June 2023
Supportive Supervision	November 2023
Community-Based MHPSS	April 2024
MHPSS in Emergencies	November 2024
Child Friendly Spaces	June 2025

The trainings delivered by the RoE and MHPSS Hub teams were highly praised by National Societies, who described them as high quality, relevant, and participatory [337, 543, 788]. The Hub's expertise served as the backbone of the project, providing crucial technical support and enabling harmonization across the network [337, 543].

> *"The huge advantage of this project is having technical advisors from the MHPSS hub. This was something that, I don't know, if we could have this in all projects it would really help us a lot in terms of capacity building" – National Society [40]*

Challenges often related to the difficulty of designing a training course for 28 National Societies, all at different skill levels and with varying capacities in MHPSS, as well as operating in vastly different contexts and with diverse needs [347, 733]. This diversity among attendees led to feedback that it was difficult to apply lessons learned in the Budapest or online workshops within their local contexts, which impacted the relevance of the material [229]. Other feedback noted that the trainings were more tailored to less experienced National Societies in MHPSS, meaning those with greater prior experience gained less from the sessions [255, 807].

Some project members felt there had been an underestimation of the support needs of National Societies with no prior MHPSS experience [633]. These Societies required more foundational training before more complex skill sets could be introduced [634]. This created challenges during the project design stage, as National Societies were tasked with designing MHPSS project activities before fully understanding the concepts or needs they addressed [468, 548]. Pressure was further increased by the emergency context, which demanded the rapid delivery of PFA and conflicted with a slower, capacity-assessment-driven training approach [706, 828]. Balancing training delivery between in-person and online formats proved challenging. Some attendees valued the depth of the multi-day Budapest trainings and the opportunity for in-person workshops, while others found the time and travel commitments difficult:

> *"It takes a lot of time with these long trainings and that it requires travelling... Even though it's not the best output to have them digitally, it will make them easier to participate for more."*
> *– National Society Focal point [186]*

To improve reach and accessibility, remote learning solutions were introduced in early 2023. TGLF and Tdh were contracted for approximately €1M budget to deliver online trainings focused on PFA for Children, which was a key capacity gap identified by National Societies not originally covered by the MHPSS Hub [656, 758]. The Hub continued providing technical bilateral assistance for in-person PFA for Children trainings and delivered a regional Child Friendly Spaces training in Budapest, alongside advisory services to link the online platforms with overall project implementation [760, 761].

TGLF delivered large-scale peer-learning cohorts engaging over 3,000 practitioners, while Tdh provided e-learning modules (513 completions globally), webinars, and the ChildHub platform across 25+ countries. Together they targeted frontline actors, teachers, social workers and volunteers when specialist psychologists were scarce [1054].

Digital tools showed clear strengths. Tdh's webinars engaged hundreds of professionals, with recordings extending reach beyond live sessions. TGLF's peer-learning model provided validation and professional solidarity, generating 119 practitioner-led case studies. Ukrainian-language content proved particularly relevant, with 190 e-learning completions and strong engagement in peer cohorts.

However, significant challenges emerged (see Case Study box). The shift from planned Training-of-Trainers to peer learning, while innovative, meant high participation numbers did not translate to certified competencies [658]. Content and format did not consistently reflect systematic analysis of NS capacity gaps, and sessions were sometimes unrelated to participant needs, with limited accompanying structured materials. Many NSs viewed peer learning as peripheral compared to traditional training, questioning its practical application value. Coordination between IFRC, Tdh, and TGLF remained largely parallel rather than integrated, limiting coherence [759]. Reliance on self-reported outcomes without independent validation, reduced institutional embedding, and uncertain sustainability beyond project funding further constrained systematic impact.

Case Study Insight: Digital Learning Partners TGLF and Tdh - Scale vs. Integration

What they delivered: TGLF and Tdh were contracted for ~€1M (~3% of EU4Health budget) to extend MHPSS capacity for child-focused practitioners. TGLF ran peer-learning cohorts (PFA Connect, Accelerator) reaching 3,000+ participants across multiple languages, producing 119 case studies. Tdh delivered e-learning (513 global completions, 270 in EU4Health countries: 73% Ukrainian-speaking), webinars (e.g., 426 registrants, 262 live participants), and the ChildHub platform spanning 25+ countries.

Strengths: Cost-efficient scale; validated frontline practitioners experiencing isolation; strong Ukrainian engagement; recordings extended reach; practitioner-generated studies grounded content in realities.

Challenges:

- Peripheral positioning: Many NSs viewed peer learning as light touch training and an unclear fit with their institutional strategies
- Challenges in coordination: TGLF, Tdh, and IFRC sometimes operated in parallel, reducing coherence
- Design misalignment: Content at times not reflecting a systematic learner needs analysis; sparse structured materials
- No certification pathway: Shift from planned ToT to peer learning meant participation ≠ accredited competency
- Evidence gaps: Self-reported outcomes only; no pre/post assessment or independent validation of practitioner skills or child wellbeing

Key lesson: Digital scale alone insufficient. Effectiveness requires strategic integration, certification pathways, and institutional embedding from design phase.

National Societies themselves also delivered a broad range of PFA trainings, both in-person and online. These covered basic PFA as well as trainings for different targets, including PFA for children and young peers, the two tailored approaches developed under the project, as well as adaptations for humanitarian workers, teachers, emergency responders, those working with complex trauma, and the private sector [833]. As expected, these trainings were usually more contextualised to local needs and adapted to the target groups. However, feedback still occasionally highlighted the need for even greater contextualisation, with participants requesting training based on real-life scenarios from their work [65]:

> *"Would be good to tailor and develop training according to the needs on the field (more one day targeted in-depth trainings)." In-country PFA trainee* [65]

Case Study Insight: Lithuania Adapts PFA Training for Local Context

Lithuanian Red Cross transformed the Regional PFA training into an 8-hour "PFA Basic" course - significantly shorter than the original multi-day format. They incorporated Ukrainian-specific scenarios based on real situations volunteers encountered, such as supporting a woman experiencing survivor guilt at aid distribution points or helping a teenager facing cyberbullying.

Through this approach, 2,239 people were trained (exceeding their 2,050 target) across 10 cities, with 27 volunteer trainers delivering 90% of sessions, showcasing how adapting international frameworks through shorter formats and real-life scenarios can increase both accessibility and effectiveness. Participants rated the training 9.6/10 on average, particularly valuing the practical, contextualized approach.

This evaluation makes the following recommendations for this section:

1. **Conduct intensive project management capacity assessments before implementation.** Programs should implement 2-week project management bootcamps and comprehensive capacity assessments to identify necessary skills and resourcing before beginning activities, as quick emergency timelines often lead National Societies to start implementation without fully mapping requirements, resulting in challenging administration later [630, 553, 471, 940, 942, 636, 108].

3.9

2. **Implement tiered training approaches based on pre-existing MHPSS capacity.** Use capacity assessments to establish differentiated training content matching varying organizational knowledge levels, ensuring both newcomers and experienced National Societies benefit appropriately from technical support rather than using one-size-fits-all approaches [229, 733, 808].

4.2

2.2.3 Effectiveness in achieving capacity strengthening goal, outputs & outcomes

The primary aim for the capacity strengthening component was to ensure increased capacities of RCRC staff and volunteers, frontline responders and other professionals in PFA and MHPSS. This was achieved through two primary activities:

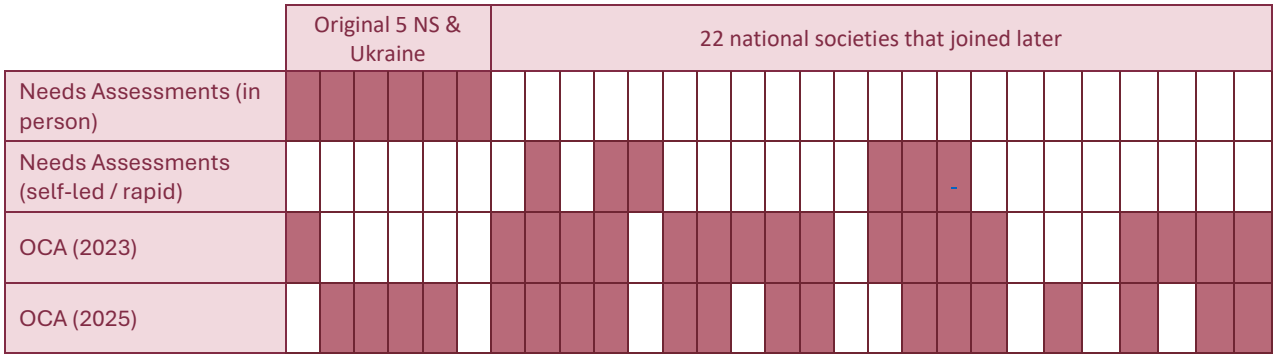
1. **Activity 1.1**: Needs assessments in each country to identify needs and resources, map relevant service platforms, guide development of trainings and establish or strengthen referral mechanisms.

2. **Activity 1.2**: The training of RCRC staff and volunteers, Ukrainian health workers, frontline responders and other health care professionals to provide PFA and other MHPSS support.

For Activity 1.1, in-depth needs assessments were conducted in all five of the original National Societies, as well as in Ukraine. However, only 6 of the 22 National Societies that later joined the project carried out such assessments [719, 720]. This was largely due to time pressures, as late-joining Societies needed to begin PFA implementation quickly, making longer studies infeasible [706, 719]. In some National Societies, assessments took different formats such as rapid assessments and focus group discussions, but there was a challenge in consolidating the results at the central level, despite progress reports where NSs reported on Activity 1.1. This uneven uptake and inconsistent consolidation led to some early NS having better diagnostic grounding while some later NS struggled to align activities to actual needs [468].

While many National Societies completed an OCA survey in 2023 and received MHPSS Hub support [720, 754], **absent comprehensive capacity assessments created implementation challenges**. Project requirements and needed capacities were often unclear, particularly when those designing and implementing the project differed [548]. Without structured baselines, capacity strengthening became reactive rather than strategic, addressing immediate gaps but not systemic weaknesses [791]. A mandatory in-depth capacity assessment during inception would have enabled more effective capacity strengthening and MHPSS activities [600, 791]. These gaps revealed the extensive foundational training needed across the network.

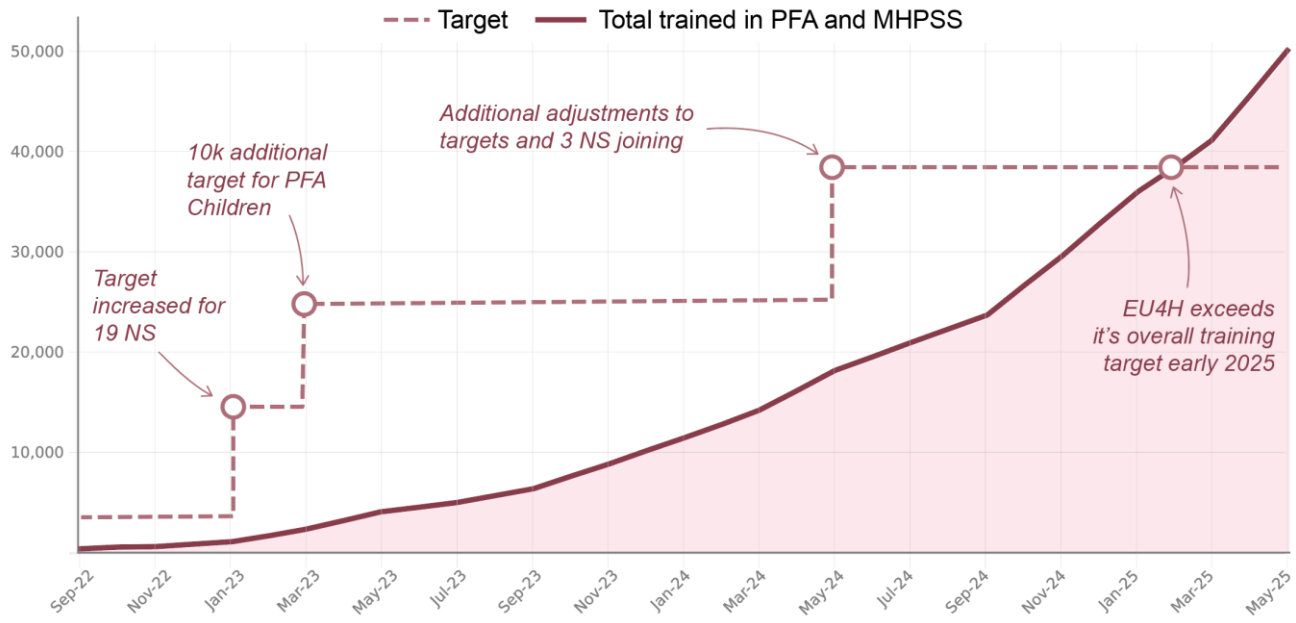
Table 4 - Capacity assessments undertaken by national societies



For Activity 1.2, the indicator target for the number of health professionals, volunteers, first aid responders, and other professionals trained in PFA and MHPSS underwent several revisions. For the original five National Societies, the target was set at 4,155. With the addition of 23 more National Societies, along with an increased sub-target of 10,000 for PFA for Children, the overall target was revised to 38,000.

As shown inFigure 10 **below, this target was surpassed by early 2025, with 50,052 individuals trained by May 2025, exceeding the target by 31%**. This represents a major achievement for the EU4Health project, particularly given the rapid expansion of participating National Societies. The sub-target of 10,000 professionals trained to support displaced children from and within Ukraine was also exceeded, reaching 12,739 through a combination of remote learning solutions and National Society-led trainings.

Figure 10 - Total trained in PFA and MHPSS under Indicator 1 (including indicator 1.2 and 2) versus targets



The Training of Trainers (ToT) model was instrumental in achieving project targets, successfully cascading PFA knowledge to a large number of staff, volunteers, and professionals [995, 999]. The approach was built on central ToT Regional trainings in Budapest for project focal points and key staff, who then delivered subsequent ToT sessions across regional branches in their own countries. Feedback from the National Societies that attended indicated the trainings were well-received and highly valued. This model not only expanded reach but created sustainable in-country training capacity, though its success varied depending on how well NS selected and supported trainers [15, 30].

However, challenges arose with the implementation timeline. A push was made for the ToT sessions to occur as early as possible to allow sufficient time for the cascaded trainings [706, 818]. This meant that initial sessions took place before all National Societies could identify suitable participants and, in some cases, while contracts were still being finalised [818]. This weakened cascade effectiveness at the start, as unsuitable trainers sometimes reduced the scale of downstream trainings.

In response, the MHPSS Hub adapted its approach. Following the first training in 2022, it developed a more thorough, guided process to help National Societies select participants based on both their technical and facilitation skills [820]. Furthermore, a Community of Trainers (CoT) was established in English and Ukrainian for trained trainers from the Budapest ToTs, to facilitate trainer exchanges and peer support, reducing the demand on the MHPSS Hub for direct technical assistance [765, 821].

> *"We had the community of trainers that was functioning for almost a year... a possibility for the trained trainers to meet at exchange and also be followed by the facilitators and technical advisors...it was very successful...bringing their own examples and their own challenges, very practical, and bringing it to the operational level" – IFRC project team [765]*

Recruiting Ukrainian-speaking participants for the ToT proved difficult, with only 14 taking part in the June 2023 Budapest training [832]. This reflected a broader challenge that some National Societies faced in recruiting Ukrainian and Russian speakers for their projects [665, 670]. Despite this initial difficulty, of the

more than 50,000 people subsequently trained in MHPSS including PFA, 2,365 were Ukrainian or Russian speakers.

No official target was set for this group, as it was not possible to determine the number of relevant Ukrainian or Russian-speaking professionals in each country [380]. However, National Societies were strongly encouraged to train as many as possible [560]. Engagement however varied significantly across regions. Seven National Societies reported training zero Ukrainian or Russian speakers, while approximately 30% of the 2,365 were trained by the Ukraine NS, and another 50% from just four other National Societies. Although these additional four NS were all countries in proximity to Ukraine, the figures highlight a considerable disparity in implementation. This uneven distribution meant that language-sensitive provision was highly dependent on a handful of NS, leaving others under-equipped to reach displaced populations effectively.

Case study insight: Bulgarian Red Cross showed the strengths of a ToT approach

The Bulgarian Red Cross trained 1,326 staff and volunteers in PFA, exceeding their target of 1,297. Using 22 volunteer trainers from regional branches, they delivered 28 training sessions across diverse groups including 271 displaced from Ukraine (the fourth highest NS), 114 healthcare workers, and 112 volunteer psychologists. This cascade approach maximized reach while minimizing costs, as the BRC focal point noted, "if you train a trainer you can do whatever you want without money much easier." The model created sustainable capacity, with trained trainers able to continue delivery independently and BRC planning to commercialize PFA training through evolving partnerships with Bulgarian public sector bodies.

The PFA for Children initiative was consistently reported as effective at the practitioner level. Participants gained confidence, practical tools, and a sense of professional solidarity while feeling less isolated. They particularly valued the training's practicality for skills like active listening and calming techniques. This effectiveness translated into tangible benefits for children and their families. Case studies documented improved caregiver-child relationships, children resuming play, feeling calmer after traumatic events, and showing better interactions in the classroom, being outcomes that practitioners attributed to applying skills from the training. Caregivers also reported an improved ability to support their children through enhanced communication and stress management techniques learned in the sessions. These results illustrate how child-focused training can deliver both immediate psychosocial benefits and longer-term caregiver empowerment.

With these findings in mind, the evaluation makes the following recommendations for this section:

3. **Integrate MHPSS capacity into existing organizational structures early while measuring benefits**. Programs should push for integration of MHPSS focal points and capacity into established NS structures from project inception, measuring organizational benefits to build internal justification for sustained investment beyond project funding, as some roles risk being lost post-project while others successfully secured additional donor funding [48, 284, 539, 327, 339].

4. **Develop targeted outreach protocols for Ukrainian-speaking professionals**. Create systematic approaches through relevant networks to identify qualified professionals and establish tiered engagement pathways matching skill combinations with appropriate training opportunities, as some NS struggled with language and experience barriers despite successfully training 2000+ Ukrainian speakers [88, 668, 832].

4.4

5. **Integrate MHPSS capacity systematically into emergency response protocols and activation procedures.** Establish standardized protocols for deploying trained PFA personnel during emergency responses, including pre-positioned MHPSS specialists in emergency response teams, integration of PFA into standard operating procedures for disaster response, and clear activation criteria for scaling MHPSS support based on incident severity and affected population size to ensure immediate psychosocial support availability rather than reactive deployment.

2.2.4 Impact on MHPSS service quality

While several indicators provide quantitative insight into the number of people reached through PFA and MHPSS trainings, assessing the broader impact of this capacity strengthening is more challenging. This difficulty stems from a lack of consistent, project-wide baseline and endline measurements. This gap means quantitative data shows coverage but not service quality or behavioural change, limiting evaluative certainty. Nevertheless, available data and qualitative evidence suggest that EU4Health significantly strengthened many National Societies' ability to provide MHPSS services, in some cases transforming from no provision to dedicated units and contributed to raising the overall quality of MHPSS provision within host-country systems, though unevenly across contexts.

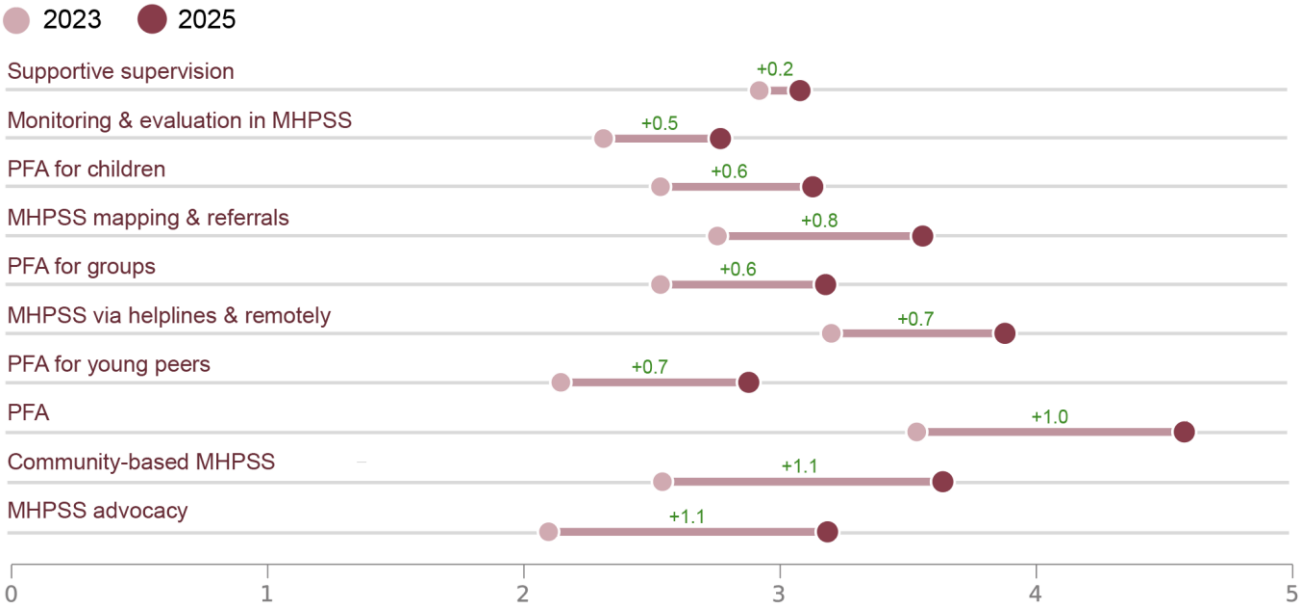
The OCA offers the best available dataset for this purpose, with 18 National Societies conducting one in 2023 and 19 in 2025. However, this data has some limitations:

1. The wording of questions and answers sometimes differs between the two surveys.
2. The surveys are self-assessments, often completed by a single staff member.
3. The staff member who completed the first OCA was sometimes different from the one who completed the second.
4. Not all of the same National Societies completed both the first and second assessments.
5. Without a control, it is not possible to tell what change was attributable to EU4H, however given the timing and scale, it is reasonable to infer EU4H contributed significantly to observed gains.

Figure 11 shows the change in self-reported MHPSS competency between 2023 and 2025. On a scale where 0 represents 'no skill' and 5 means one 'can train others on the topic', every skillset demonstrated improvement. **The largest gains were observed in MHPSS Advocacy, Community-Based MHPSS, and PFA**. Areas such as Supportive Supervision, Monitoring & Evaluation in MHPSS, and PFA for Children showed more modest growth, improving between 4-12% over the two-year period. These smaller gains suggest that technical skills and supervisory competencies are more challenging to develop than frontline PFA delivery capabilities. **The slower progress in supervision and M&E is particularly significant**, as these functions underpin the sustainability and quality assurance of

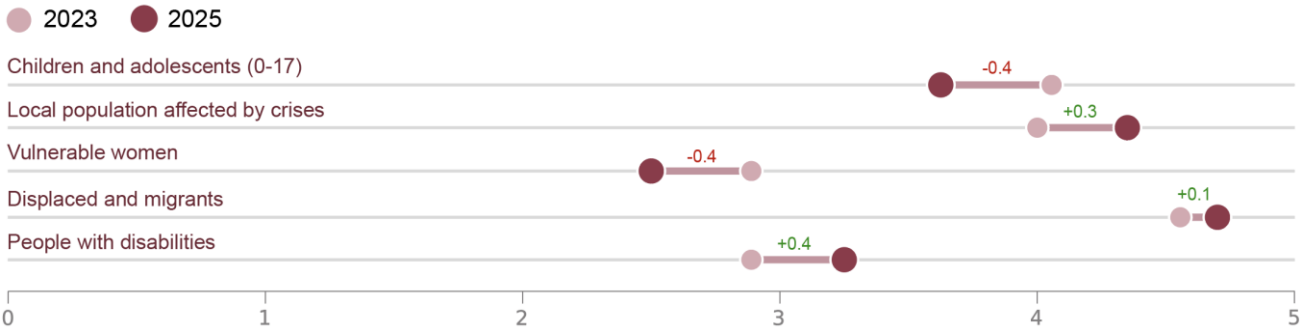
MHPSS systems. These persistent gaps may ultimately limit long-term program effectiveness despite substantial gains in frontline skills.

Figure 11 - Change in level of competency for different skills with 0 being 'no skill' and 5 being 'can train others on topic' (OCA 2023 [N=18] versus OCA 2025 [N=19])



When examining experience with different population groups, the data shows that average competency improved for supporting displaced groups and migrants, local people affected by crises, and people with disabilities. However, there was a decrease of around 10% in self-reported experience with children and adolescents and vulnerable women, being the thematic area TGLF was contracted to train. While not all these groups were within the project's direct scope, the decrease in capacity for children and adolescents is noteworthy given the project's later focus on PFA for Children. This apparent decline may reflect stricter self-assessment as understanding deepened but nonetheless points to a mismatch between project priorities and practitioner confidence.

Figure 12 - Change in level of competency in dealing with different groups with 0 being 'no skill' and 5 being 'can train others on topic' (OCA 2023 [N=18] versus OCA 2025 [N=19])



Qualitative data from in-depth interviews reveals a much broader and more profound impact, showing that several National Societies achieved clear and significant transformation. This was particularly true for the original five participating NS and for less experienced NS that began with little existing capacity [322, 712, 713]. Here qualitative data is more powerful than OCA, capturing organisational transformation rather than incremental skills shifts:

> *"Small NS who didn't have much MHPSS experience prior to the project... They took the task very seriously. You can see the huge build of capacity and how they start having teams, hiring people, institutionalising. It was really fast and impressive." – IFRC project team [322]*

The scale of this transformation was most powerful for those starting from scratch [1, 100]. As one NS focal point reflected:

> *"It was 2024 when officially we wrote the MHPSS pillar into our organizational strategy because it wasn't there before. So we were very new. We started from scratch, actually." – NS Focal point [100]*

Another described their initial situation: "We don't have any MHPSS activities... And at the beginning, I was totally alone... I'm responsible for everything." [1] By the end of the project, this same individual reported a complete turnaround:

> *"We have people trained, we have materials, we have activities going on, we have a MHPSS unit." – National Society Focal point [76]*

This growth involved not just adding services but also restructuring organisations [539]. One NS explained, "Within this project, we managed to strengthen our capacity on PFA provision, and we established a separate PFA training sector within the MHPSS unit." [539] Others developed innovative delivery models, such as a pilot program that equipped first aid providers with "PFA backpacks" to integrate psychological support into existing emergency response systems [136, 542].

Project staff emphasised the significance of this progress, particularly given the low starting point for many [712]. This journey, from having no MHPSS programmes or even focal points to building fully functional units, was described as a highlight of the project for some:

> *"it's also a fantastic story for those national societies that has been really a long way developing completely from scratch...it's even more uplifting to see where they are now after three years. It's really amazing." – IFRC project team [713]*

Case Study Insight: Lithuanian Red Cross created an MHPSS Unit from Scratch

The LRC transformed from having minimal MHPSS experience to establishing a dedicated Unit within two years of EU4Health. Starting in early 2023, they built the unit by hiring 16 psychologists and creating a formal organizational structure with split leadership between service delivery and training, moving MHPSS from a project-based approach to an institutionalized function within the LRC training Academy.

This structural change enabled systematic data management through Salesforce CRM, mandatory PFA integration into volunteer onboarding, and development of a sustainable ToT model with 27 volunteer trainers. Looking forward, the LRC plans to leverage the MHPSS Unit to identify additional funding streams beyond EU4Health, maintain core training capacity through the volunteer trainer structure, and continue partnerships with government ministries for e-learning development.

2.2.5 Efficiency of design and implementation for MHPSS capacity strengthening

The Training of Trainers model emerged as a highly effective mechanism for efficient capacity strengthening across national societies, creating a sustainable resource for PFA dissemination at relatively low cost [995, 999]. The project successfully trained thousands in PFA through ToT approaches,

with many national societies developing dozens of trainers who can cascade knowledge throughout their organizations and communities [275, 999]. While cost-efficient and scalable, the model's effectiveness was uneven across NS, those with strong branch structures cascaded effectively, while weaker NS struggled to institutionalise training beyond initial enthusiasm.

While the ToT model proved effective for initial capacity strengthening, high trainer turnover presented challenges requiring constant retraining cycles [15, 227, 391]. National societies identified this as a critical sustainability issue, with trained volunteers frequently leaving after receiving their training [227, 228].

Retention agreements were suggested by some as a practical solution, creating informal contracts that establish mutual benefit [30]. For example, national societies could offer annual refresher training and accreditation in exchange for trainers committing to deliver one training session monthly or bi-annually [30]. This approach creates a clear value exchange that benefits both the organization and the volunteer trainers. This highlights a fundamental tension in humanitarian capacity strengthening: reliance on volunteers offers reach but undermines retention. Without systematic retention strategies, ToT risks becoming a cycle of one-off trainings rather than an embedded system.

Acquiring formal accreditation emerged as a crucial factor in both trainer retention and program sustainability [94, 128]. Accreditation serves multiple purposes: it provides trainers with professional credibility, increases their commitment to the program, and makes the training offer more attractive to various stakeholders in both public and private sectors. This approach could be piloted as a low-cost "soft contract" mechanism, but feasibility will vary by context. For example, in highly volunteer-driven NS it may risk deterring participation unless paired with tangible incentives.

One national society achieved strong success through permanent accreditation from the Ministry of Education for their PFA Basic and PFA for Kids programs [128]. This accreditation made their trainings particularly attractive to social workers and educators who require 46 hours of professional development every three years, with the PFA training covering 8.5 hours of these requirements [128]. As one respondent noted:

> *"Now we have [accreditation]. That means it's more attractive now for social workers, for education... because it's obligatory for those specialties to have some kind of trainings to improve their skills, 46 hours in three years. And we're covering 8.5 hours." [128]*

Accreditation not only supports retention but also strategically positions NS as recognised training providers in national systems, a pathway to sustainability through fee-based services or government partnerships [94, 530].

The EU4H project achieved 85% budget utilization through effective reallocation strategies, though implementation varied significantly across national societies. While some successfully redirected underspent training budgets to community-based MHPSS services [74], others struggled to deploy allocated resources effectively.

> *"I try to understand why such a low budget spend by some NS and most of them, it is because they do not realize that certain things were available for funding such as renting of a space for activities." – IFRC project staff* [89]

This divergence shows how project flexibility enabled strong reallocations in some NS but also exposes capacity gaps in financial literacy and planning in others [89]. Future programming should consider budget coaching alongside technical training.

National societies demonstrated significant hesitancy in hiring staff due to sustainability concerns [364, 554]. Organizations dependent on volunteers feared creating positions they couldn't maintain post-project, while those receiving free partner services worried about reputational damage when unable to continue paying after funding ended. These valid concerns, rooted in diverse employment contexts, left many focal points severely overburdened [553]. One respondent noted that "80% of my time is taken up by admin," directly impacting MHPSS service delivery. This trade-off between protecting sustainability and meeting surge demand illustrates a systemic humanitarian challenge: short-term funding cycles disincentivise staff investment, ultimately reducing service quality in peak demand phases.

Despite legitimate sustainability concerns, short-term employment contracts could have provided temporary surge capacity without long-term obligations [555]. Several interviewees suggested that emergency spending protocols or stronger rapid response culture could better support the sudden capacity increases required for large-scale projects like EU4Health. The tension between immediate project needs and long-term sustainability limited both project impact and placed unsustainable burdens on existing staff, highlighting a critical challenge for future humanitarian initiatives [58, 274].

The sharing of MHPSS resources between NS, the Hub, and IFRC created an efficient knowledge exchange system through multiple platforms including the MHPSS Hub resource library, SharePoint, and Trello boards [16]. While this infrastructure enabled valuable guidance exchange and prevented duplication of effort [40], translation emerged as the primary bottleneck limiting dissemination speed. Materials like Group PFA guidance experienced delays, arriving beyond the point they were useful for some NS [16]. Attempts to address this through university translation partnerships or AI translation tools sometimes proved insufficient for the nuanced requirements of psychosocial materials. A clearer sharing protocol with dedicated translation resources could therefore address material exchange [267], ensuring innovative approaches developed in one country could be rapidly adapted across the network. Translation gaps represent more than a logistical issue; they are equity barriers. Without timely materials in local languages, innovations remained inaccessible, reinforcing uneven capacity growth across the network.

With these findings in mind, the evaluation makes the following recommendations for this section:

6. **Set formal trainer retention agreements with minimum delivery requirements**. Create agreements requiring minimum annual delivery sessions from trained trainers in exchange for free

training, accreditation and refresher support to address high trainer turnover that creates challenging retraining cycles [30, 146, 1016].

4.1

7. **Establish flexible staffing frameworks for emergency scaling.** Develop surge spending protocols and temporary capacity frameworks that enable rapid scaling without compromising organizational sustainability or creating unrealistic employment expectations, addressing NS hesitancy to hire full-time staff due to sustainability concerns [389, 72, 555].

4.0

8. **Streamline resource sharing with rapid translation protocols.** Establish efficient material sharing systems with rapid translation and review processes that enable NS to more quickly exchange materials and expertise, addressing delays that reduced material timeliness [267, 973].

4.4

2.2.6 Coverage of MHPSS capacity strengthening activity

The project successfully trained a broad range of stakeholders across all 28 participating National Societies, reaching 25,828 Red Cross staff and volunteers, 12,739 teachers, social workers and health professionals, and 11,485 other professionals**.** Training extended beyond the Red Cross movement to include first-line responders such as teachers, social workers, police and medical workers. External professionals, particularly social workers and educators, participated to meet professional development requirements, demonstrating the project's success in building MHPSS capacity across diverse professional networks.

Figure 13 - Breakdown of those trained in PFA as of May 2025.

However, coverage gaps emerged. Ukrainian-speaking facilitators remained limited across many NS, with only modest numbers as covered elsewhere in this section, representing the most significant gap given the value of Ukrainian/Russian-speaking PFA capacity [832, 665]. PFA for children also emerged as a gap, though this was partially addressed through remote learning solutions with TGLF [656, 659].

Coverage through TGLF was primarily directed at external practitioners rather than National Societies. Participants included teachers, social workers, psychologists, and other child-facing professionals, many of whom were working directly with displaced children in schools and community settings [1054]. This expanded reach beyond the Red Cross network and allowed the project to address child-specific MHPSS gaps. However, inclusivity was uneven: uptake depended on internet access, language availability, and professional incentives. Because NS were not directly involved in the rollout

[654], the integration of learning into NS programming was limited, leaving coverage largely dependent on individual practitioners' engagement rather than institutional systems.

Branch coverage varied considerably, with some NS ensuring representation by inviting volunteers from each branch to central training sessions, while others struggled with participation, particularly in decentralized NS where some branches did not engage with the project.

2.2.7 Participation and accountability of MHPSS capacity strengthening

NS were stretched generally and might have benefitted from more specific guidance on role specifications — for example, which roles require full-time commitment, what a project team structure might look like, and important qualities of key personnel, as noted earlier in section 2.1.4, Box 2. This was also linked to issues of pay scales, volunteerism, and human resource management more broadly, which will be discussed further in the following section.

National Societies demonstrated highly varied approaches to monitoring and data management throughout the project, with outcomes ranging from sophisticated systems to basic manual tracking [287, 994]. Many NS successfully developed centralized data management systems that integrated case management with Protection, Gender and Inclusion (PGI) approaches, enabling them to track not only service delivery but also demographic and vulnerability characteristics of those reached. This variation meant that while some NS could generate disaggregated insights to inform programming, others produced only minimal compliance reporting, limiting comparability across the network [994].

Some NS made strong progress, advancing from simple Excel spreadsheets to fully developed databased management systems (like CRM tools) that proved invaluable for tracking recipient support, measuring project indicators, and identifying gaps in coverage to support targeted outreach [88]. These systems also strengthened Community Engagement and Accountability (CEA) by enabling better feedback mechanisms and more responsive programming. However, PMER capacity remained a persistent challenge against other organizational priorities, with many NS lacking dedicated PMER support staff [553, 902].

Practical data collection challenges varied significantly across NS, reflecting different levels of digital capacity and resources [675]. Monitoring gaps included issues such as manual budget calculations and varying digital skills among some NS staff, which created additional administrative burden and potential for errors [675]. Some project indicators were interpreted differently, particularly Ukrainian-speaking capacity metrics that "only count health professionals, not the broader pool of Ukrainian-speaking volunteers," thereby underrepresenting actual language capabilities within organizations [380].

The project's approach to measuring effectiveness revealed important gaps between quantitative outputs and qualitative impact assessment. While training numbers provided useful broad understanding of outreach and capacity strengthening efforts, they offered less insight into training quality and actual skill acquisition. Some National Societies took initiative to implement pre- and post-training assessments through surveys or focus groups to measure knowledge gains and training effectiveness, but this wasn't systematic across all NS, making project-wide impact assessment challenging [972].

