Report
Adolescent pregnancy in Romania

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Authors: Dr. Michaela Iuliana Nanu[1] – Research Scientist (Grade 1), Dr. Ecaterina Stativa[1] – Research Scientist (Grade 1), Dr. Daniela Vălceanu[2], Dr. Marina Ruxandra Oţelea[3]

1- "Alessandrescu-Rusescu" Mother and Child Health Institute, Bucharest

2- National Public Health Institute, Bucharest

3- SAMAS Association

Executive summary

Adolescent pregnancies – and adolescent parenthood in particular – carry high social and economic costs and have a bearing on health, social benefits and even crime. Early school leaving as a result of pregnancy and childbirth prevents girls from completing the education they need to acquire a profession, making it more difficult to later find a job. Unemployment, and hence poverty, will consequently affect this group of people and their children. Research has highlighted the worrying cyclicality of the phenomenon, which is perpetuated in a family generation after generation, dragging along lots of economic, social and health-related vulnerabilities.

Materials and methodology

This study comprises three separate analyses:

1. A review of current legislation on adolescent pregnancy and childbirth prevention, which looks at strategies and policies in the fields of health, education and child protection with a view to gaining insight into the current legislative background.

2. An analysis meant to identify the socio-demographic, educational and cultural profiles of young women likely to become mothers before the age of 18 as well as their opinions and attitudes about reproductive health, based on the secondary analysis of the data presented in the Romanian Reproductive Health Survey.

3. An analysis meant to identify the opinions, attitudes and suggestions of professionals and decision-makers from central and local levels with regard to the measures that would be most effective in reducing the phenomenon over time, based on the information collected during group

discussions (focus groups) with professionals and individuals discussions (semi-structured interviews) with public policy makers in the field of adolescent health.

Findings and discussions

1. **Lack of a coherent policy and standards of practice in the field of reproductive health for the professionals involved in adolescent work**

Adolescents in general are not regarded as a priority across strategic documents on reproductive health. *The policy on the monitoring and evaluation of the mother and child health strategy* and of the family planning programme *does not include indicators related to adolescent reproductive health.*

There is currently no sign of *clearly demarcated roles and aligned responsibilities for* different authorities or *standards for providing contraceptive counselling to adolescents in general and to socially disadvantaged teenagers in particular*, whereas *responsibilities for the prevention of unintended pregnancies are ambiguously assigned to a large number of professionals* (community health nurses, social workers, health mediators, general practitioners, gynaecologists, family planning doctors, DPH doctors), who *don't seem to be in tune or sufficiently aware of their professional complementarity*.

There is a lower number of *trained professionals* available to provide family planning counselling to adolescents and *postgraduate training* on specific topics for professionals working in the area of *adolescent* reproductive health, with a different basic training (teachers, nurses, midwives, physicians, psychologists, social workers and community health nurses), is not encouraged or supported as a means to *harmonise their activitie*s.

2. **Lack of a coherent health education programme for adolescents**

Under-age mothers are not a compact group sharing the same characteristics and needs. Health education is currently optional in schools and does not successfully provide information meant to promote non-risky sexual behaviours and prevent adolescent pregnancy.

According to the professionals interviewed in this research, low participation, the poor organisation of the activities by staff with insufficient competencies or skills (homeroom teacher, biology teacher, school doctor*), the lack of performance standards and the lack of a communication strategy targeted at the opponents of sex education* – parents, teachers, religious leaders – are all factors that make these actions reach unsatisfactory outcomes.

3. **One-dimensional approach to under-age mothers across social services, focused on financial support**

Child protection services usually focus their interventions on the provision of *cash benefits or services/allowances* to these young mothers, *yet these actions fail to prevent repeat pregnancies.*

Most under-age mothers have dropped out or leave school when they become mothers. No *educational measures* are being implemented *for socially disadvantaged adolescents and early school leavers*, who are largely excluded from information and education activities, thus heightening the risks of inappropriate sexual behaviours and unintended pregnancies.

What is missing is *a network of psychologists – integrated into social assistance services* – that can *develop and implement support programmes for under-age mothers.*

4. **Inadaptability of family planning services to the needs of adolescents, especially of those from disadvantaged families**

Given its current disorganisation, the family planning network can no longer provide the necessary framework for contraceptive counselling and care in general, which incidentally restricts adolescents' access to these services in both urban and rural areas.

Adolescents' access to family planning services and their use of modern contraceptives are hampered by the fact that those services do not offer *a friendly and confidential environment as well as* by their lack of information, stigma, cultural and religious barriers, making them more vulnerable to unintended pregnancies.

Contraceptives can no longer be obtained for free, which experts think makes young people, in particular those from socially disadvantaged groups, seek family planning services and use contraception considerably less.

5. **Low adolescent involvement in positive changes**

Sustained community awareness campaigns focused on adolescent sexuality, the risks of unintended pregnancies and ways to prevent them are sporadic and lack financial support from the government.

Policies and current social practices refer almost exclusively to under-age mothers, yet all adolescents should be included, as some of them are the *fathers of the children* born to under-age

mothers, the latter's future partners or support people who are the closest to under-age mothers and their children.

Stigma, as a psychological or social event, is a barrier to adolescents' access to family planning services and reproductive health counselling. It is also the cause of *their non-participatory attitude when it comes to changing things for the better*.

6. Lack of an information system regarding adolescent reproductive health

The data collected are not systematically analysed and *there is no data sharing policy*. As a result, *such data are rarely used for planning and making policy decisions at system level.*

There is a lack of funding for *studies and research* meant to identify the specific needs and expectations of Romanian adolescents and to inform both policies and standards of practice in the field.

Adolescent pregnancy studies conducted so far focus on *under-age mothers while neglecting male adolescents*.

Conclusions and recommendations

Health policies

Revise and adapt the legal framework for reproductive health policies, with the active involvement of young people in the organisation and implementation of sexual and reproductive health activities that do not require parental consent to participation. Include the issues of reproductive health and *adolescent pregnancy prevention* in the *National Health Strategy 2021-2025,* based on *social and ethical values,* as a standalone component aimed at addressing inequalities in adolescent care. Draw up a plan of appropriate measures for age-relevant issues in the field, with the collaboration and participation of schools, local leaders, local authorities and community leaders. Extend the reproductive health policy evaluation system to include mandatory *indicators measuring inequalities in health care, social assistance and access to education*.

Interinstitutional cooperation

A *multi-dimensional, complex approach* is needed, *as part of integrated public policies regarding sex education, community awareness of specific needs in the field and the provision of services tailored to adolescents' psychological and emotional profiles.* Develop *interinstitutional*

cooperation networks with a view to establishing cross-cutting measures for the prevention of adolescent pregnancies, with the participation of – among others – the Ministry of Health, the Ministry of Education, the Ministry of Interior (the police), universities, mayoralties, NGOs, associations assisting Roma communities and with a clear definition of roles and responsibilities.
Set up a *communication and cooperation network* in the field and address inequalities in adolescent care for reproductive health through *sustainable projects*. *Develop partnerships between governmental institutions and NGOs* for initiatives that address the needs of young people and adolescents in the field of reproductive health in general and in the area of pregnancy prevention in particular.

Evidence-based policy development

Carry out *quantitative and qualitative research* on the sexual behaviours of young girls and boys so that relevant data can be used to develop and improve adolescent reproductive health and pregnancy prevention services for young people.
Conduct *adolescent and youth reproductive health surveys* on a regular basis; collect data based on nationally representative samples; process and analyse sexual and reproductive health data to inform future policy decisions.
Run *comparative analyses and forecasts and develop alternative strategies to address youth sexual and reproductive health issues*.
Assess *cultural and motivational factors contributing to pregnancies among adolescent and under 15-year-old girls and develop specific interventions for different age groups.*
Create *educational programmes* addressing the cultural factors identified as well as specific interventions for different cultural groups (the Roma, vulnerable populations living in rural areas and poor urban communities, etc.), targeting both young people and parents, community leaders, etc.

Provision of tailored educational and reproductive health services to adolescents

Sex education

Include *sexual and reproductive health education* in the syllabus as a *compulsory subject matter*; *create content that is appropriate to the child's age, issues* and level of understanding and teach it starting with the early stages of school; include *equality- and non-discrimination-based* approaches in IEC programmes implemented for adolescents in the field of reproductive health.

Develop a communication strategy and ensure the transparent provision of sex education in schools for all stakeholders: parents, teachers, community leaders.

Organise *adult education programmes* for parents and teachers so that they can acquire the skills needed to offer adolescents information and guidance on safe and responsible sexual behaviours.

Friendly family planning services

Reorganise family planning services by *setting up adolescent- and youth-friendly services* and identifying opportunities to restore the network of family planning/sexual and reproductive health services, thus providing access to rural populations. Choose youth-populated areas (university campuses) as locations for such services.

Set up *youth information centres* focusing on sexual and reproductive health, with a friendly atmosphere, and/or create reproductive health-related websites for young people.

Set *standards for family planning services targeting adolescents*, based on the development of *clinical guidelines* with a dedicated chapter on adolescents, in line with international standards and WHO documents.

Ensure the *provision of free contraceptives to adolescents* in general and to disadvantaged ones in particular.

Training of staff from adolescent reproductive health services

Increase the number of professionals working in the field of adolescent and youth sexual and reproductive health, train the staff from health, educational, social services and other relevant areas on how to provide sexual and reproductive health information and advice to youth and adolescents; *develop a training curriculum and educational materials in accordance with international standards*.

Reconsider the roles of nurses and midwives, promote and include these qualified and lower-cost professionals in the health education services delivered by family planning offices.

Community awareness

Develop an *advocacy strategy on youth reproductive rights* to raise decision-makers' awareness of reproductive health so as to consider it a national priority.

Initiate *education programmes for parents* so that they can offer adolescents guidance on safe sexual behaviours; multidisciplinary and interinstitutional cooperation. Find creative ways of using mass media and social media to provide appropriate information to young people.

Spur collaboration with the community, *involving community leaders*, the church and the media.

Use *mass media and social media* to share information between relevant political actors, stakeholder institutions and the community.

Draw up and distribute information materials on sexual and reproductive health that are appropriate to different age groups and communities, including socially disadvantaged ones.

Social policies

Ensure more responsible interventions from stakeholders with a remit to identify and condemn child sexual abuse, by evaluating their work on a regular basis.

Provide *psychological support* to children from broken families, with migrant parents and other vulnerable groups.

Implement dropout prevention policies on a large scale, with a focus on rural areas and the Roma.

Enhance access to reproductive health services for children from placement centres/adoptive families.

Implement reproductive health measures at community level, including access to free contraception for adolescents from vulnerable families.

Abbreviations

CHN – Community health nurse

DPH – Directorate for Public Health

FP – Family planning

GDSACP – General Directorate for Social Assistance and Child Protection

GP – General practitioner

IMCP – “Alessandrescu-Rusescu” Institute for Mother and Child Protection

OB/GYN – Obstetrics and gynaecology

SD – School doctor

WHO – World Health Organisation

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CHAPTER 1.
STATEMENT OF THE PROBLEM

Adolescent pregnancies – and adolescent parenthood in particular – have caught the attention of governments from different countries due to their high social and economic costs. They have a bearing on health, social benefits and even crime. Early school leaving as a result of pregnancy and childbirth prevents girls from completing the education they need to acquire a profession. This makes it more difficult to later find a job. Unemployment, and hence poverty, will consequently affect this group of people. Research has highlighted the worrying cyclicality of the phenomenon, which is perpetuated in a family generation after generation, dragging along lots of economic, social and health-related vulnerabilities.

Literature treats adolescent pregnancy more as a public health issue, yet there is little evidence that teenage motherhood can pose a risk to mother and child health (Lawlor & Shaw, 2002), especially if it occurs at the age of 15-19 years and not earlier.

Nevertheless, numerous studies provide evidence that premature birth and related impairments are more common in children born to adolescent mothers than in those born to adult mothers (Iorga et al., 2016). In addition, it is found that many adolescent mothers experience health issues during pregnancy, such as anaemia, pregnancy-induced hypertension and intrauterine growth restriction, much more frequently than adult mothers. Moreover, teen mothers' newborn children face a higher risk of dying. Other negative implications are a poor prognosis for future pregnancies (Markovitz, Cook, Flick and Leet, 2005) and cognitive developmental delays for the mother and child (Hobcraft and Kiernan, 2001; World Health Organisation, 2011). These adverse effects could also be explained – at least to some degree – by the fact that adolescent mothers are confronted with poverty and various forms of deprivation and they engage in different risky behaviours, such as smoking or illicit substance use (Imamura et al., 2007).

As proven by other research, chronological age alone is a good predictor of pregnancy outcomes, with adolescent mothers being a high-risk group because of their demographic characteristics and social disadvantage (Penman-Aquilar et al., 2013).

In Romania, the proportion of adolescent mothers (mothers who gave birth before the age of 20) has fluctuated by roughly 10 per cent in recent years (National Institute of Statistics, 2017). In 2018, 18,631 teenage girls became mothers. Out of them, 705 were younger than 15 years of age.

In 2019, the total number of adolescent pregnancies dropped to 16,639 (9 per cent less than in 2018), mostly due to a decline in pregnancies occurring at ages 15 to 19 years (a 9.3 per cent reduction versus a decrease of only 3.9 per cent for all ages under 15).

The regional distribution of adolescent pregnancies in 2018 and 2019 is shown in Figure 1 and Figure 2.