This highlighted a fundamental tension in large-scale capacity strengthening programs between the need for standardized metrics and the reality of diverse organizational contexts and capabilities. Key recommendations that emerged included incorporating demonstrated knowledge increases through standardized tests, tracking percentages of trained individuals who successfully applied their PFA/MHPSS skills within three months of training, and establishing PMER capacity as a precondition for grants while ensuring all monitoring tools and procedures are fully established before implementation [791].

Case Study Insight: Danish Red Cross - PFA Assessment Methods

The DRC used multiple evaluation methods to assess PFA training effectiveness. They conducted post-training satisfaction surveys capturing both numerical ratings and detailed feedback, with one 25-participant survey showing high satisfaction and identifying valued elements like practical roleplays and real-life cases. They implemented evaluation workshops using visual methods where participants provided structured feedback through images and discussions, revealing both strengths and improvement areas such as needs for "longer sessions with more group interactions." Additionally, they conducted feasibility interviews with diverse participants including older volunteers and Ukrainian refugees to assess training preferences and effectiveness across different demographics.

This approach provided comprehensive feedback on training quality, participant satisfaction, and practical application, though focused on post-training assessment rather than measuring knowledge gains through pre/post testing.

With these findings in mind, the evaluation makes the following recommendations for this section:

9. **Develop guidance for NS on key project role specifications including key skills and level of effort the role requires.** Develop formal role requirements based on successful coordinator profiles: Ukrainian language/community connections, MHPSS experience, networking abilities. Mandate full-time positions for programs of this scale. Include in future emergency response plans
10. **Establish dedicated PMER capacity as project prerequisite**. Develop PMER capacities with dedicated budget allocation and early recruitment of specialists or volunteers to implement centralized data management, as many NS lacked dedicated PMER support making impact assessment challenging [287, 88].

4.6

11. **Require MHPSS data collection capacity as funding precondition**. Ensure all monitoring tools are in place, staff are sensitized to data collection protocols, and at least one trained person per organization can manage MHPSS data collection before grant approval, as PFA data collection is notoriously difficult.
12. **Refine indicators to measure training quality alongside quantity**. Include percentages of trained individuals demonstrating increased knowledge through pre/post-tests and those applying PFA/MHPSS skills within three months of training to track effectiveness beyond simple training numbers.

2.3 Evaluation of Caring for Staff and Volunteer (CfSV) Initiatives

2.3.1 Overview

This section evaluates CfSV MHPSS activities provided to RCRC staff and volunteers themselves, examining how the project supported their wellbeing and capacity to deliver services.

2.3.2 Relevance of design for supporting wellbeing of staff, volunteer & frontline workers

To support NS in meeting the MHPSS needs of staff, volunteers and frontline responders for effective crisis response, the CfSV component of the project was planned around three core activities:

- Training team leaders in care and support provision (Activity 2.1),
- Enabling team leaders to deliver ongoing supervision and support (Activity 2.2), and
- Establishing or strengthening organizational structures for systematic wellbeing monitoring and support (Activity 2.3).

The aims of CfSV initiatives were to build leadership capacity in stress management and peer support approaches, integrating wellbeing frameworks into HR policies, and implementing various support methods including peer-to-peer groups, stress management training, regular supervision sessions, team debriefings, self-care resources, social media platforms for staff connection, and post-incident support using Group PFA.

The CfSV component was designed with strong flexibility and adaptability to be applicable to diverse contexts. As one project staff member noted:

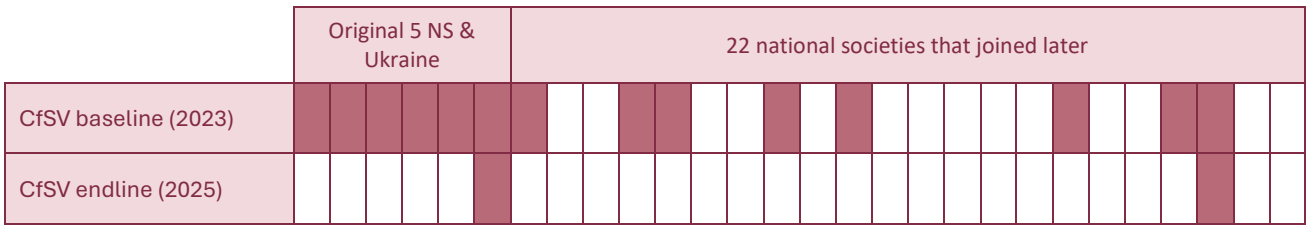
> *"We took it in a very sensitive way to say you are allowed to do whatever is feasible for you to be done... the fact that we kept it free and based on the needs and based on the capacities allowed the national societies to find niche solutions within their capacities" IFRC project team [978]*

This flexibility enabled national societies to tailor approaches to their specific contexts rather than imposing a one-size-fits-all model, since many had varying capacities, pre-existing CfSV initiatives, and level of integration across branches. The design was also driven by real experiences and needs. The inclusion of CfSV was advocated for based on COVID-19 burnout experiences:

> *"We also fight to have this component caring for staff and volunteers because we thought also our experience during the COVID-19 showed that there was a huge burnout among the frontline responders" - IFRC Project team [446]*

A baseline CfSV survey was completed by all the original five NS and Ukraine, plus eight later joining national societies. The survey was intended to serve as a baseline with an endline survey following in 2025, however only two national societies were able to complete the endline due to time constraints.

Table 5 - Caring for Staff and Volunteer baseline and endline survey completions across national societies



Baseline surveys were self-led, and therefore were sometimes completed with different methodologies, however eight baseline surveys were cross-compatible, providing 391 responses from volunteers and 240 responses from staff for analysis. These baseline limitations reduced ability to measure change uniformly throughout the project and across NS, reducing the evaluative strength of the CfSV component.

These surveys showed that at the beginning of the EU4Health project staff members primarily reported stresses related to systemic organizational issues within their NS including reduced communication between departments, lack of clear role definitions and responsibility assignments, inadequate institutional support when team problems arise, and high workloads requiring unpaid overtime. They also cited challenges with leadership, not enough training opportunities, and in some cases, preferential treatment of certain employment types over others. These baseline findings underscore that CfSV was not an optional add-on but a necessary corrective to systemic organizational stressors already undermining staff and volunteer wellbeing.

Volunteers however presented a more varied picture, with many highlighting no issues at all, but others did report sometimes feeling undervalued and unsupported, lacking clear contact persons within the organization, and experiencing task overload. Some volunteers note insufficient motivation beyond task assignments, poor integration into the organization's mission and values, and inadequate consideration of their work schedules.

Figure 14 - % of staff and volunteers who feel exposed to different wellbeing risks (N= 240 staff & 391 volunteers)

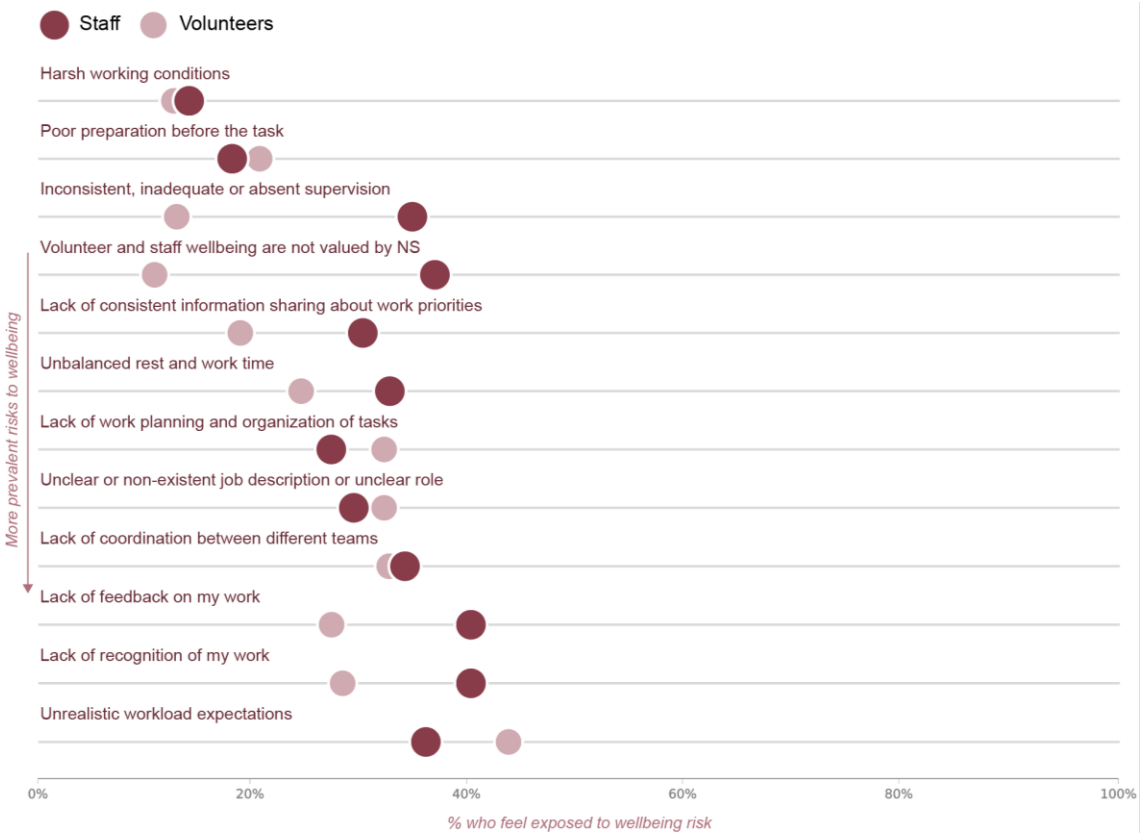


Figure 14 **shows the perceived exposure to different risks by respondents**, with staff generally reporting higher exposure to a range of stresses in their day-to-day. The highest risks for both groups related to unrealistic workload expectations and lack of recognition, feedback and coordination on

work. In the face of these results, the CfSV objectives and activities were therefore highly relevant to the needs of staff and volunteers across all national societies.

2.3.3 Effectiveness of MHPSS activities for staff and volunteers

The main CfSV project indicator was Indicator 5: 'Number of staff, volunteers and frontline responders receiving MHPSS'. The target was initially set at 4,155 for the original 5 NS but increased to 23,000 by the end of the project as more NS joined. This target was surpassed in late 2024, eventually reaching 35,301 by May 2025, 53% above target and representing a major success of the project.

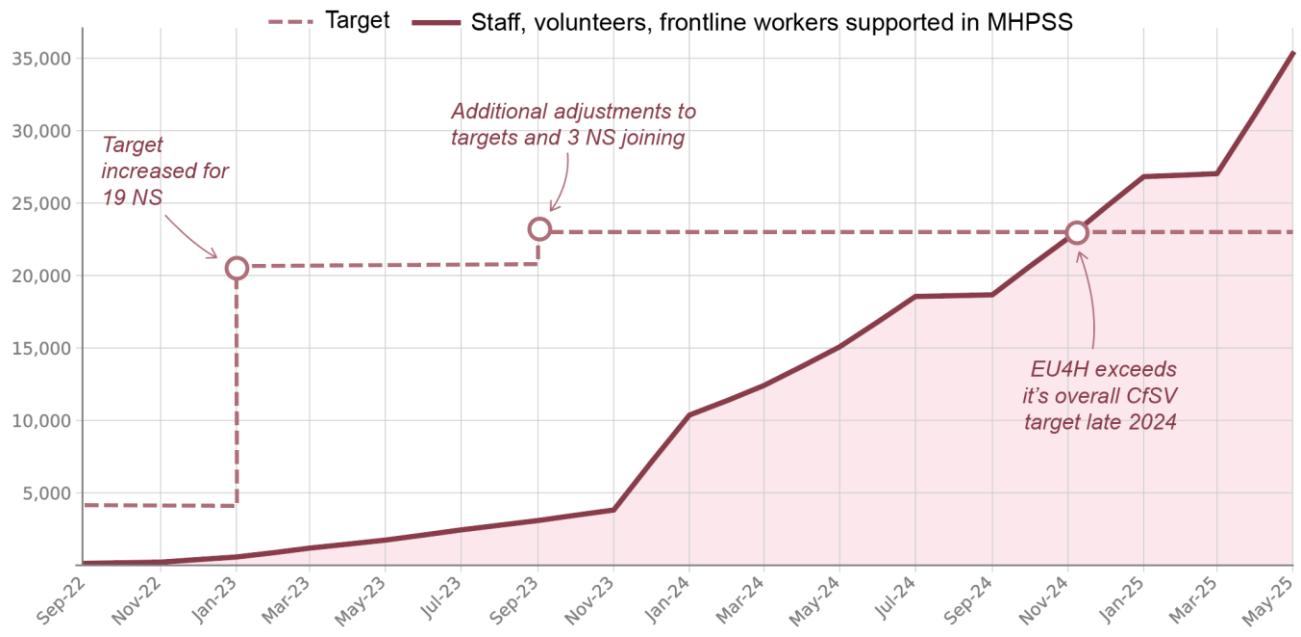
The most significant progress in CfSV outcomes occurred during the project's final phase, with 8,000 additional instances of MHPSS recorded between March and May 2025. This concentrated improvement reflects the strategic prioritization decisions made throughout the project period.

Initially, CfSV initiatives were deprioritized in favour of direct humanitarian response activities focused on supporting people displaced from and within Ukraine and building operational capacity for this large undertaking. As one National Society focal point explained:

> *'There was also so much push to deliver on helping the Ukrainian people, that that part [CfSV] was happening after." – National society focal point* [356]

This prioritization meant that most National Societies only began fully implementing CfSV initiatives during the project's final year, limiting the timeframe for achieving comprehensive outcomes.

Figure 15 - Simplified total trained in PFA and MHPSS under Indicator 1 (including indicator 1.2 and 2) vs targets



The evaluation of CfSV effectiveness and impact is also constrained by limited data availability. With only two endline CfSV surveys conducted, it is difficult to provide a robust quantitative

assessment of activity area effectiveness, however the organisational capacity assessment, although an incomplete sample (19/28 national societies) did have some CfSV related questions, and revealed mixed progress on some key indicators between 2023-2025:

Policy and Planning: The proportion of responding National Societies with formal CfSV policies or plans remained the same at 56% of respondents.

Peer Support Systems: There was a slight decline in National Societies offering peer support groups, decreasing from 58% to 53%.

Localisation of CfSV materials : Whilst there was great progress during the EU4Health project in translating CfSV materials into local languages, there is still some way to go with only around 20% of national societies having CfSV materials translated and adapted into their local contexts (see Figure 16).

These findings suggest that while the project achieved significant reach in its final months, the compressed implementation timeline likely limited the depth of institutional capacity strengthening across participating National Societies.

Figure 16 - Number of NS with translated and adapted CfSV materials (OCA, 2025)

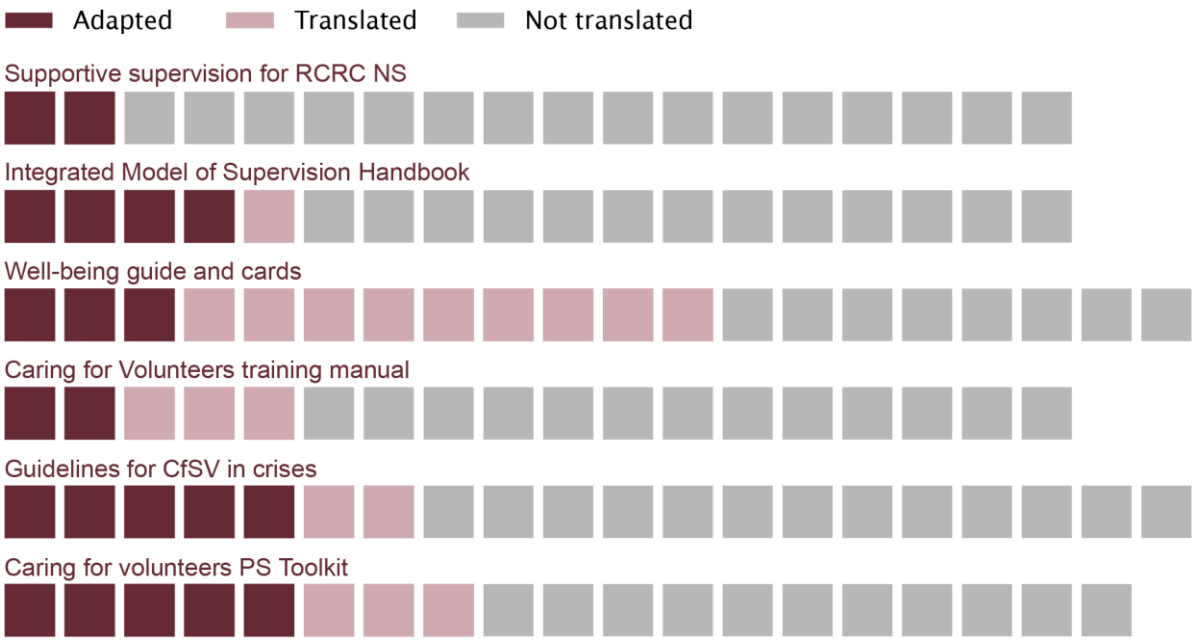
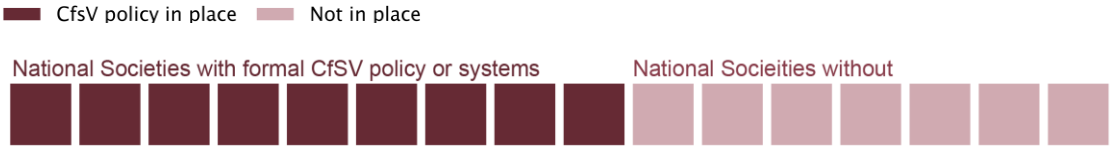


Figure 17 - 7 out of 16 national societies still do not have a formal CfSV policy in place (OCA 2025)



Qualitatively in the interviews, HR buy-in emerged as a critical barrier to effective CfSV implementation [1002]. HR departments were sometimes described as "reluctant" to conduct wellbeing assessments, with one focal point explaining:

> *"Whenever we ask people how they feel and what is wrong with the system, it raises a lot of structural problems, which the national society is not too keen on." – National society focal point [224]*

Where HR engagement did occur, it sometimes remained focused on tackling issues such as annual leave, sick pay, and structural issues rather than psychosocial wellbeing [252]. The fragmentation between HR departments (responsible for staff) and volunteer management departments also complicated implementation [984], with some National Societies' CfSV support focusing only on volunteers. This lack of HR support sometimes left MHPSS staff as "the lone voice" advocating for staff wellbeing [430], though there were successful exceptions where HR teams combined forces with focal points, leading to initiatives such as integrating PFA modules into volunteer onboarding [253]. Many focal points were also encouraged by the 2019 Red Cross commitments, which established wellbeing as a shared organizational responsibility including HR, providing a good tool for internal CfSV advocacy [430].

> *"CfSV is the most political topic because it's not only MHPSS, it's also HR; volunteer recruitment; positioning of the National Society in the community; and questioning the identity of who is the helper." - IFRC project team [977]*

Beyond HR challenges, senior management engagement proved uneven, creating implementation barriers that often exceeded EU4Health focal points' mandate and resources. While some Secretary Generals and branch managers questioned the necessity of CfSV initiatives [424] or imposed conditions like keeping MHPSS positions volunteer-based [431], others did engage when the value became clear [849].

Despite these constraints, many focal points made strong progress, delivering training and raising awareness while recognizing that full institutional transformation would require broader organizational commitment over time [482]. Some national societies successfully developed policies and wellbeing centres [324], showing that while challenging, system-level change was achievable when conditions aligned.

Supportive supervision also emerged as one of the most valued and effective CfSV interventions [417]. The regional training in Budapest created strong momentum for internal advocacy and capacity strengthening [766, 969], and the approach proved both cost-effective and scalable - identified as "the lowest cost/capacity approach which could still be effective" [418]. Participants reported being "very, very happy with the support" received through peer support groups and supervision sessions [222], generating such high demand that national societies continued requesting more training throughout the project [423].

> *"Supportive supervision had very good feedback... people that I've sent to attend those sessions are very, very happy with the support that they're getting" – National Society focal point [222]*

Integrating brief wellbeing components into mandatory onboarding also delivered high impact with low capacity [419]. These trainings could simply consist of reminding staff to prioritise their own wellbeing and stress, and field visits consistently revealed how valuable staff found them. As one respondent described it: "You can't pour from an empty cup" [888].

"Stress management training was great success. We had really great feedback… trauma intervention training… about boundaries… how to set up healthy boundaries and protect yourself from re-traumatization" – National Society focal point [290]

With these findings in mind, the evaluation makes the following recommendations for this section:

1. **Establish multi-level wellbeing systems with early HR buy-in**, appointing dedicated wellbeing focal points with protected time and direct executive reporting to ensure clear transitions from MHPSS to organization-wide responsibility. [981]

4.5

2. **Develop rapid matchmaking tools for supportive supervision**. Create systems to quickly match staff and volunteers with appropriate supervisors based on role and availability

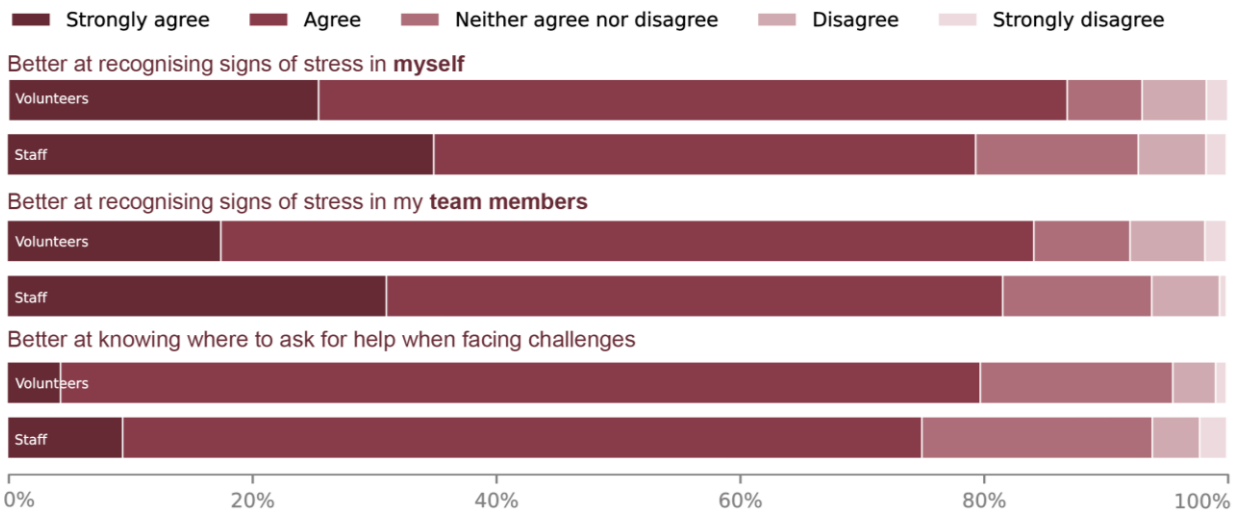
4.0

3. **Integrate CfSV responsibilities into leadership performance frameworks.** Include specific CfSV support responsibilities in leadership job descriptions and performance evaluations, with clear expectations for team wellbeing monitoring, supportive supervision delivery, and staff/volunteer retention metrics to ensure systematic implementation rather than voluntary adoption. [980]

2.3.4 Impact of the project on mental health and wellbeing of RC personnel?

Despite limited data from the two endline surveys (180 staff and 114 volunteers in two countries), the findings demonstrate strong positive impact across key wellbeing indicators. All three measures achieved 79%+ agreement rates, with respondents reporting improved abilities over the past year to recognize signs of stress in themselves, signs of stress in teammates, and know who to ask for help when facing workplace challenges.

Figure 18 - % of staff and volunteers reporting improved wellbeing between 2024-2025 (CfSV survey, 2025)



Knowing who to ask for help showed the greatest overall improvement, with 89% of volunteers and 80% of staff agreeing they had experienced progress in this area. The lowest improvement score, though still substantial at 79% agreement, was staff's ability to recognize signs of stress in themselves. Although this represents a small sample and causality between EU4H initiatives cannot be definitively established, these indicators suggest strong success in achieving CfSV objectives.

Qualitative recommendations within the survey on sustaining CfSV impact focus on three interconnected areas:

- **Workplace flexibility and conditions**: many called for more flexible schedules, remote work options, improved physical workspaces, and better work-life balance through measures like paid leave and reasonable workloads.
- **Psychological and emotional support**: respondents asked for more regular counselling services, decompression sessions, stress management training, and mental health monitoring,
- **Recognition and community building**: some asked for more fair compensation, team-building activities, informal gatherings, cultural events, and appreciation systems.

Despite the challenges, CfSV initiatives created meaningful and lasting impacts across multiple levels. Staff and volunteers reported large impact from supervision sessions and stress management training [290, 428], with many learning to set healthy boundaries and actively using wellbeing resources for self-care [212]. Beyond individual benefits, the project catalysed systemic changes - several national societies developed policies, trained supervisors, and established wellbeing centres [324], with one becoming "a role model" for caring for staff and volunteers across the Red Cross [77]. Importantly, these positive outcomes were achieved despite systemic weaknesses identified in the OCA, such as translation gaps, uneven HR buy-in, and limited peer support structures, showing that tangible wellbeing improvements were still possible even where organizational foundations remained fragile.

Perhaps most significantly, CfSV shifted fundamental understanding about wellbeing in humanitarian work [801], with organizations recognizing that "humanitarian burnout is real and that people are our greatest resource, but also our greatest responsibility" [93]. While structural challenges remain, many described the EU4Health project as leaving enduring "traces" in how organizations approach staff wellbeing [983] - moving it from an optional add-on to an essential foundation for sustainable humanitarian service.

> *"Because of this project [EU4Health], we actually have CfSV incorporated, and that helped us to push it to the other activities and projects" – National Society Focal point [540]*

With these findings in mind, the evaluation makes the following recommendations for this section:

4. **Implement supportive supervision early with structured leadership and comprehensive coverage**. Implement supportive supervision early on with structured leadership and opt-out participation since those needing support most may not seek it [418]. Develop rapid matchmaking tools for supportive supervision considering team, experience, front-line exposure, and training needs to ensure comprehensive coverage.

5. **Develop proactive risk assessment frameworks for CfSV needs identification.** Establish systematic processes to identify high-risk roles, operational periods, and situations requiring enhanced CfSV support, including front-line responders, emergency deployment teams, and staff working with populations experiencing distressing events, to enable preventive rather than reactive wellbeing interventions.

2.3.5 Efficiency of MHPSS support for staff and volunteers

CfSV initiatives demonstrated clear patterns of efficiency, with low-cost interventions often achieving the highest impact and sustainability. Group supervision and intervision emerged as "the lowest cost/capacity approach which could still be effective" [418], requiring primarily structured leadership rather than expensive resources. Similarly, short mandatory trainings integrated into onboarding proved "actually quite low effort high impact" [419], with one-hour webinars described as generating high engagement while requiring minimal investment [22].

In contrast, external psychological services proved costly and unsustainable. External therapy helplines were costly and not clear how to fund beyond EU4H [416], with limited ability to assess effectiveness due to anonymity requirements. The data shows limited evidence of national societies continuing these services post-project, with many unable to justify the high costs against unclear benefits. Funding however wasn't always the core issue of external helplines, with some seeing them as outsourcing of more internal structural issues rather than long-term solutions.

The most efficient approaches tended to build on existing structures and internal capacity. Internal supervision "works better than external supervision" [54] while avoiding costly consultant fees. The project helped organizations recognize and systematize supportive practices they were already doing informally [311, 318], with creative low-cost solutions like Denmark's pocket guides and Sweden's gamified self-care videos achieving high engagement [596]. This evidence strongly indicates that sustainable CfSV requires investing in internal peer support systems and embedded practices rather than expensive external services that create dependency without building lasting organizational capacity.

Case Study Insight: Lithuania's Supportive Supervision System

Lithuania successfully revitalized its staff and volunteer support through the EU4Health projects emphasis on supportive supervision. While buddy systems had previously existed but lapsed due to dependence on personal rapport, the project trained 20 internal supervisors through IFRC courses and established both group and individual supervision sessions.

This reached 736 staff and volunteers (95% of target) and proved highly effective according to participant feedback. There remain some implementation challenges, such as some supervisors being particularly over capacity supervising up to 15 individuals, and broader departments are yet to be integrated. However, efforts are still ongoing to train more volunteer supervisors and further institutionalise the practice.

With these findings in mind, the evaluation makes the following recommendations for this section:

6. **Start manageable wellbeing activities while establishing long-term institutional foundations**. In the short-term, implement manageable wellbeing activities like peer support circles [289], whilst laying foundations for long-term institutional CfSV approaches through staff/volunteer onboarding focused on awareness and stress management [419, 935].

4.5

7. **Include wellbeing and PFA training in all mandatory onboarding**. Include PFA, wellbeing and boundary-setting in all mandatory onboarding to prepare staff/volunteers for emotional demands of front-line work [253, 982].

4.8

2.3.6 Coverage

Coverage gaps occasionally occurred for certain groups, with core staff and volunteers typically being the primary focus while more peripheral roles such as contractors, mediators, or external psychologists sometimes lacked the same coverage or operated separate, non-integrated peer support networks [309, 315, 427]. These gaps usually stemmed from limited resources, particularly when comprehensive coverage for core staff was not yet fully established. This unevenness risked creating a two-tier system where core staff benefited from systematic support while peripheral or contract roles remained more exposed to stress without comparable resources.

Branch-level integration presented a challenge, particularly in decentralized National Societies where coverage depended heavily on branch manager buy-in [1003]. In some cases, staff and volunteers benefitted from supportive supervision and CfSV surveys, while in others, little or no structured support was provided. This led to variations within the same organization, with some branches achieving strong coverage while others lagged behind [875]. Despite these localized challenges, coverage was broad at the international level, as demonstrated by **Error! Reference source not found.**, with major achievements m ade in placing CfSV on organizational agendas and increasing awareness among a wide range of staff, volunteers, and broader support teams [324, 919].

With these findings in mind, the evaluation makes the following recommendations for this section:

8. **Establish clear eligibility criteria for who should receive Care for Staff and Volunteers (CfSV) support.** Define which roles qualify for CfSV interventions, including interpreters, cultural mediators, psychologists and contractors [68, 315], regardless of employment status, to prevent support gaps and ensure all frontline personnel have access to wellbeing services.

4.5

2.3.7 Participation and accountability of MHPSS support for staff and volunteers

For many NS, monitoring CfSV indicators was a new experience, making the EU4Health project a great opportunity to begin implementing suitable M&E systems. The completion of CfSV surveys by 14 National Societies, with many receiving hundreds of responses across branches [139], represented a significant success and served as a powerful tool to showcase internal needs and advocate to senior management for the importance of CfSV activities and support [848].

To build upon these achievements, annual CfSV surveys would be highly effective for tracking needs and demonstrating the impact of initiatives like supportive supervision on personnel wellbeing. Integration of such measures within HR systems would further support institutionalization of staff and volunteer wellbeing as a regularly tracked indicator alongside financial or activity metrics. While staff and volunteer needs often appear obvious and unsolvable, such as reduced workloads or higher pay [420, 429], the EU4Health project revealed that CfSV survey findings varied significantly between NS. For example, whilst they often did point towards the larger structural causes of stresses, many identified more achievable measures such as specific trainings or clarity on departmental interactions, representing feasible and low-cost initiatives that could go a long way to addressed wellbeing.

For future projects, greater impact measurement could be achieved through additional CfSV indicators that include additional insights such as the number of trained team leaders, unique staff and volunteers receiving support, and percentage of staff reporting improved wellbeing after accessing specific services, thereby supporting better assessment of causality (see Table 6 below).

Table 6 - Recommended future indicators for CfSV

EU4H CfSV indicator	Alternative EU4H CfSV indicators
Number of staff, volunteers and frontline responders receiving MHPSS	1a. Percentage of trained team leaders providing regular supportive supervision to their teams 1b. Estimated # of unique staff and volunteers receiving support 1c. Percentage of staff and volunteers reporting improved well-being or reduced stress after accessing support

With these findings in mind, the evaluation makes the following recommendations for this section:

9. **Track CfSV indicators through M&E frameworks to secure senior management buy-in**. Track CfSV indicators such as burn-out measures as well as impact of activities through M&E frameworks to show effectiveness and as evidence for internal diplomacy with senior management [848] to secure buy-in for wellbeing initiatives as essential support rather than burden.

4.4

10. **Establish comprehensive CfSV measurement and tracking systems for systematic impact assessment.** Regular CfSV surveys beyond baseline assessments [225, 291] while implementing multi-dimensional tracking systems that monitor supervisor-to-supervisee ratios, frequency and quality of support sessions, staff/volunteer retention and burnout rates correlated with CfSV participation, and longitudinal wellbeing scores to enable systematic support development, evidence-based program refinement, and demonstration of concrete organizational benefits over time.

4.5

2.4 Evaluation of Coordination Mechanisms

2.4.1 Overview

The coordination section examines how different stakeholders worked together across six relationships that shaped project implementation.

2.4.2 Coordination with Funder

The coordination between EU4Health's funder and implementing partners evolved through distinct phases, from rapid emergency response to gradual adaptation to changing realities. This journey reveals both the challenges of aligning institutional requirements with field needs and the potential for flexibility when all parties commit to responsive adaptation rather than predetermined outcomes. The following analysis examines how coordination structures both enabled and constrained the project's ability to respond to the evolving displacement crisis.

The proposal development process reflected emergency response pressures but created downstream complications. The project design was developed in a matter of weeks, following a primarily funder-led framework that offered limited opportunity for Red Cross strategic input, particularly from NS [331, 579, 332]. This rushed timeline, while understandable given the humanitarian imperative, set the stage for coordination challenges that would persist throughout implementation.

Despite structural constraints, the funder's commitment enabled unprecedented MHPSS capacity strengthening across Europe. The funding scale and geographic scope, eventually reaching 28 National Societies, represented a significant investment in addressing psychosocial needs of displaced populations [1056]. This support proved crucial even as both parties navigated the complexities of adapting programming to evolving needs.

Real-time feedback drives responsive programming, but certain decisions could have been expedited with more direct field-to-funder dialogue. Effective MHPSS implementation requires mechanisms for unfiltered field insights to reach decision-makers promptly. Traditional reporting structures, though organizationally sound, sometimes created natural delays between emerging field realities and strategic responses

The shift to longer-term programming illustrated coordination complexities. Despite National Societies identifying CBMHPSS needs early and IFRC raising this during January 2023 proposal revisions, shifting from emergency response priorities required substantial evidence and time, with approval secured in May 2024.

Both funder and implementers eventually showed important flexibility, validating the potential for adaptation within formal frameworks. The approval of CBMHPSS programming demonstrated both parties' capacity to respond to field evidence [351, 460, 842, 277]. This evolution, while slower than ideal, proved that sustained dialogue and commitment to impact could overcome initial rigidities.

Funder earmarking requirements limited flexibility to meet the diversity of needs among target populations, leading to programming gaps. Although other pledges channelled through the Emergency Appeal partially addressed these gaps, this principally benefited countries close to Ukraine, creating disparities for more distant National Societies [332].

Despite challenges, the partnership demonstrated how large-scale humanitarian initiatives can evolve toward greater effectiveness. The collaboration enabled unprecedented MHPSS capacity strengthening across Europe, reaching 28 National Societies and thousands of beneficiaries. While structural constraints initially limited agility, both funder and implementers showed increasing flexibility over time, proving that impact-focused dialogue can transcend procedural barriers. This mutual adaptation journey, from rigid frameworks to responsive programming, offers valuable lessons for future emergency responses. Building in structured learning phases, direct feedback mechanisms, and technical expertise from the outset would allow similar partnerships to combine the benefits of substantial investment with the agility required for effective humanitarian action

With these findings in mind, the evaluation makes the following recommendations for this section:

1. **Build in a structured learning phase within donor agreements.** During the first 3-6 months, activities, targets, and methods could be adjusted based on field realities within overall objectives, requiring documentation but no formal amendments. This would enable rapid response to emerging patterns, field-driven refinement of indicators and methodologies, and reduced administrative burden for necessary adaptations.

4.6

2. **Dedicated technical dialogue spaces.** Funder-implementer interactions could benefit from protected time specifically for MHPSS technical discussions, as administrative and compliance topics can understandably dominate limited meeting time. Creating structured opportunities for technical exchange, distinct from oversight-focused sessions, could facilitate exploration of field-based learning and methodological adaptations. This approach recognizes that both accountability frameworks and technical depth contribute to successful MHPSS outcomes.

3. **Create real-time feedback loops between field implementations and strategic decision-making.** Establish a monthly question submission system where NS can send queries to be addressed in funder coordination meetings, with documented responses distributed to all NS. This mechanism would allow NS to raise concerns, seek clarifications, or highlight challenges without needing to join crowded calls. Questions could be collected in advance, discussed during regular funder-implementer meetings, and formal responses circulated to all 28 NS within 48 hours. This creates transparency and institutional memory while avoiding logistical chaos.

2.4.3 Internal project team coordination

IFRC coordination teams demonstrated resilience while managing significant expansion. The project grew from 5 to 28 National Societies, experiencing three official starts and six kick-off meetings [701]. While external consultants helped supplement the core team, overall coordination capacity did not scale with the expanded scope [478, 638, 772, 1066]. Project changes and limited staff departures necessitated some team restructuring, though those concerned committed to proper handovers. Trust-based coordination and strong relationships proved important for managing the expanded portfolio [370, 569].

Strategic workforce planning requires better alignment with project timelines, particularly during rapid emergency response deployment. The natural lag between identifying staffing needs and having personnel in place meant coordination teams often managed expansion while understaffed. The convergence of urgent implementation demands, evolving operational requirements, and standard hiring timelines resulted in capacity gaps during crucial phases when support needs were most acute. It was noted that additional time on operational foundations at the start would have been beneficial [714].

Despite capacity constraints, coordination mechanisms evolved to maintain network coherence. Biweekly meetings and extensive bilateral support connected the growing network, though demanding significant time from stretched staff [549, 583, 975]. Role clarity between coordinators and technical advisors developed over time [321], with a breakthrough in early 2024 when paired coordinator-advisor teams began conducting joint NS meetings, significantly improving effectiveness [704].

Technical expertise made important contributions to NS success, with potential for additional strategic input. The MHPSS Hub effectively supported implementation activities, and there may have been opportunities to draw even more on this expertise in programmatic planning and strategic adaptations [332, 748, 812].

With these findings in mind, the evaluation makes the following recommendations for this section:

4. **Build Coordination foundations early.** Within the learning phase, dedicate focused time to developing RACI matrices and decision frameworks across RoE/Hub/NS while enabling priority emergency activities through simplified pathways [321, 604, 632, 703, 714, 724]. Refine these structures based on early implementation experience, validating in technical induction meetings. [701, 704].
5. **Scale coordination capacity proportionally** when expanding project scope, using clear ratios based on NS numbers and complexity [772]
6. **Fast –track recruitment and provide dedicated HR support to enable rapid emergency project mobilization.** In emergency responses, deploy specialized HR teams from day one to fast-track recruitment, handle contracts, and manage administrative setup across multiple countries.
7. **Establish formal pathways for technical input into strategic and programmatic decisions.** Design coordination structures that bring technical expertise into planning conversations early and consistently. Options include technical representation in steering committees, joint technical-coordination briefings for donors, and/or technical review of strategic proposals pre-finalization.

2.4.4 Coordination between NS and Project Advisors and Coordinators (RoE and Hub)

The NS-IFRC relationship matured progressively from monitoring-focused interactions to 'genuinely supportive' partnerships. Initial coordination emphasized compliance and reporting requirements, with some NS experiencing the relationship as more supervisory than collaborative [294]. However, this dynamic evolved toward mutual problem-solving as understanding developed. This transformation, while significant, took time to develop and faced persistent challenges.

Coordination teams needed internal alignment on key project elements before disseminating guidance, with critical information clearly prioritized. While extensive information was shared, fundamental aspects like indicator definitions required both internal consensus and elevated visibility within communications [584, 667]. Key technical specifications often got buried in broader information flows, compounding confusion when verbal briefings were the primary channel: *"I would prefer to have much more information given in written...not being said on the monthly meetings"* This mirrors issues noted in the PMER/data management section, suggesting wider project knowledge management issues.

The project navigated diverse organizational cultures and partnership expectations. For several Western European NS accustomed to being donors, receiving IFRC funding introduced new compliance requirements and reporting relationships [478, 571]. Additionally, NS with established MHPSS programs sometimes found centralized project requirements didn't fully accommodate their existing expertise and contextual approaches, while less experienced NS at times risked being overwhelmed [26, 232]. These differing perspectives reflected the inherent complexity of coordinating diverse organizations with varied capacities and contexts.

In response to these diverse needs, IFRC's support approach evolved to some extent to balance standardization with NS-specific contexts. Coordination teams maintained personalized support through biweekly meetings and extensive bilateral engagements, with trust-based relationships becoming essential for navigating varied NS capacities [549, 583, 975, 370, 569]. The introduction of paired coordinator-technical advisor support in early 2024 proved transformative, providing NS with clearer points of contact and technical focal points who understood local contexts and languages [704, 545, 547].

Partnership strengths emerged through adaptive support mechanisms. Successes included valuable M&E support for NS who openly acknowledged capacity gaps in monitoring and evaluation [244], and the hub's flexibility in adapting from advisory to implementation support roles when needed. Adaptations demonstrated both parties' commitment to practical solutions over rigid frameworks.

With these findings in mind, the evaluation makes the following recommendations for this section:

8. **Conduct 4-week NS consultation including capacity assessment before proposal submission.** This pre-proposal phase should evaluate existing MHPSS capabilities, staffing availability, and contextual factors to ensure realistic planning and appropriate support levels [639, 757, 469, 942].

4.2

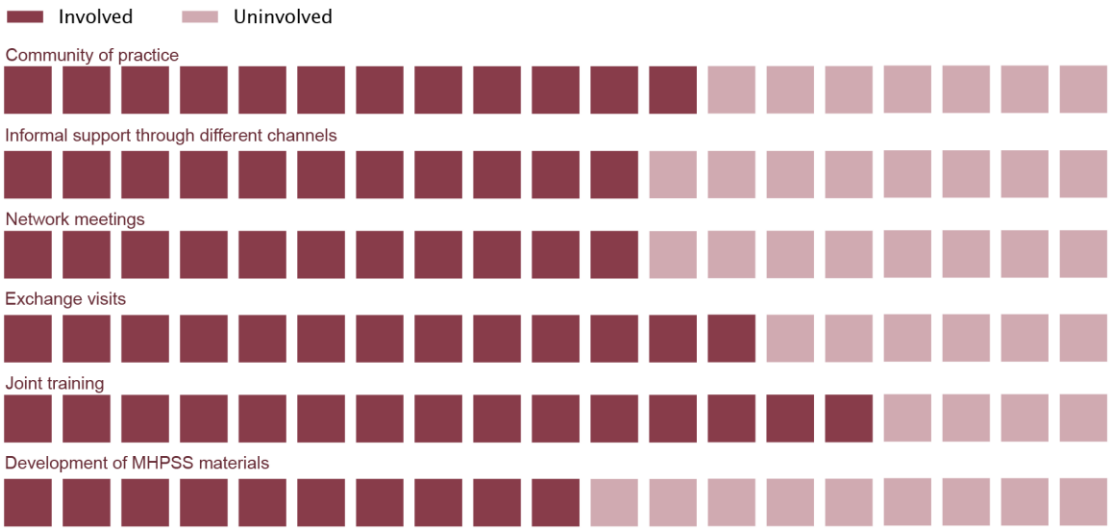
9. **Create a written repository for all key program decisions and guidance.** Establish a centralized, accessible platform documenting indicator definitions, programming decisions, and evolving guidance to prevent confusion and ensure consistency across all participating NS [49, 91, 943].
10. **Develop differentiated support models based on NS capacity assessments. Create tiered frameworks recognizing varying MHPSS expertise and organizational maturity across the 28 NS** [26, 232, 478]. Provide light-touch coordination for experienced NS with established systems, intensive support for those without. This respects local expertise while maintaining standards.

4.4

2.4.5 Coordination between NS

NS-to-NS coordination provided valuable peer learning and support, particularly through informal networks and exchange visits, though systematic knowledge sharing mechanisms could have been further developed.

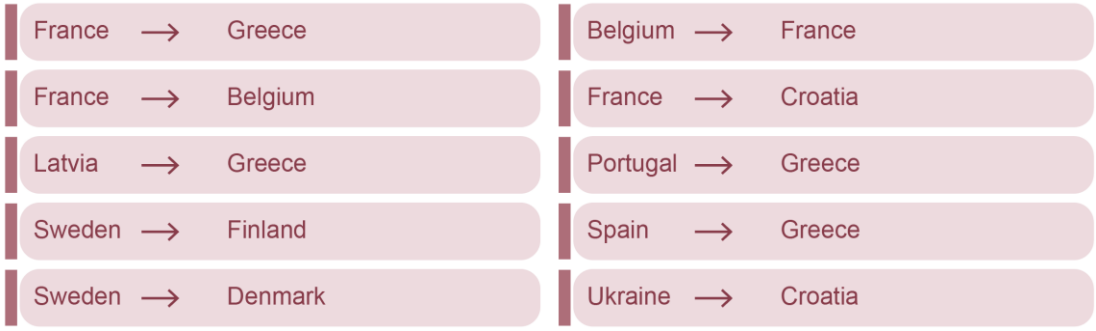
Figure 19 - Bi-lateral activities National Societies participated in (OCA, 2025)



The Baltic Community of Practice showcased effective small-group coordination mechanisms. The Baltic NS established a community of practice that convened regularly throughout the project to discuss progress, troubleshoot challenges, and share ideas. NSs also had the opportunity to present good practices during the monthly meetings. Still, this smaller forum proved particularly valuable given the difficulty of contextualizing specific issues during broader calls with all 28 participating National Societies, each facing distinct contexts and circumstances. While meetings have become less frequent as the project has wound down, participants plan to continue developing this collaborative structure into the future, recognizing its ongoing value for regional coordination.

Exchange visits enabled powerful cross-learning and practical adaptation of successful models. Croatian RC's veteran rehabilitation centres inspired Ukrainian RC's memorialization practices; Hellenic RC's cultural mediator model was adopted by multiple NS; Danish RC's digital tools helped Swedish RC overcome procurement barriers [173, 205, 1068]. Greece emerged as a learning hub attracting multiple visits, while France acted as a connector node. These connections sparked lasting collaborations including co-developed PFA tools and adapted art therapy approaches [1068, 205].

Figure 20 - NS pairs who did exchange visits during EU4Health



Earlier implementation and broader dissemination could have amplified peer learning impact. Most exchange visits occurred late in 2024, limiting time to integrate learned practices [1069]. While emergency response understandably took initial priority, earlier exchanges could have informed rather than inspired implementation. Additionally, valuable insights from bilateral exchanges often remained within those partnerships rather than spreading across all 28 NS. More systematic dissemination mechanisms could have multiplied the reach of innovations discovered through peer learning.

Informal interactions and IFRC-facilitated connections created important support networks. Regional NS meetings fostered honest discussions, with participants noting: *"I got so much more from the informal meetings* (interactions)*...where we could* (say)*, did you hear this? What did you think?"* [204]. IFRC events connected NS who "*wouldn't have proactively reached out to each other*" without organized gatherings [243], while bilateral calls provided stable coordination channels between implementations [174].

While bilateral exchanges flourished, network-wide communication mechanisms might have been more fully realised. Individual NS developed strong peer relationships and sharing practices, but these connections didn't extend systematically across all 28 participating countries [1008]. The project relied primarily on monthly meetings and personal contacts rather than structured platforms for ongoing exchange [281]. A best practices document was developed near the project's end, but its late timing limited its utility within this project (though valuable for future initiatives).

With these findings in mind, the evaluation makes the following recommendations for this section:

11. **Establish structured exchange programs early in project timeline.** Launch peer visits within the first quarter to shape implementation rather than inspire too late, using early exchanges to inform programming decisions across the network [764].

4.5

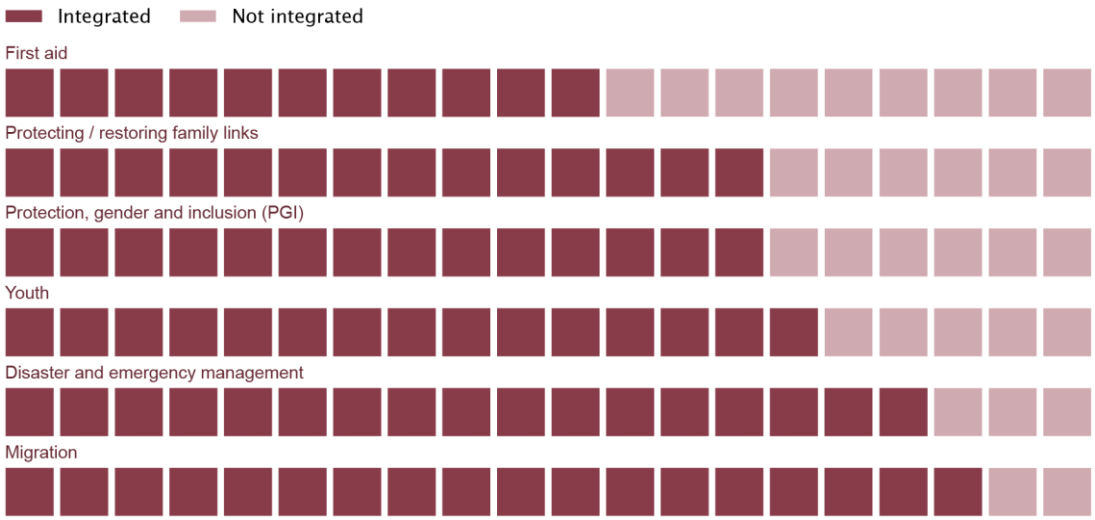
12. **Create ongoing practitioner networks beyond focal points.** Fund dedicated peer learning coordination that includes daily implementers, not just management, ensuring practical knowledge flows between those delivering services [206].

4.3

2.4.6 Internal NS Coordination

The project catalysed unprecedented collaboration across traditionally siloed NS departments while exposing fundamental structural challenges. MHPSS's inherently cross-sectoral nature forced departments to work together in new ways, though success varied dramatically based on organizational structure, leadership buy-in, and project placement.

Figure 21 - Integration of MHPSS internally across 20 National Societies (OCA, 2025)



Project placement often undermined coordination from the start. When MHPSS landed in "non-natural" departments (e.g., migration instead of health), or separated from existing MHPSS focal points, internal tensions occurred [734, 795]. Often, existing MHPSS focal points weren't budgeted into projects, preventing engagement of those largely responsible for broader NS MHPSS [797]. The cross-cutting nature of MHPSS created persistent confusion: *"we still don't know where it lands internally ...does it sit with disaster response...social units...or departments working with refugees?"* [793].

Resource allocation patterns exacerbated coordination challenges. NS strongly preferred allocating funding to existing staff rather than hiring dedicated personnel, with staff taking on EU4Health responsibilities without reducing existing workloads [405]. This led to widespread burnout: *"I'm now being in more than 20 calls where people are crying because they are burned out"* [405]. Bureaucratic recruitment processes (up to two months per hire) further delayed implementation [272].

Decentralized governance created some of the most significant coordination barriers. Many NS branches operated as "almost 100% independent" entities, requiring separate agreements and unable to receive direct instructions from headquarters [353, 323]. This autonomy meant some branches refused participation entirely due to staffing requirements or political positions on Ukraine [43]. The sometimes "huge digital divide" between well-equipped headquarters and branches with "only one computer" further complicated coordination and data collection [365]. One coordinator reflected: *"I should have gone earlier directly to the people in charge...it would have been time consuming but still faster"* [237].

Success required strong internal diplomacy and senior leadership engagement. Coordinators spent "lots of time on internal advocacy and diplomacy" to get projects accepted across departments [947]. NS with senior management buy-in, like Slovakia where the SG engaged in budget negotiations, treated challenges as institutional rather than project-specific [558]. Portugal meanwhile has MHPSS across departmental lines, supporting coordinated service delivery [955].

Breaking silos created both opportunities and tensions. Where successful, projects facilitated coordination between divisions that rarely interacted, health and social welfare established joint working groups for the first time [308]. The Hub promoted MHPSS as requiring "collaborative effort of different departments...each adding a brick" [960]. However, information gaps persisted, those attending

proposal sessions often weren't implementers, requiring IFRC to "triangulate" through separate meetings for project management, finance, and communications teams [592, 593].

With these findings in mind, the evaluation makes the following recommendations for this section:

13. **Map organizational structures during inception** to identify natural project homes, existing focal points, and branch autonomy levels before placement decisions [734, 795]
14. **Mandate senior leadership engagement** from inception through implementation, ensuring Secretary General/CEO-level buy-in transforms project challenges into institutional priorities [558]
15. Include **MHPSS focal point funding in project budgets** recognizing their coordination role as essential infrastructure requiring dedicated time allocation [797]

4.6

16. **Fund dedicated project positions** rather than overloading existing staff, accepting temporary employment of thematic specialists as sector standard practice for one-off projects [405, 406]
17. **Position MHPSS as a cross-cutting strategic priority** from project start, steering committees, joint working groups, with representation from health, social, migration, and emergency depts [308, 960]

4.5

2.4.7 Coordination with non-RC stakeholders

External coordination with governments and non-RC actors varied significantly by country context, with success dependent on early engagement, established relationships, and NS auxiliary role strength. Strategic positioning required navigating complex political dynamics between donors, governments, and implementing partners across diverse national humanitarian architectures.

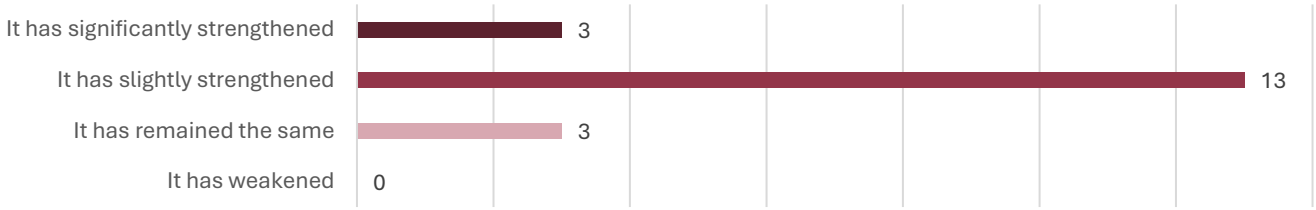
Strategic government partnerships enabled effective Red Cross positioning where established relationships existed. NS secured positions at reception centres during arrival phases and multi-ministerial coordination through various mechanisms including cabinet centres, emergency services, and technical working groups [256, 525, 877]. One NS reported particular success with a Cabinet-level Mental Health Coordination Centre that facilitated partnerships across five ministries [523]. Another NS's co-chair role in MHPSS Working Groups facilitated connections with major NGOs and UNICEF [78].
NS auxiliary roles varied dramatically, creating different starting points for coordination. While some NS leveraged strong government relationships for immediate engagement, many European NS faced weak government connections and limited Red Cross recognition, requiring extensive work on "national acceptance" before project implementation [958, 401]. This variation in starting auxiliary status fundamentally shaped coordination possibilities and timelines.

Early Ukrainian community engagement proved transformative for program success. Czech Republic demonstrated best practice through systematic external coordination. A core stakeholder group brought together Ministry of Interior, Ministry of Health, Fire Brigade Service (holding national MHPSS emergency mandate), Police Service, and social welfare representatives, enabling strategic

alignment and coordinated response planning. CZRC simultaneously built bridges with Ukrainian communities through psychologist associations, embassy partnerships, Telegram channels, and culturally-adapted campaigns in Ukrainian language. They navigated public sentiment challenges through targeted outreach via local branches, schools, municipalities, and Ukrainian psychologist conferences, while leveraging NGO networks including WHO and UNHCR partnerships. This multi-level coordination - from ministerial to community level - exemplified effective external partnership building for MHPSS service delivery.

Coordination mechanisms varied in availability and structure across contexts. MHPSS-specific coordination platforms existed primarily in neighbouring countries, while others operated without dedicated frameworks [854, 1010]. Unlike other humanitarian sectors with established clusters, MHPSS lacked systematic coordination structures in many locations [402]. Where technical working groups existed, their size, membership stability, and accessibility for NS participation varied considerably [525].

Figure 22 – NS self-assessment of auxiliary role change as a result of EU4H. Validation workshop, September 25



Measurement approaches focused on activity rather than partnership quality. Coordination effectiveness was measured by meeting counts rather than partnership outcomes or signed MOUs, missing opportunities to demonstrate real impact through formal agreements and referral pathways [411, 649]. Multi-donor environments created additional complexity, with NS needing clearer frameworks for complementary funding and combined visibility [536].

With these findings in mind, the evaluation makes the following recommendations for this section:

18. **Map stakeholder landscape early and establish MOUs to clarify roles and referral pathways.** Conduct comprehensive mapping within the first month, identifying government ministries, Ukrainian organizations, NGOs, and coordination platforms before engagement strategy design [649, 273].
19. **Engage all relevant stakeholders from day one.** Map and connect with Ukrainian organizations, government ministries, NGOs, and humanitarian actors within the first month to enable co-design, prevent duplication, and ensure coordinated, culturally appropriate MHPSS delivery [208, 744, 649, 273]

4.4

20. **Develop more robust coordination indicators beyond meeting counts.** Track formal partnerships through signed MOUs, established referral pathways, and documented collaborative outcomes rather than attendance figures [649].
21. **Position NS as preferred MHPSS partners through consistent quality service delivery.** Build credibility through systematic engagement with health, social affairs, and migration ministries while actively participating in coordination platforms [622, 1024, 491].

4.0

2.5 Sustainability

2.5.1 Overview

As the EU4Health project ends, its conclusion reveals divergent trajectories across National Societies. Some have secured or are pursuing alternative continuation funding [285, 257], while others report no funding beyond October 2025 [25] with multiple MHPSS streams ending simultaneously [214]. This varied landscape creates fundamentally different starting points for post-project sustainability across the four project components. The lack of harmonized sustainability planning across NS risks fragmentation and loss of EU4H gains.

2.5.2 Direct MHPSS Activities

Direct MHPSS Activities face the most immediate sustainability challenges. While some NS secured or are pursuing AMIF or bilateral funding to continue Ukraine displacement services [285], overall, most activities end this year. [25] Some NS that integrated activities into existing structures demonstrate better resilience, having deliberately avoided creating unsustainable "specific interventions." [185] The project successfully employed Ukrainian facilitators, providing displaced individuals with fair compensation and meaningful work while delivering culturally appropriate peer support. As funding concludes, NS explore various sustainability models such as leveraging volunteer structures and dedicated funding, though prospects to maintain valuable capacity remain uncertain. [199] Some NS have explored serving broader displaced populations to enhance funding appeal. [29]

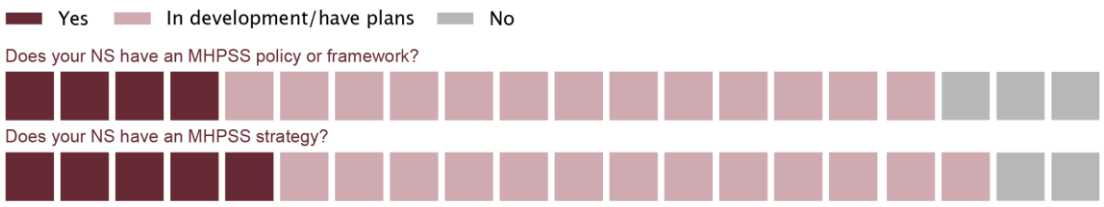
2.5.3 Capacity Strengthening

MHPSS capacity strengthening shows strong sustainability potential. Several NS achieved permanent training integration into organizational catalogues [48] and ministry accreditation positioning PFA within national professional development requirements [128, 530]. One NS established MHPSS teams in 23 out of 24 regional branches with municipal partnerships [531, 132]. Revenue generation through commercialized training, private sector contracts, and first aid integration creates self-sustaining models [251, 310, 226].

However, sustained impact faces critical challenges. High staff turnover causes capacity loss, with one NS training 50 people but retaining "very few active trainers" [15,227,391]. EU4H focal points who hold substantial implementation capacity, cannot be retained by many NS. Without trainer databases, retention agreements, and systematic knowledge management, capacity leaves with individuals [618].

The greatest risk is NS inability to secure funding beyond EU4Health. Realizing sustainability potential requires 2-3 additional years of support [92], yet some NS felt sustainability planning came too late [146]. NS leadership often resisted structural commitments due to sustainability concerns. While capacity strengthening is "one of the cornerstones of future sustainability" [885] only 4 of 20 NS have MHPSS policies and 5 have comprehensive strategies, though most plan to develop them.

Figure 23 - NS with MHPSS policy or strategies at the end of EU4Health (OCA, 2025)



2.5.4 CfSV

Caring for Staff and Volunteers sustainability depends heavily on addressing structural organizational barriers. Some NS embedded CfSV measures into organizational practice, including buddy systems, external psychological support, and supervision structures with secured alternative funding [500, 540]. The systematic incorporation of supportive supervision showed particular promise, with many NS "having the intention to continue" these structures post-project [766]. The component successfully raised awareness about staff wellbeing as a previously underdeveloped area, prompting some NS to successfully integrate actions into policies and practices beyond EU4Health [482, 540].

However, fundamental sustainability challenges persist at the organizational level. Significant factors affecting staff wellbeing, such as low pay, systemic overwork, and broader institutional issues, remain "beyond the control of those implementing EU4Health" [420]. In some cases, organizational constraints meant MHPSS focal points remained volunteer positions despite requiring extensive weekly hours [431], highlighting the gap between wellbeing principles and organizational realities. Evidence suggests that sustainable volunteer engagement requires "core paid staff for volunteers to stick to" [432].

Long-term sustainability will likely also require systemic organizational change beyond project interventions. Without shifting to "strategic HR models with institutionalized staff/volunteer care as cross-cutting responsibility" [1034], individual CfSV initiatives cannot adequately address systemic challenges. Sustainable CfSV ultimately requires organizational commitment and structural reforms that extend well beyond the scope of project-based interventions.

2.5.5 Coordination

Coordination sustainability reflects mixed outcomes between structural achievements and constraints. In some cases, the project made progress in breaking traditional silos within NS [595], with some reporting the project was "instrumental in establishing sustainable frameworks for integrating MHPSS into core operations" [1056]. However, structural misalignments threaten these gains. MHPSS focal points often existed but weren't budgeted into projects, preventing meaningful engagement of those responsible for coordination [759, 797]. This gap between organizational ambition and resource allocation undermines long-term coordination capacity.

Figure 24 - To what extent did your NS auxiliary role increase as a result of EU4Health (Validation workshop, 2025)

The majority of NS consider that their position as an MHPSS provider in the national context has somewhat strengthened. The Czech Red Cross has increased its partnership with the fire service, responsible for MHPSS in emergencies and have developed MOUs with relevant state actors, while the Bulgaria Red Cross recently held a MHPSS conference attended by key government stakeholders. Others such as the Croatian Red Cross already had a strong mandate and strengthened it during EU4Health, working with education sector among others. Elsewhere, many NS are at an earlier stage in this effort, and a first step has been sensitizing MHPSS internally within their NS.

The broader funding landscape poses additional sustainability challenges. European funding priorities shifting from health to security creates an increasingly difficult environment, with future

opportunities having "restricted budgets and eligibility" [493]. Reliance on short-term humanitarian grants "creates vulnerability to funding gaps and limits strategic planning" [1040]. Future sustainability depends on diversifying funding across public, funder, and private sources while embedding MHPSS in "national and EU-level policy frameworks and funding structures" [1067]. Evidence suggests strengthening existing capacities proves more sustainable than "shiny" new initiatives for funder visibility [538]. Mechanisms built on existing structures and relationships show better resilience than project-specific arrangements.

2.5.6 Recommendations for Sustainability

EU4Health has successfully built MHPSS capacity across European NS. Whether this investment translates into lasting change depends on immediate decisions about funding, integration, and organizational prioritization. As one participant observed, **"Mental health should not be a fad"** [923] - ensuring it becomes a permanent part of humanitarian response requires action now:

1. **Develop comprehensive sustainability strategies from project inception -** Create sustainability plans during the first quarter that include revenue diversification, integration with existing services, and clear transition pathways [146, 184]. Avoid designing standalone interventions.

4.4

2. **Establish sustainability as a key performance** indicator - Monitor and report on sustainability progress throughout implementation, not just at project end. Regular reviews should assess funding diversification, institutional embedding, and knowledge retention mechanisms.

3.9

3. **Position MHPSS as cross-cutting strategic priority from start -Build MHPSS into existing funded IFRC programs** [90, 153] across health, migration, and emergency response, moving from project-based to core programming with **dedicated budget lines** [276].

4.5

4. **Create sustainable staffing structures** Recognize that sustainable service delivery requires "core paid staff for volunteers to stick to" [432]. Establish dedicated MHPSS positions within organizational structures rather than relying on volunteer focal points for intensive coordination roles.
5. **Institutionalize knowledge and learning** Develop systematic documentation and knowledge management systems to prevent loss of expertise with staff turnover [618].
6. **Establish multi-level wellbeing systems with HR buy-in**, appointing dedicated wellbeing focal points with protected time and direct executive reporting to ensure clear transitions from MHPSS to organization-wide responsibility [437, 981, 252, 876]

4.5

7. **Include MHPSS, including PFA, CFSV and staff wellbeing in all mandatory onboarding** to prepare staff/volunteers for emotional demands of front-line work [242, 428]

4.8

8. **Develop monetization pathways for commercial PFA training**. Provide guidance on opportunities for trainer-delivered commercial PFA to create sustainability mechanisms for ToT approach [152, 310, 226].

4.4

3. Conclusions and Recommendations

This conclusions section consolidates the evaluation's findings by presenting summarised recommendations alongside action owners responsible for implementation. These summaries are extracted from the main report, where fuller context, justification, and detail for each recommendation can be found in the relevant sections. The recommendations are assigned to four key stakeholder groups: the funders (responsible for policy frameworks and funding flexibility), the Project Lead/ Coordinators (coordinating regional cooperation and system design) e.g., IFRC Leadership and SPRM and MHPSS Hub for technical input, NS HQ and local Leaders (strategic decision-making and project design), and NS Project lead and implementers (operational delivery and service provision).

3.1.1 Recommendations for MHPSS for the displaced

Recommendation	Funders	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
1. Build adaptive frameworks with pre-approved crisis modifiers into initial donor agreements	■			
2. Design proportional programming prioritizing main displaced population but reserved allocations for host communities and other displaced groups	■	■		
3. Recruit native speakers and diaspora speakers using diaspora networks from project initiation			■	
4. Utilize community-preferred communication channels from the start rather than defaulting to helplines			■	■
5. Develop impact-focused theories of change at inception that link MHPSS activities to community integration outcomes		■		
6. Implement systematic qualitative monitoring from project start, including longitudinal tracking		■		
7. Strengthen referral mechanisms and map pathways between MHPSS layers from inception			■	■
8. Design a graduated inception allowing time for needs assessment while ensuring immediate emergency PFA		■		
9. Mandate systematic needs assessments from project start using standardized tools		■	■	
10. Support flexible budgets that enable responsive, cost-based programming	■	■		
11. Bridge funding gaps from emergency appeal support to longer-term related projects to prevent loss of beneficiary contact between phases			■	
12. Create guidance for balancing volunteer ethos with project funding			■	
13. Strengthen project resource development coordination mechanisms		■		
14. Map and target underserved groups early through structured protocols			■	■
15. Improve branch engagement through early intervention and HQ support			■	
16. Involve implementing PMs in NS proposal development to align budgets with operational realities, where not possible, ensure continuity presence		■		■
17. Strengthen PMER systems from project start with dedicated expertise		■	■	
18. Establish rapid mobilization register for overall project coordination		■	■	
19. Standardize M&E systems at project start with clear indicator definitions		■		

3.1.2 Recommendations for MHPSS capacity strengthening

Recommendation	Funders	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
1. Conduct intensive project management capacity assessments before implementation		■		
2. Implement tiered training approaches based on pre-existing MHPSS capacity		■		
3. Integrate MHPSS capacity into existing organizational structures early while measuring benefits			■	
4. Develop targeted outreach protocols for Ukrainian or project relevant language-speaking professionals			■	
5. Integrate MHPSS capacity systematically into emergency response protocols and activation procedures		■		
6. Set formal trainer retention agreements with minimum delivery requirements			■	
7. Establish flexible staffing frameworks for emergency scaling		■		
8. Streamline resource sharing with rapid translation protocols		■		
9. Develop guidance for NS on key project role specifications including key skills and level of effort the role requires (e.g., full-time role, 80% role etc.)		■		
10. Establish dedicated PMER capacity as project prerequisite		■		
11. Require MHPSS data collection capacity as funding precondition		■		
12. Refine indicators to measure training quality alongside quantity		■		

3.1.3 Recommendations for caring for staff and volunteers

Recommendation	Funders	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
1. Develop multi-level wellbeing systems with early HR and management buy-in and dedicated focal points			■	
2. Develop rapid matchmaking tools for supportive supervision		■		
3. Integrate CfSV responsibilities into leadership performance frameworks			■	
4. Implement supportive supervision early with structured leadership and comprehensive coverage			■	
5. Develop proactive risk assessment frameworks for CfSV needs identification			■	
6. Start manageable wellbeing activities while establishing institutional foundations			■	
7. Include wellbeing and PFA training in all mandatory onboarding			■	
8. Establish comprehensive CfSV eligibility criteria for all frontline roles			■	
9. Track CfSV indicators through M&E frameworks to secure snr management buy-in			■	
10. Establish comprehensive CfSV tracking for systematic impact assessment		■		

3.1.4 Recommendations for coordination

Recommendation	Funders	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
1. Build a structured learning phase within donor agreements	■			
2. Establish dedicated technical dialogue spaces	■	■		
3. Create real-time feedback loops between field implementations and strategic decision-making		■		
4. Build coordination foundations early		■		
5. Scale coordination capacity proportionally when expanding project scope		■		
6. Ensure Fast-track recruitment and dedicated HR support		■	■	
7. Establish formal pathways for technical input into strategic and programmatic decisions		■		
8. Conduct 4-week NS consultation including capacity assessment before proposal submission		■		
9. Create a written repository for all key program decisions and guidance		■		
10. Develop differentiated support models based on NS capacity assessments		■		
11. Establish structured exchange programs early in project timeline		■		
12. Create ongoing practitioner networks beyond focal points			■	
13. Map organizational structures during inception to identify natural project homes			■	
14. Mandate senior leadership engagement from inception through implementation			■	
15. Include MHPSS focal point funding in project budgets		■		
16. Fund dedicated project positions rather than overloading existing staff			■	
17. Position MHPSS as a cross-cutting strategic priority from project start			■	
18. Map stakeholder landscape early and establish MOUs to clarify roles and referral pathways				■
19. Engage all relevant stakeholders from day one to ensure comprehensive coordination				■
20. Develop more robust coordination indicators beyond meeting counts		■		
21. Position NS as preferred MHPSS partners through consistent quality service delivery			■	

3.1.5 Recommendations for sustainability

Recommendation	Funders	IFRC / Project	NS HQ /local	NS Project lead
1. Develop comprehensive sustainability strategies from project inception		■		
2. Establish sustainability as a key performance indicator		■		
3. Position MHPSS as cross-cutting strategic priority from start			■	
4. Create sustainable staffing structures			■	
5. Institutionalize knowledge and learning		■		
6. Establish multi-level wellbeing systems with early HR buy-in			■	
7. MHPSS training including PFA, wellbeing and boundary-setting in all mandatory onboarding			■	
8. Consider monetization pathways for commercial PFA training			■	

The EU4Health project's achievements in reaching 643k instances of support across 28 countries while building sustainable MHPSS capacity demonstrates the RCRC Movements ability in Europe to adapt and scale during crisis. The project's evolution from emergency response to community-based programming, coupled with successful capacity strengthening that transformed organizations from minimal MHPSS provision to dedicated units, provides a robust foundation for future displacement responses.

The recommendations identified can provide a roadmap for enhancing adaptive programming frameworks, strengthening early diaspora engagement, and institutionalizing staff wellbeing systems. With lessons learned from coordination challenges and innovative solutions like cultural mediator models already spreading across the network, the RCRC is better positioned in Europe to deliver culturally appropriate, integrated MHPSS services from day one of the next crisis. Implementation of these recommendations will enable more responsive, inclusive, and sustainable mental health support that serves both displaced populations and host communities while protecting the wellbeing of humanitarian responders themselves.