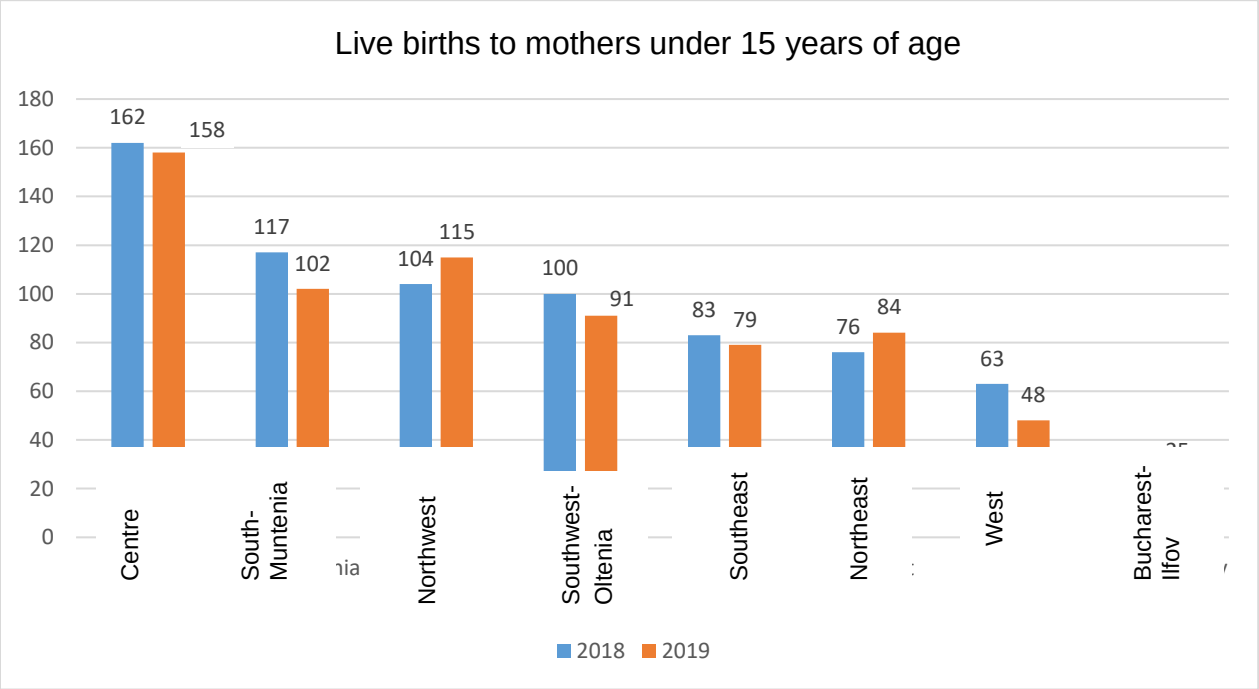

Figure 1 – Number of live births to mothers under 15 years of age

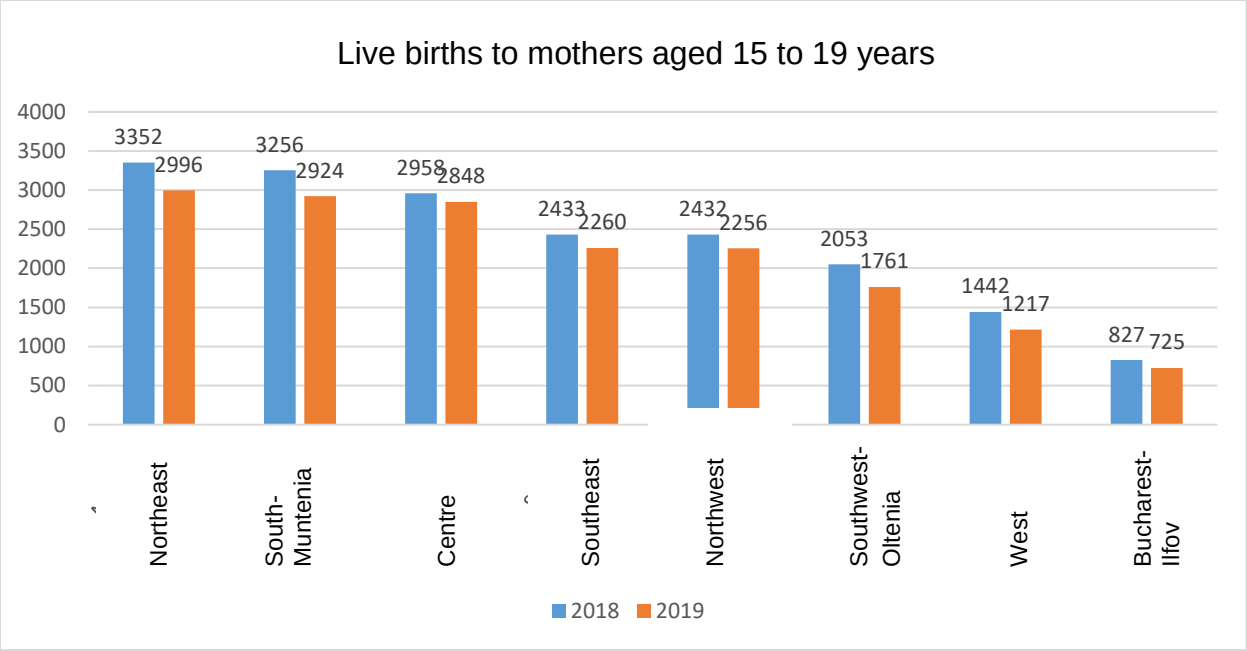

Figure 2 – Number of live births to mothers aged 15 to 19 years

We see an increase of 11 per cent in the number of pregnancies for all ages under 15 in the Northwest and the Northeast. In all the other regions, the number of pregnancies has dropped among both under 15-year-old girls and adolescents aged 15 to 19 years (a decline between 2 per cent and 24 per cent in 2019 versus 2018).

As far as county distribution is concerned, in 2018, the highest birth rates for under 15-year-old adolescent girls (counties with a number of births over the 75th percentile, namely over 23 births/year) were reported – in descending order – in the following counties: Mureş, Braşov, Dolj, Argeş, Timiş, Bihor, Bacău, Olt, Constanţa, Galaţi and Sibiu. In 2019, the largest number of cases is once again found in the county of Mureş (69 pregnancies), followed by Dolj (47 pregnancies), Braşov (40 pregnancies), Bihor (38 pregnancies), Bacău (31 pregnancies), Constanţa (26 pregnancies), Dâmboviţa (23 pregnancies) and Satu Mare (23 pregnancies). This age group witnesses a more than 40 per cent increase in 2019 compared with 2018 in the counties of Tulcea, Hunedoara, Dâmboviţa, Botoşani, Neamţ, Suceava and Maramureş.

Regarding adolescent girls aged 15 to 19 years, in 2018, the largest number of pregnancies was recorded in the counties of Mureş (883 pregnancies), Dolj (833 pregnancies), Iaşi (818 pregnancies), Braşov (761 pregnancies), Bacău (676 pregnancies), Bihor (673 pregnancies), Constanţa (664 pregnancies), Suceava (575 pregnancies), Prahova (532 pregnancies) and the city

of Bucharest (525 pregnancies). In 2019, despite a 3 to 24 per cent decline, figures that fall beyond the 75th percentile are still reported in the counties of Mureş (827 pregnancies), Braşov (761 pregnancies), Dolj (700 pregnancies), Iaşi (691 pregnancies), Bacău (654 pregnancies), Constanţa (616 pregnancies), Bihor (593 pregnancies), Suceava (512 pregnancies), Dâmboviţa (503 pregnancies) and Prahova (483 pregnancies).

As to the fathers of children born to teen mothers, there is a relatively large number of fathers aged 15-19 years.

As far as the child's rank is concerned, the incidence of repeat pregnancies reached a plateau, with almost identical percentages in 2018 and 2019. Hence, most mothers under the age of 15 were first-time mothers (97.25 per cent in 2018 and 96.58 per cent in 2019). Surprisingly enough though, there were also mothers who had their second child, with a share in total under 15-year-old mothers that was slightly higher in 2019 (3.42 per cent versus 2.61 per cent in 2018). Third-time mothers are reported only in 2018 (one mother under 15 years of age).

Among mothers aged 15 to 19 years, the proportion of repeat pregnancies is relatively stable. Thus, 74.72 per cent in 2018 and 74.06 per cent in 2019 were first-time mothers; 20.95 per cent in 2018 and 21.62 per cent in 2019 had their second child; 3.9 per cent and 3.88 per cent, respectively, their third; 0.04 per cent and 0.06 per cent, respectively, their fifth. In 2018, one mother in the age group 15-19 years delivered her sixth child. The stability of the figures is even more upsetting as it may be based on a lasting trend, with a quarter of teen mothers having more than one child before they reach adulthood.

Within the European Union, Romania ranks among the top two countries with the highest adolescent birth rates (the number of births per 1,000 women aged 15-19 years and 15-17 years). In fact, in 2016, Romania and Bulgaria reported birth rates that stood at 34 and 36.8 births respectively per 1,000 women aged 15-19 years, three times higher than the EU average. The smallest birth rates among women aged 15 to 19 years were recorded in Denmark (1.5), Slovenia (1.6) and the Netherlands (1.7). The latest European statistics do not mention births to under 15-year-old girls, probably because those are rare events. Yet, in Romania, they reach a prevalence rate of 4 per cent.

The number of abortions is also high among adolescents. In 2017, 412 abortions were reported for girls under 15 years of age and 5,955 for those aged 15-19 years. A decreasing trend is seen in the

following years, though their number remains very high – 4,883 in 2018 and 4,290 in 2019. In 2018 and 2019, no abortions were reported among girls younger than 15 years of age.
The European countries that dealt with high adolescent birth rates in the past, like Great Britain, have managed to reduce the phenomenon thanks to appropriate cross-sectoral policies reaching at-risk groups. It is interesting that, at the level of the European Union, high adolescent birth rates are not necessarily typical of developing countries. For example, before the accession of Romania and Bulgaria to the EU, the United Kingdom (Great Britain) ranked first in the EU in terms of live births to adolescent girls ages 15-19 years and had a rate of 26.5 births per 1,000 adolescent girls in 2006, as compared to the European mean of 15 births per 1,000 adolescent girls (Office for National Statistics, 2014; Lawlor & Shaw, 2004). It should be noted that, by 2012, the UK rate dropped to 14 live births per 1,000 adolescent girls aged 15-19 years (Office for National Statistics, 2014; Robson and Berthoud, 2003).

At least three sectors should develop strategies and policies for the prevention of adolescent pregnancy and childbirth: education, health and child protection.
Since *"births to under-age mothers bear medical, social, cultural, economic, demographic implications",* the implementation of measures meant to prevent pregnancies at young ages will consequently have effects like the *"reduction of infant mortality"* (health mediator) and *"maternal deaths"* (DPH inspector), *"lower risks of sexual disease transmission and premature birth"* (GDSACP), *"avoidance of abortion"* (FP doctor), *"protection of children's health"* (school doctor)*, "prevention of unintended pregnancies and child abandonment, ensuring the physical and mental health of future adults, the normal development of young people and of their future children"* (GP) and *"preparing them to become parents when they can take care of themselves and their children"* (school doctor).

Effects of measures aimed to prevent pregnancies at young ages, according to different types of professionals

Opinion regarding the effects of measures aimed to prevent adolescent pregnancies	**Professional**
The implementation of measures meant to prevent pregnancies at young ages will consequently have effects like:	

Reduction of infant mortality	Health mediator
Reduction of maternal deaths	DPH inspector
Lower risks of sexual disease transmission and premature birth	GDSACP
Avoidance of abortion	FP doctor
Protection of children's health	School doctor
Prevention of unintended pregnancies and child abandonment, ensuring the physical and mental health of future adults, the normal development of young people and of their future children	GP
Preparing adolescents to become parents when they can take care of themselves and their children	School doctor

Adolescent pregnancy and childbirth are most visible across the healthcare sector, although the latter's responsibilities for teen pregnancy prevention are quite limited.

The countries that have implemented prevention programmes have focused on the formal education delivered in schools. Literature also mentions programmes for parents of adolescents aimed at improving communication. The experience of other countries with remarkable results shows that school-based education can be effective, as it targets the entire population concerned.

In Romania, over the past 20 years, new institutions have been set up in the local communities and they could be involved in adolescent pregnancy and childbirth prevention in a more direct manner. We are talking about community health nurses and social workers, health and school mediators. Even if their work has indisputably helped improve the overall circumstances of children, the prevention of adolescent pregnancies remains an outstanding issue.

Interinstitutional cooperation at central and local levels is needed to design strategies, policies and intervention programmes.

Although Romania's administrative and legal frameworks allow for the efficient provision of sexual and reproductive health-related information and services, recent years have witnessed a setback in terms of population's access to these services, as reflected in the declining indicators presented in the 2016 Reproductive Health Survey (Suciu et al., 2016) and by a series of studies and reports made by experts from different organisations active in the field.

To gain deeper knowledge of adolescent pregnancy, childbirth and parenthood, we intend to analyse the risk factors associated with this phenomenon and the extent to which health policies respond to the identified needs.

CHAPTER 2.
OBJECTIVES

This research pursues the following objectives:

1. **Make a review of current legislation** on adolescent pregnancy and childbirth prevention;

2. **Identify the socio-demographic, educational and cultural profiles of young women** likely to become mothers before the age of 18 and **their opinions and attitudes about reproductive health**;

3. **Identify the opinions, attitudes and suggestions of professionals and decision-makers from central and local levels** with regard to the measures that would be most effective in reducing the phenomenon over time;

4. **Make recommendations for improving the current situation**.

CHAPTER 3.
MATERIALS AND METHODOLOGY

In order to reach Objective 1, we will look at strategies and policies in the fields of health, education and child protection with a view to gaining insight into the current legislative background.

In order to achieve Objectives 2 and 3, the data presented in the Romanian Reproductive Health Survey will be used, along with the information collected during group discussions with professionals and individual discussions with public policy makers in the field of adolescent health.

Data collection tools

The secondary analysis of research data focused on the items concerning respondents' distribution by area of residence, age, educational attainment, number of pregnancies, contraceptive knowledge, use of contraceptive methods, attitude towards reproductive health and domestic violence.