> *"Despite all the challenges, I would like to highlight the beautiful fact that IFRC can do so many things, which is also an important message for the EU Commission, but also for the IFRC. Having such a huge work force in different settings very locally that align to the same principles and that are trained in the same topics. But this is really like a benefit not so many other parties can offer... 28 countries doing, okay, different things, but still under one same goal, which is amazing, I think"* - NS Focal Point

4. Appendices

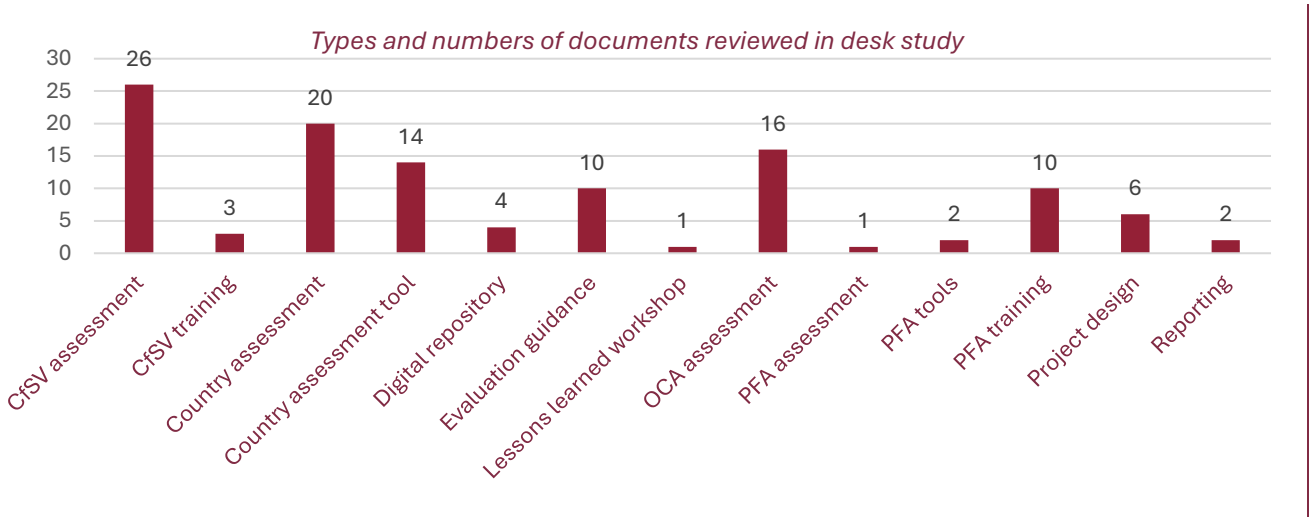
4.1 Appendix A: Sampling Strategy

Criteria	Belgium	Bulgaria	Croatia	Czech Republic	Denmark	Estonia	Finland	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Lithuania	Luxembourg	Montenegro	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	Ukraine
1. Pressure (displaced per capita at peak)	low	high	low	high	low	high	low	low	low	low	low	low	low	low	high	high	low	low	high	low	high	low	low	low	low	high
2. Capacity - experience in MHPSS	high	low	low	low	high	low	high	high	high	low	low	high	low	high	low	low	high	low	low	low	low	low	low	high	high	high
3. Capacity - levels of staff training & resources for MHPSS (at start)	low	low	low	high	low	high	low	low	high	high	high	low	low	low	high	high	high	high	high	high	high	high	high	high	low	low
4. NS engagement & resource investment in EU4Health	low	high	high	high	high	low	high	low	high	high	high	high	low	low	high	high	low	low	high	high	high	high	high	high	high	high
5. Ease of engagement & responsiveness of NS	high	high	high	high	high	low	low	low	low	low	low	high	high	low	high	high	low	high	high	low	high	high	low	low	high	high
6. Availability of quantitative & qualitative data	high	high	high	low	high	low	high	low	high	high	low	high	high	low	low	low	high	high	low	low	low	low	low	high	high	high
7. Language and Logistics (Poor, Good, Med)	G	M	M	M	G	M	M	M	G	M	M	G	G	M	M	M	G	M	G	M	M	M	M	M	G	P
8. Cultural alignment between host country and Ukraine	low	high	low	high	low	high	low	low	low	low	high	low	low	low	high	high	low	high	high	low	low	high	high	low	low	high
9. Gini / Disparities in Socioeconomic Status	low	high	low	low	low	low	low	low	low	low	low	low	low	high	high	high	low	high	low	high	high	low	high	high	low	low
10. Have they had evaluations / monitoring visits?	yes	yes	no	yes	yes	yes	yes	no	no	yes	yes	yes	no	yes	yes	no	yes	no	yes	yes	yes	yes	yes	yes	yes	no

4.2 Appendix B: Data Collection Methods Mapped to Evaluation Areas

	Data source	1. Evaluate MHPSS activities provided to displaced populations	2. Evaluate change in NS/NS country MHPSS capacity	3. Evaluate support of RC staff and volunteers	4. Evaluate wider coordination
Desktop	Exchange visits	■	■	■	■
	IFRC funding data		■		■
	Dashboard: EU4Health 6 Indicators	■	■	■	■
	Lessons learned workshop	■	■	■	■
	CfSV I (2023)		■	■	■
	CfSV II (2025)		■	■	■
	OCA I (2023)	■	■		■
	OCA II (2025)	■	■	■	■
	Needs Assessments (in person)	■	■		■
	Needs Assessments (self-led)	■	■		■
	PFA Training feedback		■	■	
	TGLF assessment of trainee satisfaction		■	■	
	MHPSS Interventions Catalogue	■	■	■	■
	Dashboard: EU4Health Implementation PSC	■	■		
Primary data collection	NS staff remote KIIs	■	■	■	■
	NS staff field visits	■	■	■	■
	NS survey	■	■	■	■
	PDUs engaged in field	■			
	EU4H External partners engaged in field				■
	RoE KIIs	■	■	■	■
	MHPSS Hub KIIs	■	■	■	■
	Validation workshop	■	■	■	■

4.3 Appendix C: Types of Documents Reviewed



Description of types of documents reviewed

Document Type	Description
Reporting	Narrative reports which outline progress at key project stages, and indicator dashboards
Project design	Project proposals and communication plans
PFA training & tools	Tools and templates to support Psychosocial First Aid training implementation and monitoring
PFA assessment	Data collected from Psychosocial First Aid training assessments
OCA assessment	Data collected through two Organisational Capacity Assessment surveys taken by NS' (2023/25)
Lessons learned workshop	(Feb 2024) Recommendations and commitments from NS partners on the EU4Health program
Evaluation guidance	Guidance, templates and materials on supporting evaluation of MHPSS projects
Digital repository	Proposal and method for creating a digital repository of MHPSS best practice
Country assessment tool	Tools to support partner NS's in conducting national MHPSS assessments
Country assessment	Completed national assessments by partner NS's on MHPSS capacity and needs
CfSV training	Data collected on assessment of Caring for Staff and Volunteer trainings delivered
CfSV assessment	Data collected in two Caring for Staff and Volunteer Surveys (2023/25)
RC MHPPS Response to International Armed Conflict	Overview of Eu4Health project as well as early recommendations
Case study NS' EU4H evaluations	Final project evaluation reports conducted by case study NS's.
Key outcomes, learnings and way forward of MHPSS in URCS in Ukraine based on eu4health	Between January and May 2025, the Ukrainian Red Cross, with support from the Danish Red Cross and external consultants, conducted a strategic assessment of its MHPSS programming
Insights from EU4Health exchange visits: Scaling MHPSS Innovations and Practices through Peer Learning across NS	Exchange visit findings are derived from outcome harvest studies conducted within the EU4Health project, complementing outcome harvest data collection efforts at the end of the EU4Health project

4.4 Appendix D: Field Visit Report summaries

The field visits to case study National Societies provide critical ground-level insights into EU4Health implementation, capturing experiences of front-line implementers, recipients, and local partners through direct observation and stakeholder consultations at service delivery sites.

The visits captured implementation innovations, documented best practices, identified solutions to challenges, and gathered evidence-based recommendations for future programming, ensuring findings were grounded in implementation realities. This appendix only shares executive summaries and recommendations for each case study, but full versions of each case study report will be available separately.

Overview of Case Studies

Spain: Following a challenging initial phase marked by organizational restructuring and coordination difficulties, the Spanish Red Cross demonstrated remarkable adaptability and resilience. The project showcased strong team culture and exceptional ability to build community amongst displaced Ukrainian participants, with many recipients transitioning to volunteer roles that helped scale efforts. Despite late project initiation, the programme successfully delivered community-based MHPSS activities that tripled reach in its final year, building sustainable volunteer networks and fostering deep connections within the Ukrainian community.

Bulgaria: The Bulgarian Red Cross exemplified how EU4Health funding can strengthen already mature MHPSS capabilities. Building on over 20 years of MHPSS experience, BRC used the project to expand service reach from 6 to 14 regions, enhance coordination with government ministries and international partners, and develop sophisticated referral systems including dual helplines with integrated case management. The project's success in demonstrating organizational capacity provided the evidence base for establishing a permanent four-person MHPSS unit, institutionalizing expertise that previously relied on individual capacity and positioning BRC as a leading MHPSS provider nationally.

Lithuania: The Lithuanian Red Cross demonstrated how EU4Health can enable rapid MHPSS capacity development from minimal foundations. Starting with virtually no MHPSS experience, LRC scaled to establish a fully embedded MHPSS unit. The project catalysed organizational transformation through strategic integration into the LRC Academy, establishment of sustainable ToT structures with 27 volunteer trainers, and development of systematic capacity-building frameworks that positioned the organization as a key national emergency response partner with enhanced visibility and coordination across government and humanitarian sectors.

Czech Republic: The Czech Red Cross undertook proactive engagement of local branches and leveraged early emergency positioning to build MHPSS infrastructure across 13 of 14 regions. Present in Regional Assistance Centres from the beginning of PDU arrivals, CZRC's visibility attracted 287 Ukrainian persons to be involved in the project. Building on pre-existing capacity and fire service partnerships, CZRC trained 849 personnel in stepped care approaches from basic PFA to specialized interventions. While basic interventions succeeded through interpreters, complex trauma work faced linguistic barriers, and interpreters lacked wellbeing support despite exposure to distressing narratives. Regional variations varied but Zlín's pedagogical centre integration enabled 5,000 interventions for 50 families and Ústí's community centre prevented elderly isolation. Individual coordinator capabilities—Ukrainian heritage, community connections, institutional navigation—proved an important success determinant. CZRC emerged as a more recognized mental health actor with a 2030 strategy.

4.4.1 Case Study Visit Report: Bulgarian Red Cross

SARDE undertook a 3-day field visit to Bulgaria in July 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The Bulgarian Red Cross EU4H project reached 39,057 people displaced from Ukraine through a multi-layered approach including helpline sessions, face-to-face consultations, and community-based interventions, exceeding its original target by 25%. The project demonstrated effective combination of basic PFA to comprehensive community-based approaches recognizing that 70% of Ukrainians needed support beyond first-level interventions. This included culturally-adapted services with 271 trained Ukrainian volunteers providing peer-to-peer support.

Bulgaria wasn't among the original five countries in the EU4Health proposal despite high Ukrainian arrivals from the crisis start. However, their existing MHPSS capacity and country appeal meant BRC was active in MHPSS provision from the beginning, with their prior work potentially mitigating the later EU4H start more effectively than in other National Societies. The EU4H funding being dedicated solely to MHPSS, unlike the broader Ukraine appeal, allowed the BRC to develop specialized capacity.

The separate Greenline and PSS helpline system provided an advanced case management structure built upon a previous COVID project setup, where each caller had integrated case notes alongside psychologist notes. Call line workers, all psychologists themselves, acted as information brokers who stayed within basic PFA boundaries and referred quickly to a specialized list of all NGO services, demonstrating a sophisticated triage and referral system.

Whilst the Bulgarian government lacks strong capacity in preventative MHPSS for displaced groups, the BRC fills this critical gap. The EU4H lead acknowledges that integrating BRC expertise into government plans is essential for sustainability and is actively working toward more systemic coordination with government and related actors for longer-term integration.

The BRC indicator numbers were recorded robustly, with services broken down by type of activity and diligently recorded by regional coordinators. BRC's extensive experience in delivering projects, including MHPSS, means they are well-versed in monitoring and accustomed to project audits, offering potential learning for other National Societies' approaches.

The EU4H lead carries most of the organization's MHPSS capacity representing a vulnerability. Therefore plans are underway to establish a four-person MHPSS unit by late 2025 to institutionalize this expertise and eliminate this single point of failure, with two staff focused on proposals and funding and two on implementation and coordination.

The ToT model proved cost-effective and sustainable, with 22 trainers from regional branches delivering PFA training to 1,326 staff and volunteers across all 28 Bulgarian regions which will provide continued capacity building without substantial funding. Burnout however is still prevalent and will require deeper monitoring to ensure staff and volunteer wellbeing is strategically addressed.

The project showed that vulnerability among displaced populations is not constant, requiring continuous adaptation of services and recognition that housing policies, financial support, and integration services all contribute to mental health outcomes, highlighting the need for MHPSS to be understood as interconnected with all other humanitarian sectors rather than a standalone intervention.

	Recommendation	Owner
Staffing Planning	**Establish the planned four-person MHPSS unit by late 2025 to eliminate single point of failure risk**. The current concentration of MHPSS capacity in the EU4Health lead creates critical vulnerability. Implement the planned structure with two staff supporting project bids/proposals and two focused on implementation/coordination to ensure institutional resilience and capacity continuity.	NS Leaders
Project Design	**Continue to expand MHPSS services beyond basic PFA to include specialized trauma support**. Develop practical PTSD training and step-by-step approaches for working with people experiencing deep psychological trauma, as 70% of Ukrainians need support beyond first-level interventions as 2025 assessment shows.	Project Lead; NS Implementers
	Address psychiatric care access barriers through system-level solutions. Work with government health authorities to increase availability of Ukraine/Russian-speaking psychiatrists and improve referral pathways between BRC services and formal mental health systems.	NS Leaders; NS Implementers
Capacity	**Commercialize and mainstream PFA training across public sectors**. Integrate PFA training into Bulgaria's educational system and expand to public sector workers including teachers, firefighters, and police officers. This strategy could create sustainable revenue streams while embedding MHPSS capacity within national systems.	NS Leadership; NS Implementers
PSS & Capacity Building	**Implement pre- and post-training assessments to validate effectiveness**. Develop systematic testing for PFA trainings to measure actual learning outcomes and skill acquisition, enabling evidence-based improvements in training delivery and participant competency assessment.	NS Implementers
	Develop differentiated training pathways based on existing capacity levels. Create advanced training options for organizations with established MHPSS foundations, as initial training was noted as being more tailored towards National Societies with very limited capacity, making it less applicable to contexts with existing expertise.	Project Lead
CfSV	**Implement annual staff wellbeing surveys to track workforce mental health systematically**. Establish regular assessment of burnout risk, job satisfaction, and impact of supervision mechanisms to identify emerging needs, demonstrate program impact to donors, and ensure support services remain responsive.	NS Leaders; NS Implementers
	Transition to cost-effective CfSV models for sustainability. Implement larger group supervision sessions with single supervisors and recruit volunteer psychologists from outside the system to serve as supervisors, ensuring continuity of support systems beyond project funding.	NS Leaders; NS Implementers
M&E	**Address technical challenges with the PSS system experiencing data** loss by upgrading software infrastructure with future funding, moving beyond current USB backup solutions to ensure data integrity and improve monitoring capabilities.	NS Leadership; NS Implementers
	Develop quantitative impact measurement tools for MHPSS interventions. Move beyond qualitative assessments by implementing standardized outcome measures and developing proxy indicators for mental health improvements to better demonstrate program effectiveness to donors and stakeholders.	NS Implementers; Project Lead
Coordination	**Formalize government partnerships for long-term MHPSS integration**. Build on the successful June 2025 international conference momentum to establish formal agreements with Ministry of Health and municipalities for integrating BRC MHPSS services into national mental health strategies and emergency response frameworks.	NS Implementers

4.4.2 Case Study Visit Report: Lithuanian Red Cross

SARDE undertook a 3-day field visit to Lithuania in June 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The Lithuanian Red Cross successfully scaled from minimal MHPSS experience to delivering 30,683 instances of support to displaced Ukrainians by hiring 16 psychologists and implementing comprehensive services including psychological first aid, recovery groups, art therapy, and individual counselling. This rapid deployment was essential given that 20% of Ukrainians in Lithuania required mental health support, with only 40% finding their needs partially met through existing services.

Program effectiveness significantly improved when marketing shifted from clinical terminology like "stress management training" to accessible language such as "women's clubs" leading to increased registrations. Recipients rated Ukrainian psychologists who had experienced displacement themselves as more effective due to their intuitive understanding and community-building approach, while Lithuanian psychologists brought valuable integration support and alternative therapeutic methods including mindfulness techniques.

The project demonstrated strong impact with 95% of recipients reporting improved psychosocial wellbeing and high satisfaction ratings averaging 9/10. Sustained demand was evident through continuous group meetings lasting over a year, with some participants describing their local branch as their "second home." The rapid service delivery within 24 hours compared favourably to mainstream national services, though gaps remained in reaching Ukrainian men and teenagers despite targeted programming efforts.

Training initiatives achieved scale, with 2,239 people trained in psychological first aid and MHPSS approaches across 10 cities, exceeding the target of 2,050. The establishment of a ToT structure using 27 volunteer trainers proved highly effective for sustainability, while the integration of training programs into the LRC Academy created better long-term strategic planning and institutionalization through e-learning platforms and improved data management systems.

Staff and volunteer support structures were strengthened through supportive supervision training for 20 internal supervisors and external therapy provision, reaching 736 individuals or 95% of the target. However, challenges emerged including supervisor capacity constraints, with some supporting up to 15 individuals, and financial limitations that restricted external therapy to crisis cases only. The 16 Ukrainian psychologists faced particular burnout risks due to experiencing refugee trauma while providing support to others alongside other roles.

Coordination efforts positioned the LRC as a key national emergency response partner, with successful collaboration across six government registration centres and participation in national MHPSS platforms. The project enhanced organizational visibility and capacity demonstration while establishing valuable partnerships with government ministries, universities, and NGOs. However, internal coordination faced some challenges during leadership transitions.

The program's sustainability faces risk with EU4Health funding ending in October 2025, potentially resulting in losing the 14 Ukrainian psychologists despite continued demand. While the volunteer trainer structure and LRC Academy integration support long-term capacity, ongoing municipal funding and inclusion in regional projects remain essential for service continuation beyond the current funding cycle.

	Recommendations	Owner
MHPSS	**Maintain comprehensive, flexible service delivery model with targeted vulnerable population coverage** - Establish and maintain the full spectrum of MHPSS services continuously, recognizing that individuals arrive at different crisis stages with varying needs, while developing baseline diagnosis systems with specific quotas and priority categories for the most vulnerable populations	NS Leaders
M&E	**Implement comprehensive data collection and disaggregation system** - Develop a structured PGI approach that enables systematic data collection and recipient disaggregation by language, age, disability, gender and nationality, building on the LRC Academy system development for more targeted service delivery	Funders, RoE
	Develop impact measurement and evaluation frameworks - including pre- and post-tests to understand sustained individual impact for training, as well as considering individual monitoring for MHPSS support whilst preserving confidentiality, strengthening the connection between needs assessments and activity design through deeper analysis	Funder, RoE
Capacity building	**Strengthen organizational integration and capacity building systems** - Enhance the integration of psychologists into the broader MHPSS Unit and LRC Academy structures to provide continuous support, systematic training opportunities, and resource recommendations aligned with strategic needs and vulnerability assessments	NS Leaders
	Develop culturally responsive and targeted training programs - Design and implement structured cross-cultural training for all MHPSS personnel including Ukrainian psychologists, with specific programming targeted to Ukrainian stakeholders to address cultural competency gaps and improve service relevance	NS EU4H team
	Implement enhanced practical and interactive training approaches - include more simulation-based practical situations, real-life Red Cross volunteer scenarios, and increased interactive activities to improve engagement and practical skill development	NS EU4H team
CfSV	**Develop supervision and support systems** - Expand the pool of trained volunteer supervisors to reduce current burdens (some supporting up to 15 individuals), consider implementing mandatory supervision particularly for high-stress roles such as case managers and lawyers, and explore more integrated support structures for contracted psychologists to complement existing intervision sessions	NS Leaders
	Create improved wellbeing monitoring and response systems - Establish more frequent anonymous feedback channels beyond annual surveys, re-run the CfSV survey to identify current stressors and training needs, implement ongoing adaptation of support measures as crisis situations evolve, and provide resilience courses in response to emerging volunteer needs	NS EU4H team
	Provide specialized support for Ukrainian psychologists - Develop additional support activities focused on long-term stress management for Ukrainian psychologists who face unique challenges of providing refugee support while experiencing displacement themselves, and provide clearer client-boundary guidance to protect staff wellbeing	NS EU4H team
Coord	**Strengthen community partnerships and stakeholder engagement** – Continue building relationships with Ukrainian stakeholders including schools and community organizations to support more precise impact, and further institutionalize engagement with Lithuanian schools where Ukrainian children attend	NS Leaders
Knowledge management	**Leverage organizational development for continuous improvement** - Utilize the newly established MHPSS Unit structure to build upon EU4Health project learnings, implement more systematic feedback collection mechanisms, and establish sustainable institutional knowledge management systems	NS Leaders
	Enhance technical expertise integration and knowledge management - Establish stronger mechanisms to leverage knowledge transfer from experts and psychological organizations specializing in migration issues such as identity loss and acculturation stress management, building on established migration-focused psychological frameworks.	RoE, NS Leaders

4.4.3 Case Study Visit Report: Spanish Red Cross (SpRC)

SARDE undertook a 3-day field visit to Malaga in June 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The SpRC delivered significant achievements in implementing the EU4Health project following a challenging start. The project's first 17 months were impacted by organizational restructuring, internal coordination issues, and limited branch engagement, delaying the official launch until September 2023. However, the SpRC gained substantial momentum and delivered strong results.

This delayed start meant that by the time delivery began in September 2023, 1.5 years after peak Ukrainian border movement, PFA had limited applicability due to being past the acute emergency phase. However, following the approval of community-based MHPSS activities, which were more appropriate for this later crisis stage, SpRC was able to deliver more relevant support. Indicator 4 (instances of support) surged from 2,100 to 6,200 between November 2023 and March 2024, tripling the total reach achieved during the entire first 17 months, fuelled by CBMHPSS activities and 'active calling' - calling up PDUs who have previously requested support. The latter had 4948 valid calls (valid = answered and by the right person), 3004 of which did not require follow-up support, 1178 required minor assistance ('oriented calls'), and 766 of which led to further support referral.

Trust, stigma and outreach were significant challenges which were best addressed with support from Ukrainian practitioners due to their shared language and cultural experience. Ukrainian-led delivery helped recipients better open-up and benefit from MHPSS support offered. Even then, it was still a challenge and required significant time and relationship building.

PFA effectiveness varied significantly by delivery context, crisis timing, and target group. Co-located delivery (e.g., reception centres) enabled easier engagement, while decentralised delivery offered more anonymous, neutral spaces. Certain groups could respond better when activities were framed as practical training to help others rather than support for themselves. These insights highlighted the need for a range of tailored approaches to maximise engagement and coverage.

EU4Health staff and volunteers worked very hard but were over-stretched. Project management provided PFA training in addition to their core duties, and other key team members such as PFA trainers balanced voluntary training provision with other full-time roles. Whilst such practices are common in the RC, the SpRC had the second lowest percentage budget spent on staffing of all EU4Health NS.

Concerns about setting precedents for funding activities that the SpRC usually secured at no cost contributed towards this budget underspend. Whilst such caution showcased strong principles of sustainability, it impacted the initial rate of delivery. Still, this resourcefulness and a strong volunteer base should support any continuation or evolution of activities beyond the EU4Health funding period.

Coordination was challenging from the outset. Internally, SpRC Health and Emergency teams as well as many regional branches did not participate due to project funding being restricted in supporting those displaced from Ukraine only, which some viewed as conflicting with their principles of impartiality and operational approach. Externally, overlapping funding streams and concerns about duplicating existing refugee support services of the 18-month state program created administrative issues. This required complex navigation of service gaps and the short-term targeting of a smaller recipient pool.

Strong relationships were clear between EU4Health staff, volunteers, and recipients, with obvious mutual warmth. CfSV was integrated into PFA training, with additional support initiatives introduced recently. Both observations and recipient feedback indicated that the EU4Health team is highly supportive and open to volunteers, with many recipients transitioning to volunteer roles long-term. Among the recipients interviewed (~30), experiences were consistently positive.

	Recommendations	Owner
Staffing Planning	**Strengthen project recruitment framework** - Design future programs with more staffing capacity, considering the needs of the project across the programme length, and considering short-term contracts and missions to support delivery.	NS & Project Leaders;
	Internal Secondments - The project had Ukrainian staff who had to balance EU4Health volunteering with everyday duties. Stronger mechanisms which allow people in the SpRC to be seconded more flexibly to projects for which they have unique skills would be beneficial.	NS Leaders
Project design and delivery	**Integrated & flexible MHPSS programming** - Promote integrated design in future MHPSS programs more inclusive of host communities & other vulnerable groups. This should include entry point strategies using CBMHPSS and differentiated approaches tailored to each phase.	Funders
	Flexible project design - Consider how a more flexible, yet structured approach might be used in future design to meet specific circumstances of NS, while maintaining standard approach	Funder; Project Lead
	Longer inception large scale projects - In the case of SpRC, this might have helped ensure better development of project targets, coordination between SpRC sectors, more effective project staffing, and enhanced advocacy efforts with regional branches and stakeholders.	Funder; Project lead
PSS & Capacity	**Specialized training capacity development** - Address identified gaps including PFA for children, suicide prevention, gender-based violence, and supervision frameworks while building sustainable trainer networks beyond single-person dependencies	NS Implementer
	Language & culture - translate useful materials earlier (use tools like DeepL) and expand native-speaking capacity as this proved key for trust-building. 'Active calling' is best done by volunteers who speak recipient language. Volunteers with PSS skills can provide tech support to handlers.	NS Implementer
CfSV	**CfSV institutionalization** - Move beyond informal peer support to establish systematic wellbeing monitoring through annual CfSV surveys & action plans, clear structures for staff support, and formal accountability mechanisms integrated with existing RC systems for full welfare oversight.	NS Leaders
	Senior leadership engagement in CfSV – SpRC leadership discuss points raised in survey and develop (participatory, transparent) action plan that addresses staff and volunteer concerns	NS Leaders
M&E	**Systematic impact measurement implementation** - Establish pre/post assessment frameworks, integrated feedback mechanisms, and systematic impact measurement tools to better understand program effectiveness and guide resource allocation	NS Implementer
Coordination	**Early stakeholder coordination** - Implement comprehensive coordination with government ministries, branches, and external partners during project design phase rather than post-approval to avoid service duplication issues and maximize reach	Funder; Project lead
	Strengthen internal coordination structures - Design clear coordination protocols between organizational departments – in this case Health and Emergency teams – to ensure more coordinated response to any future crises and/or project opportunities	NS Leaders
	Leadership continuity measures - Establish mechanisms to prevent project delays, drawing lessons learned from the delayed start of EU4Health in Spain. Develop standardized protocols including succession planning, knowledge transfer & interim arrangements during transitions.	NS Leaders
Knowledge & sustain.	**Financial Guidelines** - Create spending guidance for future programs that reflect on 'spending precedent' issue (see exec summary). Outline approaches that enable effective delivery without unsustainable precedents, balancing efficiency with operational effectiveness	IFRC, NS leaders
	Best Practice Documentation - Systematically capture successful approaches for replication in future e.g., relationship-building approach & CBMHPSS approaches that proved more effective for longer-term displaced populations. Establish relevant knowledge transfer with other teams	NS Implementer

4.4.4 Case Study Visit Report: Czech Republic Red Cross (CzRC)

SARDE undertook a 3-day field visit to Czechia in July 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

Czech Red Cross's EU4Health experience offers critical lessons for future programming. The evaluation examined Zlín, South Bohemia and Usti, which collectively received over 50% of Czech Red Cross EU4Health funding and remained active at project conclusion. Key findings were as follows:

CzRC's presence in emergency reception centres from day one created lasting advantages. Operating in Regional Assistance Centres (KACPU) during the March-April 2022 peak arrivals built visibility and trust, leading 287 Ukrainian professionals to proactively approach CzRC for work.

CzRC designed a stepped care model on the basis that early intervention could prevent mental health escalation. The approach progressed from psychological first aid to crisis intervention, with EmotionAid and Assist techniques intended as PTSD prevention. The rationale assumed effective early trauma response would minimize need for psychiatric referrals—an approach aligned with established trauma intervention principles, though systematic outcome data collection was unavailable.

Language support strategies showed varied effectiveness across intervention complexity levels. CzRC's early engagement of the national interpreters' union created sustainable capacity, with 287 Ukrainian speakers trained. While basic psychological first aid translated effectively, complex trauma interventions were less suitable for interpretation. An important learning emerged regarding interpreters' wellbeing—these professionals experienced pressure from translating distressing stories without access to organizational support systems, a gap identified only after significant exposure.

Program parameters faced system constraints. A three-session limit on psychologist sessions was implemented to ensure project compliance. This required functioning referral pathways, yet Czech psychiatric waiting lists left some clients unsupported after CzRC sessions ended. Another challenge was incremental approvals delaying interventions—summer camps were piloted first, and broader CBMHPSS authorized only after proving need, missing critical early opportunities.

In the case study regions Zlín created a replicable integrated service model serving 50 families through 5,000 annual interventions via coordination with pedagogical centres, schools, and healthcare; Prachatice revealed service gaps with only limited MHPSS consultations and group sessions focused on social activities rather than psychological support; Ústí effectively reached elderly populations through a community centre providing 3,500 annual interventions, though capacity remained constrained by regulations limiting Ukrainian psychologists to 10,000 CZK monthly earnings.

Individual coordinator capabilities emerged as a key determinant of regional success. Effective coordinators shared specific traits: Ukrainian language skills or heritage, established community connections, MHPSS experience, and ability to navigate Czech institutional systems.

CzRC has evolved into a recognized mental health actor within Czech Republic's institutional landscape. Emergency services routinely request CzRC support following proven responses to 2024 floods and Prague shooting. The Mental Health Strategy 2030 embeds MHPSS organizationally, though funding remains uncertain—only Zlín secured one government position. Revenue diversification through training accreditation shows promise. Nevertheless, the project permanently enhanced CzRC's capacity to serve all crisis-affected communities, not just displaced populations.

Topic	Recommendations	Funders	Project Lead	NS Leaders	NS Implementers
Replication & Scale	Document and systematize Zlín's integrated multi-stakeholder model, particularly the embedding of services within existing structures (pedagogical centres, schools, healthcare). Create implementation toolkit for other regions that emphasizes supplementation not replacement of state services		X	X	X
Coordinator Specifications	Develop formal role requirements based on successful coordinator profiles: Ukrainian language/community connections, MHPSS experience, networking abilities. Mandate full-time positions for programs of this scale.		X	X	
Staff Care Systems	Establish comprehensive staff care covering ALL personnel exposed to trauma, including interpreters. Develop specific support protocols for auxiliary staff who currently fall outside organizational care systems		X	X	X
MHPSS Service Design	Enable flexible service provision beyond rigid session limits when referral pathways are compromised. Prachatice specifically needs psychologist-supervised groups and enhanced individual support. All regions assess gaps in services for elderly and single adults	X	X	X	X
Data & Monitoring Systems	Implement integrated data systems: digital tracking of personnel competencies, impact monitoring beyond counts, and quality indicators. Fragmented records and estimation-based reporting hindered early response. Invest in information infrastructure parallel to service delivery		X	X	X
Sustainability	Build on current momentum: e.g., establish annual mental health forum leveraging CzRC's new key player status; and/or develop 3-year funding strategy targeting corporate and foundation partners			X	
Knowledge Management	Create peer learning mechanisms using Zlín and Ústí as teaching cases. Document evolution from emergency KACPU response to sustained programming. Capture lessons on interpreter engagement model for replication		X		X
Admin Guidance	Provide comprehensive administrative support package for future programs including procurement procedures, documentation requirements, and realistic staffing models. Admin. capacity building as important as technical training		X		
Program Flexibility	Enable adaptive programming from project start. Early CBMHPSS authorization would have better matched evolving needs. Design future responses with built-in flexibility for natural progression from emergency to integration support	X	X		
Early Response Positioning	Capitalize on value of early visible presence. CzRC's KACPU involvement from day one created trust enabling organic recruitment and community engagement. Ensure NS are positioned at initial reception points in future crises	X	X	X	
Language Strategy	Create comprehensive language support framework distinguishing between intervention types. Basic PFA works via interpretation; complex trauma work requires native speakers. Train interpreters specifically in MHPSS terminology and provide them with psychological support		X	X	X

SARDE

Final Evaluation of the IFRC EU4Health Project:

Provision of Quality and Timely Psychological First Aid to People Affected by Ukraine Crisis in Impacted Countries

Case Study reports: Spanish Red Cross, Bulgarian Red Cross, Lithuanian Red Cross & Czech Republic Red Cross

October 2025

Evaluation Period: March-October 2025

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Introduction

The field visits to case study National Societies provide critical ground-level insights into EU4Health implementation, capturing experiences of front-line implementers, recipients, and local partners through direct observation and stakeholder consultations at service delivery sites.

These visits assess project performance against the four key objectives by examining how effectively MHPSS services reach displaced populations, evaluating service quality and beneficiary satisfaction. The visits assess National Society capacity strengthening by observing trained staff in practice and understanding how enhanced capabilities integrate into organizational systems. Caring for Staff and Volunteers implementation is evaluated through consultation with project personnel about wellbeing experiences. Coordination mechanisms are examined at operational level, observing internal and external coordination practices.

The visits capture implementation innovations, document best practices, identify solutions to challenges, and gather evidence-based recommendations for future programming, ensuring findings are grounded in implementation realities.

Overview of Case Studies

Spain: Following a challenging initial phase marked by organizational restructuring and coordination difficulties, the Spanish Red Cross demonstrated remarkable adaptability and resilience. The project showcased strong team culture and an ability to build community amongst displaced Ukrainian participants, with many recipients transitioning to volunteer roles that helped scale efforts. Despite late project initiation, the programme successfully delivered community-based MHPSS activities that tripled reach in its final year, building sustainable volunteer networks and fostering deep connections within the Ukrainian community.

Bulgaria: The Bulgarian Red Cross exemplified how EU4Health funding can strengthen already mature MHPSS capabilities. Building on over 20 years of MHPSS experience, BRC used the project to expand service reach from 6 to 14 regions, enhance coordination with government ministries and international partners, and develop sophisticated referral systems including dual helplines with integrated case management. The project's success in demonstrating organizational capacity provided the evidence base for establishing a permanent four-person MHPSS unit, institutionalizing expertise that previously relied on individual capacity and positioning BRC as a leading MHPSS provider nationally.

Lithuania: The Lithuanian Red Cross demonstrated how EU4Health can enable rapid MHPSS capacity development from minimal foundations. Starting with virtually no MHPSS experience, LRC scaled to establish a fully embedded MHPSS unit. The project catalyzed organizational transformation through strategic integration into their learning academy, establishment of sustainable ToT structures with 27 volunteer trainers, and development of systematic capacity-building frameworks that positioned the organization as a key national emergency response partner with enhanced visibility and coordination across government and humanitarian sectors.

Czech Republic: Czech Red Cross (CzRC) proactive engagement of branches and early emergency positioning built MHPSS infrastructure across 13 of 14 regions. Their early visibility attracted 287 Ukrainians to be involved in the project. Building on MHPSS capacity and fire service partnerships, CzRC trained 849 personnel in approaches from basic PFA to specialized interventions, emerging as a recognized MHPSS actor with a 2030 strategy. Regional impact varied but successes were numerous, including Zlín's integration with a regional pedagogical centre to support ~50 families, support for elderly Ukrainians in Teplice. Individual coordinator capabilities proved an important determinant.

Case Study Visit Report: Bulgarian Red Cross

Executive Summary

SARDE undertook a 3-day field visit to Bulgaria in July 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The Bulgarian Red Cross EU4H project reached 39,057 people displaced from Ukraine through a multi-layered approach including helpline sessions, face-to-face consultations, and community-based interventions, exceeding its original target by 25%. The project demonstrated effective combination of basic PFA to comprehensive community-based approaches recognizing that 70% of Ukrainians needed support beyond first-level interventions. This included culturally-adapted services with 271 trained Ukrainian volunteers providing peer-to-peer support.

Bulgaria wasn't among the original five countries in the EU4Health proposal despite high Ukrainian arrivals from the crisis start. However, their existing MHPSS capacity and country appeal meant BRC was active in MHPSS provision from the beginning, with their prior work potentially mitigating the later EU4H start more effectively than in other National Societies. The EU4H funding being dedicated solely to MHPSS, unlike the broader Ukraine appeal, allowed the BRC to develop specialized capacity.

The separate Greenline and PSS helpline system provided an advanced case management structure built upon a previous COVID project setup, where each caller had integrated case notes alongside psychologist notes. Call line workers, all psychologists themselves, acted as information brokers who stayed within basic PFA boundaries and referred quickly to a specialized list of all NGO services, demonstrating a sophisticated triage and referral system.

Whilst the Bulgarian government lacks strong capacity in preventative MHPSS for displaced groups, the BRC fills this critical gap. The EU4H lead acknowledges that integrating BRC expertise into government plans is essential for sustainability and is actively working toward more systemic coordination with government and related actors for longer-term integration.