The following tools were used for data collection purposes:

- The focus group guide presented in Annex 1 was used to gather data from professionals.
- The semi-structured interview guide presented in Annex 2 was used to gather data from decision-makers.

CHAPTER 4.
FINDINGS

4.1. Objective 1 – Review of current legislation on adolescent pregnancy and childbirth prevention

International background

Adolescent pregnancy is analysed based on Romanian reproductive health strategies and legislation, corroborated with international strategies and laws on sexual and reproductive health. Defined by the World Health Organisation (WHO) as a state of physical and mental well-being, sexual and reproductive health has gained new grounds and has become a new focus area for the WHO, documented in its *Regional Strategy on Sexual and Reproductive Health – 2001* and *Global Strategy on Reproductive Health – 2004*, which have informed national policies and strategies adapted to local needs.

Under Health 2020, its health and well-being policy framework drawn up in 2012, the World Health Organisation has provided support to governments and civil society "to ensure health systems that are universal, equitable, sustainable and of quality, including for sexual and reproductive health". In its turn, the WHO/Europe Action Plan for Sexual and Reproductive Health, adopted in 2016, set objectives and public policy directions based on the Health 2020 strategy. The Plan should be adapted to the national context, in accordance with the international agreements signed by each state.

The WHO/Europe Regional Action Plan includes adolescent sexual and reproductive health as a focus area, with the following targets:

- Develop an appropriate legal framework for the free enjoyment of reproductive rights;
- Optimise school-based sex education and extend the syllabus to include the concept of the right to choose in sexuality-related matters;
- Promote dual protection (against unwanted pregnancies and sexually transmitted infections);
- Distribute free-of-charge or affordable contraceptive products to disadvantaged groups, including adolescent girls;
- Ensure quality family planning services, appropriate counselling and confidentiality;
- Ensure adequate services and information for adolescents, youth and disadvantaged or minority populations while respecting their values and cultural diversity;
- Set up reproductive health services for men;
- Provide adequate training to health professionals as well as training and support to influencers (parents, teachers, pharmacists, community leaders, etc.) so that they can communicate with adolescents;
- Provide education and information on gender equality as well as prevent and combat domestic violence and gender violence.

National background

In Romania, reproductive health was prioritised right after the events that took place in 1989 and one of the first laws that were passed concerned the liberalisation of abortion, with the development of a family planning policy which involved setting up the contraception network, providing relevant staff training, offering free contraceptives and raising community awareness of contraception as a means to prevent unintended pregnancies.

In 2002, the *"Strategy on Sexual and Reproductive Health 2002-2006"* was developed and adopted as a programmatic document based on the WHO Regional Strategy and other relevant strategic documents. It set objectives, responsibilities, resources, monitoring activities in the field and made a reference, among other things, to youth sexual and reproductive health.

The Strategy states *the basic principles of reproductive health provision*:

1. Universal access to sexual and reproductive health services and family planning services;

2. Alignment with international standards and recommendations, ensuring quality reproductive health services based on scientific evidence;
3. Respect for universal human rights to culture, religion, ethical values;
4. Health promotion and a key focus on preventive care;
5. Integration of reproductive health services into basic medical services, especially into primary health care, so as to make them more accessible to the population;
6. Active participation of individuals, groups, communities and institutions in the development of health services.

Based on WHO standards, in 2002, the "National Programme for Women's and Children's Health" was developed and adopted under Ministry of Health Order, comprising a *family planning sub-programme* that included staff training for the provision of relevant services, access to free contraceptives, in particular for disadvantaged populations, public awareness of family planning and reproductive health services.

The same year, the "Alfred Rusescu" Institute for Mother and Child Protection (IMCP) set up – under the "National Programme for Women's, Children's and Family Health (NP3)" implemented by the Ministry of Health – the *National Community Health Nursing Programme*, which later became an independent programme meant to provide marginalised groups, in particular the poor and uninsured population residing in rural areas, with access to basic health care, including reproductive health services, as well as to promote family planning methods. Health mediators facilitate communication between Roma communities and health professionals, contributing to more effective health interventions in Roma communities with a traditional cultural system (MoH Order no. 619/2002).

For a strong articulation of health policies in the European context, based on the strategic directions set out in the Europe 2020 strategy ("Health 2020") of the WHO Regional Office for Europe, in 2014, GD no. 1028 approved the "National Health Strategy 2014-2020 – Health for Prosperity", a document that integrates reproductive health into Strategic Focus Areas 1 and 3 under Women's and Children's Health, which is viewed as a priority area.

Under Strategic Focus Area 1, Specific Objective 2 aims at providing family planning, lowering the number of unintended pregnancies, decreasing the incidence of abortion on demand and

reducing abortion-related maternal deaths. Strategic Focus Area 3 includes cross-cutting measures for interinstitutional cooperation in the field of reproductive health.

The family planning measures proposed in the document are:

1. Build capacities for planning programmes, forecasting the requirements and monitoring the distribution of free contraceptive products;
2. Offer eligible people access to contraceptive products distributed for free, based on appropriate actions (centralised purchasing, continued purchase and distribution, availability of a wide range of contraceptive methods that are crucial to effective interventions);
3. Extend the availability of integrated family planning/reproductive health service providers by training primary health care staff on family planning matters, particularly in the areas with disadvantaged people/groups (rural areas, poor urban communities, youth/adolescents assisted by service providers trained to deliver age-appropriate services, etc.);
4. Extend the work of family planning offices/centres with additional reproductive health competencies and services;
5. Raise public awareness of reproductive options and inform the population about those options – including via modern ICT solutions – and target vulnerable people/groups with high risks of unintended pregnancy and whose needs are not covered by first-line medical services.

Although the "National Health Strategy 2014-2020" focuses on mother and child health and nutrition while also including the "National Programme for Women's and Children's Health", with all its components, in a document on the current state of reproductive health in Romania (the 2019 report of the mission carried out by the Department of Reproductive Health of the WHO Regional Office for Europe – "Assessment of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage in Romania"), WHO experts state that Romania actually has no sexual and reproductive health strategy. They also believe that it is difficult to judge whether the broad concept of sexual and reproductive health is currently a priority for the Government.

Bearing in mind the requirements set out in the "National Health Strategy 2014-2020", the Ministry of Health plans to implement the family planning measures defined in the Strategy by

developing and adopting – under ministerial order – a sub-programme called "Unintended pregnancy prevention through increased access to family planning services" under the Mother and Child Health Programme. This programme focuses on the purchase and free distribution of contraceptives via the family planning and GP offices included in the Programme, the obstetrics and gynaecology offices from specialist outpatient clinics and hospitals as well as via gynaecology departments, especially to disadvantaged populations, including adolescent girls.

The above-mentioned documents (both the Strategy and the National Programme) refer to the general population and, though mentioned, adolescent population is not prioritised across the approach and there is no mention of any aspects specific to this age or to this target group.

Furthermore, although the international community considers the association of reproductive health with the rights, freedoms and gender equality, a topic first tackled in 1994 in the Programme of Action adopted at the International Conference on Population and Development, which took place at Cairo in 1994, Romania's National Strategy on Gender Equality 2018-2021 attaches no importance to this issue and makes no reference to family planning services and access to contraceptives.

Nevertheless, numerous studies and reports on reproductive health services highlight cases of discrimination and cultural prejudice against early school leavers and the unemployed or based on social status, ethnicity, residence. Women are the main beneficiaries of reproductive health services, whereas men – with their specific needs – are only viewed as service supporters and partners. No information is available regarding the way in which the system responds to the need for reproductive health services of persons with a different sexual orientation.

A national strategic document that is relevant for increasing access to sexual and reproductive health/family planning information and services is the "Multi-Annual Integrated Plan for Health Promotion and Health Education", which was drawn up by the Presidential Administration and the Ministry of Health to address a number of health problems affecting the population, based on the data collected at the level of public health facilities and on the information provided by a series of national studies and international collaborations.

The measures proposed are justified by the negative trends seen in specific health indicators at European level, such as the number of adolescent pregnancies or the early motherhood phenomenon.

The Plan presents detailed objectives, including the training of staff from the health and education systems with a view to building their capacities to carry out health promotion activities as well as activities and strategic partnerships focused on health education and health promotion, including on sexual and reproductive health issues.

The provision of reproductive health services is legally stipulated under:

- Health Law no. 95/2006 of 14 April 2006;
- Framework contract on health service delivery;
- Technical rules for implementing curative healthcare programmes;
- Order no. 358/2014 issued by the Director of the National Health Insurance House; and
- Law on patient rights (Law no. 46/2003).

Law no. 45/2020 on health education

In 2020, a decisive step was made towards sex education, with the adoption and enactment of a law stipulating the obligation for educational establishments to deliver, at least once a semester, programmes focusing on education for life and health education, including sex education.

Thus, the legal act amended Law no. 272/2004 on the protection and promotion of children's rights, laying down the obligation for local public administration authorities and all public or private institutions working in the field of education to carry out education for life and health education programmes in educational establishments with a view to preventing sexually transmitted diseases and adolescent pregnancy.

Just a few weeks after its enactment, Law no. 45/2020 – which had replaced the term 'sex education' with 'health education' – was amended to reinstate the previous terminology.

Under these circumstances, the question is whether an adolescent age 16-18 still needs parental consent to attend sex education classes, since such consent is not required for getting contraceptives from a family planning office.

4.2. Objective 2 – Identification of socio-demographic and cultural characteristics and their association with risky behaviours affecting reproductive health and with adolescent pregnancy

In order to reach this objective, a secondary analysis of reproductive health survey data (2016) was conducted, paired with the findings of other research. The analysis assessed knowledge of different reproductive health aspects (like family planning, use of specialised services, risk factors, etc.), adolescent girls' attitudes towards sexuality and sexual behaviours, actual or perceived deficiencies regarding young people's sexual readiness. The 517 people aged 15-18 years included in the secondary analysis sample account for a tenth of the total research sample and, even if it does not include the criteria used to ensure a representative selection, the sample maintains key characteristics reflecting the diversity of situations nationwide, including the territorial distribution by area of residence and development region.

4.2.1. Adolescent pregnancy

Adolescent pregnancy is a social phenomenon in Romania. According to the data provided by the National Institute of Statistics, in Romania, ***727 adolescent girls under the age of 15 and 18,753 girls aged 15 to 19 years*** became mothers in 2018. As far as under 15-year-old mothers are concerned, ***19 had their second child*** and one of them had her third child, while among adolescent girls aged 15-19 years, ***3,929 had their second child***, 731 – their third, 72 – their fourth, 8 – their fifth and one of them had her sixth child.

An alarming fact is that the prevalence of under 15-year-old mothers is rising.

The 2016 Reproductive Health Survey shows that, in the total sample of adolescent girls (517 girls), 186 were sexually active, accounting for 35.97 per cent. Out of them, 6.4 per cent (33 adolescent girls) had one or two children and 8.5 per cent (44 teenage girls) were pregnant when the survey was conducted (Table 1).

The area of residence influences the likelihood of adolescent motherhood, as the proportion of adolescent girls who have given birth or are pregnant is almost twofold higher in rural areas than in urban areas, a trend that persists until the age of 16 years and reverses after that age, with percentages reaching higher levels in urban areas (Table 1).

Table 1. Number of children born to adolescent mothers

		Rural	Urban	Total	**Rural**	**Urban**	**Total**
1	**No child**	209	275	484	**91.7%**	**95.2%**	**93.6%**
2	**1 child**	16	10	26	**7.0%**	**3.5%**	**5.0%**
3	**2 children**	3	4	7	**1.3%**	**1.4%**	**1.4%**
	TOTAL	228	289	517	**100.0%**	**100.0%**	**100.0%**
Pregnant at the time of research		25	19	44	**11.0%**	**6.6%**	**8.5%**

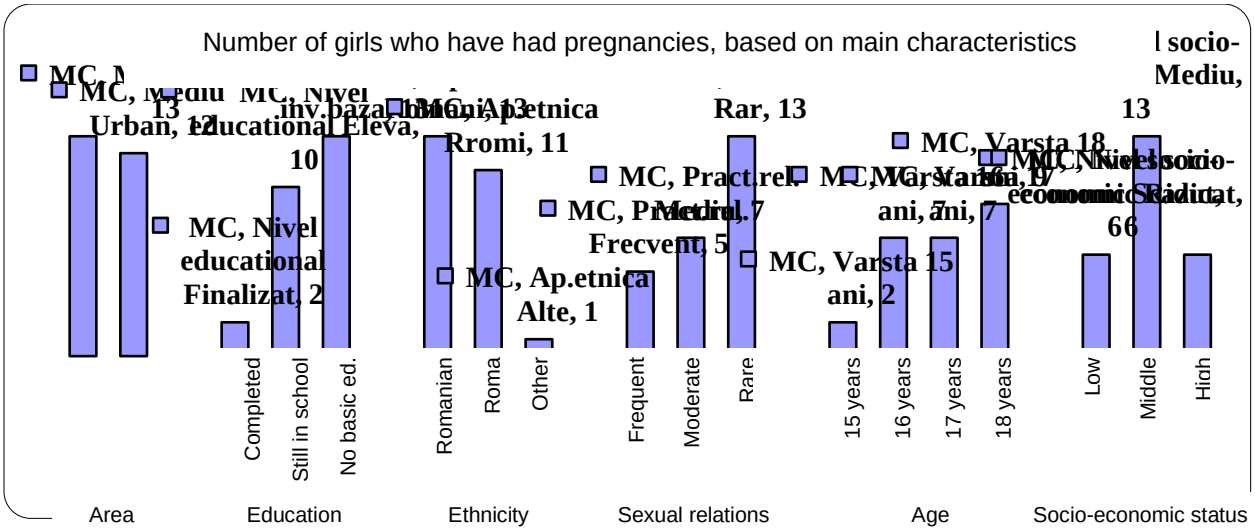

Figure 3 – Main characteristics of under-age mothers, based on area of residence

As seen in Figure 3, most under-age mothers have a poor level of education, they got pregnant despite having rare sexual relations, they come from a middle socio-economic background and many of them are Romanian or Roma.

Table 2. Percent distribution of answers

	First sexual experience	First relationship	First pregnancy	First birth
Under 15 years	**22.5%**	**28.0%**	**25.6%**	**11.8%**
15 years	**21.3%**	**26.0%**	**32.6%**	**29.4%**
16 years	**24.4%**	**18.0%**	**20.9%**	**26.5%**
17 years	**23.8%**	**18.0%**	**16.3%**	**29.4%**

18 years	**8.1%**	**10.0%**	**4.7%**	**2.9%**
	100.0% 50	**100.0% 43**	**100.0% 43**	**100.0% 34**
Youngest age	**9 years**	**13 years**	**13 years**	**14 years**
Average age	**15.6 years**	**15.5 years**	**15.4 years**	**15.8 years**

Among adolescent girls who have already experienced childbearing, the average age of first pregnancy is 15.4 years, according to the 2016 RHS, while the average age of first birth is 15.8 years. The lower limit – that is the youngest mother – stands at 13 years and 14 years, respectively (Table 3).

Table 3. Age of first pregnancy – 43 subjects

	Rural	**Urban**	**Total**	**Rural**	**Urban**	**Total**
13 years	1	1	2	4.0%	5.6%	4.7%
14 years	3	6	9	12.0%	33.3%	20.9%
15 years	10	4	14	40.0%	22.2%	32.6%
16 years	7	2	9	28.0%	11.1%	20.9%
17 years	3	4	7	12.0%	22.2%	16.3%
18 years	1	1	2	4.0%	5.6%	4.7%
Total	25	18	43	100%	100%	100%
Average age at first pregnancy				**15.4 years**	**15.3 years**	**15.4 years**

The majority of girls say that their first sexual partner was their boyfriend, fiancé or friend, 5 per cent of adolescent girls mention sexual assault/rape and 40 per cent refuse to say what kind of relationship they had with the child's father when they first got pregnant (Table 4).

Given the aforementioned age of adolescent girls at first pregnancy, the fact that so many of them are unwilling to mention the kind of relationship they had with the child's father shows the vulnerability of that relationship.

Table 4. Relationship with the child's father at first pregnancy

	43	100%
1. Live-in partner	2	**4.7%**
2. Fiancé	5	**11.6%**
3. Boyfriend	12	**27.9%**
4. Friend	3	**7.0%**
5. New/casual acquaintance	1	**2.3%**
6. Rape/incest	2	**4.7%**
No response	16	**41.9%**

Table 5. Age of first birth N = 34

	Rural	Urban	Total	Rural	Urban	Total
14 years	2	2	4	10.0%	14.3%	11.8%
15 years	5	5	10	25.0%	35.7%	29.4%
16 years	7	2	9	35.0%	14.3%	26.5%
17 years	5	5	10	25.0%	35.7%	29.4%
18 years	1	0	1	5.0%	0.0%	2.9%
Total	20	14	34	100%	100%	100%
Average age at first birth				15.9 years	15.7 years	15.8 years

First pregnancy and first birth – for those who had such experiences – occurred at young ages, with no major differences between urban and rural girls. What is particularly alarming is the proportion of adolescent girls who become mothers at the age of compulsory schooling (14-15 years). With regard to the early occurrence of these events, professionals believe that poverty and challenging backgrounds contribute to these phenomena among young girls.

"Lack of communication in the family" (family planning doctor), *family disorganisation* (GDSACP, psychologist), *"young girls being left unattended by their parents, the economic migration of parents, the feeling that their family doesn't love them, the quest" lead to early sexual relations not only among the Roma, but also in Romanian families and other ethnicities* (general

practitioner). As far as the Roma are concerned, this is also determined by a cultural factor, as *"Roma communities marry their children off very young"* (general practitioner).

According to professionals, *"the children born to these under-age girls will be brought up by child mothers, they will be deprived of proper family socialisation, they will be marginalised by their preschool peers and it will be practically impossible for them to fit into society"* (general practitioner from a rural community).

Opinions regarding the causes of adolescent pregnancy	**Professionals**
Lack of communication in the family	Family planning doctor
Family disorganisation	GDSACP, psychologist
Young girls being left unattended by their parents, the economic migration of parents, the feeling that their family doesn't love them, the quest lead to early sexual relations not only among the Roma, but also in Romanian families and other ethnicities	General practitioner
The cultural factor – *Roma communities marry their children off very young*	General practitioner

Educational attainment is inversely proportional to relationship experience, the number of births and pregnancies. Hence, people with the lowest educational attainment (level C) show the highest number of pregnancies (31.7 per cent), over three times higher than those who have completed level A or B. Instead, relationship experience is the richest among those who have completed level B (Table 6). Also, the share of adolescent girls with education level C who are currently pregnant is at least 4.5 times higher than that of girls with level A or B. Regarding ethnicity, the proportion of girls with relationship experience, children or pregnant before the age of 18 is over six times higher among the Roma than among Romanians, although the number of adolescent girls with sexual experience is comparable to that of girls from other ethnicities analysed. We should mention that, given the small number of people belonging to other ethnicities than Romanian and Roma, we cannot make comparative assessments.

Table 6. Marital status, number of children and pregnancy status, based on adolescent girls' educational attainment

		Marital status			**Number of children**		**Pregnant at the time of research**	
		Relationship experience	Sexual experience	No sexual experience	No child	1-2 children		Total
	Education							
1	Edu A	9	49	43	97	4	7	101
2	Edu B	21	71	261	340	13	17	353
3	Edu C	20	16	27	47	16	20	63
	Ethnicity							
1	Romanian	28	116	302	427	19	25	446
2	Roma	19	13	16	35	13	16	48
3	Hungarian or other	3	7	13	22	1	3	23
	Education							
1	Edu A	**8.9%**	**48.5%**	**42.6%**	**96.0%**	**4.0%**	**6.9%**	**100.0 %**
2	Edu B	**5.9%**	**20.1%**	**73.9%**	**96.3%**	**3.7%**	**4.8%**	**100.0 %**
3	Edu C	**31.7%**	**25.4%**	**42.9%**	**74.6%**	**25.4%**	**31.7%**	**100.0 %**
	Ethnicity							
1	Romanian	**6.3%**	**26.0%**	**67.7%**	**95.7%**	**4.3%**	**5.6%**	**100.0 %**
2	Roma	**39.6%**	**27.1%**	**33.3%**	**72.9%**	**27.1%**	**33.3%**	**100.0 %**
3	Hungarian or other	**13.0%**	**30.4%**	**56.5%**	**95.7%**	**4.3%**	**13.0%**	**100.0 %**

4.2.2. Risk factors for adolescent pregnancy

a) Sexual experience

An early sexual debut means a few good years of sexual experiences before the age of 18 and hence the likelihood of becoming a mother over that period of time.

The sample structure based on sexual experience and age is seen in Figure 4.

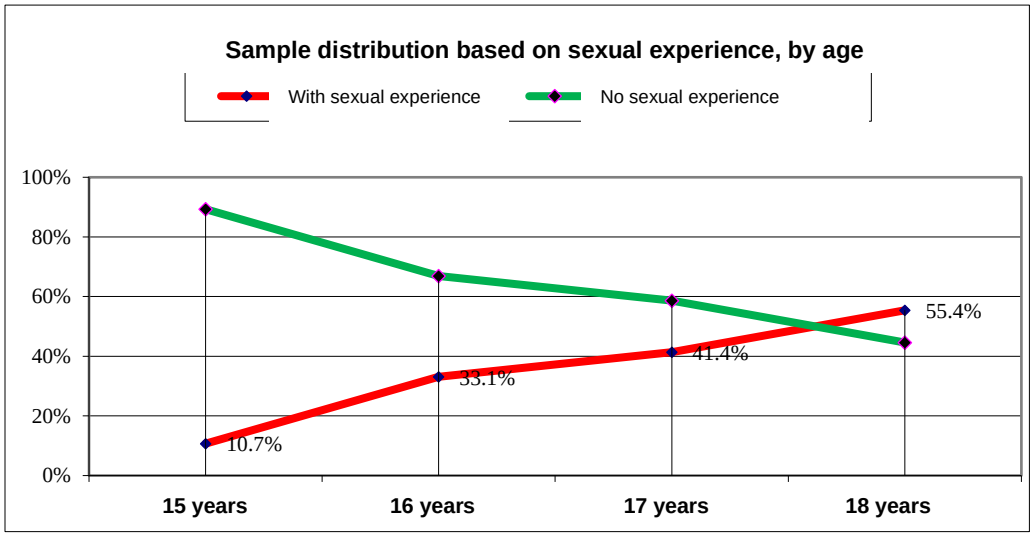

Figure 4 – Sample distribution based on sexual experience, by age

The girls in the research sample had their first sexual experience at an average age of 15.6 years, with the youngest age standing at 9 years and with under 15-year-olds reaching a share of almost 20 per cent. The high prevalence of early sexual relations among the Roma with poor educational attainment highlights the population that should be targeted by public policies aimed at reducing adolescent pregnancy and childbirth rates.

The average age of first sexual experience is lower in uneducated and Roma girls. The high prevalence of sexual relations before the age of 16, in particular before age 15, is also seen in poorly educated adolescent girls (Table 7).

Table 7. Age of first sexual experience, by area of residence, educational attainment and ethnicity

			Under 15 years	**15 years**	**16 years**	**17 years**	**18 years**	**Total**
		517	36	34	39	38	13	160
Area of residence	Rural	228	19	18	20	18	4	79
	Urban	289	17	16	19	20	9	81
Education	Completed	101	5	4	12	19	8	48
	Still in school	353	9	20	24	19	5	77
	No basic education	63	22	10	3			35
Ethnicity	Romanian	446	18	27	34	33	12	124
	Roma	48	14	6	4	3	1	28
	Hungarian or other	23	4	1	1	2		8

Table 8. Share and average age of first sexual experience, by area of residence, educational attainment and ethnicity

		Total, all ages	**<15 years**	**15 years**	**16 years**	**17 years**	**18 years**	**Average age**
		160	**22.5%**	**21.3%**	**24.4%**	**23.8%**	**8.1%**	**15.6**
Area of residence	Rural	79	**24.1%**	**22.8%**	**25.3%**	**22.8%**	**5.1%**	**15.5**
	Urban	81	**21.0%**	**19.8%**	**23.5%**	**24.7%**	**11.1%**	**15.7**
Education	Completed	48	**10.4%**	**8.3%**	**25.0%**	**39.6%**	**16.7%**	**16.3**
	Still in school	77	**11.7%**	**26.0%**	**31.2%**	**24.7%**	**6.5%**	**15.8**
	No basic education	35	**62.9%**	**28.6%**	**8.6%**	**0.0%**	**0.0%**	**14.1**
Ethnicity	Romanian	124	**14.5%**	**21.8%**	**27.4%**	**26.6%**	**9.7%**	**15.8**

	Roma	28	**50.0%**	**21.4%**	**14.3%**	**10.7%**	**3.6%**	**14.7**
	Hungarian or other	8	**50.0%**	**12.5%**	**12.5%**	**25.0%**	**0.0%**	**14.9**

Table 9. Distribution of adolescent girls with sexual debut before the time of research, by area of residence, educational attainment and ethnicity

			<15 years	**15 years**	**16 years**	**17 years**	**18 years**	**Average age**
		160	22.5%	21.3%	24.4%	23.8%	8.1%	15.6
Area of residence	Rural	79	24.1%	22.8%	25.3%	22.8%	5.1%	15.5
	Urban	81	21.0%	19.8%	23.5%	24.7%	11.1%	15.7
Education	Completed	48	10.4%	8.3%	25.0%	39.6%	16.7%	16.3
	Still in school	77	11.7%	26.0%	31.2%	24.7%	6.5%	15.8
	No basic education	35	62.9%	28.6%	8.6%	0.0%	0.0%	14.1
Ethnicity	Romanian	124	14.5%	21.8%	27.4%	26.6%	9.7%	15.8
	Roma	28	50.0%	21.4%	14.3%	10.7%	3.6%	14.7
	Hungarian or other	8	50.0%	12.5%	12.5%	25.0%	0.0%	14.9

In almost half of cases, the place of first sexual experience is the partner's home, reaching a share that is much higher than that of other places (Table 10). This can create a number of problems, such as losing control of the situation or risky behaviours, and hence potential abuse, including sexual abuse.

Table 10. Place of first sexual experience

	Rural	**Urban**	**Total**	**Rural**	**Urban**	**Total**
Shared home	1	0	1	**1.1%**	**0.0%**	**0.5%**
His home	41	49	90	**45.6%**	**51.0%**	**48.4%**

Her home	8	13	21	**8.9%**	**13.5%**	**11.3%**
Friend's home	3	2	5	**3.3%**	**2.1%**	**2.7%**
Hotel	5	3	8	**5.6%**	**3.1%**	**4.3%**
Other	22	14	36	**24.4%**	**14.6%**	**19.4%**
No response	3	2	5	**3.3%**	**2.1%**	**2.7%**
Total	90	96	186	**100.0%**	**100.0%**	**100.0%**

Table 11. Age of first partner

	Rural	Urban	Total	**Rural**	**Urban**	**Total**
15-19 years	34	38	72	**37.8%**	**39.6%**	**38.7%**
20-24 years	27	30	57	**30.0%**	**31.3%**	**30.6%**
25-29 years	5	2	7	**5.6%**	**2.1%**	**3.8%**
≥30 years	2	3	5	**2.2%**	**3.1%**	**2.7%**
No response	15	10	25	**16.7%**	**10.4%**	**13.4%**
Total	90	96	186	**100.0%**	**100.0%**	**100.0%**

The Reproductive Health Survey shows that the age of first sexual partner is close to that of the adolescent girl in almost 70 per cent of cases, yet a relatively high proportion of teenage girls – most of them from rural areas – refused to give the age of their first partner. According to the professionals who participated in qualitative research, partners may be of different ages, older *"by approximately 10-15 years, some are over 25 years old (a 10 to 15-year age gap)"* (community health nurse)*, "more experienced"* (general practitioner). In some cases, *"they are teenagers* [like for example] *in the case of the Roma"* (general practitioner) *"or of the same age, classmates"* (FP doctor). *"Whilst there are applicable laws (namely the law banning sexual relations with a minor), they are not rigorously enforced. Hence, the number of adolescent births stagnates or even tends to rise"* (general practitioner).