The BRC indicator numbers were recorded robustly, with services broken down by type of activity and diligently recorded by regional coordinators. BRC's extensive experience in delivering projects, including MHPSS, means they are well-versed in monitoring and accustomed to project audits, offering potential learning for other National Societies' approaches.

The EU4H lead carries most of the organization's MHPSS capacity representing a vulnerability. Therefore, plans are underway to establish a four-person MHPSS unit by late 2025 to institutionalize this expertise and eliminate this single point of failure, with two staff focused on proposals and funding and two on implementation and coordination.

The ToT model proved cost-effective and sustainable, with 22 trainers from regional branches delivering PFA training to 1,326 staff and volunteers across all 28 Bulgarian regions which will provide continued capacity building without substantial funding. Burnout however is still prevalent and will require deeper monitoring to ensure staff and volunteer wellbeing is strategically addressed.

The project showed that vulnerability among displaced populations is not constant, requiring continuous adaptation of services and recognition that housing policies, financial support, and integration services all contribute to mental health outcomes, highlighting the need for MHPSS to be understood as interconnected with all other humanitarian sectors rather than a standalone intervention.

Recommendations outlined in full in the report include:

Establishing the planned four-person MHPSS unit by late 2025 to eliminate single point of failure risk. Current concentration in the EU4H NS lead creates vulnerability—implement structure with two staff supporting project bids and two focused on implementation ensuring institutional resilience.

Continuing to expand MHPSS services beyond basic PFA to specialized trauma support, developing practical PTSD training and step-by-step approaches for deep psychological trauma. The 2025 assessment shows 70% of Ukrainians need support beyond first-level intervention. Address psychiatric care barriers by working with government to increase Ukrainian/Russian-speaking psychiatrists and improve referral pathways.

Commercializing and mainstreaming PFA training across Bulgaria's educational system and public sectors including teachers, firefighters, and police. This creates sustainable revenue while embedding MHPSS capacity within national systems. Develop differentiated training pathways based on existing capacity levels, as initial training targeted NS with limited experience.

Implementing systematic measurement and assessment through pre/post-training tests measuring actual learning outcomes and standardized impact indicators demonstrating program effectiveness. Upgrade technical infrastructure addressing PSS system data loss, moving beyond USB backup solutions.

Strengthening staff support systems through annual wellbeing surveys tracking burnout risk and supervision impact. Transition to cost-effective models using larger group supervision sessions with volunteer psychologists from outside the system ensuring sustainability beyond project funding.

Formalizing government partnerships building on the June 2025 MHPSS conference to establish formal agreements with Ministry of Health and municipalities, integrating BRC MHPSS into national strategies and emergency response frameworks for long-term sustainability.

Visit Overview

National Society: Bulgarian Red Cross

Locations: Plovdiv

Visit Dates: 7-8 July 2025

Evaluation Team: Jonah Rudlin, Kieran Birtill

SARDE undertook a 2-day field visit to Plovdiv, accompanied by Bulgarian Red Cross EU4Health Focal Point. Plovdiv was chosen as it hosts one of the largest Ukrainian communities in Bulgaria and represents a key implementation site with the highest concentration of EU4Health activities still on-going across the country's 14 participating regions.

The visit took place over two days and included visits to the Bulgarian Red Cross Plovdiv headquarters.

Key informant interviews were conducted with the BRC EU4Health lead, regional MHPSS coordinators, Ukrainian and Bulgarian psychologists, Ukrainian volunteers trained in PFA, municipal authorities, and partner organizations including the Ukraine Centre. Focus group discussions were conducted with MHPSS service recipients, volunteer trainers, and supervisors to capture diverse perspectives on project implementation and impact.

Stakeholder Consultation Matrix

Type	Number of persons per stakeholder type	Total persons
Project Lead	1	27
Project Staff	7	
Volunteers	4	
Displaced Recipients	9	
Partners	3	
Govt/	3	

Component 1: MHPSS for Displaced Populations

Program Overview

The Bulgarian Red Cross provided comprehensive MHPSS support to 39,057 displaced Ukrainians through a multi-layered approach. This included a dedicated helpline (6,357 individual sessions), face-to-face psychological consultations (7,329 sessions across 14 regions), and community-based interventions such as art therapy, stress relief groups, and child-friendly spaces. Services were delivered through 14 regional branches, humanitarian service points, and distribution centres where 60,000 people from Ukraine passed through.

The project effectively addressed high mental health needs among displaced populations. According to the BRC 2023 needs assessment, 70-93% of displaced groups reported difficulties accessing mental health services, with significant proportions experiencing sleep problems, anxiety, and daily negative emotions[KB1]. The project provided culturally-adapted support including Psychological First Aid, crisis intervention, peer-to-peer support programs with trained Ukrainian volunteers, and group activities for children and adults. Services were well-received, with positive feedback about feeling welcomed and supported. However, gaps remained in psychiatric care access. These gaps stemmed from language barriers, geographic coverage limitations as the project scaled down, and challenges with state integration systems for long-term mental health support.

Relevance

The project demonstrated strong relevance through comprehensive and ongoing needs assessments throughout the implementation period. Three major assessments were conducted: a February 2023 assessment surveying 3,100 Ukrainians that identified 70% reporting mental health needs affecting daily functioning; a July 2023 assessment with 1,212 respondents that revealed specific challenges including sleep difficulties (81%), anxiety (80%), stress (67%), and anger management issues (65%); and a January 2025 assessment of 2,603 respondents showing 48.1% experiencing daily negative emotions and 93.2% facing difficulties accessing mental health services. These assessments consistently identified main stressors as financial difficulties, traumatic events, fear for the future, family issues, social isolation, health issues, and discrimination.

The initial February 2023 assessment revealed a critical gap: basic PFA alone would be insufficient, as many Ukrainians needed support beyond first-level interventions. This finding drove the project's evolution toward more comprehensive community-based approaches. While the project began with PFA training as the core intervention across 12 regions, it strategically expanded its scope. The program developed a comprehensive portfolio including helpline consultations addressing daily life difficulties, anxiety, trauma, and adaptation challenges; art-therapy activities to build resilience and belonging; group activities for children's adaptation; and Internet Coffee groups providing practical information on jobs, health, and education. The project prioritized cultural and linguistic appropriateness by training 271 Ukrainian citizens in PFA, with 211 becoming volunteers providing peer-to-peer support. Project leadership determined that Ukrainian psychologists were better suited for higher-level interventions, while the Bulgarian Red Cross proved highly effective at providing the first step in psychological support.

As the conflict progressed, the project recognized that vulnerability is not constant and adapted to changing needs, particularly around integration. Evidence showed that Ukrainians arriving in 2024 were more likely to integrate than in 2022, leading to requests for Bulgarian psychologists to help integrate children and recognition of ongoing PTSD support needs. This evolution reflected the project's

key learning that effective MHPSS requires a comprehensive approach that extends beyond mental health services alone. Housing policies, financial support, and integration services all contributed to reduced stress levels and better mental health outcomes.

Coverage

The BRC MHPSS program operated across 28 regions, concentrated in 6 major cities. In Plovdiv, most activities focused on children and their mothers, with service users receiving one-on-one psychological support. Child-centered services were well developed, including Child Friendly Spaces in Plovdiv, Dobrich and Burgas, art therapy activities, group adaptation programs, the Helfi child first aid training program, summer camps, and specialized support for children with special needs including autism.

The project employed multiple outreach channels to engage Ukrainian communities, recognizing the importance of diverse communication methods for effective reach. Social media played a key role, with the project maintaining several Telegram groups for Ukrainians, the COMPASS channel on Telegram, and official Facebook pages. Word-of-mouth proved equally important as a primary way Ukrainians learned about services.

Strategic engagement at key locations was crucial. Distribution centres rather than borders became primary discovery points where people learned about available support. The Migration organisation providing temporary residence cards also served as a referral source, directing people to services. Coordination meetings with partner organizations further expanded reach.

This multi-channel approach was believed to have been effective. Project staff were confident that non-participation was largely due to people not requiring services rather than inadequate outreach. The 3,500 Ukrainians in their main online group demonstrated the significant digital engagement achieved through these diverse communication strategies.

However, coverage gaps could still potentially exist, since core support concentrated on women with children, with less focus on reaching women without children or men. Teenage boys also proved particularly reluctant to seek help, requiring parental facilitation to access services. Additionally, the program could not provide high level psychiatric-level support, and referrals to the health system were complicated by the shortage of Russian-speaking psychiatrists in Bulgaria, creating a barrier for those needing complex mental health interventions.

Effectiveness

The BRC response appears to have been highly organised, with holistic MHPSS support from the bottom to higher up the pyramid. This involved large teams of psychologists across national regions who were trained and provided with very clear rules by the BRC EU4H lead – they felt like they were part of a structure, well supported with clear mandates and strong connections to other resources, which made them feel more confident, and in turn made the recipients feel that confidence too. Drawing on over 20 years of MHPSS experience, BRC's approach extended from the bottom to further up the pyramid than most other National Societies, with this prior experience enabling them to effectively deliver services across the full spectrum of MHPSS interventions from basic psychological first aid to more specialized support.

The project achieved strong quantitative outcomes, reaching 39,057 total MHPSS recipients, nearly 125% of the original target. This comprehensive reach included 6,357 individual helpline sessions, 7,329 face-to-face psychological consultations across 14 regions, and support for 25,371

Ukrainians through BRC regional branches. Additional community engagement involved 3,500 Ukrainians in online support groups and 4,000 people participating in various support groups.

Multiple strategic approaches contributed to project effectiveness, with children serving as the crucial entry point for reaching adults. The children-first engagement strategy proved particularly successful because when Ukrainians first arrived, their priorities were survival basics, food, shelter, and aid, with MHPSS support coming only after they felt safe. Adults rarely approached activities independently but would attend children's programs. Initially, parents wouldn't leave their children alone, but once they observed their children relaxing and having fun, they too would relax and become more receptive to support.

The BRC youth volunteer activities were particularly valued for instilling agency, and described by service users as "very important, really uplifts children." These joint sessions where "kids play & mums share info" created valuable informal PSS opportunities, allowing parents respite while facilitating peer support and information sharing. Red Cross engagement at border crossings was crucial for establishing initial trust, while careful language choices, using terms like "emotional support" rather than "psychological support", helped reduce stigma and increase uptake.

The indirect service provision approach of making support available without pressure allowed people to access help when ready. Cultural factors also supported success, with Ukrainians feeling more comfortable in Bulgaria than other EU countries and reporting better access to support than they had experienced in Ukraine. The reported reduced prevalence of mental health stigma among Ukrainian refugees, who largely had prior therapy experience, seems to have facilitated engagement in contrast to experiences in other National Society contexts.

Despite overall success, several factors limited effectiveness. Persistent outreach challenges meant some individuals remained unreachable despite extensive efforts; limited availability of Russian-speaking psychiatrists was a challenge for complex case referrals; and technical issues with data management systems requiring manual backup procedures providing challenges to data storage and monitoring.

Impact

As with many National Societies, measuring the quantitative impact of MHPSS interventions proved challenging, with stakeholders noting it was "very difficult to measure" and could mostly be assessed through qualitative insights. Despite these measurement limitations, qualitative evidence demonstrated significant positive changes across multiple domains. PFA interventions for children were viewed as particularly impactful as noted, while sustained service engagement patterns for others indicated meaningful connection with support services.

The project showed substantial impact on trust and service engagement within Ukrainian communities. Success was observable through "seeing repeat callers on the helpline, seeing length of calls, seeing the kids becoming verbal," demonstrating both sustained engagement and therapeutic progress. Word-of-mouth recommendations became a powerful driver for service uptake, with satisfied service users drawing others into the support network and creating organic expansion of service reach, which could also be taken as a proxy for impact.

At the community level, the project appeared to support effective integration. The Red Cross "became a big heart for the Ukrainians" according to municipal authorities, who reported BRC supporting "all vulnerable groups" with "strong MHPSS" and receiving consistently positive feedback on

services. This institutional recognition positioned BRC as a trusted and essential resource within the broader humanitarian response ecosystem.

Direct beneficiary testimonials revealed personal impact, with recipients describing both practical and emotional support. Simple gestures like receiving "a hug" during border crossings made people arriving from Ukraine "feel wanted and welcomed," while comprehensive support enabled others to believe they were "strong" and could "continue ahead" for themselves and their children. Unintended positive impacts included empowerment effects, where housing policies with time limits encouraged integration, volunteering opportunities gave youth "agency," and participation in Red Cross activities enabled some people from Ukraine to "become the leaders in their community."

However, January 2025 assessment data revealed significant ongoing challenges that highlight the limits of project impact. Despite extensive service provision, 93.2% of respondents still faced difficulties accessing mental health services, with only 4.9% seeking professional help for stress. Mental health indicators remained concerning, with 48.1% experiencing daily negative emotions and 67.15% reporting poor sleep linked to stress. Stakeholders anticipated "a lot more need in the future" for ongoing PTSD support, suggesting that while the project provided crucial immediate relief, longer-term mental health needs will require sustained intervention beyond the project timeframe.

Efficiency

Efficiency barriers emerged when Ukrainian refugees required specialized psychiatric care beyond the project's scope. The project had limited ability to provide high-level psychiatry support and needed to refer cases to Bulgaria's formal health system. However, the formal health system had a shortage of Russian-speaking psychiatrists, creating bottlenecks in referral processes and delays in care delivery. This language barrier in the external health system, combined with a broader gap between government health services and psychological support for "state integration," resulted in care discontinuity and reduced overall efficiency of comprehensive mental health support.

The project's design featured both efficiency enhancers and constraints. The lean staffing model with only two full-time employees demonstrated cost-effectiveness but limited direct implementation capacity. However, the centralized structure of Bulgarian Red Cross significantly improved coordination efficiency across organizational levels. Strategic border work proved crucial for building trust and ensuring effective service uptake at refugees' entry points. Most notably, the one-stop shop approach, combining basic needs, social support, and psychological support in collaboration with partners like the Ukraine Centre, maximized resource impact by reducing navigation burden on recipients while coordinating service delivery.

Sustainability

The Bulgarian Red Cross has developed comprehensive plans to institutionalize and expand its MHPSS capacity beyond the current project period. While the current EU4Health lead carries a significant portion of the organization's MHPSS capacity, creating a critical vulnerability where "if lead leaves the MHPSS capacity at national level collapses," there are plans to establish a dedicated four-person MHPSS team with two staff supporting project bids and proposal development, and two focused on implementation activities, to support the current EU4Health lead. Although geographic coverage is being reduced with the project ending and support continuing only in the "two biggest regions," the project's success has driven organizational recognition at the highest levels, with EU4Health being "the reason why the Secretary General recognized that a MHPSS unit expansion could be needed." Implementation is planned for late 2025 with funding secured through late 2026, providing a clear pathway for transitioning from individual expertise to institutionalized capacity.

A key strategic aim of the EU4Health project was to demonstrate how effective MHPSS and PFA create cross-sectoral benefits, with reduced stress levels facilitating easier uptake and access across all humanitarian services. This approach positions MHPSS not as a standalone intervention but as a foundation that supports and enhances the effectiveness of all other programming areas, strengthening the case for sustained organizational investment in these capabilities.

Accountability & management

Close collaboration with multiple partners prevents replication of activities and ensures proper service delivery. BRC coordinates with a comprehensive network including humanitarian organizations (UNHCR, UNICEF, WHO, Caritas, Bulgarian Woman Fund, IOM, FAR, AKNO), Ukrainian community organizations (Ukrainian Centre and COMPASS Centres with 6 locations coordinating monthly across the country), government agencies, and the Bulgarian Association of Psychologists. This coordination framework is particularly notable for the COMPASS centres' systematic monthly coordination across multiple locations nationwide.

Monitoring and data collection are well-organized, with all information gathered in a consistent and rigorous manner based on past organizational experience. The project maintains dedicated EU4Health documentation stamps for relevant materials, ensuring audit readiness and compliance with funding requirements. However, technical challenges have emerged with the PSS system experiencing data loss issues that required USB backup solutions. The organization aims to upgrade the software system with future funding to address these technical limitations and improve data management capabilities.

Component 2: National Society Capacity Strengthening

Relevance

BRC recognized from previous responses that national health systems had limited capacity for specialized mental health support, creating potential gaps in care continuity. While EU4Health appropriately focused on PFA and PSS as foundational services, this systemic limitation shaped BRC's comprehensive approach from inception. Drawing on extensive MHPSS experience from previous displacement crises, the team understood that protracted displacement typically progresses through predictable stages—from acute emergency needs to complex trauma requiring specialized intervention. They anticipated that significant numbers would eventually need ongoing PTSD support and that engaging experienced Ukrainian psychologists would require more sophisticated approaches than basic PFA training alone.

The BRC diligently implemented core requirements yet simultaneously prepared for the fuller spectrum of needs they knew would emerge. They adapted PS Centre materials to Bulgarian context, trained Ukrainian psychologists in PFA and developed essential first-line support. While maintaining this foundational framework, the team also began developing capacity for more complex interventions, understanding that some beneficiaries would inevitably require support beyond basic psychosocial assistance as their displacement extended from weeks into months.

As the crisis evolved from acute emergency to long-term displacement, these preparations proved prescient. BRC developed practical PTSD training and structured trauma intervention approaches—not exceeding project scope but thoughtfully addressing identified gaps where national

systems couldn't meet emerging needs. This pragmatic evolution balanced maintaining robust PFA services as the foundation while building readiness to support beneficiaries whose needs progressed beyond basic psychosocial support, ensuring no one fell through the care continuum gaps.

Coverage

The PFA training coverage demonstrated strong reach and scope across multiple stakeholder groups. The 1,326 trained spanned all 28 Bulgarian regions with concentrated efforts in the 6 biggest cities and detailed implementation across 14 regions. This wide geographic spread ensured national-level capacity building rather than localized pockets of expertise.

The training successfully extended beyond traditional humanitarian actors to include 114 healthcare workers (doctors and nurses), 26 social workers in the Restoring Family Links sector, 271 people from Ukraine, 112 volunteer psychologists, and specialized groups such as sport coaches working with children and teenagers. The cascade training model proved highly effective, with 22 trainers from regional branches delivering 28 regional training sessions, creating sustainable capacity multiplication across the country.

Effectiveness

The Bulgarian Red Cross successfully trained 1,326 staff and volunteers in Psychological First Aid across the project period, exceeding the target of 1,297. This achievement was built upon a comprehensive Training of Trainers approach, with 22 psychologists from all 22 regional BRC branches completing ToT in PFA during January and February 2023, creating a sustainable foundation for ongoing training delivery.

The project's reach extended beyond internal BRC capacity to include diverse stakeholder groups. A total of 271 Ukrainian refugees were trained in PFA, with 211 subsequently becoming BRC volunteers and actively participating in MHPSS activities within their communities, demonstrating effective community integration and capacity building. The training program also reached 114 health workers across 14 regions and 26 social workers in the Restoring Family Links sector, showcasing the project's broader sectoral impact.

The training program was formalized through certification and maintained strict adherence to Red Cross mandate boundaries. All participants received certificates from the Bulgarian Red Cross upon completion, validating their knowledge and skills in PFA and PSS and enabling them "to effectively respond to the psychosocial needs of individuals and communities affected by crisis, disaster, or emergencies." The training successfully established clear boundaries and understanding of the Red Cross mandate, with Ukrainian psychologists understanding that their "task was to not make therapy, but PFA and PSS," ensuring appropriate service delivery within humanitarian frameworks.

A key factor contributing to this effectiveness was the project's ability to build upon existing organizational strengths. As noted by the BRC director, "we already had the experts to scale PFA," indicating that the project successfully leveraged pre-existing capacity rather than starting from zero. However, while the Regional Office Europe was seen as supportive for training overall, the initial training was noted as being more tailored towards National Societies with limited capacity, making it less applicable to the BRC context and suggesting the need for more advanced training options for organizations with established MHPSS foundations. Additionally, there were no pre or post tests for the trainings, or ways to validate the effectiveness of the training done on an individual level, which could be an important improvement for future programming to better measure actual learning outcomes and skill acquisition.

Impact

The project generated significant positive organizational changes within the Bulgarian Red Cross, with leadership noting that "we have built capacity - higher than before EU4Health - capacity can be transferred," indicating sustainable improvements to institutional capabilities. This enhanced capacity strengthened "the capacity and sustainability of BRC's workforce while ensuring safer, more effective support for affected communities," demonstrating clear benefits for both internal organizational resilience and external service delivery quality.

The training programs had notable professional development impacts on both staff and volunteers, particularly among Ukrainian participants who experienced transformational leadership development. As highlighted in focus group discussions, "Because of the RC training and this project, they became the leaders in their community." The training enabled participants to develop new collaborative approaches, with volunteers gaining understanding of "different experience to working with others" and "how to work as a team of psychologists." Importantly, the focus on crisis intervention skills as well as general mental health approaches proved particularly valuable, with additional specialized training in art therapy and trauma work being especially helpful for psychologists.

The project's impact extended well beyond the EU4Health program through spillover effects and broader system integration. The MHPSS capacity built through EU4Health has been leveraged to support a health in emergencies project funded by the Canadian Red Cross, demonstrating immediate transferability of developed capabilities. Municipal authorities expressed strong interest in expanding PFA training to public sector staff including firefighters, police officers, and teachers, recognizing the training's value beyond humanitarian contexts. This external validation was reinforced by municipal representatives who saw no barriers to training PFA within municipalities, indicating clear potential for future partnerships and broader training delivery that could extend the project's impact across multiple sectors.

Sustainability

As noted, the EU4Health project has established a foundation for long-term MHPSS capacity through plans for a dedicated four-person MHPSS unit within Bulgarian Red Cross. This unit will eliminate the single point of failure risk while enabling strategic expansion, with two staff focused on proposals/funding and two on implementation/coordination which can include supporting further trainings beyond the EU4Health project.

Sustainability is built on a cascading training model where volunteers were trained in both PFA delivery and supervision. As one director explained, "If you train a trainer you can do whatever you want without money," demonstrating how the train-the-trainer approach enables scalable capacity without ongoing external funding.

The BRC plans to commercialize PFA training by integrating it into Bulgaria's educational system and expanding to public sector workers including teachers and firefighters. This strategy to "make PFA training recognised by educational system - start to sell it" could create sustainable revenue streams while embedding MHPSS capacity within national systems, ensuring continuity beyond project completion.

Efficiency

As noted, the trainings achieved great efficiency through strategic resource allocation and structural advantages. With only two full-time staff, the program successfully trained 1,326 Red Cross personnel

and 271 Ukrainian volunteers through a Training of Trainers (ToT) model that created significant multiplier effects.

The ToT structure, combined with Bulgaria's centralized Red Cross organization, enabled rapid and cost-effective scaling. The centralized Bulgarian Red Cross structure further facilitated coordination and streamlined implementation across 22 regional branches, maximizing reach while minimizing administrative overhead.

Accountability & management

The training programs demonstrated strong organizational accountability through well-structured national implementation that scaled effectively across Bulgaria's centralized Red Cross network. Training delivery was formalized with participants receiving certificates from the Bulgarian Red Cross that validated their knowledge and skills in PFA and PSS, enabling them "to effectively respond to the psychosocial needs of individuals and communities affected by crisis, disaster, or emergencies."

Red Cross Red Crescent principles were thoroughly embedded throughout the training curriculum, ensuring strict compliance with organizational mandates. Training specifically reinforced that volunteers should only focus on providing support at the base of the MHPSS pyramid ‘’ you cannot ask them to do therapy," demonstrating clear boundaries and regulatory adherence that protected both recipients and the organization from scope creep.

For future programming, implementing pre- and post-tests on a sample of trained participants could provide deeper validation of training effectiveness and enable systematic identification of knowledge gaps and additional skill development needs. This would strengthen the evidence base for training impact while supporting continuous improvement in program delivery and participant competency assessment.

Component 3: Caring for Staff & Volunteers

Support Overview

The BRC implemented a comprehensive CfSV program that trained 10 trainers who delivered CfSV training to 382 staff and volunteers, establishing structured care systems including individual and group supervision sessions, peer support networks, a dedicated CfSV helpline, and referral pathways to mental health professionals - a significant expansion from previous limited psychological debriefing to a full support ecosystem. The program benefited from strong leadership commitment, with the BRC EU4Health lead having a PhD in CfSV and prioritizing it as a key area. However, a primary challenge was financial sustainability post-project, with leadership concerned about continuing "what we do now (is) because we have money - question is how will we continue to do in same way without the money," requiring transition to cost-effective models like larger group supervision and volunteer supervisors to maintain the support systems.

Relevance

The Bulgarian Red Cross demonstrated strong awareness of staff and volunteer wellbeing challenges, recognizing that their workforce faces prolonged exposure to high-stress environments while supporting traumatized populations, leading to risks of emotional over-involvement and difficulty maintaining professional boundaries. Ukrainian volunteers faced particular challenges providing

support to people experiencing similar trauma to their own. Prior to the project, support was limited to psychological debriefing after difficult cases, but the initiative expanded this to include structured individual and group supervision sessions specifically designed to address secondary traumatic stress, with the CfSV training program adapted to the Bulgarian context. The support system aligned with EU priorities on mental health and workforce resilience while directly supporting EU4Health objectives for strengthening health systems and crisis preparedness.

To strengthen evidence-based decision-making and track the effectiveness of wellbeing interventions, implementing an annual staff wellbeing survey could provide systematic monitoring of workforce mental health, stress levels, and support needs. This would be particularly feasible if the proposed MHPSS unit is established with dedicated resources, enabling regular assessment of burnout risk, job satisfaction, and the impact of supervision and support mechanisms. Such data would help identify emerging needs, demonstrate program impact to donors, and ensure that support services remain responsive to evolving staff and volunteer challenges.

Coverage

To date, 382 staff and volunteers have received CfSV training and supervision support, though detailed breakdowns between staff and volunteer participation are not currently available in the data. The CfSV initiative remains in early implementation stages, with supervision group sessions planned to continue and expand across regions beyond the current coverage. The newly established supervision helpline has received limited calls thus far, which is expected given its recent launch, but it represents an important mechanism for broadening support coverage across the BRC network. As the program matures, more detailed data collection on CfSV participation, including staff versus volunteer engagement, geographic distribution, and utilization rates of different support mechanisms, will be essential for understanding the full extent of coverage and identifying gaps in wellbeing support provision.

Effectiveness

The project achieved 88% of its CfSV target, reaching 382 staff and volunteers against a goal of 436. The initiative successfully expanded wellbeing support beyond the previous limited approach of post-incident debriefing to include structured supervision training, which volunteers described as “very helpful” and valuable. Six supervision sessions were conducted where participants gathered to share experiences, with team building and networking recognized as particularly effective elements - participants emphasized the importance of "being together" for peer support and connection.

The main challenges to effectiveness include the ongoing reality of high workloads and limited funds, with volunteers acknowledging the difficulty of maintaining their own mental health under pressure. Despite these challenges, the expansion from reactive debriefing to proactive supervision and peer support represents significant progress in supporting wellbeing.

Impact

Beyond qualitative insights from staff and volunteers who view the supervision structures as helpful for their wellbeing, there are currently no impact indicators to measure CfSV outcomes. This gap could be

addressed through annual wellbeing surveys for staff and volunteers, alongside analysis of helpline utilization statistics expected later in 2025.

Efficiency

The CfSV program demonstrated strong efficiency through its train-the-trainer approach, with 10 trainers cascading knowledge to 14 team leaders who then provided ongoing supervision to 382 staff and volunteers, creating a significant multiplier effect. The director noted that training trainers enables activities to continue more easily when funding is less secure. Group supervision sessions brought participants together for shared support, maximizing impact through collective rather than individual delivery. The integration of CfSV into the broader MHPSS framework, rather than operating as a standalone program, improved efficiency while strengthening workforce capacity and ensuring safer, more effective community support - achieving dual benefits from a single intervention.

Sustainability

Current CfSV activities face significant sustainability challenges, being entirely dependent on project funding with only two full-time positions supported by EU4Health. The director acknowledged this vulnerability, asking "how will we continue to do in same way without the money?" To address these constraints, Bulgarian Red Cross is developing several sustainability strategies: implementing larger group supervision sessions with single supervisors to reduce costs, recruiting volunteer psychologists from outside the system to serve as supervisors, and planning an MHPSS unit expansion. If established by September or October, this unit would provide a one-year runway to 2026 to embed CfSV activities more permanently within the organization's structure.

Accountability & management

As noted, CfSV has been efficiently scaled with limited resources. However, to expand further and ensure sustainability will require broader capacity building and institutionalization into core BRC operations, ensuring its longevity and persistence beyond project funding. This institutional embedding should be supported by systematic data collection and monitoring of staff wellbeing through annual surveys and regular tracking mechanisms, establishing the evidence base needed for responsive management and continuous improvement of CfSV.

Component 4: Stakeholder Coordination

Internal coordination

The centralised structure of the Bulgarian Red Cross significantly facilitated internal coordination throughout the EU4Health program. With its extensive network of 28 regional branches, 16,000 long-term volunteers, 145,000 members, and 13 additional humanitarian service points, the BRC had a robust infrastructure that made coordination easier compared to more decentralized national societies.

The IFRC provided strong and consistent coordination support through multiple mechanisms. Bi-monthly meetings were held with the IFRC lead for sharing insights across national societies, while the Regional Office Europe (ROE) offered valuable implementation flexibility and organized monthly problem-solving sessions when multiple national societies faced common challenges. As noted by participants, ROE's approach of sharing insights "indirectly" was seen as respectful and effective. Close collaboration between the BRC MHPSS Coordinator and IFRC Operation manager ensured effective cross-cutting support in community engagement, accountability, protection, gender, and inclusion, with all MHPSS activities closely integrated with those funded through the IFRC Ukraine appeal.

The MHPSS capacity built through EU4Health was successfully leveraged across the wider RCRC Movement. This included projects supported by the Canadian Red Cross and Hong Kong Red Cross, demonstrating active cross-Movement collaboration and the transferability of the developed capacity. The BRC EU4Health lead also contributed to wider Movement learning by sharing child-friendly space practices with the IFRC ROE MHPSS Hub, while participation in the 2023 European Network for Red Cross Red Crescent MHPSS Forum strengthened international connections and knowledge exchange.

External coordination

External coordination with government actors proved effective at multiple levels. Municipalities developed strong referral pathways, directly sending Ukrainian refugees to Red Cross for MHPSS services. Municipal representatives reported that the three-year crisis period significantly strengthened their relationship with the Red Cross, with one noting they had "direct contact to the director" and describing the Red Cross as having "become a big heart for the Ukrainians" and "like a family to the Ukrainian community."

The BRC worked closely with government agencies at local, regional, and national levels through various formal mechanisms. A significant milestone was the June 2023 roundtable on MHPSS provision for vulnerable groups, which brought together representatives from the Ministry of Health, Social Services Agencies, Municipal Authorities, the academic community, and psychologists. This was followed by hosting an international conference in June 2025 on "Mental Health in the Context of Crisis and Vulnerability" that included the Deputy Minister of Health, parliament health commission president, and key stakeholders - significantly raising BRC's visibility as a leading MHPSS provider in Bulgaria.

Humanitarian sector coordination operated primarily through the monthly cross-sectoral MHPSS Technical Working Group meetings, established in December 2022 in line with IASC guidelines and the global MHPSS Minimum Service Package. These meetings involved WHO, NCPHA, UNICEF, UNHCR, IOM, FAR, AKNO, and other NGOs working with Ukrainians, with 57 coordination meetings held overall. Participants shared information about reach, best practices, and ensured comprehensive coverage despite not all organizations working nationwide.

The Ukraine Centre and BRC had close collaboration preventing activity duplication and ensured proper service delivery. This included bidirectional referrals - with BRC sending people to the Ukraine Society for psychological support and vice versa - and joint activities such as cooking clubs and art therapy classes conducted collaboratively at the beginning of the response. Partners noted that "knowing what everyone's doing helps people to be served properly" and that much of the Ukraine Centre's MHPSS setup was learned from the BRC.

While coordination achieved notable successes, with Red Cross being more visible at borders than UNHCR and UNICEF and being recognized as "the first NGO that gave a hand immediately," challenges remained. These included difficulties with psychiatric referrals due to language barriers (few Russian-speaking psychiatrists), gaps in government mental health coverage, tensions between preventive psychosocial work and psychiatric services, and some coordination challenges with UNHCR at COMPASS centres. Municipality representatives also noted that other NGO work was "less systematic as RC - is more about organizing a few activities."

Overall, the EU4Health program enabled BRC to become highly visible in the MHPSS field in Bulgaria, with the program lead finding it an excellent opportunity to significantly advance their MHPSS capacity. The experience highlighted a key lesson that "mainstreaming with other sectors within the crisis response is crucial" as there are many cross-cutting activities requiring appropriate organization and coordination.

Recommendations

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Staffing - Establish the planned four-person MHPSS unit by late 2025 to eliminate single point of failure risk. The current concentration of MHPSS capacity in the EU4H NS lead leaves vulnerability. Implement the planned structure with two staff supporting project bids & two focused on implementation to ensure institutional resilience & capacity continuity.			X	X
Continue to expand MHPSS services beyond basic PFA to include specialized trauma support. Develop practical PTSD training & step-by-step approaches for working with people experiencing deep psychological trauma, as 70% Ukrainians need support beyond first-level intervention as 2025 assessment shows.		X	X	X
Address psychiatric care access barriers through system-level solutions. Work with government health authorities to increase availability of Ukraine/Russian-speaking psychiatrists & improve referral pathways between BRC services & formal mental health systems.			X	X
Capacity - Commercialize & mainstream PFA training across public sectors. Integrate PFA training into Bulgaria's educational system & expand to public sector workers including teachers, firefighters, & police officers. This strategy could create sustainable revenue streams while embedding MHPSS capacity in national systems.			X	X

Recommendation	Donor	IFRC / Project coordinators	NS HQ/local leaders	NS Project lead
Implement pre- & post-training assessments to validate effectiveness. Develop systematic testing for PFA trainings to measure actual learning outcomes & skill acquisition, enabling evidence-based improvements in training delivery & participant competency assessment.				X
Develop differentiated training pathways based on existing capacity levels. Create advanced training options for organizations with established MHPSS foundations, as initial training was noted as being more tailored towards NS with very limited capacity.		X		
Implement annual staff wellbeing surveys to track workforce mental health systematically. Establish regular assessment of burnout risk, job satisfaction, & impact of supervision to ID emerging needs, demonstrate program impact to donors, & ensure support services remain responsive.			X	X
Transition to cost-effective CfSV models for sustainability. Implement larger group supervision sessions with single supervisors & recruit volunteer psychologists from outside the system to serve as supervisors, ensuring continuity of support systems beyond project funding.			X	X
Address technical challenges with the PSS system experiencing data loss by upgrading software infrastructure with future funding, moving beyond current USB backup solutions to ensure data integrity & improve monitoring capabilities.			X	X
Develop quantitative impact measurement tools for MHPSS. Move beyond qualitative assessments by implementing standardized outcome measures & developing proxy indicators for mental health improvements to better demonstrate program effectiveness to donors & stakeholders.	X	X		X
Formalize government partnerships for long-term MHPSS integration. Build on the June 2025 MHPSS conference to establish formal agreements with Ministry of Health & municipalities for integrating BRC MHPSS in national MHPSS strategies & emergency response frameworks.				X

Case Study Visit Report: Lithuanian Red Cross

Executive Summary

SARDE undertook a 3-day field visit to Lithuania in June 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The Lithuanian Red Cross successfully scaled from minimal MHPSS experience to delivering 30,683 instances of support to displaced Ukrainians by hiring 16 psychologists and implementing comprehensive services including psychological first aid, recovery groups, art therapy, and individual counselling. This rapid deployment was essential given that 20% of Ukrainians in Lithuania required mental health support, with only 40% finding their needs partially met through existing services.

Program effectiveness significantly improved when marketing shifted from clinical terminology like "stress management training" to accessible language such as "women's clubs" leading to increased registrations. Recipients rated Ukrainian psychologists who had experienced displacement themselves as more effective due to their intuitive understanding and community-building approach, while Lithuanian psychologists brought valuable integration support and alternative therapeutic methods including mindfulness techniques.

The project demonstrated strong impact with 95% of recipients reporting improved psychosocial wellbeing and high satisfaction ratings averaging 9/10. Sustained demand was evident through continuous group meetings lasting over a year, with some participants describing their local branch as their "second home." The rapid service delivery within 24 hours compared favourably to mainstream national services, though gaps remained in reaching Ukrainian men and teenagers despite targeted programming efforts.

Training initiatives achieved scale, with 2,239 people trained in psychological first aid and MHPSS approaches across 10 cities, exceeding the target of 2,050. The establishment of a ToT structure using 27 volunteer trainers proved highly effective for sustainability, while the integration of training programs into the LRC Academy created better long-term strategic planning and institutionalization through e-learning platforms and improved data management systems.

Staff and volunteer support structures were strengthened through supportive supervision training for 20 internal supervisors and external therapy provision, reaching 736 individuals or 95% of the target. However, challenges emerged including supervisor capacity constraints, with some supporting up to 15 individuals, and financial limitations that restricted external therapy to crisis cases only. The 16 Ukrainian psychologists faced particular burnout risks due to experiencing refugee trauma while providing support to others alongside other roles.

Coordination efforts positioned the LRC as a key national emergency response partner, with successful collaboration across six government registration centres and participation in national MHPSS platforms. The project enhanced organizational visibility and capacity demonstration while establishing valuable partnerships with government ministries, universities, and NGOs. However, internal coordination faced some challenges during leadership transitions.

The program's sustainability faces risk with EU4Health funding ending in October 2025, potentially resulting in losing the 14 Ukrainian psychologists despite continued demand. While the volunteer trainer structure and LRC Academy integration support long-term capacity, ongoing municipal funding and inclusion in regional projects remain essential for service continuation beyond current funding.

Recommendations outlined in full in the report include:

Maintaining comprehensive, flexible service delivery recognizing individuals arrive at different crisis stages. Develop baseline diagnosis with specific quotas and priority categories for most vulnerable populations while ensuring full spectrum MHPSS services remain available.

Implementing systematic data and impact measurement through structured PGI approach enabling disaggregation by language, age, disability, gender, and nationality. Build on LRC Academy system for targeted delivery while developing pre/post-tests for training impact and confidential MHPSS monitoring.

Strengthening organizational systems and integration by embedding psychologists into broader MHPSS Unit and LRC Academy structures. Expand supervision capacity reducing current burden on supervisors, with mandatory supervision for high-stress roles like case managers.

Developing culturally responsive capacity through structured cross-cultural training for all MHPSS personnel, including Ukrainian-specific programming addressing competency gaps. Implement interactive approaches using simulation-based situations and real RC volunteer scenarios.

Creating robust wellbeing support systems with regular, anonymous feedback channels beyond annual surveys. Re-run CfSV surveys identifying current stressors and adapt support measures as crises evolve. Provide specialized support for Ukrainian psychologists facing unique challenges, including clearer client-boundary guidance.

Building community partnerships and knowledge management by strengthening relationships with Ukrainian stakeholders, particularly schools. Leverage new MHPSS Unit structure to advance EU4H learnings while establishing mechanisms for knowledge transfer from migration psychology experts addressing identity loss and acculturation stress.

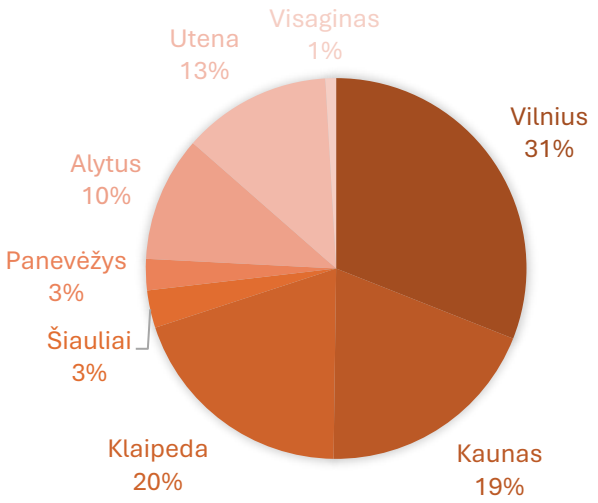
Visit Overview

National Society: Lithuanian Red Cross
Locations: Vilnius and Kaunas
Visit Dates: 25th-27th June 2025
Evaluation Team: Jonah Rudlin, Marta Siciarek.

The evaluation team conducted a 3-day field visit to Vilnius and Kaunas, accompanied by Lithuanian RC's EU4Health staff coordinator, former project manager, and psychologist coordinator. These branches were selected as the most active regions for psychosocial activities in 2025, representing 50% of total program spending. (see pie chart to right).

The research included interviews and focus groups with the LRC EU4H management team, the local branch EU4Health teams in Vilnius and Kaunas, broader RC project staff, psychologists and health professionals, volunteers and project recipients.

BUDGET ALLOCATION FOR LRC PSYCHOSOCIAL SERVICES IN 2025



Stakeholders engaged

Location/ stakeholder	EU4H Leader-ship	MHPSS Staff	Volunteers	Displaced Recipients	*Total*
Manager of LRC programs	1				
CfSV / EU4H staff Coordinator	1				
LRC Academy / PFA training manager		1			
Ukrainian psychologists in Vilnius		3			
Recipient of CBMHPSS and 1-1 counselling in Vilnius				10	
Kaunas community engagement coordinator/specialist		3			
Ukrainian psychologists in Kaunas			3		
Recipients of CBMHPSS and 1-1 counselling in Kaunas				8	
Volunteer coordinator in Vilnius		1			
Internal supervisors for CfSV in Vilnius			6		
PFA volunteer trainers			3		
Preparedness and Crisis Response Team volunteers			7		
Total	2	8	19	18	47

Component 1: MHPSS for Displaced Populations

Program Overview

The Lithuanian Red Cross launched the EU4Health project in early 2023 despite minimal MHPSS experience. The initiative addressed critical gaps first identified during the 2021 Belarusian migration crisis and further exposed when 70,000 Ukrainian refugees arrived in Lithuania. Following extensive needs assessment and leveraging experience from operating six refugee registration centres, the organization hired 14 Ukrainian and two Lithuanian psychologists to deliver comprehensive MHPSS support.

By July 2025, Lithuanian Red Cross had provided 30,683 MHPSS interventions to Ukrainians, approaching their 35,000 target. Services included PFA, community-based group activities (recovery groups, parent training, women's clubs, art and clay therapy, teen board-game clubs, mindfulness sessions), and individual counselling. The project established a standalone helpline later integrated into the national 111 humanitarian line.

Relevance

Initial assessments in Spring 2023 revealed that 20% of Ukrainians in Lithuania required mental health and psychosocial support (MHPSS), yet only 40% of those had found their needs partially met. Key barriers included language constraints, mental health stigma, and limited Ukrainian-language state services. Based on these findings, the program evolved beyond basic PFA training at distribution centres to implement more advanced interventions combining community-based MHPSS and higher-tier approaches.

The core intervention, Skills for Psychological Recovery (SPR), was designed to address post-trauma situations and problem-solving skills, complemented by psychosocial activities including art therapies, nature clubs, and children's clay-modelling workshops.

Initial uptake was slow until marketing language shifted from clinical terminology like "stress management training" to accessible terms such as "women's clubs" and "personal boundaries," incorporating facilitator photographs. This rebranding significantly increased registrations.

By late 2024, as Ukrainian concerns shifted from displacement shock to integration challenges, the curriculum was refreshed accordingly. SPR modules expanded to address long-term coping strategies including job-search stress management, navigating Lithuanian school systems for parents, and maintaining cross-border relationships, ensuring content aligned with evolving community needs rather than initial acute distress.

Focus group participants emphasized that service needs change throughout crisis phases, with initial priorities being shelter and cash assistance before MHPSS activities. Group activities served as effective entry points before individual counselling. Recipients recommended maintaining the full service spectrum continuously, recognizing that individuals arrive at different stages with varying needs.

Original activity flyers (left) were rebranded (right) to include less clinical language and to show the psychologist, greatly increasing engagement

Coverage

Communication of activities currently relied on signposting at border crossings, group chats on Telegram (1,315 members in Vilnius, 1,066 in Kaunas) and Viber (834 in Kaunas), word-of-mouth referrals, and occasional targeted outreach efforts. Collaboration with NGOs including Caritas and Save the Children, alongside partnerships with Ukrainian Centres, helped broaden outreach and strengthen service uptake across the network.

At least seven of fourteen branches established MHPSS services for Ukrainians, located in areas with the highest concentration of Ukrainian residents. Reflecting broader displacement demographics, women have been the most consistently engaged group, particularly through women's clubs and art therapy sessions, or indirectly through their children's participation. Children have been effectively reached through art-based activities and child-friendly spaces (part-funded by EU4Health and the Canadian Red Cross), though teenagers present ongoing challenges despite introducing board game clubs and activities like bracelet making, which aren't always sustained.

Partnerships have been established with Ukrainian International Schools across the country, with some psychologists serving as counsellors to support cross-referral and conducting activities such as winter workshops to promote Red Cross services. However, connections to Lithuanian schools where some Ukrainian children attend remain limited, with plans underway to further institutionalize this engagement.

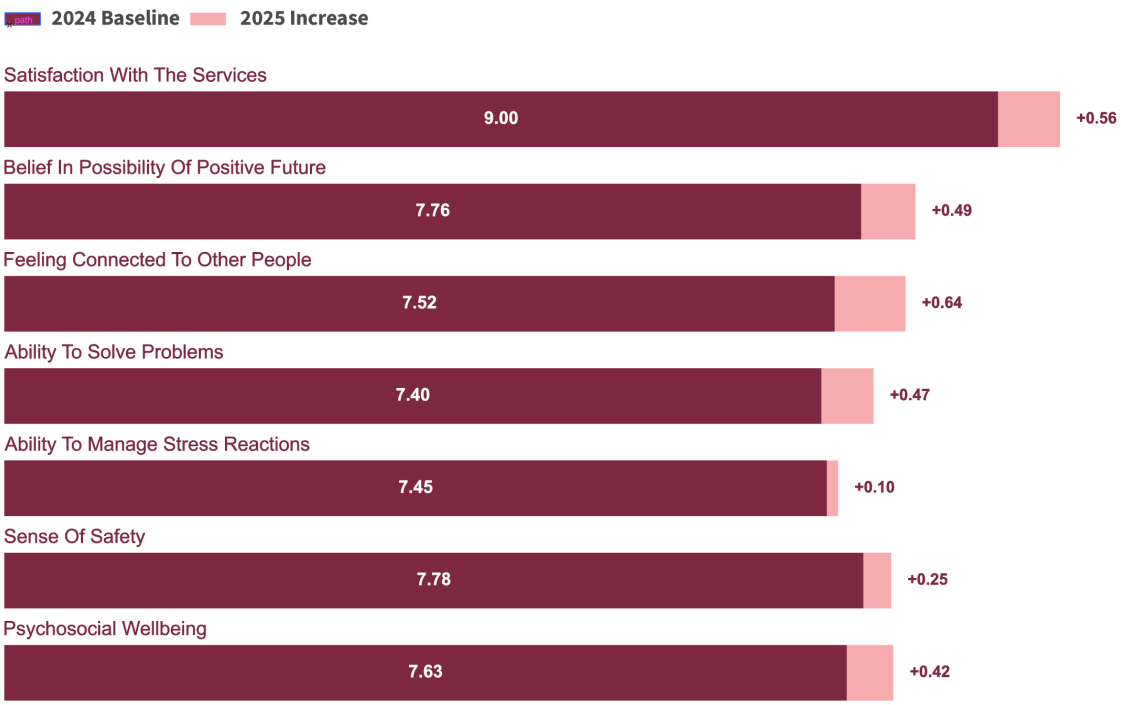
Older populations have been reached through tailored initiatives including senior clubs and warm visits, but engagement remains challenging due to digital exclusion, which may explain why only 15% of respondents in the 2023 needs assessment were aged 55 and above. Some LGBTQ+ individuals have participated in one-off activities, though no structured approach currently exists for these groups. Men from Ukraine remain notably absent from activities. While the majority of displaced communities are women and children, like all National Societies engaged, men still appeared to be underrepresented in terms of service supports. Consideration should be given to hiring male psychologists or developing tailored programming to better reach this population.

While Protection, Gender and Inclusion training is mandatory for LRC staff and volunteers, their outreach and coverage of MHPSS activities would benefit from a structured PGI approach to enable clearer data collection and recipient disaggregation, as well as establishing vulnerable priority categories for strategic engagement. The LRC Academy is developing such a system with data collection priorities including age, disability, gender and nationality, which could prove valuable for supporting more systematic coverage of needs. Coverage could then be ensured based on baseline diagnosis establishing target numbers of recipients, including specific quotas for the most vulnerable.

Effectiveness

Evaluation QR code feedback forms with 191 responses showed strong outcomes across all areas: 9.28/10 average satisfaction rating, with 165 respondents (86%) maintaining consistent weekly attendance and 96 respondents (50%) participating for 1-3 months, indicating sustained involvement. There was also a slight improvement across all wellbeing indicators between 2024 and 2025.

Comparison between 2024 and 2025 average wellbeing indicator scores 1-10 (n=191)



Recipients consistently described higher effectiveness when working with psychologists whose backgrounds closely matched their own experiences. Ukrainian psychologists who had experienced displacement themselves were particularly valued for their intuitive understanding of emotional needs and ability to serve as community builders. These professionals were characterized by recipients as

having a more confident, direct, and goals-oriented approach to life-building rather than focusing on past experiences.

Lithuanian psychologists brought distinct strengths in supporting integration efforts and offering alternative therapeutic approaches including mindfulness techniques. In Kaunas specifically, group activities and excursions proved highly effective for stress reduction, relationship building, and cultural integration, though some recipients emphasized that individual therapy remained essential to maximize the benefits of group sessions. However, participants rated the higher-level MHPSS approach of SPR as most effective when compared to lighter-touch activities.

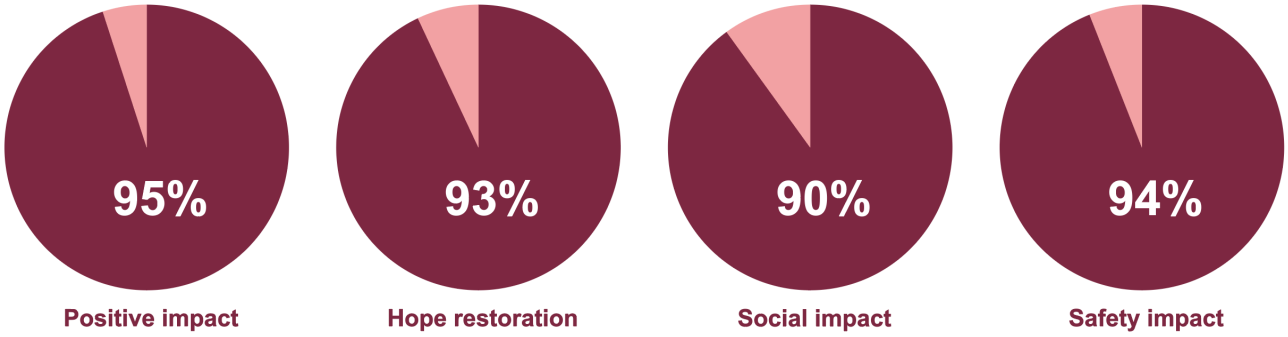
The Lithuanian Red Cross's fast service delivery was highly valued by recipients, with support available within 24 hours compared to mainstream national services. This accessibility, combined with long-term and non-committal service options, increased participation rates by lowering entry barriers and overcoming stigma. Psychologists observed that individual consultations worked best for children while group activities better suited adults through supporting communication skills.

The helpline program delivered psychological first aid in 25% of approximately 1,000 calls received over a six-month period, demonstrating the integrated delivery of MHPSS support alongside other services. While the majority of calls related to financial assistance for housing rental costs and 10-15% involved general inquiries such as job searching and paperwork assistance, the provision of PFA to vulnerable groups including elderly people, individuals with disabilities, and large families illustrated how psychological support was woven into broader humanitarian assistance.

Impact

The MHPSS services showed a strong impact with 191 responses (95%) strongly agreeing that activities improved their psychosocial wellbeing, while only one person disagreed across this measure. Impact was consistent across all domains: 96% reported enhanced problem-solving confidence, 95% improved stress management abilities, 94% enhanced sense of safety, 93% restored hope, and 90% strengthened social connections. Current confidence levels averaged 7.65/10 for problem-solving abilities, with less than 2% negative responses across all impact measures, though stress management received the lowest current rating at 7.52/10, indicating ongoing need.

Percent recipients agreeing/strongly agreeing that the activities had impact (n=191)



Sustained demand and repeat attendance served as key impact indicators, with activities showing strong long-term membership being maintained while others were rebranded based on engagement levels. As late as June 2025, psychologists reported delivering up to 30 sessions per week due to continued demand. Some groups in Kaunas had been meeting continuously for over a year, with

participants describing the branch as their 'second home', demonstrating significant attachment and impact.

Focus group feedback from psychologists revealed that 90% of participants "feel results very quickly" and display signs of emotional release and improved functioning. However, psychologists noted that more comprehensive impact measurement tools, including pre- and post-tests, would be necessary to understand sustained individual impact and identify which specific activities address particular challenges. This deeper analysis could strengthen connection between needs assessments and activity design, though such measurement approaches present implementation challenges.

Efficiency

The 16 psychologists across branches were employed on a flexible freelance basis at 30 euros per hour for consultations and 50 euros for group activities, enabling efficient scaling of services in line with demand. Most psychologists retained capacity to deliver additional activities, with service delivery primarily constrained by demand and funding rather than staffing limitations. This operational efficiency allowed the LRC to utilize its entire budget effectively, resulting in selection as one of eight societies to receive a cost extension.

Despite operational success, concerns emerged regarding psychologist burnout as many juggled multiple roles alongside uncertainty about future funding for their services. Additionally, there appeared to be missed opportunities for better knowledge transfer from experts and psychological organizations specializing in forced migration issues such as identity loss, acculturation stress management, and related challenges. While the MHPSS Hub provided support, the changing coordinator roles within the LRC may have hindered efficient access to this specialized expertise, leading to a more ad-hoc approach rather than building on established migration-focused psychological frameworks.

Accountability & management

The 16 psychologists receive support from a Vilnius-based coordinator who conducts regular intervision sessions, tracks activity delivery, and manages recipient referrals. While activities were initially designed centrally following needs assessments, psychologists operate with considerable independence in their delivery, which effectively enables flexible approaches and allows professionals to leverage their specializations while maintaining ownership over session formats.

However, this independent delivery model potentially creates gaps in quality assurance and comprehensive supervision support. Enhanced integration of the 16 psychologists into the broader MHPSS Unit and LRC Academy could address these concerns by providing continuous support, training opportunities, and resource recommendations aligned with strategic needs and vulnerability assessments of Ukrainians in Lithuania.

Sustainability

EU4Health funding has been extended twice and currently ends in October 2025, with ongoing efforts to secure municipal funding and inclusion in regional AMIF projects to ensure continuity. However, there is significant risk that all 14 Ukrainian psychologists will need to be terminated when EU4Health funding concludes in October 2025, despite continued demand for services.

Budget reductions have already necessitated cuts to psychological services, particularly one-on-one counselling, even as demand remains strong. The operationalization of the broader LRC MHPSS Unit presents a crucial opportunity to enable service continuation and provide capacity for identifying additional funding streams to support ongoing psychological support services.

Component 2: National Society Capacity Strengthening

Capacity Building Overview

Under the EU4Health project, significant capacity building was implemented by the LRC to strengthen MHPSS support nationally. The training structure of the LRC has been highly effective, with 2,239 people trained in PFA and MHPSS approaches by July 2025, exceeding the target of 2,050. Initial trainings focused on PFA for front-line staff and volunteers as well as supporting delivery of the SPR (skills for psychological recovery) activity for displaced Ukrainians. Organization of the trainings then moved under the leadership of the LRC Academy in mid-2024, which implemented a long-term strategic approach leveraging a volunteer Train-the-Trainer structure, showcasing a strong model for future sustainability. However, gaps remain in delivering more targeted training for Ukrainians, and further relationships could be developed with Ukrainian stakeholders such as schools to support more precise impact.

Relevance

Due to limited experience of MHPSS in Lithuania pre-EU4Health, training needs were broad. The Spring 2023 capacity assessment revealed particular gaps in delivering deeper psychological support beyond PFA, especially for trauma treatment such as PTSD and adaptation issues affecting children. In response to identified challenges, particularly stigma and lack of trust, Ukrainian psychologists were onboarded and trained in the tailor-made SPR approach which became the core MHPSS activity, as well as PM+ (stress management and problem-solving) and suicide prevention. Psychologists received additional capacity building in trauma, child psychology, and therapeutic methods such as art and sand therapy. Short online seminars (e.g., PFA for children, stress management) complemented in-person sessions.

For the PFA training, a delivery framework was established based on the EU4Health Budapest workshop, which provided a solid foundation but proved difficult to scale and required contextual adaptation. By late 2024, the LRC Academy had assumed ownership of training programs, developing a new mandatory 8-hour PFA Basic training designed to improve accessibility through its more compact format while being better adapted to the Lithuanian context.

Whilst PFA basic training incorporated Ukrainian-specific simulation exercises, none of the engaged staff had experienced these simulations in their own training, revealing possible gaps in refugee-specific trauma and cross-cultural competencies. Staff opinions varied considerably regarding cultural differences when serving Ukrainian recipients, with some minimizing differences while others emphasizing substantial distinctions. This divergence highlighted the possible need for structured cross-cultural training for all MHPSS personnel, including Ukrainian psychologists.

Training participant feedback (n=178) validated these insights, with those trained requesting more simulation-based practical situations and improved orientation for new arrivals. These suggestions

underscore the ongoing need to adapt training content to meet evolving field requirements and ensure maximum relevance for frontline MHPSS workers particularly in supporting Ukrainians.

Examples of contextual PFA scenarios created by the LRC Academy for roleplaying supporting someone who has recently arrived from Ukraine

> *"A Ukrainian woman comes to a humanitarian aid point to collect an assistance package (clothes, hygiene items). As she begins to speak, she starts crying and talks about the war in her homeland, her deceased husband, and the guilt she feels for not staying in Ukraine. The woman is experiencing a lot of pain and despair, but she opens up, accepts help, and gradually calms down."*
>
> *"A Ukrainian teenage boy comes to the center. He recently experienced cyberbullying. It's very difficult for him to talk about it because he's afraid that some of his new friends may have been involved in the offensive comments. The teenager feels hurt and isolated and fears that the situation will only get worse. He says that because of this incident, he has lost confidence in himself and no longer wants to go to school."*

Coverage

With 2,239 people trained in PFA and MHPSS approaches across 10 cities, the program achieved broad coverage. Those trained included LRC staff and volunteers, health professionals, teachers (although not in Ukrainian-language schools), social workers, civil servants in the Ministry of Social Affairs, LRC disaster management volunteers, as well as some private sector employees. However, data was not disaggregated by language spoken, making it impossible to evaluate coverage for Ukrainians specifically. Given that PFA training was primarily aimed at LRC staff and volunteers, only a few sessions were conducted for non-native speakers.

Effectiveness

The structured Training of Trainers (ToT) system has effectively supported delivery, with three LRC staff trained at the Budapest ToT event, then in turn training 27 volunteer PFA trainers, who have since trained 90% of the 2,200+ trained. The contextualization and shortening of the PFA training, supported by e-learning, has also greatly enhanced accessibility and uptake.

While the PFA Basic 8-hour length has increased accessibility, it remains too long for some volunteers. The LRC is looking to split the theoretical component into an e-module while retaining a half-day practical training to support greater flexibility. E-learning has also effectively allowed the provision of training over specific identified needs, such as PFA for children, stress management, and coping with death.

Training participant feedback (n=178) showed very positive responses, with most participants expressing gratitude and satisfaction using phrases like "everything was excellent," "very useful," and "thank you for the trainings." Participants particularly valued the interactive and engaging delivery style, professional and competent lecturers who were praised as empathetic, warm, and knowledgeable, and the good structure and clarity of information presentation. This positive reception was reflected in quantitative scores, with both training usefulness and trainer effectiveness averaging 9.6 out of 10.

Participants identified several areas for improvement, including requests for more practical examples and real-life scenarios particularly from Red Cross volunteer work rather than abstract examples, additional stress management techniques, consideration of pre-holiday scheduling impacts on work hours, and inclusion of more interactive activities.

Impact

Training on delivery of the SPR activity was particularly impactful, with recipients viewing that activity as having the most impact on their wellbeing. PM+ training was also seen as very effective in supporting Ukrainians later in the crisis who were experiencing deep depression and inaction. Suicide prevention triaging provided to psychologists was reported as "very important" for managing high-risk cases and was described as already having been applied in real situations, such as in a recent case with a Ukrainian teenager.

Psychologists have noted that the SPR, PM+, and suicide prevention trainings have supported their own career development and ability to work as practitioners supporting migrants beyond the program. Emergency response volunteers found the restructured PFA course to be much more useful than former PFA training they had received.

Post-training feedback forms (n=178) used by volunteer trainers consistently rated above 9/10 in terms of usefulness by participants. Participant feedback showed that many found the content useful and applicable to their lives, indicating the training's potential to influence their professional practice and personal development. The emphasis on interactive elements and practical value suggests participants gained knowledge and skills they could implement in their work supporting recipients.

However, there is a challenge in understanding the degree to which those trained will be applying their training specifically to displaced Ukrainians. For example, disaster response volunteers do not work specifically with Ukrainians, though following a recent apartment explosion there was a Ukrainian family living in the block. Considerations could be made for developing a follow-up survey for those trained to understand applicability of knowledge received and in which contexts they have applied it.

There is also not currently a systematic pre/post assessment of knowledge or skill acquisition in place, which could improve the robustness of training and enable greater feedback on the effectiveness and impact of training modules provided.

Accountability and management

Integration of the trainings into the LRC Academy in partnership with the MHPSS Hub has enabled a coordinated long-term strategic plan for MHPSS trainings. Such ownership has allowed for more advanced management systems, which began with Excel sheets and has since transitioned to Salesforce CRM. This has allowed for more rigorous data collection and analysis, as well as the current development of the PGI approach, enabling greater alignment between training and needs. Ownership by the LRC Academy has also enabled better integration of MHPSS training modules into broader LRC training pathways through their e-learning platform, increasing institutionalization.

Efficiency

Efficient partnerships have been established with government, such as the development of e-learning modules centred on PFA with migrants being developed with funding from the Ministry of

Social Affairs. The plan is to later adapt these modules for LRC staff and volunteers as well as broader stakeholders. Commercial trainings have also been conducted for high-risk professions, as well as private companies like banks. The trainings continue to receive high demand, and ongoing partnerships with municipalities and national government suggest continued relevance and visibility.

Sustainability

The training of 27 volunteers to deliver the PFA Basic course has supported long-term sustainability in delivery after funding ends, given that volunteers remain, or periodic ToT trainings are conducted to maintain the number of trainers. While the commercialization of PFA training provides a useful income stream (€8-10,000 per year), the value is not enough to support all MHPSS training needs, and therefore continual partnerships and project funding will be necessary to maintain MHPSS capacity nationally both within and outside the LRC.

Component 3: Caring for Staff & Volunteers (CfSV)

CfSV Overview

Since the project's launch, 736 staff, volunteers, and frontline responders have received MHPSS support, achieving 95% of the 778 target. While the LRC had existing supervision structures, these were not deeply institutionalized and components like buddy systems had struggled to be sustained. The EU4Health project provided an opportunity to refocus efforts, introducing a supportive supervision system for emotional support, skills development, and quality assurance, alongside external and free one-on-one therapy. Despite these interventions, like many Red Cross societies, challenges remain in system costs and capacity, with many staff and volunteers still heavily reliant on informal peer support and self-coping strategies.

Relevance

The need for enhanced support was clear from a 2023 survey showing 59% of staff and 26% of volunteers often felt unable to cope with stress. The top stressors highlighted in the CfSV survey were repeated exposure to traumatic stories, poor organisational communication, and loss of motivation among staff, while volunteers specifically cited guilt and helplessness from "never doing enough." To address these challenges, individual and group supportive supervision sessions were implemented to provide a space for sharing experiences and discussing challenging cases, thereby improving communication. Additionally, PFA training integrated self-care elements to emphasize the importance of individual wellbeing.

Coverage

Fifteen staff were initially selected and trained as supportive supervisors through a five-day Budapest course and a three-day follow-up led by the MHPSS Hub. Since then, five additional staff have been trained internally as supervisors and are available to deliver both group and optional one-to-one sessions.

The volunteer PFA trainer cohort benefits from a support system offering supervision and intervision approximately every two to three months for skill development and emotional release.

For emergency response volunteers, debriefings are now conducted after traumatic deployments such as search and rescue operations, led by the EU4Health LRC coordinator. Team leaders from crisis-response volunteers have also received specialized training to conduct these debriefings themselves. An external psychologist was also contracted to provide anonymous counselling services for both staff and volunteers.

The 16 psychologists providing MHPSS support for Ukrainians operate under a different support structure, relying primarily on peer support through intervision group conversations led by the psychologist coordinator within the MHPSS Unit, supplemented by access to individual therapy for processing challenging cases. While this arrangement provides valuable peer connection, it may result in these contracted psychologists having less comprehensive support coverage compared to core staff and volunteers. Ukrainian psychologists have reported experiencing burnout due to juggling multiple roles, while simultaneously facing the distinctive challenge of experiencing refugee trauma as they provide support to others. This suggests an opportunity to explore more integrated support structures that could complement their existing intervision sessions. Although their professional work often serves as a meaningful coping mechanism, developing additional support activities focused on long-term stress management could further strengthen the wellbeing of this dedicated group of professionals who are managing complex personal and professional demands.

Effectiveness

The MHPSS Hub Supportive Supervision training was described as very effective and useful by all participants, who greatly valued both the approach and materials. Since the project's launch, 736 staff, volunteers and frontline responders have received MHPSS support, vs the target of 778.

While supervision structures have been described as useful, several challenges have emerged. More volunteer supervisors are needed, as some currently support up to 15 individuals, creating an unsustainable burden. Since participation remains voluntary and is not contractually required, some supervisors recommend making supervision mandatory, particularly for high-stress roles such as case managers and lawyers where staff who most need support often do not request it.

Supervisors have identified additional needs including peer-to-peer check-ins, a stronger self-help culture, and clearer client-boundary guidance to protect staff wellbeing. Early in the project, severe burnout affected engagement staff before psychologists were available. However, PFA training proved valuable in emphasizing the importance of volunteers protecting their own wellbeing before helping others, offering an efficient mechanism for enhancing overall staff and volunteer wellbeing.

Financial constraints have also impacted services: the contracted external psychologist's sessions were initially unlimited but later capped at ten due to costs, and budget cuts now restrict external one-to-one therapy to crisis cases only. Additionally, a previously useful buddy system that paired newcomers for mutual support has lapsed, as its effectiveness depended heavily on personal rapport between participants.

Impact

While a baseline assessment of staff and volunteer wellbeing was conducted through the CfSV survey in 2023, no follow-up survey has been undertaken, making it difficult to quantify the impact of measures implemented under the EU4Health project. However, qualitative feedback from various

stakeholders provides insights into effectiveness. Emergency response volunteers found PFA briefings particularly helpful in managing their own anxiety and stress during crisis responses. Although current demand for supervision among PFA volunteer trainers remains low, those who utilize it highly value the support. Additionally, there is excitement for a planned yearly residential support event designed for team building and peer support.

The evolving nature of the crisis requires ongoing adaptation of support measures. For instance, the growing threat of conflict in Lithuania has created new challenges for volunteers, who report experiencing emotional strain from public scrutiny as their presence serves as a reminder of potential danger. In response to these emerging needs, some volunteers have requested resilience courses and an official Red Cross public message to counter negative community feedback, highlighting the importance of continual reassessment and responsive support strategies.

Efficiency

The external therapy provision has been partially funded by revenue from commercial PFA trainings; however, the cost has remained prohibitive, resulting in reductions to the service offering. This demonstrates that external therapeutic support might not be a realistic long-term solution for staff and volunteer wellbeing under current financial constraints.

Sustainability

The LRC now has the capacity to train additional internal supervisors, which could help reduce the burden on the 19 supervisors currently working at minimal cost. However, the feasibility of expanding this approach depends on the availability and capacity of internal staff and volunteers to support the initiative on an ongoing basis.

Accountability and management

With the new MHPSS Unit now in place, the LRC is better positioned to build upon CfSV efforts under the EU4Health project and begin collecting more structured feedback on wellbeing across the organization. While staff feedback is currently collected through an annual survey, some respondents have indicated that more frequent, anonymous feedback channels could better support CfSV efforts.

Re-running the CfSV survey would provide valuable indicators on current top stressors and identify what additional training could help support staff and volunteers in their work. The implementation of mandatory PFA training, which incorporates self-care elements, should also strengthen organizational wellbeing efforts moving forward.

Component 4: Stakeholder Coordination

Internal coordination

At the project's outset, internal coordination faced initial challenges due to very low MHPSS capacity and evolving management structures. Periods of leadership transition created shifting ownership, making pan-project insights and institutional knowledge gained from the MHPSS Hub and IFRC RoE team slightly difficult to maintain. However, the establishment of the MHPSS Unit with

multiple staff and split leadership between MHPSS support and training has now created a solid and effective foundation for service delivery and coordination.

A slight separation still remains between the EU4Health psychologists providing support for Ukrainian recipients and the core MHPSS team, which could be further strengthened. Regarding cross-branch coordination, while the LRC operates as a centralized system with a network department overseeing five regional managers, programme-to-branch coordination can still be challenging and may require earlier buy-in to project aims.

Monthly meetings with IFRC ROE and the MHPSS Hub, plus bi-monthly calls with EU National Societies and a Baltic community of practice, have proven highly effective according to the LRC, with no suggested improvements for coordination between IFRC and national societies.

External coordination

The LRC has positioned itself as a key national partner for emergency response, with the Ukraine crisis and EU4Health project serving as a crucial opportunity to demonstrate this capacity, particularly through its coordination role with six of seven government registration centres alongside the Migration Department. The LRC participates in the UNHCR response plan, sits on national MHPSS platforms, and holds quarterly coordination meetings with public authorities on refugee support.

The EU4Health project has helped sustain this role while advancing visibility and showcasing organizational capacity. This includes ongoing engagement with the Ministry of Social Affairs and Ministry of Health on context-specific PFA training and e-learning, successful coordination with The Ukrainian Centre (VDU) for venue provision and participant recruitment, and liaison work with schools and local NGOs for activity scheduling and promotion.

Additional partnerships include maintaining links with Caritas, Save the Children, German Red Cross and Somali Red Crescent for integration work, while commercial PFA trainings for private companies and Vilnius municipality both raise funds and widen partnerships. A Vilnius University professor has delivered Skills for Psychological Recovery training to project psychologists, and further engagements are planned with senior advisors in the Ministry of Labour and Social Affairs to align integration policy.

While crisis-response volunteers sometimes refer complex cases to public health crisis centres, language barriers persist, indicating that greater collaboration with state health systems would be needed to formalize these referral pathways.

Recommendations

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Maintain comprehensive, flexible service delivery model with targeted vulnerable population coverage - Establish full spectrum of MHPSS services recognizing that individuals arrive at different crisis stages with varying needs. Develop baseline diagnosis with quotas & priority categories for most vulnerable.			X	
Implement comprehensive data collection & disaggregation system - Structured PGI approach that enables systematic data collection & recipient disaggregation by language, age, disability, gender, nationality building on the LRC Academy system for more targeted delivery	X	X		
Develop impact measurement & evaluation frameworks - including pre- & post-tests to understand sustained individual impact for training, & individual monitoring for MHPSS support (confidential), strengthening the connection between needs assessments & activity design	X	X		
Strengthen organizational integration & capacity building systems - Enhance integration of psychologists into broader MHPSS Unit & LRC Academy structures to provide continuous support, training, & resource recommendations aligned to needs & vulnerability assessments			X	
Develop culturally responsive & targeted training programs - Design & implement structured cross-cultural training for all MHPSS personnel including Ukrainian psychologists with Ukrainian-specific programming to address cultural competency gaps & improve service relevance				X
Implement enhanced practical & interactive training approaches - include more simulation-based situations, real RC volunteer scenarios, & interactive activities to improve engagement & practical skills				X
Develop supervision & support systems - Expand pool of trained volunteer supervisors reducing current burden. Consider mandatory supervision particularly for high-stress roles such as case managers & explore integrated support for psychologists to complement intervision.			X	
Create improved wellbeing monitoring & response – Regular, anonymous feedback channels beyond annual surveys, re-run the CfSV survey to ID current stressors & training needs, ongoing adaptation of support measures as crises evolve, & courses for emerging needs				X
Provide specialized support for Ukrainian psychologists - Activities focused on long-term stress management for Ukrainian psychologists who face unique challenges. Provide clearer client-boundary guidance				X
Strengthen community partnerships & stakeholder engagement – Continue building relationships with Ukrainian stakeholders including schools' Ukrainian children attend & community organizations to support precise impact.			X	

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Leverage organizational development for continuous improvement - Utilize newly established MHPSS Unit structure to build upon EU4H learnings, implement systematic feedback & knowledge management.			X	
Enhance technical expertise integration & knowledge management - Establish stronger mechanisms to leverage knowledge transfer from experts & psychological organizations specializing in forced migration issues such as identity loss & acculturation stress management, building on established migration-focused psychological frameworks.		X	X	

Case Study Visit Report: Spanish Red Cross (SpRC)

Executive Summary

SARDE undertook a 3-day field visit to Malaga in June 2025. The visit included engagements with national and local Red Cross EU4Health teams, psychologists, MHPSS trainers, and recipients.