As regards the socio-demographic profile of partners, professionals mentioned that: *"partners come from the same poor community, they have the same low educational attainment"* (DPH doctor), *"they belong to disadvantaged families, with fathers who are abusive to their daughters* (general practitioner), often *"they are acquaintances of the family"* (SD).

"In general, grown-up men satisfy their sexual desires with under-age girls" (GP, rural areas), *"they vanish the moment they are told about the pregnancy"* (GP), *"they refuse to recognise the child as their own"* (school doctor) and they are not involved in the girls' lives after the child is born.

In Roma communities, *"partners are chosen by the family"* (CHN, rural areas), *"many times, they are boys who are also under age, uneducated, illiterate, with parents belonging to different clans and making a dishonest living"* (GP). It sometimes happens that the adolescent girl has *"multiple partners and does not know who the child's real father is"* (DPH doctor).

Professionals' opinions regarding the status of under-age mothers' partners – socio-demographic profile

Status of under-age mothers' partners	**Professionals**
Men who are approximately 10-15 years* [older], *some are over 25 years old (a 10 to 15-year age gap)	Community health nurse
More experienced men	General practitioner
Teenagers in the case of the Roma	General practitioner
Boys of the same age, classmates	FP doctor
Whilst there are applicable laws (namely the law banning sexual relations with a minor), they are not rigorously enforced. Hence, the number of teenage births stagnates or even tends to rise.	General practitioner
Partners come from the same poor community; they have the same low educational attainment.	DPH doctor
Partners belong to disadvantaged families, with fathers who are abusive to their daughters, often "they are acquaintances of the family".	General practitioner, school doctor
In general, grown-up men satisfy their sexual desires with under-age girls.	GP, rural areas

Partners vanish the moment they are told about the pregnancy.	GP
Men often *refuse to recognise the child as their own.*	School doctor
In Roma communities, *"partners are chosen by the family".*	CHN, rural areas
In Roma communities, many times, they are boys who are also under age, uneducated, illiterate, with parents belonging to different clans and making a dishonest living.	GP
It sometimes happens that the adolescent girl has *"multiple partners and does not know who the child's real father is".*	DPH doctor

b) Marital status

Regarding marital status, given respondents' ages and the legislation concerning the minimum age for marriage, we cannot talk about legal marriage for persons who are under 18 years of age (save in exceptional cases). Moreover, the law also prohibits consensual unions for people under the age of 18. However, reality refutes these prohibitions.

As shown in Table 12, several adolescent girls said that they had lived as a couple for at least 30 days (under the same roof) or that they were in a consensual union at the time. The table below shows that almost 10 per cent of young girls lived or are living as a couple. The proportion is much higher in rural areas, 14 per cent versus 6.2 per cent in urban areas.

Table 12. Adolescent girls' relationship with their first sexual partner

	Rural	Urban	Total	**Rural**	**Urban**	**Total**
Live-in partner	4	2	6	**4.4%**	**2.1%**	**3.2%**
Fiancé	3	3	6	**3.3%**	**3.1%**	**3.2%**
Boyfriend	64	60	124	**71.1 %**	**62.5 %**	**66.7 %**

Friend	5	12	17	**5.6%**	**12.5 %**	**9.1%**
Classmate	2	1	3	**2.2%**	**1.0%**	**1.6%**
Casual/new acquaintance	1	0	1	**1.1%**	**0.0%**	**0.5%**
None, it was a rape committed by a stranger	0	3	3	**0.0%**	**3.1%**	**1.6%**
Blood relatives (father, brother, uncle, grandfather, cousin, godfather, etc.)	2	1	3	**2.2%**	**1.0%**	**1.6%**
No response	8	13	21	**10%**	**14.5 %**	**12.4 %**
Total	90	96	186	**100%**	**100%**	**100%**

The number of those with relationship experience increases with age and it is higher among girls pushing 18. Still, it should be noted that very young adolescent girls – ages 15-16 – also reported relationship experience (Table 13).

Table 13. Distribution based on marital status, by area of residence

	Rural	Urban	Total	Rural	Urban	Total
Currently in a relationship	29	17	46	12.7%	5.9%	8.9%
Previously in a relationship	3	1	4	1.3%	0.3%	0.8%
No relationship experience	58	78	136	25.4%	27.0%	26.3%
No sexual experience	138	193	331	60.5%	66.8%	64.0%
Total	**228**	**289**	**517**	**100.0%**	**100.0%**	**100.0%**
With sexual experience	90	96	186	39.5%	33.2%	36.0%
With relationship experience	32	18	50	14.0%	6.2%	9.7%

As mentioned, very young adolescent girls – ages 15-16 – also reported relationship experience. More than half of sexually active teenage girls had their first relationship before or at the age of 15, with an average age of 15.5 years. In Roma communities, the first relationship debuts early, more precisely “girls get married” at age 12-13 (group interview with professionals).

Table 14. Distribution based on marital status, by age

	15 years	16 years	17 years	18 years	Total
With relationship experience	3	10	16	21	50
No relationship experience	10	31	39	56	136
No sexual experience	108	83	78	62	331
Total	121	124	133	139	517
With relationship experience	2.5%	8.1%	12.0%	15.1%	9.7%
No relationship experience	8.3%	25.0%	29.3%	40.3%	26.3%
No sexual experience	89.3%	66.9%	58.6%	44.6%	64.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 15. Distribution of respondents who are in a relationship, based on age of first relationship (N = 50 subjects)

	Rural	Urban	Total	Rural	Urban	Total
13 years	2	1	3	6.3%	5.6%	6.0%
14 years	5	6	11	15.6%	33.3%	22.0%
15 years	10	3	13	31.3%	16.7%	26.0%
16 years	6	3	9	18.8%	16.7%	18.0%
17 years	6	3	9	18.8%	16.7%	18.0%
18 years	3	2	5	9.4%	11.1%	10.0%
Total	32	18	50	100%	100%	100%
Average age at first relationship				15.6 years	15.4 years	15.5 years

Table 16. Age of first relationship based on area of residence, educational attainment, ethnicity (absolute terms)

			<15 years	15 years	16 years	17 years	18 years	Total
		517	14	13	9	9	5	50
Area of residence	Rural	228	7	10	6	6	3	32
	Urban	289	7	3	3	3	2	18

Education	Completed	101		1	1	4	3	9
	Still in school	353	4	5	7	3	2	21
	No basic education	63	10	7	1	2		20
Ethnicity	Romanian	446	4	8	7	6	3	28
	Roma	48	8	4	2	3	2	19
	Other	23	2	1				3

As mentioned above, consensual union is illegal before the age of 18 and yet not only does this happen but it happens at a very young age. It is most common in Roma teen girls and poorly educated girls. An interesting fact is that these events occur without significant differences between urban and rural areas.

According to professionals, many of the so-called marriages or consensual unions are expressions of the child's neglect in the family. *"The lack of bonding between parents (mothers) and children (daughters)"* (general practitioner), *"the lack of communication in the family"* (FP doctor), *"the feeling that their family doesn't love them"* (GP) push them into such relationships. Other causes are *"young girls being left unattended by their parents"* (GP), *"the economic migration of parents"* (GP) and *"family disorganisation leading to relationships, not only among the Roma"* (GDSACP, psychologist). *"The fear of social stigma prevents young girls from promptly seeking guidance from their family or a health worker"* (SD).

In traditional Roma communities, there is the custom of selling the young child to another family from the same community, *"there are plenty of families in traditional Roma communities that force under-age girls into early relationships/marriages"* (DPH inspector), contrary to legal regulations on child rights protection.

c) Educational issues

From a methodological perspective, in order to identify respondents' educational attainment, the questionnaire initially used for data collection focused on the highest level of education completed and, based on that, we can say that more than two thirds of subjects (**68.3 per cent**) were attending high school or vocational school at the time of interview and one fifth of subjects (**19.5 per cent**) had completed upper secondary education (high school or vocational school) at the time of

interview. The remaining **12.2 per cent** had completed four grades or less or had never attended school. Given the age group concerned, we cannot talk about educational attainment (but rather about categories of respondents with or without basic education), so the three categories identified will be referred to using the codes Edu A / B / C.

Educational attainment is inversely proportional to relationship experience, the number of births and pregnancies. Hence, people with ***the lowest educational attainment (level C)*** show the highest number of relationships (31.7 per cent), over three times higher than those who have completed level A or B. Also, the share of those who are currently pregnant is at least four times higher among poorly educated girls than among more educated girls (Table 17).

Table 17. Age of first relationship based on area of residence, educational attainment, ethnicity (percentage terms)

			< 15 years	**15 years**	**16 years**	**17 years**	**18 years**
		50	28.0%	26.0%	18.0%	18.0%	10.0%
Area of residence	Rural	32	21.9%	31.3%	18.8%	18.8%	9.4%
	Urban	18	38.9%	16.7%	16.7%	16.7%	11.1%
Education	Completed	9	0.0%	11.1%	11.1%	44.4%	33.3%
	Still in school	21	19.0%	23.8%	33.3%	14.3%	9.5%
	No basic education	20	50.0%	35.0%	5.0%	10.0%	0.0%
Ethnicity	Romanian	28	14.3%	28.6%	25.0%	21.4%	10.7%
	Roma	19	42.1%	21.1%	10.5%	15.8%	10.5%
	Hungarian or other	3	66.7%	33.3%	0.0%	0.0%	0.0%

Table 18. Marital status, number of children and pregnancy status, based on adolescent girls' educational attainment

		Marital status			**Number of children**		**Pregnant**	
		Relationship experience	With sexual	No sexual experience	No child	1-2 children	at the time of research	Total

			experienc e					
Education								
1	Edu A	9	49	43	97	4	7	101
2	Edu B	21	71	261	340	13	17	353
3	Edu C	20	16	27	47	16	20	63
	Ethnicity							
1	Romanian	28	116	302	427	19	25	446
2	Roma	19	13	16	35	13	16	48
3	Hungarian or other	3	7	13	22	1	3	23
	Education							
1	Edu A	**8.9%**	**48.5%**	**42.6%**	**96.0%**	**4.0%**	**6.9%**	**100.0%**
2	Edu B	**5.9%**	**20.1%**	**73.9%**	**96.3%**	**3.7%**	**4.8%**	**100.0%**
3	Edu C	**31.7%**	**25.4%**	**42.9%**	**74.6%**	**25.4%**	**31.7%**	**100.0%**
	Ethnicity							
1	Romanian	**6.3%**	**26.0%**	**67.7%**	**95.7%**	**4.3%**	**5.6%**	**100.0%**
2	Roma	**39.6%**	**27.1%**	**33.3%**	**72.9%**	**27.1%**	**33.3%**	**100.0%**
3	Hungarian or other	**13.0%**	**30.4%**	**56.5%**	**95.7%**	**4.3%**	**13.0%**	**100.0%**

The majority of the professionals who participated in qualitative research believe that insufficient schooling and the low level of general education are major risk factors for adolescent pregnancy (DPH inspector). *"Poor education is the leading cause", "under-age mothers come from among early school leavers and are functionally illiterate at best"* (general practitioner). *"Poor education or illiteracy is a result of* [them] *never attending school or leaving school early before they complete the educational level"* (GDSACP psychologist).

"There are girls who, for different reasons, didn't go to school or dropped out" (general practitioner), often *"young girls who drop out of school for economic reasons, which is not necessarily something that is influenced by their ethnicity"* (general practitioner).

According to professionals, some of them are *"under-age girls from rich families, with very busy parents"* (family planning doctor) *"and students who don't necessarily come from broken families, who are fooled by love". "The lack of health education notions in school/in the family"* (DPH doctor) and even the *"lack of religious education – despite religion classes being held in school"* (family planning doctor) are risk factors for adolescent pregnancy.

d) Cultural factors in Roma communities

Table 19. Distribution of subjects by ethnicity, based on educational attainment

	Educational attainment				Education-based distribution			
Ethnicity	Edu A	Edu B	Edu C	Total	Edu A	Edu B	Edu C	Total
Romanian	93	318	35	446	20.9%	71.3%	7.8%	100.0%
Roma	4	19	25	48	8.3%	39.6%	52.1%	100.0%
Hungarian or other	4	16	3	23	17.4%	69.6%	13.0%	100.0%
Total	101	353	63	517	19.5%	68.3%	12.2%	100.0%
Hi-p (9.49)								79.5

The proportion of subjects with relationship experience, children or pregnant before the age of 18 is over six times higher among the Roma than among Romanians. Given the small number of people belonging to other ethnicities than Romanian and Roma, we cannot make comparative assessments with other ethnic groups (Table 17). The share of Roma respondents with no basic education is over fifty percent (52 per cent).