The SpRC delivered significant achievements in implementing the EU4Health project following a challenging start. The project's first 17 months were impacted by organizational restructuring, internal coordination issues, and limited branch engagement, delaying the official launch until September 2023. However, the SpRC gained substantial momentum and delivered some strong ultimate results.

This delayed start meant that by the time delivery began in September 2023, 1.5 years after peak Ukrainian border movement, PFA had limited applicability due to being past the acute emergency phase. However, following the approval of community-based MHPSS activities, which were more appropriate for this later crisis stage, SpRC was able to deliver more relevant support. The number of people displaced from Ukraine requesting support (Indicator 4) surged from 2,100 to 6,200 between November 2023 and March 2024, tripling the total reach achieved during the entire first 17 months.

Trust, stigma and outreach were significant challenges which were best addressed with support from Ukrainian practitioners due to their shared language and cultural experience. Ukrainian-led delivery helped recipients better open-up and benefit from MHPSS support offered. Even then, it was still a challenge and required significant time and relationship building.

PFA effectiveness varied significantly by delivery context, crisis timing, and target group. Co-located delivery (e.g., reception centres) enabled easier engagement, while decentralised delivery offered more anonymous, neutral spaces. Certain groups could respond better when activities were framed as practical training to help others rather than support for themselves. These insights highlighted the need for a range of tailored approaches to maximise engagement and coverage.

EU4Health staff and volunteers worked very hard but were over-stretched. Project management provided PFA training in addition to their core duties, and other key team members such as PFA trainers balanced voluntary training provision with other full-time roles. Whilst such practices are common in the RC, the SpRC had the second lowest percentage budget spent on staffing of all EU4Health NS.

Concerns about setting precedents for funding activities that the SpRC usually secured at no cost contributed towards this budget underspend. Whilst such caution showcased strong principles of sustainability, it impacted the initial rate of delivery. Still, this resourcefulness and a strong volunteer base should support any continuation or evolution of activities beyond the EU4Health funding period.

Coordination was challenging from the outset. Internally, SpRC Health and Emergency teams as well as many regional branches did not participate due to project funding being restricted in supporting those displaced from Ukraine only, which some viewed as conflicting with their principles of impartiality and operational approach. Externally, overlapping funding streams and concerns about duplicating existing refugee support services of the 18-month state program created administrative issues. This required complex navigation of service gaps and the short-term targeting of a smaller recipient pool.

Strong relationships were clear between EU4Health staff, volunteers, and recipients, with obvious mutual warmth. CfSV was integrated into PFA training, with additional support initiatives introduced recently. Both observations and recipient feedback indicated that the EU4Health team is highly supportive and open to volunteers, with many recipients transitioning to volunteer roles long-term. Among the recipients interviewed (~30), experiences were consistently positive.

Recommendations outlined in full in the report include:

- **Strengthening staffing frameworks** through better capacity planning, short-term contracts, and flexible secondment mechanisms. EU4Health revealed challenges with Ukrainian staff balancing volunteering with regular duties.
- **Advocating a longer inception for large projects** to help ensure proper target development, cross-sector coordination, and branch advocacy.
- **Enabling flexible MHPSS programming** that includes host communities and vulnerable groups, with clear CBMHPSS entry strategies and phase-appropriate approaches. More adaptive designs could better meet specific National Society circumstances.
- **Addressing capacity gaps** through specialized training (PFA for children, suicide prevention, GBV, supervision) while building sustainable trainer networks.
- **Institutionalizing staff care** by moving from informal peer support to systematic monitoring through annual surveys and action plans. Leadership should engage directly with CfSV survey findings and develop transparent responses to staff concerns.
- **Implementing measurement and coordination frameworks** including pre/post assessments and impact tools to guide resource allocation.
- **Early stakeholder coordination** during design—not post-approval— to prevent service duplication, and clear protocols between Health and Emergency teams ensure coordinated MHPSS response.
- **Establishing organizational continuity** through succession planning and knowledge transfer, learning from issues like Spain's delayed EU4Health start. Also, financial guidance on 'spending precedents' to help balance project efficiency with long-term sustainability.
- **Documentation of successful approach elements** to enable replication in future MHPSS programs.

Visit Overview

National Society: Spanish Red Cross

Locations: Malaga and Almachar, 35km northeast of Malaga city

Visit Dates: 16-18th June 2025

Evaluation Team: Kieran Birtill, Jonah Rudlin.

The case study visits provide ground-level insights into EU4Health implementation by directly observing front-line staff, recipients, and partners at service delivery sites. These visits assess project performance against key objectives, evaluate service effectiveness, examine capacity strengthening, and document innovations to generate evidence-based recommendations

SARDE undertook a 3-day field visit to Malaga Spain, accompanied by Spanish RC EU4Health PM and PM Assistant and Valencia lead. Malaga was chosen as a location dissimilar to the other three case study locations (Czech Republic, Lithuainia and Bulgaria), being further away from Ukraine and with fewer Ukrainian arrivals per capita at the peak of the crisis.[1]

The visit took place over three days and included visits the Malaga Red Cross HQ and Almachar centre for displaced Ukrainians. The research included key informant interviews with the SpRC EU4H management team, the Malaga EU4H team, online focus group with EU4H leads from other Spanish regions, psychologists and MHPSS trainers, and select project recipients.

Stakeholder Consultation Matrix

Location / Stakeholder	NS EU4H Leadership	Regional EU4H leads	MHPSS Staff	Volunteers	Displaced Recipients	Govt/ Partners	Total
All	2						2
Malaga		2	6	10	14	2	34
Tenerife		1					1
Alicante		1					1
Villareal		1					1
Madrid		1					1
Total	2	6	6	10	14	2	40

Interview Methods Used: Individual interviews: 10 | Group discussions: 4

Limitations

Malaga was the only region visited during the three days of engagement due to providing the most exposure to the project in the time available. Other regions however including Tenerife, Alicante and Madrid, were engaged in remote sessions during the trip.

Translation from Spanish to English was provided by the EU4Health co-lead, alongside other project staff and volunteers. While this facilitated excellent engagement with a wide range of people involved in the project and its outcomes, it could possibly have influence on the information shared due to many different roles contributing in the same conversations.

The next section presents findings from this visit, presented by the four EU4H evaluation themes – 1. MHPSS for the Displaced, 2. MHPSS National Society Capacity Building, 3. Caring for Staff and Volunteers (CfSV), and 4. Coordination.

[1] Spain received a reported 154,000 Ukrainians at the peak of the crisis in spring 2022 – 0.33% of the total population, but much less than Czech Republic 4.67%, Lithuania 2.54%, Bulgaria 2.14%.

Component 1: MHPSS for Displaced Populations

Program Overview

Whilst the SpRC initially faced challenges in delivering PFA to people displaced from Ukraine, the transition to community-based MHPSS activities was highly successful and included building a larger community and running activities including nature trips, yoga sessions, art therapy, and cultural visits. SpRC also implemented an 'active calling' initiative where volunteers proactively reached out to Ukrainians who had previously engaged with SpRC services. These activities supported 6,200 Ukrainians between November 23 and March 24, almost tripling the reach from the previous 17 months.

Relevance

Spain, particularly its southern provinces, represents the most geographically distant participating country from Ukraine in the EU4Health project. Ukrainians arriving in Spain often had different needs compared to those in border countries. Many Ukrainians reportedly chose Spain due to existing family or economic connections, meaning many had moved past the initial emergency stage of displacement and instead required greater integration support and more in-depth trauma-informed care rather than emergency PFA.

This context, combined with project implementation delays, meant the EU4Health emphasis on PFA was not entirely suitable. The project launched in Spain in January 2023. It was further hampered by SpRC leadership changes and authorization delays, starting properly in September 2023 and for example missing the summer holidays which are key opportunities for children activities. Therefore, activities started 1.5 years after the peak movement of Ukrainians.

> *"People aren't in emergency phase, they are in recovery, so what are we doing with the looking, listening, linking?"*

Importantly, in Spain the first 18 months of care for Ukrainians including PFA, was covered under a government program which was in-part delivered by another section of SpRC. The EU4Health team could therefore only target Ukrainians outside of the government program, or that had completed the program (i.e., 18 months later). Consequently, community-based MHPSS (CBMHPSS) were seen as more relevant than direct PFA delivery for EU4H in Spain.

Despite these challenges, group PFA training with recipients played an important role by providing a structured approach to group mental health support. This format effectively engaged participants by focusing on tools to help others rather than direct personal support. In some locations, group PFA training served as an entry point for deeper one-on-one support.

Implementation was further complicated by concerns within SpRC that EU4H sole focus on Ukrainians contradicted principles of inclusivity. Only 12/52 regions agreed to participate.

Greater adaptation of the Spanish context into project design, and a longer inception period to coordinate across SpRC sections, and regions may have helped mitigate these issues.

Effectiveness

While EU4H could not support Ukrainians already in the government 18 month 'program', it filled gaps in supporting those outside of the program and allowing SpRC to continue providing some kind of mental health support to those who had finished the program.

CBMHPSS was often key for EU4H engagement with Ukrainians. CBMHPSS activities often proved "much easier to reach" than formal PFA, helping people "begin opening up" after initial stigma and creating "spaces of healing" where people could "relax and open up." It removed risk of duplicating PFA activities offered through the state program. CBMHPSS provided "safe spaces" for Ukrainians to "speak freely" and built trust for formal psychological support.

The effectiveness of EU4Health PFA for Ukrainians varied by delivery context. At reception centres, engagement was easier due to co-location, while decentralized spaces, though harder for initial engagement, benefited from more neutral, anonymous environments. Crucially, PFA was most effective when delivered by Ukrainians, even then, it required time and patience.

Different groups benefited from tailored approaches and CBMHPSS effectiveness depended on the organiser's approach and characteristics. For men, framing PFA as training to help others rather than direct support could be more effective. Classes connecting to memories and culture were particularly effective for elderly women. Classes sometimes had greater reach when organizers reflected attendee characteristics e.g., an older yoga instructor.

Spain's unique active calling approach showed mixed but generally positive results. Users were "happy to speak with someone who speaks the same language", particularly those feeling isolated. Whilst the outbound nature of calls resulted in some uninterested receivers, final call data revealed some value with 4948 valid calls received (from a total of 9458), 3004 of which did not require follow-up support, 1178 required minor assistance ('oriented calls'), and 766 of which led to further support referral.

Figure A: Active Call data from Malaga, up June 2025. Source Spanish RC

Active Call data Malaga, up 10 31/05/2025. (Source: Spanish RC)

Key Requirements for Active Call Volunteers. *(9 volunteers on what was key for callers)*

- **Language** (3) with fluency in Ukrainian helping establish trust & effective communication.
- **Previous Experience in Similar Roles** (2) Past experience in volunteer work, particularly in crisis response or community outreach, provides key foundation skills..
- **Experience and Training Background** (1) Relevant experience and relatability to the recipients, combined with appropriate training to handle sensitive conversations
- **Staff and Peer Support** (2) Adequate staff availability for guidance and support to volunteers, ensuring quality & safety of interventions. Peer support also a great help.
- **Organizational Integration and Language Resources** (1) Information to connect recipients to wider RC/non-RC resources to provide comprehensive support.

Efficiency

The SpRC's conservative spending approach, while protective against future budget shortfalls, possibly led to underutilization of EU4H funding and operational bottlenecks. Organizational caution about setting unsustainable precedents could be seen to have prevented the full use of available resources. While this protected against future budget shortfalls and maintained volunteer goodwill, it contributed to operational constraints. It is also possible that some savings could have been spent on staffing, e.g., the main EU4H PFA trainer was voluntary and limited to one session monthly due to competing responsibilities, while more generally, resourcing was limited, and staff were stretched. With leadership support and the right conditions for recruitment, this could perhaps have been better balanced with strategic spending paired with stakeholder expectation management for post-project transitions.

There were also challenges with efficiency relating to project timing and coordination due to delays in project initiation. Valuable materials and information that would have been most useful during the initial crisis period were missed:

> "*When the project started in Spain two years had passed. There were good materials (like how to speak to my child about conflict), that would have been useful for people in the beginning – lost.*"

On an activities level, efficiency could also be impacted by inconsistent participation, with planners noting "sometimes you plan for 25 and only 5 come - this happens all the time." Last-minute cancellations and population mobility made resource allocation challenging. Activities requiring financial investment were particularly problematic when attendance dropped.

Despite constraints, several approaches proved efficient. Volunteers were well managed and coordinated, providing enthusiastic and proactive project support, while community-based activities reached more people. Co-location of services improved coordination, and smaller, concentrated geographic areas were easier to manage effectively.

Coverage

Women and children formed the primary participant base across all SpRC EU4Health activities. With men officially unable to travel, they were less visible. Reports indicated men receiving animosity from other displaced populations due to martial law issues. Staff noted it was "not super clear how to engage men better." This pattern continued throughout the project with most participants across all activities being women. Some activities showed successful age diversity - the yoga class started with 5 people and grew to 14, with a wide age mix from 15-78 years old. Families were effectively engaged when activities targeted whole family units.

Elderly women (70+) proved particularly difficult to engage despite their needs. Many elderly women were reluctant to participate in activities, with staff noting "it is not easy to engage them in the activities." Older people often "don't want to leave home," creating barriers to participation. However, when they did participate, engagement was positive.

Staff identified teenagers as "a big challenge" with "high needs" but difficult to reach effectively. Young people faced additional burdens as they often spoke Spanish faster than their parents and were

relied upon to help with bureaucracy, sometimes creating a burden. In remote locations, being a teenager presented challenges with disconnection from larger communities and peers.

The Ukraine-only targeting created major obstacles to participation and reduced overall reach. Only 12 out of 50 SpRC territories agreed to deliver EU4Health because the restriction on serving only Ukrainians was contrary to Red Cross principles and impractical at implementation level. This opt-out by branches (alongside aforementioned internal coordination challenges), greatly reduced EU4H access to Ukrainians across Spain, making initial targets unfeasible. The targeting also reportedly created animosity in refugee centers where other displaced populations questioned why Ukrainians received special support like therapy and trips.

Word of mouth became the most important method for sharing activities, supported by WhatsApp groups for communication. Intensive SpRC staff outreach - making calls, organizing logistics, and facilitating individual participation - was key for maintaining engagement despite attendance issues.

Impact

Quantifying impact is challenging due to limited data, though some evaluation mechanisms were in place. The project didn't have formal impact frameworks or pre/post test evaluations, but did have monthly email surveys that was used to shape project activities, and the Ukrainian Association also collected their own feedback from referrals who attended SpRC activities, but neither of these evaluation mechanisms were available for analysis, making qualitative engagement through fieldwork the primary tool for determining impact.

MHPSS activities demonstrably helped participants overcome initial trauma-related barriers. Initially "really hard - stigma - people don't want to open up - conflict too recent," but activities "helped people to begin opening up" with nature activities and yoga facilitating "spaces of healing where people could relax and open up." Community-based activities like crafts created safe spaces for emotional expression where people could "speak freely" and "meet and stay together."

Social connection and community building showed measurable growth. The yoga class grew from 5 to 14 participants, demonstrating sustained engagement. Helpline services provided crucial language-matched support with people "very happy to speak with someone who speaks the same language." Cooking activities proved particularly impactful for older participants, connecting "to their memories" and cultural heritage while providing therapeutic value.

Individual transformation was evident in some cases. One recipient expressed pride in transitioning from recipient to volunteer, feeling "victory" in "helping others." Association partners identified art, culture, and music activities as "most productive and useful," and advice for navigating life in Spain.

Future programming would benefit from enhanced monitoring and evaluation frameworks including integrated feedback forms, pre/post assessments, and systematic impact measurement tools to better understand which activities were most effective and focus resources accordingly.

Sustainability

SpRC's conservative spending approach prioritizing volunteer networks and free activities positioned the program well for future sustainability. This cost-effective model avoided creating unsustainable precedents while building community-based MHPSS (CBMHPSS) approaches that demonstrated self-sustaining potential. Strong word-of-mouth engagement through WhatsApp groups showed how community networks could maintain activities independently.

The late start of activities related to aforementioned challenges meant that EU4Health is unfortunately coming to a close at the point where momentum is highest.

"We have been doing these great things, and now what?"

There do not appear to be structured plans for the continuation of activity beyond this year. SpRC already has MHPSS capacity in other sectors, and any evolution of EU4Health activities would need greater coordination across the organisation.

Accountability & management

Major confusion over targets significantly impacted project implementation. SpRC discovered their target was 15,000 recipients rather than 1,500 "4 months after kick-off, when doing first report" causing shock among implementers. This miscommunication between proposal writers and implementers created fundamental design challenges, as the budget was set according to the higher figure, but implementation capacity was planned for the lower number.

Community engagement and accountability mechanisms were embedded in activities. Recipients noted that monthly feedback was collected and acted upon, with activities being tweaked based on participant input, such as "adding in a Spanish language component," demonstrating responsive programming despite broader management challenges.

Multiple leadership changes caused significant implementation delays. A presidential changeover delayed outreach to branches, while changes in key staff including the director and Regional Office Europe focal point created continuity problems. Overlapping mandates between SpRC's Emergency and Health departments also created coordination challenges, compounded by competing priorities like floods in some branches.

Despite navigating this extremely challenging operational context, the SpRC demonstrated remarkable adaptability and commitment by substantially redesigning their approach to meet project objectives. Through their dedicated efforts and flexible programming, they successfully provided meaningful MHPSS support to over 6,000 Ukrainians across their operational regions, representing a significant achievement given the constraints and obstacles encountered throughout implementation.

Component 2: National Society Capacity Strengthening

Capacity Building Overview

The EU4Health project exceeded its training target, delivering PFA training to 1,429 health professionals, volunteers, and first aid responders (against a target of 1,136), of which 118 were teachers, social workers and health professionals. This was implemented through a cascading Trainer-of-Trainers (ToT) model where 31 trainers were trained across 4+ ToT sessions involving 11 territories. These trainers then trained diverse groups including psychosocial emergency teams, hospital reception staff, nurses, and Ukrainian community members. Owing to the later-term nature of the project, it was found that group PFA training was highly effective for providing more in-depth MHPSS support to recipients alongside the training, providing lessons for future programming. However, training needs still remain, for example PFA for children, suicide prevention etc.

Relevance

Program delays meant that support required was no longer necessarily emergency-focused, however, PFA training could still remain relevant and effective, particularly group PFA delivery which enabled in-depth support for displaced persons to 'validate emotions together'. Group PFA was identified as much more effective for providing ongoing psychosocial support compared to individual approaches, aligning well with the evolved needs of the Ukrainian community as the crisis progressed from acute emergency to longer-term displacement.

More broadly, the spread of PFA training can help SpRC and collaborators to be better prepared for future emergencies. As an 'emergency organisation', PFA was felt more broadly to be a 'good fit' for SpRC, aligned with its foundational mandate.

Effectiveness

The cascading ToT model proved highly effective across three levels: The initial Budapest ToT by IFRC MHPSS Hub was comprehensive and high-quality, Madrid sessions delivered by Budapest-trained trainers remained very effective though slightly distilled, and territorial-level training continued the quality cascade. This created exponential growth where 31 trainers each trained 15-20 people. The IFRC MHPSS Hub served as an excellent resource, as well as the IFRC RoE team.

Group PFA delivery alongside training was particularly effective, with recipients valuing the team-oriented, less passive approach compared to one-on-one therapy. Ukrainian-led training created essential trust and cultural understanding that Spanish-led delivery could not achieve.

Language barriers impacted training effectiveness and accessibility throughout the project. Key PFA materials, including group resources that were identified as suitable for Ukrainian recipients, were initially only available in English, limiting their practical application. The helpline PFA guide was available in Ukrainian through the IFRC MHPSS Hub, but Spanish translations were limited, creating challenges for Spanish-speaking staff and volunteers. SpRC has been addressing these gaps through collaboration with linguistic students in a local University to provide translation capacity.

Efficiency

The project faced significant efficiency challenges primarily centered around capacity and sustainability constraints. Time allocation emerged as the critical bottleneck, with the main trainer having other job responsibilities that severely limited her availability for training delivery. SpRC's organizational reluctance to hire additional permanent trainers due to sustainability concerns created a structural barrier to scaling training efforts. Funding complexities further compounded these issues, as allocating staff time to EU4Health training would require either moving budget from refugee programming to health or finding replacement staff coverage - both bureaucratically challenging processes.

Coverage

Training successfully reached diverse professional groups across multiple sectors. Initial sessions targeted social workers and nurses, followed by mixed professional groups, while ministry partnerships enabled training of hospital reception staff and government workers. Coverage extended to psychosocial emergency teams, social workers for children, crisis center mediators, and both professional staff and volunteers, demonstrating broad professional reach.

However, there was still demand for additional specialized training. Trainers identified missing components including PFA for children, including for those working with teenagers. Specific aspects requested included how to deliver bad news, supervision frameworks, suicide intervention, and extreme poor mental health cases. Additional gaps included gender-based violence and sexual abuse of minors training. Materials to support group PFA training was also limited, with some manuals available but more demand for in-person training delivery.

Impact

Recipients becoming volunteers demonstrated significant appreciation for support received and desire to give back. One volunteer exemplified this transformation - her biggest challenge upon arrival was language barriers, and not wanting others to experience the same difficulties, she volunteered to help train others. This pattern of recipients transitioning to volunteer roles was common throughout the program.

Training experiences showed meaningful personal impact beyond technical skill development. One helpline volunteer described her initial shock during the first day of two-day training sessions (9am-2pm daily), uncertain why she was there. However, once practical exercises began, the training's value became clear and she found it highly useful and meaningful for her daily work supporting Ukrainians.

Group PFA training provided dual benefits for participants' own wellbeing alongside skill development. One recipient found the group PFA training practical both for supporting others and for her own mental health and wellbeing. She particularly appreciated the group approach over one-on-one therapy, valuing the team-oriented, less passive experience. These insights suggest that group PFA training with recipients achieved significant impact beyond training objectives, substantially supporting individual wellbeing.

International knowledge exchange created lasting professional networks. Trainers reported that sharing experiences with other countries (including Iceland) was enriching, generating new ideas and forming both international and national communities of trainers that extended beyond the project period.

However, quantitative impact measurement remains limited, lacking pre/post tests or systematic feedback collection to precisely assess training effectiveness. This represents a key recommendation for future programming to better understand format effectiveness and systematically gather participant feedback for improving training modules.

Sustainability

MHPSS training provided to wider health professionals could continue to have benefits beyond the duration of the project, with 1,429 trained. There are also 31 trained trainers positioned to continue delivery. should institutional support structures remain in place. However, there is little sign of a structured plan for l**ong-term continuity** of EU4H activity. Spain RC is reportedly now working on mental health strategy but the immediate continuity after EU4H is less clear.Still, there are signs of positive changes including the community of trainers and hub functioning well, and coordination between different SpRC areas (emergency and health) improving over time, managing to coordinate to now offer **campus-wide PFA training resources to all staff through e-learning platforms.**

> *"We never had a specific MHPSS, it has only ever been crosscutting, so it was a real plus, and the people we have trained – the staff and volunteers work in a range of depts that can use this (job search team, domestic abuse team etc) are helping lots of people, vulnerable people. This work improves the quality of the work, and the volunteers – they are great support – we are 15,000 staff, 295k vols. So, we will be more prepared." – National society Focal point*

Accountability and management

While the development of a PFA course on Campus could point towards some management coordination, support from SpRC leadership for continuation of EU4H MHPSS capacity-building was not observed during the visit. Any further progress requires this coordination (see section 4).

Component 3: Caring for Staff & Volunteers (CfSV)

CfSV Overview

CfSV was integrated into PFA training with some late-project initiatives like an assessment survey and CfSV support bags, and the EU4Health team demonstrated strong openness and support to volunteers. CfSV is currently fulfilled through strong peer to peer relationships and a supportive and inclusive working environment. Whilst these are major strengths for the SpRC, there is a gap in institutionalised support for staff who are over-stretched and facing burn-out. Other initiatives beyond EU4H - not observed but referenced in the recent CfSV survey - include mental health training sessions, flexible working hours, yoga and mindfulness, and stress management guides, but these points also came up frequently as things that are missing, suggesting that initiatives are yet to be implemented across the whole NS.

Relevance

Based on the 2025 CfSV survey, there was clearly a strong need for CfSV support within SpRC, particularly for staff, with only 32% agreeing that clear support structures existed and only 47% believing SpRC allocated adequate resources for CfSV. While CfSV was incorporated as a theme within PFA trainings with a focus on self-care importance, implementation only broadened in 2025 due to programming delays, limiting the depth of measures that could be developed.

The EU4Health project provided valuable space to explore CfSV concepts and identify challenges, though measures did not fully address all needs expressed in the CfSV survey. Key survey recommendations included reduced workload and better work distribution, which was not achieved (or feasible) within project scope, and requests professional and accessible psychological support, which was addressed through making 1-on-1 support available.

Effectiveness

CfSV measures in SpRC were primarily self-led and informal, benefiting from the strong organizational inclusive culture in the workplace that provided substantial care. Volunteers, appeared open and receptive to SpRC staff and spaces. The inclusive environment was evident at Malaga HQ, where staff and volunteers warmly interacted.

However, project delays limited opportunities to implement deeper institutionalization of CfSV, making it difficult to assess effectiveness within the short timeframe. While CfSV components incorporated into PFA training were well-received - with recipients expressing benefits in remembering to prioritize self-care - development beyond this was limited to initiatives like self-care goodie bags.

Staff also called for better work-life balance and flexibility, which remained unaddressed within project limitations, while a preference for regular team meetings for emotional decompression were already happening informally through existing practices. The need for clearer communication and support structures remains a broader organizational challenge beyond the EU4Health focal point team's capacity.

Efficiency

The incorporation of CfSV into PFA training represented an efficient approach for promoting self-care measures and reaching a broader audience, with the project team noting that EU4Health's flexibility allowed efficient embedding of self-care into existing work processes rather than creating additional burdensome activities. However, late implementation significantly impacted the depth of measures that could be developed, consequently limiting their overall efficiency. While CfSV support demonstrated strong potential for efficiency through integration into existing structures, resource constraints and institutional barriers prevented full implementation from being realized.

Coverage

While the CfSV component in PFA training would have had broad impact across a wide range of stakeholders, deeper institutional CfSV structures were missing, particularly for staff rather than volunteers. The 2025 CfSV survey revealed a significant disparity in perceived support structures, with 46.90% of volunteers agreeing that clear support structures exist compared to only 32.74% of staff. This disparity reflects a pattern across many National Societies, which project leads were left to address

independently. As the survey demonstrated, staff were the key participants requiring enhanced support, indicating that future activities should prioritize addressing this coverage gap to ensure more equitable CfSV provision across all stakeholder groups.

Impact

The impact of CfSV in EU4H shows positive results in building supportive relationships and individual capacity, though wider institutional challenges remain. Strong relationships were evident between EU4H staff, with obvious mutual warmth extending to volunteers and recipients. The positive impact was demonstrated through recipients transitioning to long-term volunteers and volunteers reporting meaningful benefits - one noted that community-based MHPSS training helped him stay present-focused and manage stress more effectively.

Training integration showed measurable impact on individual awareness and skills. The 2025 CfSV survey revealed that 65.49% agreed their ability to recognize stress signs in themselves had improved over the past year, while 64.60% reported better recognition of stress signs in teammates, suggesting PFA training effectiveness. With 60.18% receiving some form of stress management or CfSV training (primarily PFA at 41.59%), there was clear reach in capacity building, though CfSV-specific training remained lower at 19.47%.

Sustainability

The sustainability of CfSV practices within SpRC faces mixed prospects, with strong foundations in peer relationships and inclusive culture but significant institutional gaps. While the project successfully integrated CfSV components into PFA training curriculum - creating a sustainable training model - and benefited from SpRC's naturally supportive organizational culture, the reliance on informal peer and team-based care systems means that CfSV remains vulnerable without deeper institutionalization.

Accountability & management

The 2025 CfSV survey revealed gaps in systematic wellbeing monitoring, with only 24.78% believing Red Cross regularly monitors staff and volunteer wellbeing, while 41.59% disagreed and 30.97% were unsure. This indicates that CfSV systems are not currently institutionalized or have patchy coverage, highlighting the need for a more systematic approach to address burnout prevention.

Moving forward, annual CfSV surveys should continue to monitor staff and volunteer wellbeing, providing insights into which measures are effective and which require adjustment. This systematic monitoring will complement existing informal care practices, helping identify support gaps before they lead to burnout while reinforcing the strong peer and team-based care culture with appropriate institutional backing.

Addressing deeper-rooted CfSV challenges will require greater involvement of broader SpRC leadership to tackle fundamental issues around management structures, feedback mechanisms, accountability systems, work-life balance, and general stress management - challenges that extend beyond the capacity of project-level interventions and demand institutional commitment at the highest organizational levels. The recent CfSV survey data provides an important resource in identifying perceived issues and solutions.

Collated survey responses to 6.1 (what support would help you in your role), 6.2 (What other activities might improve your wellbeing) & 6.3. (What can the RC do to improve the standard of care of staff and volunteers)

Most Common Issues	Possible Solutions
Stress & Burnout (8 mentions) High emotional toll, anxiety, mental exhaustion from work demands	• Stress management workshops during work hours • On-site psychologist and external counselling services • Regular wellbeing meetings for staff • Dedicated staff exclusively for stress/burnout reduction
Work Overload & Poor Distribution (9 mentions) Excessive workloads concentrated on same individuals, uneven task allocation	• Workload audit and task redistribution • Increase staffing levels or outsourcing options • Improve management practices and oversight • Implement staff recognition and support systems • Clear task allocation guidelines and capacity limits • Flexible working hours and teleworking options
Lack of Training & Development (14 mentions) Insufficient specialized training, particularly in psychological support	• Face-to-face training sessions (not just online) • Better promotion and visibility of available training • Regular refresher training programs • Manager training to facilitate work-stress management • Individual development plans with training budgets
Poor Management & Communication (10 mentions) Unclear guidelines, lack of feedback, insufficient management support	• Regular one-on-one manager meetings • Clear operational guidelines manual • Management training for supervisors • Regular team meetings and feedback sessions • Transparent communication channels
Insufficient Support Systems (13 mentions) - Lack of psychological, management, and peer support structures	• Peer support networks and buddy systems • Regular wellbeing check-ins (non-punitive follow-up) • Experience sharing platforms (blog, safe spaces, team meetings) • Resources to support rights established by agreements
Inadequate Work Environment (6 mentions) Lack of proper break spaces, physical activity areas	• Team building activities and social events • Facilitate work-life balance and digital disconnection • Improved workplace ergonomics and comfort • Dedicated relaxation spaces

Component 4: Stakeholder Coordination

Coordination in Malaga

The project leveraged existing Ukraine networks with varying degrees of engagement and effectiveness. The Ukrainian Consul was informed from the start of CBMHPSS activities, but the Consul did not wish to extend their involvement beyond basic information dissemination to include any active participation or advocacy. In contrast, the more community-based Ukraine Association, which emerged at the time of the conflict, proved to be significantly more engaged and supportive throughout the project implementation. This network demonstrated greater responsiveness and practical collaboration.

RoE coordination

While primary pressure originated from internal capacity and communication issues within the SpRC team, transitions between three different RoE coordinators at various stages created some

continuity disruptions. Language considerations presented additional complexities - generally, and during multi-country events – adding to communication challenges. While one RoE coordinator shared the same language which facilitated communication during their tenure, they only supported the SpRC for a brief period.

Despite challenges, the coordination between the core MHPSS delivery team and IFRC worked well throughout the project implementation. Whilst the SpRC delivery team faced operational pressures, they were effectively addressed through strong RoE support and guidance.

Overall project coordination

Internal coordination faced multiple structural challenges that impacted project implementation. Bureaucratic processes often created delays, with focal points sometimes unable to make immediate commitments during coordination calls without clearance from the deputy health director. The restriction to serving only Ukrainians became a obstacle for **branch participation**, as most territories could only be approached after project sign-off - too late to secure broader buy-in. This resulted in a large reduction in access to Ukrainian populations across Spain, making initial targets unfeasible.

External coordination was limited and presented challenges around service duplication and target population access i.e., EU4Health could not serve Ukrainians in the Ministry of Migration's 18-month program. While SpRC developed CBMHPSS as a gap-filling approach, the coordination challenges highlighted the need for earlier and more comprehensive stakeholder engagement across departments.

If given the opportunity to restart the project, the SpRC EU4H team would immediately engage all relevant departments - migration, training, and emergency - to establish clear coordination frameworks from the outset. The approach would emphasize that while any department could lead, coordinated involvement across all areas would be essential to prevent fragmented coordination and reduce operational pressures from unclear departmental boundaries. Such an approach needs commitment and coordination across leadership levels to ensure effective implementation.\

Recommendations

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Strengthen project recruitment framework - Design future programs with more staffing capacity, considering needs of the project across the programme length, & considering short-term contracts & missions to support delivery		X	X	
Internal Secondments – EU4H had Ukrainian volunteers who had to balance EU4H volunteering with everyday duties. Stronger mechanisms allowing people to be seconded more flexibly to projects for which they have unique skills			X	
Integrated & flexible MHPSS programming - Promote integrated design in future MHPSS programs more inclusive of host communities & vulnerable groups. Include entry point strategies with CBMHPSS & approaches per phase.	X			

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Flexible project design - a more flexible, yet structured approach might be used in future design to meet specific circumstances of NS	X	X		
Longer inception for **large projects -** For SpRC, this might have helped ensure better development of project targets, coordination between SpRC sectors, more effective project staffing, & enhanced advocacy efforts with branches	X	X		
Specialized training development - Address identified gaps including PFA for children, suicide prevention, gender-based violence, & supervision while building sustainable trainer networks beyond single-person dependencies				X
Language & culture - translate useful materials earlier (use DeepL) & expand native-speaking capacity as key for trust. 'Active calling' best by volunteers who speak language. Volunteers with PSS skills can provide technical support				X
CfSV institutionalization - Move from informal peer support to systematic CfSV monitoring through annual CfSV surveys & action plans, staff support structures, & formal accountability mechanisms integrated in existing systems			X	
Senior leadership engage in CfSV – SpRC leadership review points from CfSV survey & develop participatory action plan addressing staff/volunteer concerns			X	
Systematic impact measurement - Create pre/post assessment frameworks, integrated feedback mechanisms, & systematic impact measurement tools to better understand program effectiveness & guide resource allocation				X
Early stakeholder coordination - Implement comprehensive coordination with government ministries, branches, & external partners during design phase rather than post-approval to avoid service duplication issues & maximize reach	X	X		
Strengthen internal coordination structures - Design clear coordination protocols between departments – in this case Health & Emergency teams – to ensure more coordinated response to any future crises or project opportunities			X	
Leadership continuity - Establish mechanisms to mitigate delays, drawing lessons from delayed start of EU4H in Spain. Develop standard protocols e.g., succession plans, knowledge transfer & interim arrangements for transitions			X	
Financial Guidelines - Guidance for future programs that reflects on 'spending precedent' issue (see exec summary). Approaches enabling effective delivery without unsustainable precedents, balancing efficiency & effectiveness		X	X	
Best Practice Documentation - Systematically capture successful approaches for replication in future e.g., relationship-building approach & CBMHPSS types that proved effective. Establish relevant knowledge transfer.				X

EU4Health Case Study Visit Report - Czech Republic

Executive Summary

Czech Red Cross (CzRC) EU4Health experience offers critical lessons for future programming. The evaluation examined Zlín (Zlin region), Prachatice (South Bohemia region) and Teplice (Usti region). These regions collectively received over 50% of CzRC EU4Health funding and were some of the few that remained active at overall project conclusion. Key findings were as follows:

CzRC's presence in emergency reception centres from day one created lasting advantages. Operating in Regional Assistance Centres (KACPU) during the March-April 2022 peak arrivals built visibility and trust, leading 287 Ukrainian-speaking professionals to proactively approach CzRC for work.

CzRC designed a stepped care model on the basis that early intervention could prevent mental health escalation. The approach included basic psychological first aid through to more advanced emergency mental health support such as EmotionAid and Assist techniques intended as PTSD prevention. This rationale assumed effective early trauma response would minimize need for psychiatric referrals. This is an approach aligned with established trauma intervention principles, though systematic outcome data collection was unavailable to be able to fully assess the impact of each technique on people displaced from Ukraine (PDU).

Language support strategies showed varied effectiveness across intervention complexity levels. CzRC's early engagement of the national interpreters' union created sustainable capacity, with 287 Ukrainian speakers trained throughout the project. While basic psychological first aid techniques translated effectively, complex trauma interventions were less suitable for interpretation. An important learning emerged regarding interpreters' wellbeing—these professionals experienced pressure from translating distressing stories without access to organizational support systems, a gap identified only after significant exposure.

Program parameters faced system constraints. A three-session limit on psychologist sessions for PDU was implemented by CzRC to ensure project compliance. This required functioning referral pathways for those that required further treatment, yet Czech psychiatric waiting lists left some clients unsupported after CzRC sessions ended. Another challenge was incremental approvals delaying interventions—summer camps for young PDU were piloted first but only after extensive lobbying by CzRC; broader Community Based Mental Health and Psychosocial Support (CBMHPSS) activities were authorized only after proving need. This slow MHPSS approach transition missed critical early intervention opportunities.

In the case study regions Zlín created a replicable integrated service model serving 50 families through approximately 5,000 annual interventions via coordination with pedagogical centres, schools, and healthcare; Prachatice revealed service gaps with only limited MHPSS consultations and group sessions focused on social activities rather than psychological support; Teplice effectively reached

elderly populations through a community centre providing 3,500 annual interventions, though capacity remained constrained by regulations limiting Ukrainian psychologists to 10,000 CZK monthly earnings.

Individual coordinator capabilities emerged as a key determinant of regional success. Effective coordinators shared specific traits: Ukrainian language skills or heritage, established community connections, MHPSS experience, and ability to navigate Czech institutional systems.

The hard work by the CzRC EU4Health team, with strong NS leadership support has seen CzRC evolve into a recognized mental health actor within Czech Republic's institutional landscape. Emergency services have requested CzRC support for other emergencies in recent years including 2024 floods and a Prague shooting incident. The CzRC Mental Health Strategy 2030 embeds MHPSS organizationally. Still funding remains uncertain—only Zlín secured one government position, although proposals such as revenue diversification through training accreditation may hold promise. Overall, the project enhanced CzRC's capacity to serve all crisis-affected communities, not just displaced populations.

Recommendations outlined in full in the report (with actions tagged to appropriate actors) include:

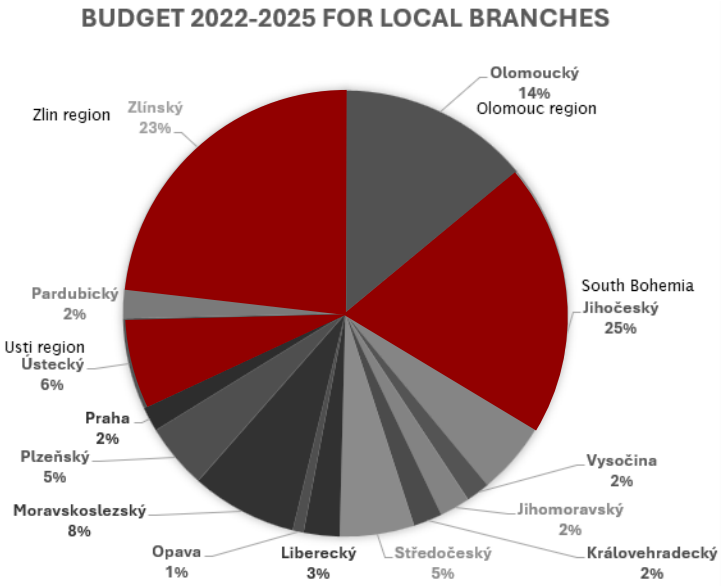
- **Document Zlín's integrated model of embedding services within existing structures** (pedagogical centres, schools, healthcare). Also, lessons from Usti's coordinated approach and broader KACPU-to-sustained programming evolution and interpreter engagement. **Create a toolkit emphasizing supplementation not replacement of state services.**
- **Formalize coordinator specification requirements for any evolution of EU4Health or for projects of a similar nature based on the qualities held by coordinators**. This includes shared language and connections with the displaced community, MHPSS experience, networking abilities, drive and determination. These qualities could be covered in a functioning team, rather than solely relying on an individual. Furthermore, mandate full-time coordination positions where the project demands this.
- **Developing tiered language framework.** Basic PFA works via interpretation; complex trauma requires native speakers with MHPSS training and psychological support.
- **Provide comprehensive staff care for all personnel exposed to trauma in MHPSS projects**, including interpreters currently outside organizational support systems.
- **Enable flexible service provision beyond rigid session limits when referral pathways fail.**
- **Implement integrated data systems** tracking personnel competencies, impact beyond counts, and quality indicators.
- **Strengthen administrative support to NS implementing teams** for such projects including procurement procedures and realistic staffing models—promote administrative capacity as being as important as technical training.
- **Design adaptive programming from start in such programs.** In this instance, early CBMHPSS authorization would have matched evolving needs better than incremental approvals.

Visit Overview

National Society: Czech Republic Red Cross (CzRC)
Locations: Zlin – Zlin region, Prachatice – South Bohemia region, Teplice, Usti region, Prague (HQ)
Visit Dates: 30th June – 3rd July
Evaluation Team: Kieran Birtill, Marta Siciarek.

The case study visits provide ground-level insights into EU4Health implementation by directly observing front-line staff, beneficiaries, and partners at service delivery sites. These visits assess project performance against key objectives, evaluate service effectiveness, examine capacity strengthening, and document innovations to generate evidence-based recommendations.

The study included visits to 3 regions – Zlin, Usti and South Bohemia. While the EU4Health project is reaching its conclusion, projects in these three regions remain active and this was a primary reason for their selection above other regions in Czechia. These 3 regions also collectively received over 50% of the CzRC EU4Health budget.



More broadly, 13 out of 14 regions in the Czech Republic were active to varying extents throughout EU4Health. Therefore, while findings are largely based on the 3 regions visited, engagements, findings and recommendations also consider broader context wherever possible.

Location	Stakeholder	EU4H Project Staff	Wider NS staff	Displaced	Govt/ Partners	Total
Cross-cutting	Previous EU4H Czech PM	x				5
	EU4H Czech PM	x				
	3 trainers	x				
Zlin – Zlinsky region	Regional branch lead		x			27
	Regional project coordinator	x				
	3 psychologists	x				
	20 beneficiaries			x		
	2x Zlin pedagogical (name)				x	
Prachatice – South Bohemia	Regional project coordinator	x				10
	Local Prachatice coordinator	x				
	8 beneficiaries			x		
Teplice – Usti region	Regional project coordinator	x				6
	2 psychologists	x				
	3 beneficiaries			x		
Total by Stakeholder		14	1	31	2	48

Component 1: MHPSS for Displaced Populations

Program Overview

The Czech Red Cross (CzRC) target was to provide 63,000 instances of support to people displaced from Ukraine (PDU) through the EU4Health project. Project activity evolved from initial provision of PFA at Regional Assistance Centres (KACPU) to longer-term MHPSS programming.

PFA began in March 2022 when the first KACPUs opened. 14 KACPU served as initial contact points for people arriving from Ukraine. Interventions in these spaces focused on immediate support techniques designed to provide mental health support after a traumatic event.

CzRC designed a stepped care model theorizing that early intervention could prevent mental health escalation (from PFA, to EmotionAid, Crisis Intervention and Assyst techniques). The rationale assumed effective early trauma response would minimize need for psychiatric referrals - an approach that aligns with established trauma intervention principles, though specific outcome data from this implementation was not systematically collected.

Types of emergency PSS delivered by CzRC

Basic PFA	EmotionAid basics	Crisis intervention	Assyst method
Basic emotional support you can give someone right after a crisis. It focuses on making them feel safe, listened to, and connected to help - not therapy, just compassion and practical assistance. Steps: *1. Look - Check what's happening and if it's safe* *2. Listen - Give attention and hear their needs* *3. Link - Connect them to help and support*	*5-step method to help people calm down quickly. Based on based on methods such as Somatic Experiencing (using body awareness to release stress), EMDR (techniques to help process traumatic memories), and polyvagal theory (uses grounding techniques to help calm the nervous system).*	*Teaches responders how to calmly and safely help someone who's having a mental health crisis or behavioural emergency, focusing on de-escalation rather than force. Includes identifying signs of distress, verbal de-escalation techniques, and active listening skills. 150 hours of training.*	*Stabilization technique used right after trauma to reduce severe distress before longer-term therapy. Uses scripted process and techniques such as specific tapping and eye and body movement to calm the nervous system and help the brain process traumatic memories. Designed to fill the gap between PFA and High-Intensity Intervention psychotherapy.*

Level of complexity

Following the closure of KACPUs in 2023, CzRC began providing MHPSS at emergency or temporary accommodation centres, providing regional intervention spaces for PFA and crisis intervention.

Over time there was a gradual return of people to Ukraine and there was felt to be a decreased need for basic PFA, leading to program expansion to include some medium-longer term PSS and community activities better targeting integration support. The report will refer to first/early phases and later project phases.

Relevance

CzRC had MHPSS capacity, but EU4Health was an important opportunity to do this more consistently as well as responding to the crisis. Czech Republic received the highest number of PDU per capita in Europe and PFA was needed from the beginning of the armed conflict. However, EU4Health launched in May 2022, and by this time arrivals had already dropped 50% from March-April

peaks. CzRC had some pre-existing PFA capacity—a small number of trained personnel working alongside Fire Brigade psychological services in KACPUs from crisis onset. Despite this foundation and strong initial training progress (384 staff and volunteers trained by October 2022), most training took place in 2023, inevitably limiting PSS provision during the early crisis phase. Nevertheless, as the emergency extended beyond initial weeks and volunteers needed to return to work, EU4Health enabled CzRC to pay some PSS volunteers—including skilled interventionists—to maintain regular, sustained presence in emergency centres.

CzRC identified after approximately 1 year of the project that the situation and requirements had evolved from PFA to CBMHPSS. CzRC made an early request for CBMHPSS to RoE, including summer camps to help Ukrainian children integrate. This was ultimately permitted, but more CBMHPSS activities would have been done if permitted earlier.

Effectiveness

CzRC delivered substantial MHPSS services, providing 61,764 instances of EU4H support to PDU, including approximately 15,144 by the end of 2023. This represents all MHPSS interventions (whether basic PFA, EmotionAid, Assist technique, or crisis intervention). In practice, the vast majority of the 61,764 was basic PFA and psychosocial support, reflecting both the pyramid of needs and resource constraints. Approximately 20 people were trained in the specialized Assyst technique with deployment limited to one region, while 40-50 received crisis intervention training. This distribution meant most PDU received basic support, with coordinators arranging specialized interventions when PFA proved insufficient—a pragmatic approach given the expensive and intensive nature of advanced training.

Language barriers presented a key implementation challenge that CzRC addressed through proactive interpreter engagement. CzRC engaged a national interpreters' union from project start, achieving varied results. Basic PFA required minimal verbal communication, with linguistic similarities between Czech and Ukrainian facilitating initial stabilization. Complex interventions like Crisis Intervention and Assyst faced significant barriers despite interpreter support.

Interpreter use created both opportunities and constraints for service delivery. Benefits included accessing technically skilled Czech PFA providers and addressing Ukrainian speaker shortages. Limitations emerged through reduced client-provider trust, translation accuracy concerns, and safeguarding risks. Interpreters lacked MHPSS-specific training, limiting complex intervention use.

Alongside interpreter services, CzRC developed substantial Ukrainian-speaking capacity. The 287 Ukrainian speakers trained (second highest outside Ukraine) emerged from CzRC's early KACPU visibility. Ukrainian psychologists proactively approached CzRC for employment rather than requiring active recruitment. This created dual service pathways—interpreted and native-language support—although most Ukrainian psychologists were onboarded after the emergency phase so in general this will have helped medium-long term MHPSS more so than PFA.

CzRC's programming evolved beyond basic PFA through both advocacy and project-wide policy changes. Summer camps—the first approved expansion—provided psychologist-supervised activities for Ukrainian children while offering parents respite time, though implementation was limited to 4-5 camps. When broader agreement later permitted CBMHPSS activities across all participating countries, CzRC expanded into adult support groups, language circles, and community activities.

The three case study regions demonstrated varying successes in providing direct MHPSS:

Zlin: Demonstrated exceptional effectiveness through an integrated service model, with 13 staff serving 50 families through ~5000 annual interventions (Zlin starting these EU4H activities in February 2024). The coordinator's half-Ukrainian heritage and local roots enabled crucial bridge-building, while strategic co-location with the Regional Pedagogical Centre facilitated daily collaboration. 3 Ukrainian RC psychologists complemented local services[2], supporting PDU and helping integration with host populations. Strong networking activated partnerships across schools, government offices, and medical services, embedding MHPSS within existing services.

The **South Bohemia** coordinator reported EU4Health providing PSS support for children, working with schools and helping children to integrate into the school system, and helping adults to orientate into the Czech social support system. The visit to **Prachatice** showed limited effectiveness with only 6 individual MHPSS consultations noted, primarily for returning clients. Those were individual consultations using Czech providers with translators, though approximately 80% of activities focused on adults. Weekly 2-hour group sessions served 10-15 adults regularly. However, significant gaps were noted - participants reported inadequate local MHPSS availability, with services concentrated in other cities or limited to online formats unsuitable for this population. The reliance on translators and perceived closedness of the host community further constrained effectiveness.

Usti region: The Red Cross work in Ústí progressed from an initial phone helpline that received minimal response, to establishing four mental health centres staffed by Ukrainian psychologists by mid-2024. After recognizing that Ukrainian refugees were reluctant to seek help from Czech psychologists, the Red Cross and a local grassroots NGO worked to recruit Ukrainian mental health professionals and shift outreach to Facebook and community networks. Small centres opened in Teplice (January 2023), Ústí town (March 2023), and Litoměřice mid-2024. This gradual expansion with culturally matched providers led to increased utilization through word-of-mouth recommendations, addressing the gap that other organizations had not filled. In Teplice, the centre provides PSS support through ~3,500 annual interventions. A FGD with elderly PDUs discussed how the centre had addressed the participants' evolving needs - from initial basic support (assistance with digital applications, emergency food aid) to sustained psychosocial care as people stabilized. Proactive outreach reportedly ensued minimal isolation among local PDUs.

Coordinator capabilities emerged as the primary determinant of regional delivery quality. Field visits identified essential characteristics including connection to Ukrainian community, drive and enthusiasm, understanding of displaced and excluded sub-populations, MHPSS experience, and project management/networking skills for system integration. The Zlín local EU4Health project coordinator exemplified these characteristics with support from her regional coordinator, Ukrainian psychologists and the pedagogical centre, while the Ústí (Teplice) coordinator effectively planned and coordinated with a local businesswoman with connections to Ukraine who had set up a grassroots NGO, and a Ukrainian psychologist who had recently arrived in the region, who had good connections and influence among PDUs locally.

[2] State funding for Zlín's pedagogical centre doesn't cover specialized foreign student integration support—only basic interpretation. The EU4H position filled this gap with comprehensive coordination and community bridging

Impact

Immediate PFA Impact: CzRC lacked robust mechanisms to monitor PFA impact. However, stakeholder interviews suggested basic objectives were met in terms of emotional stabilization enabling information processing. CzRC's partnership with the fire service enhanced national emergency MHPSS capacity, particularly in reception centres during peak displacement periods.

CzRC recruited psychologists, including Ukrainian psychologists, to provide medium-longer-term MHPSS services but limited support to three sessions per client to ensure compliance with funding requirements. The intention was for clients requiring additional support to be referred into the Czech MHPSS system. However, this design assumed functioning referral pathways. In practice, Czech healthcare's substantial waiting lists—often exceeding six months—meant clients completed CzRC sessions without accessing continued care, risking mental health regression. While CBMHPSS activities provided some stability, the gap between limited CzRC support and overwhelmed public services left many inadequately supported during critical displacement periods.

levels of observed impact in the 3 regions varied:

Zlín's integrated approach produced profound community impact. Focus group PDU described support as "crucial," with several calling it "lifesaving." The collaborative model enabled families displaced from Ukraine to successfully navigate Czech healthcare, education, and social services while addressing critical issues like trauma, bullying and school integration. Working with 3 Ukrainian psychologists helped PDUs to 'start to show emotion'. This service firstly served children, but some parents also progressed from deflecting their own needs to accepting support. Initially insisting "we're fine" when asked, parents gradually acknowledged their own struggles as children's stability improved.

Prachatice revealed significant unmet MHPSS needs alongside existing services. While language support groups provided some benefit, participants expressed isolation and difficulty opening up to families back home or connecting with the host community. The absence of local psychological support was felt, with participants requesting psychologist-led groups rather than online alternatives. Existing groups could have incorporated more psychological focus rather than remaining primarily social activities - a missed opportunity for enhanced support. Participants noted that consultation about their needs and local delivery would improve services, and children groups were oversubscribed.

The approach in Teplice transformed isolation into connection for elderly displaced persons. Participants described journeys from initial emotional closure to gradual opening and community building. The centre became a lifeline for those facing multiple losses - family separation, bereavement, health challenges, and displacement. Beyond addressing immediate needs, it prevented depression through proactive engagement and created meaningful roles for beneficiaries who transitioned to volunteers. The daily gathering of 100 participants fostered mutual recognition and support networks, with the coordinator's personalized assistance proving particularly crucial for those navigating Czech systems alone. This demonstrates how targeted support for vulnerable sub-populations can prevent isolation and build resilience within displaced communities.

Efficiency

CzRC's early crisis response maximized efficiency by delivering support when most needed. Present from the displacement crisis onset, CzRC provided immediate assistance during peak

vulnerability periods when intervention impact might arguably have been highest. This timing advantage, combined with developing fire service partnerships, enabled rapid deployment.

Regional approaches showed varying efficiency levels, with integrated models performing particularly well. Zlín's embedded approach demonstrated strong efficiency by utilizing existing infrastructure (pedagogical centres, schools), reducing duplication, and maximizing reach through institutional partnerships. The co-location model enabled daily collaboration without travel costs while Ukrainian psychologists complemented rather than duplicated Czech services, creating synergies that enhanced value for money. Given Zlín's demonstrable success with the integrated model, redirecting resources from less effective regions could have amplified impact.

Program design constraints limited potential cost-effectiveness. The three-psychology-session limit, while ensuring project compliance, may have reduced sustained impact for clients needing longer-term support, potentially diminishing return on initial investments. Delay in CBMHPSS also meant continued reliance on less relevant interventions when group approaches could have served more beneficiaries. Earlier community-based implementation might have achieved comparable outcomes more efficiently, particularly given strong Ukrainian community cohesion.

Coverage

CzRC achieved extensive geographic coverage despite challenging timing. While EU4Health began after peak arrivals - when Prague alone saw 3,000 daily arrivals in early crisis days - CzRC ultimately established services in 13 of 14 Czech regions. This near-universal coverage significantly exceeded most participating NS achievements. According to program leadership, almost every person arriving at reception centres received PFA during the initial response phase, though inevitably some individuals fell through gaps during the most chaotic early period before systematic services were established.

Early KACPU presence created lasting coverage benefits. CzRC's visibility at all Regional Assistance Centres during peak arrivals established immediate recognition among the displaced population. This initial contact point advantage persisted throughout the project—beneficiaries who first encountered CzRC at arrival continued seeking their services months later, and word-of-mouth within Ukrainian communities amplified reach beyond direct service users. Early visibility essentially created a "brand recognition" effect that enhanced coverage throughout all project phases.

Longer-term PSS coverage varied significantly by region and model. Various forms of outreach were used in Zlin, including word of mouth, social media, coordinating with diaspora organizations, accommodation facilities, and with existing institutional infrastructure such as the child protection authority. MHPSS stigma still exists for some, but the coordinator’s Ukrainian roots have reportedly helped in sensitisation of MHPSS. Still, the local focus on parents are children means that elderly and single PDU have less support. The coordinator wanted to start a door-to-door visit service for the elderly, but funding limits prevented this.

Ústí deployed 6 Ukrainian psychologists across its towns and cities showing good distribution but faced general capacity constraints as temporary protection regulations limit work allowances of Ukrainian psychologists to 10,000 CZK monthly, (or lose certain benefits), restricting professional hours. Recent regulatory changes have worsened the situation—Ukrainian refugees now face the same employment conditions as Czech citizens, preventing labor office registration for those with secondary

agreements. As the local Red Cross coordinator explained at a recent government roundtable, this regulatory framework creates a significant obstacle since the centres cannot offer full-time positions.

Prachatice showed uneven coverage - while infrastructure existed, the assessed site revealed service gaps, particularly in reaching the most vulnerable displaced populations including those experiencing social exclusion or managing complex needs such as substance dependency.

Coverage depth remained constrained by design and systemic factors. While geographic breadth was impressive, the three-therapy session limit meant deep therapeutic coverage was intentionally restricted. The program prioritized reaching more people with basic support over intensive intervention for fewer beneficiaries. This trade-off, combined with varying regional capacity and regulatory constraints, created a system with broad but sometimes shallow coverage, particularly for those with complex or long-term mental health needs.

Accountability & management

CzRC's overall coordination structure evolved during implementation. This initially relied on two part-time coordinators juggling multiple responsibilities, but the crisis scale demanded dedicated management. When the strategy lead left in early 2024, their replacement consolidated both strategic and operational duties into one full-time role, while the other coordinator moved some focus to non-EU4H crisis work. This shift brought stronger administrative systems, including structured procurement and coordination protocols. The evolution from shared part-time to single full-time ownership demonstrates that large-scale emergency responses require dedicated project management positions.

The absence of standardized administrative tools created unnecessary complexity. Coordinators developed basic operational documents—from procurement forms to training attendance sheets—through trial and error while managing urgent service delivery. Having more templates prepared and available at project start would have reduced stress and ensured consistency across regions.

Financial accountability relied on standardized payment structures and regular oversight. CzRC established clear fee schedules (300 CZK for brief interventions, 1,000 CZK for extended crisis intervention/psychologist sessions) providing transparent budget management across regions. Regular coordinator calls, budget monitoring, and hiring reviews maintained financial control. When budget constraints emerged in late 2024, CzRC implemented cuts in 8-9 regions while maintaining funding for highest-volume service areas, demonstrating responsive resource management based on utilization.

Initial monitoring relied on estimates rather than individual tracking. With thousands arriving daily and staff prioritizing service delivery over documentation, early PFA numbers were extrapolated from reception centre throughput rather than precise counts.

Regional accountability mechanisms showed significant variation. While some areas exemplified strong accountability through systematic multi-stakeholder coordination and clear service protocols, other regions operated with less structured approaches. This variation suggests that while central financial controls functioned adequately, service delivery depended heavily on regional coordinator capacity and local partnership strength. The absence of robust monitoring across regions potentially limited CzRC's ability to ensure consistent standards or identify best practices for replication.

Component 2: National Society Capacity Strengthening

Capacity Building Overview

The CzRC aimed to train 855 health professionals, volunteers, first aid responders and other professionals to provide PFA and MHPSS. Most were trained in basic PFA, with a smaller number also trained in EmotionAid basics, Crisis intervention, and Assyst method (see previous section).

Relevance

The timing of EU4H MHPSS capacity building misaligned with peak PDU need, though CzRC's existing capabilities provided a crucial buffer. The EU4Health capacity strengthening component delivered training well after peak Ukrainian displacement, creating a temporal mismatch between skill development and greatest demand. However, CzRC managed this gap better than many NS due to pre-existing PFA capacity developed through Slovakia Red Cross collaboration. This foundational knowledge enabled immediate response during critical early periods while awaiting systematic EU4Health training rollout.

Training relevance had to accommodate varying levels of NS baseline MHPSS experience. CzRC's advanced starting point creating some misalignment of training relevance. While ToT training in Budapest and subsequent programming addressed identified MHPSS gaps across regions, CzRC's relatively advanced capabilities in some MHPSS aspects meant generic training was not always optimally tailored. The challenge of designing training for NS at vastly different capability levels - from basic awareness to advanced practice - inevitably created relevance gaps for more experienced participants. Considering their existing capacity, CzRC could perhaps have benefited from advanced modules targeting their specific development needs.

Effectiveness

CzRC implemented comprehensive trainer requirements in a cascading approach that exceeded basic requirements. The Czech Red Cross ensured trainers attending Budapest ToT sessions had sufficient baseline knowledge to become effective multipliers. Within the total 849 people trained, volunteers received differentiated training based on roles - including Assyst method training, nearly 100 trained in EmotionAid basics, and others receiving specialized crisis intervention training. The majority received psychosocial support basics from 6 CzRC trainers, with others receiving PFA training through Fire Rescue Service partnerships. This tiered approach created depth of capacity across different MHPSS intervention levels, ensuring appropriate skills for various response scenarios.

EU4Health provided crucial opportunity to modernize and expand existing capabilities. While CzRC possessed PFA training materials and experience, these resources had become outdated. The program created space to update materials, refresh approaches, and build trainer confidence. Rather than simply meeting minimum requirements, CzRC leveraged funding to comprehensively upgrade their MHPSS training infrastructure, going several "steps further" than mandated activities.

Impact

Enhanced PFA capacity served Ukrainians while transforming CzRC's broader emergency response capabilities. The strengthened MHPSS skills proved invaluable beyond the Ukraine crisis - CzRC's trained personnel were requested for the Charles University shooting in Prague and Moravian flooding response, demonstrating transferable capacity gains. EU4Health proved pivotal in establishing

CzRC's PSS reputation within the integrated rescue system, leading to formal recognition including invitations to fire service training exercises.

The multiplier effect extended beyond Red Cross boundaries. Training coordination with fire services and other emergency responders created system-wide capacity improvements. Partners gained confidence in CzRC's MHPSS capabilities, leading to increased collaboration requests and joint training opportunities. This reputation enhancement positions CzRC as the recognized MHPSS provider within Czech emergency response architecture, ensuring sustainability beyond EU4Health funding.

Coverage

13 regional intervention teams were established across the country, consisting of various mental health professionals, interpreters, and professionals from the Ukrainian community. These teams included Czech psychologists, Ukrainian psychologists who arrived in 2022, trained Ukrainian interpreters from the national interpreters union, social workers, and PFA-trained volunteers. The inclusion of Ukrainian-speaking professionals served dual purposes - addressing language barriers while providing employment opportunities for qualified displaced persons. Teams varied based on regional needs, from smaller units in rural areas to larger teams in urban centres with more PDU.

Standardized training created nationwide consistency and operational agility. EU4Health enabled CzRC to expand PSS capacity from initial concentrations in Prague and North Moravia to full national coverage. By teaching PFA uniformly across all regions, CzRC achieved internal coordination that made them more nimble in deployment and more predictable to emergency partners. This standardization transformed CzRC from regionally variable to nationally consistent MHPSS provider.

Accountability & management

Administrative capacity building proved as crucial as technical skills development. A project of this scale was unprecedented for many NS, bringing unfamiliar administrative burdens including EU procurement procedures and documentation requirements. Tasks as routine as booking training venues required extensive paper trails and compliance processes that stretched existing administrative capacity. The coordinator transition in CzRC - consolidating from two positions to one handling both strategic and operational duties - demonstrated strong individual capacity, adaptability and commitment. NS could have benefited from robust guidance on IFRC project administration, procurement compliance, and documentation management.

While CzRC successfully built substantial MHPSS capacity, tracking systems remained manual throughout implementation. Regional coordinators relied on personal networks and local knowledge to deploy trained personnel effectively—a testament to their adaptability but also a systemic limitation. Recognizing this gap, **CzRC plans to digitalize capacity tracking** across all volunteer competencies.

Component 3: Caring for Staff & Volunteers

Support Overview

CzRC's staff support evolved from emergency response to structured care systems. Initial crisis deployment developed into formal wellbeing programs: trained peer supporters, psychological

supervision, team protocols. This evolution revealed important questions about organizational boundaries and who falls within protection frameworks.

Relevance

PFA training reduced stigma and increased help-seeking behaviour among CzRC staff and volunteers. The high-stress nature of the project, with coordinators managing ambitious targets while developing systems under pressure, further validated the critical importance of comprehensive staff support.

Effectiveness

CzRC developed multi-layered staff wellbeing approaches, though implementation remained uneven. The program trained 23 representatives from regional intervention teams in peer support, combining PFA with Critical Incident Stress Management knowledge. Peer support, along with professional supervision by psychologists and "buddy talk" card systems, created formal support structures. Nearly 600 volunteers were trained in PFA/PSS, crisis intervention and PEER support. Across the project 2,394 staff, volunteers and frontline responders received some form of MHPSS.

Ukrainian staff faced unique support challenges requiring adapted approaches. Field visits revealed varying implementation - In regions like Ústí, Ukrainian psychologists relied primarily on peer support networks rather than formal supervision, as supervision sessions would require interpretation. This highlighted the need for culturally and linguistically appropriate staff care models, particularly for team members who were themselves displaced persons and sometimes managing their own trauma while supporting others.

Impact

Staff wellbeing investments created organizational infrastructure for ongoing support, establishing peer support networks, supervision structures, and team meeting protocols. Desktop research indicates supervision training is planned for further integration into NS structures, with additional volunteers and CzRC members scheduled for skills training. While foundations were established through the 23 trained peer supporters and buddy card systems, full institutionalization of staff care accountability measures was still evolving.

Cultural shifts began emerging within CzRC regarding mental health discussions. The introduction of PSS vocabulary and concepts through training provided common language for discussing wellbeing. PFA-trained volunteers showed greater willingness to seek help and discuss emotions, suggesting reduced stigma around mental health within the organization. The development of systematic approaches - from buddy cards to proposed telephone support lines - indicated organizational recognition of staff care as an operational priority.

Coverage

Implementation of CfSV approaches and utilization of support varied by region. Implementation ranged from formal structures in some regions to informal arrangements in others**.** Regional variations were evident, with some areas like Zlín demonstrating regional coordinator commitment to team wellbeing, while others like Ústí showed Ukrainian staff preferring their own peer support systems.

A significant gap emerged regarding interpreter wellbeing. Despite engaging the national union of interpreters from project inception, neither CzRC nor partner organizations initially recognized interpreters' psychological support needs. Interpreters were repeatedly exposed to traumatic narratives without access to the support systems available to professional responders. While fire brigade, rescue services, and police had established self-care systems, hired interpreters fell outside these structures. This oversight became a key lesson learned.

Accountability & management

Leadership buy-in proved crucial for embedding staff wellbeing initiatives. CzRC management's strong support for MHPSS principles supported the development of formal staff care structures. The organizational recognition that staff mental health directly impacts service quality created accountability for implementing support mechanisms and longer-term sustainability prospects.

Systematic approaches to staff care remained in development phases. While CfSV foundations were strengthened in EU4Health, full institutionalization is still evolving. A KOBO monitoring system for peer interventions represented initial attempts at tracking and accountability, though comprehensive oversight mechanisms do not yet appear to be operational.

Component 4: Stakeholder Coordination

Internal Coordination

Branch coordination proved exceptionally strong through systematic early engagement. CzRC headquarters conducted extensive meetings with local branches to advocate for the program, initially emphasizing direct PFA services. Branches with humanitarian aid centres integrated MHPSS into existing services, connecting displaced persons with psychological support. This bottom-up approach allowed branches to opt in based on local capacity and demand while maintaining national leadership support. The flexible structure achieved buy-in across 13 of 14 regions, ensuring consistency while respecting regional autonomy. Early branch engagement created the foundation that enabled smooth CBMHPSS expansion when later approved.

When CBMHPSS activities were approved, CzRC empowered regional coordinators to design locally-appropriate interventions. HQ shared new possibilities through regular coordinator meetings while regions determined implementation based on population needs and existing infrastructure.

External Coordination

CzRC demonstrated intensive external engagement throughout implementation. Desktop research documents 444 coordination meetings, reflecting systematic relationship building with multiple stakeholders. The coordination approach evolved from initial bi-monthly meetings with Fire Rescue Service and other organizations to monthly sessions from 2023 onward. Key partners included Ministry of Interior, AMIGA (covering Ukrainian/Russian-speaking MHPSS experts), People in Need, Union of Interpreters and Translators, UNICEF, regional authorities, and various ministries.

Public outreach required adaptive communication strategies. Recognizing sensitivities in the social media environment, CzRC shifted from digital platforms to more direct channels. The organization

developed Ukrainian-language web resources, distributed informational leaflets through branch networks, and prioritized face-to-face engagement with schools and municipalities. This diversified approach, supported by partnerships with WHO and UNHCR networks, ensured beneficiaries could access information through trusted channels while maintaining their privacy and safety.

Strategic framework development strengthened coordination capacity. CzRC developed its first Strategic Vision for Mental Health Care and Psychosocial Support until 2030, establishing organizational MHPSS structure and formalizing collaboration frameworks with key partners. This strategic approach positioned CzRC as a recognized actor in the national MHPSS landscape.

Regional decentralization enabled locally-responsive coordination while revealing capacity variations. Zlín exemplified strong multi-organizational coordination through schools, government, pedagogical centres, and medical services partnerships. Ústí's coordinator effectively engaged emerging Ukrainian community organizations. In South Bohemia the local branches were involved in city council led reception centres from the beginning.

Sustainability

Strong institutional foundations support continuity, but sustainability outlook varies—systematic government engagement (Ministries, Fire Brigade, Police) and community partnerships created lasting MHPSS infrastructure, anchored by CzRC's Mental Health Strategy - 2030. Still, current funding only maintains four regions at reduced capacity until the end of the year, while new income streams develop. Zlín's evolution into a recognized "Centre of Psychological and Social Services" with state funding for one position demonstrates breakthrough potential.

Revenue diversification and service expansion signal emerging sustainability potential. Accredited PFA training can generate fees with more courses planned, public mental health communication has helped to reach new audiences via social media, and community centre proposals await funding decisions. These initiatives and others can further position CzRC as an established mental health actor building sustainable services atop emergency response foundations. The challenge remains translating multiple small revenue streams into comprehensive program support.

Capacity gains require systematic reinforcement. PFA gained recognition as core competency alongside first aid, with partners valuing enhanced collaboration: "the training made us more interesting partners." However, this strategic progress lacks financial underpinning. Despite management support and dedicated fundraising efforts, the EU4H project manager position remains unfunded beyond 2024. While small follow-on projects with Ukrainian psychologists provide temporary bridges, the gap between approved strategy and available resources threatens hard-won capacity gains. Systematic challenges persist—budget lines and formal policies remain undeveloped, refresher training confirmed skills deterioration without practice, and regional continuity depends on individual coordinators rather than institutional structures. Yet CzRC's enhanced reputation, proven emergency response capability, and the Mental Health Strategy 2030 provide foundation stones for future development. The challenge now lies in building sustainable structures atop these achievements.

Recommendations

Recommendation	Donor	IFRC / Project coordinators	NS HQ /local leaders	NS Project lead
Replication & Scale - Document and systematize Zlín's integrated multi-stakeholder model, particularly the embedding of services within existing structures (pedagogical centres, schools, healthcare). Create implementation toolkit for other regions that emphasizes supplementation not replacement of state services			x	x
Coordinator Specifications - Develop formal role requirements based on successful coordinator profiles: Ukrainian language/community connections, MHPSS experience, networking abilities. Mandate full-time positions for programs of this scale. Include in future emergency response planning		x	x	
Staff Care Systems - Establish comprehensive staff care covering ALL personnel exposed to trauma, including interpreters. Develop specific support protocols for auxiliary staff who currently fall outside organizational care systems		x	x	x
Enable flexible service provision beyond rigid session limits if referral pathways are compromised. Prachatice needs psychologist-supervised groups and enhanced individual support. All regions assess gaps in services for elderly and single adults	x	x	x	x
M&E - Implement integrated data systems: digital tracking of personnel competencies, impact monitoring beyond counts, and quality indicators. Fragmented records and estimation-based reporting hindered early response. Invest in information infrastructure parallel to service delivery		x	x	x
Sustainability - Build on current momentum: e.g., establish annual mental health forum leveraging CzRC's new key player status; and/or develop 3-year funding strategy targeting corporate and foundation partners			x	
Knowledge Management - Create peer learning mechanisms using Zlín & Ústí as teaching cases. Document evolution from emergency KACPU response to sustained programming. Capture lessons on interpreter engagement model for replication		x		x
PM - Provide comprehensive administrative support package for future programs including procurement procedures, documentation requirements, and realistic staffing models. Admin. capacity building as important as technical training		x		
Design - Enable adaptive programming from project start. Early CBMHPSS authorization would have better matched evolving needs. Design future responses with built-in flexibility for natural progression from emergency to integration support	x	x		
Early Response Positioning - Capitalize on value of early visible presence. CzRC's KACPU involvement from day 1 created trust enabling organic recruitment & community engagement. Ensure similar positioning in future crises	x	x	x	
Language - Comprehensive language support framework distinguishing between MHPSS intervention types. Basic PFA works well with interpretation, but complex trauma work works better with native speakers. Train interpreters in MHPSS terminology & offer them psychological support too.		x	x	x

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Written by: SARDE Consultants Kieran Birtill and Jonah Rudlin, with research support by Marta Siciarek and Ayesha Khalil.

Steered by: IFRC Evaluation Management Team

Commissioned by: International Federation of Red Cross and Red Crescent Societies (IFRC)

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