According to professionals, *"often, under-age pregnant girls come from Roma communities"* (CHN from a rural community), *from Roma families with a history of under-age mothers* (general practitioner from a rural community). The Roma *"live in compact communities that follow traditions and customs (arranged marriages)"* (health mediator). *"These under-age mothers are bought based on the arrangements parents make"* (general practitioner). *"Roma girls don't go to school because they don't have money, so they stay home and become mothers at 13-14, with boys who are 15-16 years old. Because of their ethnicity, young Roma people have no decision-making power"* (health mediator). *"You see 13- or 14-year-old girls with babies in their arms not knowing what to do with them, so they leave them in the care of older women in the community and they go*

out to play" (health mediator). In Roma communities, teen mothers are quite common because, in their culture, they get married at 12-13 and, by the time they are 19, they have already had four pregnancies. *"Young girls age 13-14 who get pregnant say there is nothing they can do if their men don't want to wear a condom. Many young women with lots of children don't want to use an IUD because of their family, their customs – they are Roma."*
"There are times when a girl, age 15-16, is already sexually active but hasn't got pregnant and she goes to the general practitioner complaining that she doesn't have a child and the man she lives with will leave her".

e) Socio-economic factors

Regarding the socio-demographic profile of adolescent mothers, the professionals who participated in qualitative research expressed rather conflicting views, probably influenced by the cases they had actually come across. Still, it is noted that they tend to believe that under-age mothers come from socio-economically disadvantaged backgrounds: *"they come from remote rural communities"* (DPH inspector), *"from isolated communities, with difficult access to health and social services"* (hospital doctor), *"they live in disadvantaged areas where lack of education and poverty pose great risks"* (health mediator), *"they come from areas with high crime rates, unemployment, misery, prostitution"* (GP), *"areas/neighbourhoods secluded from the rest of the population, areas that the authorities consider to be dangerous"* (general practitioner).
"Many under-age mothers come from rural areas, from disadvantaged groups, from families with poor education and school failure" (school doctor), *"socially marginalised families"* (FP doctor), *"families with no education"* (DPH inspector), *"no jobs and no identity documents"* (DPH inspector), *"single-parent families"* (CHN), *"families affected by domestic violence, with the under-age girl looking for protection elsewhere, yet she becomes a victim herself"* (GDSACP social worker).
"The social benefits and the child benefit that full-time schoolgirls get are an important source of income for disadvantaged families" (FP doctor) and contribute to soaring birth rates in these populations. A family planning doctor talks about *"the child benefit as an income source", "girls who were using contraception are no longer interested in doing that and they come to the* [family] *planning office to have the IUD removed. A girl in ninth grade gets pregnant and has the baby;*

two years later, she gets pregnant again and she continues to receive the child benefit; then she has her third baby. That is her only source of income".

f) Religious affiliation

According to qualitative research participants, certain religions (Baptists, Pentecostalism) encourage teen pregnancies, as pregnant adolescent girls *"come from these families as well"* (general practitioner).

4.2.3. Pregnancy prevention

a) Contraceptive information

The 2016 Reproductive Health Survey shows that a high proportion of adolescent girls – 95.5 per cent of the girls included in the research sample – are familiar with at least one method of contraception, with minor differences noted between sexually active girls and sexually inexperienced girls as regards knowledge of modern methods. As far as traditional methods are concerned, these are more known to sexually active girls than to those who are not sexually active.

Figure 5 – Contraception methods known to subjects

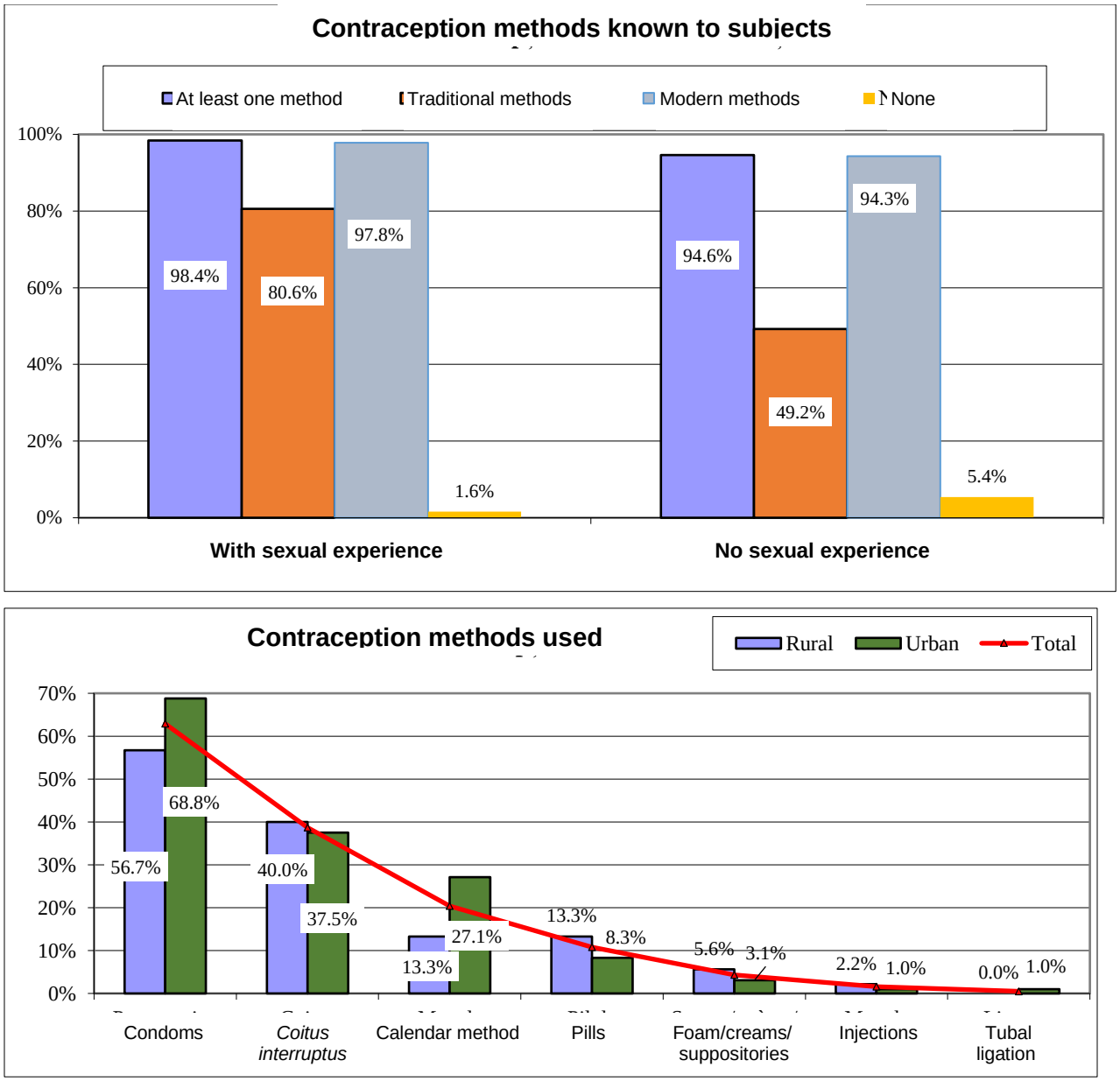

Figure 6 – Sample distribution based on subjects' knowledge of contraception methods

The condom and the birth control pill are the best known contraceptive methods in both groups – girls with or no sexual experience – without major differences between the two groups. All the other methods are more known to girls with sexual experience and the greatest difference is reported in regards to *coitus interruptus*, a method that is better known by sexually active adolescent girls. In both groups, the least known contraceptive methods are those that are less frequently used in Romania, like vasectomy and the vaginal insertion of the diaphragm (Figure 6).

Contraceptive knowledge improves with age and educational attainment, being the lowest at age 15 and among adolescent girls with no or poor education and increasing with age. Ethnicity and the practice of religion are factors that influence the acquisition of contraceptive knowledge, as data indicate that the Roma and those who attend religious services very rarely have the lowest level of contraceptive knowledge (Table 20). No differences are found in the knowledge of contraceptive methods between city girls and country girls or based on socio-economic status.

Table 20. Adolescent girls' knowledge of contraceptive methods, based on selected characteristics

Total	**Total**	**95.9%**
Area of residence	Rural	96.5%
	Urban	95.5%
Education	Completed	98.0%
	Still in school	96.9%
	No basic education	87.3%
Ethnicity	Romanian	96.4%
	Roma	91.7%
	Other	95.7%
Religious service attendance	Frequent	99.2%
	Moderate	95.8%
	Rare	94.4%
Age	15 years	93.4%
	16 years	94.4%
	17 years	97.7%
	18 years	97.8%
Socio-economic status	Low	96.7%
	Middle	95.9%
	High	95.8%

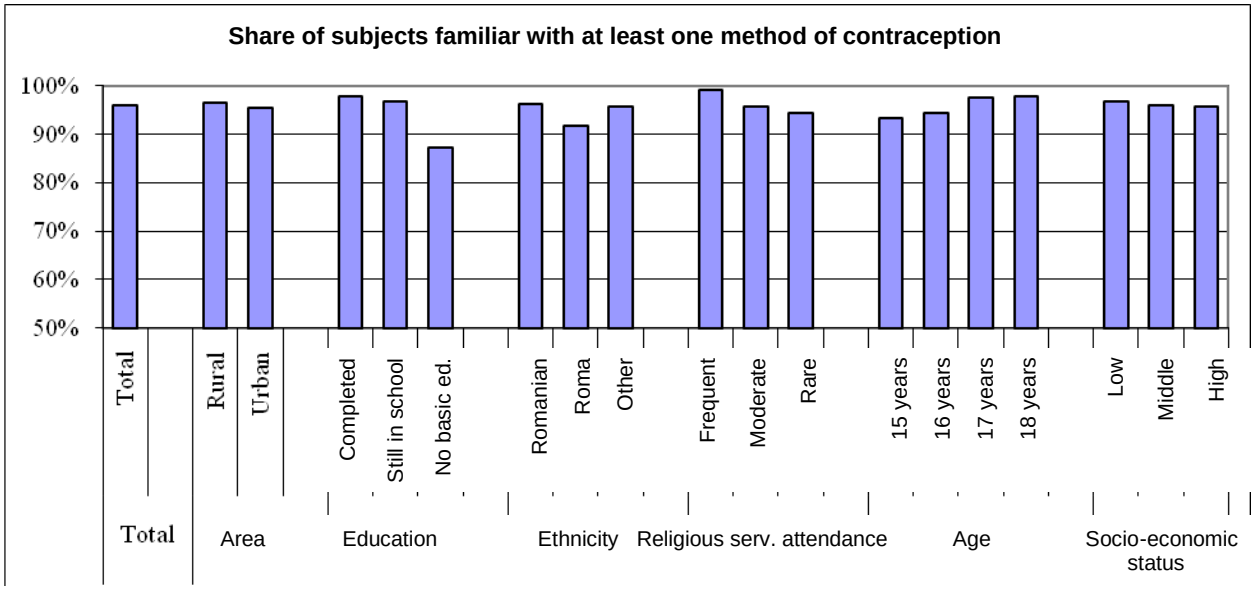

Figure 7 – Share of subjects familiar with at least one method of contraception

Table 21 – Sources of information on contraception methods

	Medical sources	School	Family/friends	Mass media
Birth control pills	36.2%	8.7%	35.6%	13.1%
IUD	37.6%	5.6%	33.1%	14.7%
Condoms	24.3%	7.6%	51.2%	11.1%
Spermicide	32.9%	9.2%	34.2%	15.8%
Diaphragm	41.0%	16.7%	10.3%	25.6%
Tubal ligation	32.4%	8.4%	30.7%	16.8%
Vasectomy	44.8%	8.6%	17.2%	22.4%
Contraceptive injections	41.1%	7.1%	23.2%	18.8%
Calendar method	9.6%	4.4%	65.4%	9.9%
Coitus interruptus	10.1%	3.7%	65.4%	6.5%

Sources of contraceptive information

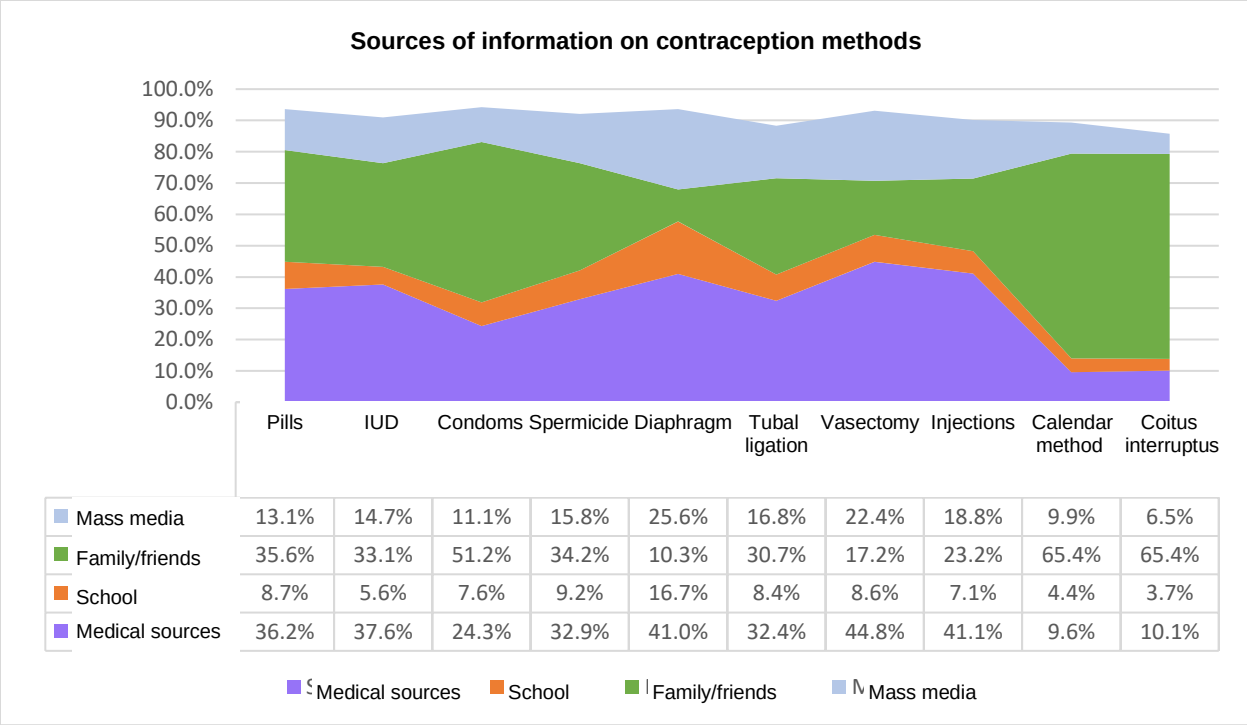

Figure 8 – Sources of information on contraception methods

As highlighted by the 2016 Reproductive Health Survey, teenage girls' sources of contraceptive information are health professionals for modern contraception and family and friends for traditional contraception. Health professionals and the media have a greater influence on the acquisition of knowledge about less frequently used methods, such as tubal ligation, vasectomy, the diaphragm and contraceptive injections, whereas family and friends play a bigger role when it comes to traditional methods and condoms.

The information received in school reaches low shares, namely 3 to 9 per cent, depending on the contraceptive method (Table 21, Figure 8).

Adolescent girls mention that their favoured source of information is the doctor – 64.2 per cent, followed by other health professionals – 13.5 per cent, whereas school is preferred only by 7.4 per cent of them.

According to the professionals who participated in qualitative research, the shortcomings reported in regards to pregnancy prevention are closely linked to the fact that *"health education is insufficient"* (school doctor), *"early education on sexuality and pregnancy prevention is missing"* (health mediator), *"sex education is not provided in schools and in the family"* (family planning doctor), *"prevention education is not delivered in schools and high schools"* (general practitioner).

Also, there is a lack of *"extracurricular educational programmes focused on reproductive health"* (school doctor).

The education *"meant to promote a healthy lifestyle and reproductive health"* (CHN from a rural community) is poorly organised, as *"there is a shortage of educational experts and of teacher training programmes on reproductive health"* (school doctor) and *"there is not enough collaboration between educational stakeholders"* (general practitioner).

b) Use of contraception at first sexual intercourse

Table 22. Use of birth control at first sexual intercourse

	Rural	Urban	Total	**Rural**	**Urban**	**Total**
1. YES	35	47	82	**38.9%**	**49.0%**	**44.1%**
2. NO	36	33	69	**40.0%**	**34.4%**	**37.1%**
3. Do not remember	9	1	10	**10.0%**	**1.0%**	**5.4%**
4. No response	10	15	25	**11.1%**	**15.6**	**13.4%**
Total	90	96	186	**100.0%**	**100.0%**	**100.0%**

More than 44 per cent of adolescent girls said they had used a contraceptive method during their first sexual intercourse. The share of urban users is 10 per cent higher than that of users from rural areas, namely 37 per cent of adolescent girls, which means that more rural girls didn't use contraceptives during their first sexual intercourse. We believe that those who didn't respond or didn't remember hadn't actually used birth control, so a total of 56 per cent probably didn't use contraception at all.

Specialised literature mentions that the use of contraception at first sexual intercourse is a predictor of future contraceptive use.

Table 23. Birth control method at first sexual intercourse

	Rural	Urban	Total	**Rural**	**Urban**	**Total**
1. Condoms	76	0	76	**94.3%**	**91.5%**	**92.7%**
2. Calendar method	1	0	1	**0.0%**	**2.1%**	**1.2%**
3. *Coitus interruptus*	5	0	5	**5.7%**	**6.4%**	**6.1%**

Total	35	47	82	**100.0%**	**100.0%**	**100.0%**

Table 24. Person making the decision about the birth control method used at first sexual intercourse

	Rural	Urban	Total	**Rural**	**Urban**	**Total**
1. The woman	3	2	5	**8.6%**	**4.3%**	**6.1%**
2. The partner	9	10	19	**25.7%**	**21.3%**	**23.2%**
3. Both	23	35	58	**65.7%**	**74.5%**	**70.7%**
Total	35	47	82	**100.0%**	**100.0%**	**100.0%**

Out of all users, 92.7 per cent chose the condom, while the others resorted to traditional methods like *coitus interruptus* and the calendar method. In most cases, the method was chosen by both partners, 70.7 per cent, or by the partner, 23.2 per cent.

c) Contraceptive use experience

Table 25. Sample distribution according to contraceptive methods used, based on selected characteristics

		Contraceptive use				Methods used			
		Users	Non-users	Total users	Total non-users	Traditional methods	Modern methods	Traditional methods	Modern methods
		154	32	82.8%	17.2%	80	127	43.0%	**68.3%**
Area of residence	Rural	72	18	80.0%	20.0%	39	56	43.3%	**62.2%**
	Urban	82	14	85.4%	14.6%	41	71	42.7%	**74.0%**
Education	Completed	45	13	77.6%	22.4%	24	35	41.4%	60.3%
	Still in school	85	7	92.4%	7.6%	38	79	41.3%	85.9%
	No basic education	24	12	66.7%	33.3%	18	13	50.0%	36.1%
Ethnicity	Romanian	120	24	83.3%	16.7%	56	107	38.9%	74.3%
	Roma	24	8	75.0%	25.0%	18	12	**56.3%**	37.5%
	Other	10	0	100.0%	0.0%	6	8	60.0%	80.0%

Age	15 years	8	5	61.5%	38.5%	4	7	30.8%	53.8%
	16 years	31	10	75.6%	24.4%	12	27	29.3%	65.9%
	17 years	50	5	90.9%	9.1%	30	42	54.5%	76.4%
	18 years	65	12	84.4%	15.6%	34	51	44.2%	66.2%

A share of 82.8 per cent of adolescent girls used contraception at least once, with 68.3 per cent having used modern methods and 43.0 per cent, traditional methods.

The use of contraception methods is more widespread in urban areas, among adolescent girls who are currently in school, among Romanian teenage girls and young girls over 17 years of age.

Modern contraception is more common in urban areas, while the shares of those who use traditional methods are similar in urban and rural areas. Roma girls use contraception less and prefer traditional contraceptive methods.

Contraception network

Apart from educational issues, professionals also mentioned that a factor contributing to adolescent pregnancy is the **disorganisation of the family planning network** –*"lack of family planning offices"* (school doctor), *"lack of easy access to family planning services in general"* (general practitioner)*"* and for *"adolescent girls in particular, the inaccessibility of health services for adolescents from socially disadvantaged families"* (CHN from a rural community).

Procurement of contraceptives

According to the professionals involved in qualitative research, for adolescent girls without money for an IUD and birth control pills, *"the fact that free contraceptives are no longer available is a factor contributing to unintended pregnancies".* They mention *"the lack of programmes providing free contraceptives"* (FP doctor) or *"the lack of free products for at-risk groups"* (FP doctor), *"the lack of contraceptives under the national programme (condoms/intrauterine devices/oral contraceptives for vulnerable groups)"* (DPH doctor).

Health mediators think that Roma women are more at risk, as *"it is more difficult for them to get birth control pills because they are poor and have no financial means"*, and suggest that *"funds should be allocated for underprivileged people, otherwise much younger girls, aged 11-12 years, will become mothers".*

Furthermore, certain contraceptives used and accepted by underprivileged groups are no longer available free of charge; *"contraceptive injections worked very well, but they're gone"* (health mediator).

According to qualitative research participants, *"adolescents from functional families don't turn to family planning services because they are not confidential or youth-friendly"* (GP).

Issues regarding the staff involved in the prevention of adolescent pregnancies and/or the provision of social support to under-age mothers

Staff shortages, *"a very low coverage with community health nurses (CHN)"* (CHN from a rural community), *"the lack of community health nurses, especially in rural areas"* (DPH doctor) are barriers to contraceptive access for adolescent girls from socially disadvantaged groups, according to the professionals involved in qualitative research – *"the lack of a community mediator makes contraceptive communication quite difficult"* (general practitioner).

4.2.4. Adolescent pregnancy care

School doctors assume an indirect role in the prevention of adolescent pregnancies and think that *"the institution is not directly but indirectly responsible for organising health education and sex education activities and classes. Moreover, when a school girl gets pregnant, the school doctor ought to monitor her health, together with the general practitioner and the specialist"* (school doctor). *"We always have one or two pregnant girls, from grade 9 to grade 12"* (school doctor). *"Most of them carry their babies to term, they give birth, they come back to school. Many of them wait for so long that it gets difficult to terminate the pregnancy and they ask for my help – 'Send me somewhere so that no one finds out what I did!' Most of them say it was casual sex, others that they were raped. They carry their pregnancy to term because they don't communicate with their parents."*

School doctors have limited responsibilities. Many adolescent schoolgirls who get pregnant –those from underprivileged backgrounds in particular – cannot receive prescriptions or referral letters for further tests from school doctors. The school has a psychologist on site as well, who is often consulted, especially in case of trauma and if the adolescent girl says she was raped. The

psychologist offers counselling services in particular situations, but – unfortunately – few schools have psychologists, especially in disadvantaged areas.

At community level, local authorities/mayoralties are responsible for preventing adolescent pregnancies and assisting under-age pregnant girls through community health nursing. In disadvantaged communities, the **community health nurse** and the health mediator identify the under-age childbearing girl, report adolescent pregnancies to relevant authorities, monitor the pregnant girl, provide counselling for preventing unintended pregnancies in under-age girls and identify health and social needs for securing health and social benefits.

Provision of **care to pregnant women, including pregnant adolescent girls,** is set out in Law no. 5/2006, which also specifies the **general practitioner's** duty to register insured and uninsured pregnant women.

4.3. Objective 3 – Professionals' opinions, attitudes and suggestions

Objective 3 aims to identify the opinions, attitudes and suggestions of professionals and decision-makers from central and local levels with regard to the measures that would be most effective in reducing the phenomenon over time.

To pursue the objectives and directions for action proposed under sexual and reproductive health strategies, based on the needs identified, public policies have been developed as a sum of interdependent decisions endorsed by relevant political actors to provide increased and equitable access to pregnancy prevention services integrated into broader sexual and reproductive health services.

Next, we will analyse the extent to which sexual and reproductive health policies available in Romania cover adolescents' needs, whether they are specific to this target group and whether they prevent unintended pregnancies in an integrated manner, according to relevant public stakeholders involved in qualitative research, while also looking at the measures that the latter think should be taken to reduce adolescent pregnancies.

a) Sex education policy

According to the professionals working in the health, education and social sectors, one of the factors contributing to adolescent pregnancies is the fact that *"early sex education is missing"* (GDSACP, social worker), especially among adolescents from underprivileged groups.

In their opinion, sex education should be provided early on, in different forms, as an academic or extracurricular subject adapted to *each age group* (GP), *"with a focus on pregnancy-related issues in the case of teenagers"* (SD), *communication* (health mediator), building self-confidence, negotiation skills, decision-making skills for girls and carrying out sex education activities centred on specific needs for boys.

Sex education, either in or outside schools, is delivered by teachers of different disciplines, educators or health professionals, provided that they are *"people who are dedicated and trained in this area"*. In schools, it may be the biology teacher or any other properly trained teacher. Lessons can be held for the whole class, since *"*[when they are] *in greater numbers, they push each other to speak"*, leaving shame aside; for small groups, if teachers think it is difficult to catch students' attention when they are more numerous; or in the form of caravans *"that interested children can approach to ask questions"* (SD).

In larger groups, notes can be used so that more children can provide answers on the debated topic at the same time.

Sex education activities are more effective when there is collaboration between the school, the medical office and the family, which means that the child's needs are covered effectively.

"The lack of trained teachers, of teacher training programmes on reproductive health" (SD) or even *"the shortage of qualified health professionals (SD and school nurse) in educational establishments"* (CHN from a rural community) exert a negative influence on adolescents' knowledge and behaviours intended to prevent adolescent pregnancies.

The delivery of sex education in schools comes up against many barriers, starting with opposition from parents, teachers or school management. *"Parents don't want adolescents to participate in these activities and some of them cause huge scandals in school."* There are also teachers who think that *"instead of preventing risky sexual behaviours, sex education encourages them".* Furthermore, school management sometimes rejects or forbids the involvement of family planning doctors in these activities.

Sex education is currently included in the syllabus as an optional subject matter under health education. In order to participate, students need parental consent. The subject includes learning

objectives and activities focused on sexual and reproductive health topics, such as: female body clock, male body clock, responsible sexual behaviours, attitudes towards sexual debut, myths about sexualisation/sexual behaviours (behavioural reactions to anatomical and physiological manifestations during puberty), sexually transmitted infections, HIV/AIDS risk behaviours, life plans, family, social relationships, impact of sexual relations on future life, conception and pregnancy, risks associated with pre-adolescent and adolescent pregnancy for the mother and child, abortion, family planning, counselling, domestic violence, sexuality, sexual abuse.

In accordance with applicable laws, sex education classes are given by teachers of different disciplines, ranging from biology to physical education, but their involvement in these classes is dictated more by financial interests and their desire to work extra hours than by their calling. As regards school-based sex education, the content and level of detail are often decided by teachers themselves, who are influenced by their knowledge in the area and by their own religious and cultural views.

Health professionals working in or outside the school, family planning doctors and general practitioners can be invited by the teaching staff to participate in and carry out sex education activities in schools or they show their willingness to participate in such activities for they are convinced that *"by getting information straight from a professional, under-age girls will gain – at a young age – proper knowledge on how to prevent an unwanted pregnancy"*.

According to their statements, some school doctors believe they have a duty to provide sexual health education by organising and carrying out health education activities and classes: *"as a high school doctor, I have to conduct health education classes and sex education is one of the topics that are tackled"*.

Health education, including sex education, is delivered in placement centres and to institutionalised children, as it is a well-known fact that they are particularly vulnerable to risky behaviours.

In disadvantaged communities, an important role in providing education for the prevention of adolescent pregnancies is played by the community health nurse and the health mediator, who are responsible for counselling, informing and guiding socially disadvantaged families or Roma families on the importance of education, prevention of early marriages, use of contraceptive methods and awareness of the risks associated with adolescent pregnancy both for the future

adolescent mother and for the child. In the majority of cases, girls are educated by the **community health nurse and the health mediator** during house calls or in groups set up at community level. The ***community health nurse*** *is responsible for reporting the cases to relevant authorities, monitoring pregnant girls if their pregnancy has been detected, providing counselling for preventing unintended pregnancies in under-age girls, identifying health and social needs, securing health and social benefits. The role of the* ***health mediator*** *is to advise, inform and guide the extended Roma family on the importance of education as well as on the prevention of early marriages, given potential risks both for the future under-age mother and for the child.*

b) Policy on the provision of sexual and reproductive health services to adolescents

Adolescent health and sexuality are sensitive issues which should be tactfully and skilfully tackled by professionals who are familiar with the field and the psycho-emotional development of teenagers.

Adolescents and young people benefit from the same reproductive health services as adults in adult healthcare facilities, primary care practices, specialist outpatient clinics or obstetrics and gynaecology departments.

Formally, family planning, pregnancy care and postpartum care are integrated into primary health care and family planning offices are integrated into specialist outpatient clinics that are run within health facilities.

Pursuant to applicable laws, both insured and uninsured citizens can benefit from a family planning consultation with a general practitioner under the basic package or the minimum package of services.

1. General practitioners*, according to current legislation, offer advice on contraception, prescribe contraceptives and refer the patient to the specialist if they detect a specific pathology. They also have "the duty to offer health education during their meetings with the target population, adults and adolescents, in both rural and urban areas, namely during individual patient visits at the practice or during house calls for the treatment of medical conditions"* (GP). According to the general practitioner, this kind of education – *"I slip in some health education between recommendations and advice"* – works because *"the people concerned don't feel constrained by unsolicited 'medical education'"* (GP).

Contrary to the provisions on the reimbursement of services by the National Health Insurance House, family planning services are not stimulating for general practitioners because they are not reimbursed and, therefore, they are rarely or never delivered.

The family planning network is complemented by family planning offices set up within obstetrics and gynaecology clinics.

In accordance with applicable laws, family planning offices currently offer family planning counselling to adolescent girls, prescribe oral contraceptives, refer them to obstetrics and gynaecology services, if needed, or insert IUDs. The network used to work very well in the past, offering free-of-charge services to disadvantaged people under the National Programme for Women's and Children's Health. After a series of dysfunctions in the National Family Planning Programme, the work of family planning offices has now been reduced. Many doctors have moved to either family medicine or other specialties and, therefore, work in this area has lost much of its role related to the provision of specific services and has been limited to consultations and advice on contraceptive methods. Nonetheless, practising family planning doctors are still willing to get involved in sex education activities in schools and high schools and work with qualified school employees, should they request it (FP doctor).

Family planning offices are rarely visited by under-age pregnant girls, as adolescents seek these services to a lesser extent because they are not friendly, they are *"set up in OB/GYN clinics where adults and adolescents risk running into each other and there is no confidentiality whatsoever"* (GP).

Family planning also involves OB/GYN specialists from obstetrics and gynaecology clinics and hospitals, but those services can only be accessed by those who have health insurance. OB/GYN specialists resort more often to abortion and, regarding contraception, they are more involved in IUD insertion procedures. Post-abortion contraceptive counselling is not a common practice and, as far as adolescents are concerned, OB/GYN doctors have neither the skills nor specific training to offer them advice. Often, the OB/GYN turns to abortion because *"it is more profitable and faster"* and it frequently happens that teenage girls who have had four or five abortions have never received contraceptive counselling from a doctor (family planning doctor).

There are also doctors involved in conducts that foster unfair competition between private and public sectors, as they first examine the adolescent girl in the public health facility and then refer her to their private practice for IUD insertion, with the patient often giving up for financial reasons.

2. Community health nursing

In some communities, the family planning doctor, community health nurses and health mediators had a good cooperation in the past. They would visit the disadvantaged community once a month, the mediator – as a local professional – would manage to mobilise adult women and adolescent girls and the nurse would talk to them and give them contraceptives. The practice was based on relevant WHO guidelines. That way of working was effectively used from 2007 to 2012. There are people who got trained as mediators in those communities. Now, mediators are hired by the mayoralty, at the request of the mayor.

Generally, in Romania, young people access reproductive health services on rare occasions, which is due to the following reasons:

- Current legislation provides that under 16-year-old girls need parental consent to purchase contraceptives and pregnant girls who are under 16 years of age need parental consent to receive care.
- Reproductive health services are set up in OB/GYN departments and outpatient clinics, which fail to provide the confidentiality and privacy adolescents need.
- Youth health activities are not based on international quality standards and there are no practice guidelines in place for the provision of reproductive health services and contraceptive counselling in general and to adolescents in particular.
- The idea of adolescent- and youth-friendly services is not even promoted and the development of an adolescent-friendly service has not gained political buy-in.

c) Policy on the training of health professionals and other health service providers

Rationale

1. General practitioners have limited knowledge and skills for the provision of family planning services to adolescents, especially the skills required for communicating with and counselling adolescents. In the past, general practitioners received information on contraceptive distribution

during the courses organised by SECS. The number of doctors with such knowledge has now dropped significantly after many of them left the system.
Romania's accession to the EU put a halt to international funding and, consequently, contraceptive training activities were no longer organised for health professionals.
Presently, practical and theoretical knowledge related to family planning and counselling is gained during family medicine and obstetrics & gynaecology residency training, with no reference to the target population – adolescents.

2. As regards community health nursing, the postgraduate training module for community health nurses includes mother and child care and family planning topics, with courses focusing mainly on disadvantaged communities, communication and provision of counselling to vulnerable groups, with no specific reference to adolescents.

d) Policy on funding for reproductive health services and contraceptive purchase

Pursuant to Law no. 95/2006 and GEO no. 72 of 20 September 2006, the delivery of family planning services to insured and uninsured citizens is funded under contracts concluded between general practices and the DPH for family planning services and special counselling services. In addition, different components of sexual and reproductive health services are funded under national prevention programmes, covered by the Ministry of Health based on state budget funds, and under curative healthcare programmes, covered by the National Health Insurance House.

Funding of contraceptive purchase

Contraceptive purchase	**Funding**
Birth control pills, condoms, IUDs under the National Programme for Women's and Children's Health – the Family Planning Programme	MoH budget, until 2012
Birth control pills available in pharmacies based on a prescription from a general	Charged

practitioner, a family planning doctor or a specialist	
Emergency contraceptive pills – available over the counter in pharmacies	Charged
Condoms – available in stores	Charged
IUD	NGOs
IUD insertion	Charged
Contraceptives (birth control pills, condoms) purchased by the family planning office from a contingency fund and distributed at the office	Charged a low price

As regards the availability of contraceptives for adolescents, although the aforementioned legal acts propose the provision of free contraceptives under the women's health sub-programme, they practically stopped being available for free a few years ago due to lack of budget allocations, as the provisions regarding the health technology assessment process delay the registration of contraceptives and hamper their purchasing from the state budget.

Also, the list of essential medicines covered by the medical insurance does not include contraceptive products. Adolescents have to buy contraceptives at the pharmacy, based on a prescription from a general practitioner, a family planning doctor or an OB/GYN.

Since contraceptives are not reimbursed, many adolescents cannot afford to buy them and, consequently, give up using contraception altogether.

A small number of family planning offices still hand out condoms for free thanks to old stocks or partnerships with different NGOs.

Family planning offices sometimes have contingency funds that they use to purchase contraceptives at much lower costs than the market price. In some cases, they manage to sell contraceptives at a smaller price than pharmacies after purchasing them at hospital level, in which case supplies depend on hospital procurement practices.

There were also – seemingly implausible – accounts of OB/GYN doctors from public health facilities refusing to insert for free an IUD that an adolescent girl had received from a charitable organisation, which made the patient give up contraception and, a few months later, she came back for a check-up and she was pregnant (FP doctor).

The lack of free contraceptives (FP doctor), *the dysfunctions affecting the national programme for years, with the shortage of contraceptives (condoms/intrauterine devices/oral contraceptives for vulnerable groups* (DPH doctor), and the lack of a policy regarding the reimbursement of contraceptives restrict adolescents' access to contraception.

e) Policy on raising community awareness of adolescents' sexual and reproductive health rights and modern contraceptive options

After Romania's accession to the EU, the country no longer benefited from international development funds, which had been the main source of funding for the implementation of information campaigns on reproductive health, including those targeted at adolescents.

Nowadays, the National Public Health Institute (NPHI) carries out isolated public initiatives and has implemented a few small-scale "Contraception Day" events, focusing on adolescent reproductive health and contraception. Some NGOs sharing information and messages online have carried out a few actions as well. However, there were also mentions of positive examples regarding *"collaboration with the mayoralty to raise community awareness through group meetings held to share contraceptive information, especially in socially disadvantaged communities"* (CHN).

Negative campaigns

"Also, there have been negative campaigns on TV saying that contraceptives are not good for you, that contraceptives can cause different diseases. Comments saying that people who used contraceptives died also appeared in the media. These comments are unfounded and are based on a lack of information" (school doctor).

"Young people heard that they shouldn't get the injection because they would not be able to have children anymore and that the injection was intended only for certain people – rumours that started on Facebook" (general practitioner).

All these rumours have contributed to lower acceptance of contraceptives among adolescents and to pregnancies.

f) Policy on interinstitutional cooperation in the field of adolescent reproductive health

Although delivering family planning, contraception or pregnancy monitoring services to adolescents often involves interdisciplinary and sometimes interinstitutional cooperation, in practice, such cooperation is quite poor.

- There is no well-defined contraceptive path for adolescents, with the family planning service working as a relay.
- Deficiencies are found in the communication and information shared by general practitioners, family planning doctors, school doctors and obstetricians/gynaecologists, along with overlapping responsibilities – instead of complementary actions.
- Also, interaction and communication between health, social, education and law enforcement (police, local public administration) systems are deficient.

g) Policy on discrimination prevention and gender equality

In Romania, the prevention and elimination of all forms of discrimination, including discrimination affecting the right to health, are legally stipulated as follows: prevention of discrimination – Law no. 48/2002, sanction of all forms of discrimination – Law no. 48/2002, patient rights – Law no. 46/2003, gender equality – Law no. 202/2002. The health insurance law explicitly mentions the non-discriminatory delivery of health services. However, all these laws do not make explicit references to sexual and reproductive health rights and non-discrimination. In fact, the economic, educational or cultural status acts as a barrier to family planning access.

Looking at gender equality, it doesn't seem to be a topic of interest either for family medicine, family planning, obstetrics and gynaecology specialists or for educational stakeholders, being seldom tackled during educational activities centred on reproductive health. In the majority of cases, the responsibility for contraception and pregnancy prevention during adolescence lies exclusively with the girls.

Gender equality policies and programmes are not even known by the main social stakeholders that should implement them.

CHAPTER 5.
DISCUSSIONS

The secondary analysis and the discussions held with professionals indicate that adolescent girls who become mothers are not a homogenous, compact group.

Using *school enrolment and economic status* as criteria, we can classify mothers into two sub-groups: mothers who are not enrolled in education and mothers who are enrolled in education.

1. Those that are no longer in school normally come from vulnerable groups. Some of them already live with their partners. We do not know how many of them wanted to become mothers so early. It is very unlikely that these girls have enough reproductive health knowledge, at least as regards contraception and the prevention of sexually transmitted diseases. The few places that deliver this kind of education in Romania have upper secondary school students and rarely lower secondary school students under 15 years of age as beneficiaries. Counselling, which is often provided by community health nurses after childbirth, may be useful in preventing future pregnancies at a young age. Still, if they come from poor communities and are already living with their partners, giving birth to children who are a source of income can prevail over birth control interests.
2. The second group consists of girls who are enrolled in education and become mothers by accident as they lack knowledge on how to prevent an unwanted pregnancy. As mentioned by hospital-based social workers, these schoolgirls often live with their partners.

Adolescent pregnancy prevention is a complex effort, requiring interventions that need to cover several areas (education, health, social assistance) in order to deliver results.

Based on *social status*, we can distinguish three sub-groups:

1. Adolescent girls who become mothers by accident. These teenage girls do not come from economically disadvantaged families, they have not dropped out of school, they do not belong to a disadvantaged ethnic group, they are over 15 and they have completed compulsory education or more.
2. Adolescent mothers from poor, broken families, possibly early school leavers, from rural and urban areas, of all ethnicities.
3. Adolescent mothers living in traditional ethnic communities. In these traditional groups, pregnancy or birth at a very young age is neither an accident nor the result of not knowing how to prevent unintended pregnancies.

As shown by the discussions held with professionals and resource persons, in some communities (for example, Roma communities), early "marriage" is a deep-rooted tradition that is hard to break. It occurs in a complex cultural setting which defines the way of living in these communities. Their way of living is based on rules and values in total contradiction with the principles that define the rule of law, the status of children and the status of women in Romanian society today.

(For the Roma) Traditions play a major role in the social organisation of the community and their mentality is change-resistant (Preoteasa A. M. et al., 2009).

Girls aged 9-12 years are placed with their future partner's family following a transaction. Some experts who are familiar with traditional Roma communities say that such placement is aimed at making sure the girls don't lose their virginity until their designated partners reach sexual maturity and that they learn the ways of the family in order to please their partners and their families as much as possible (Burtea, 2002). After their placement, girls lose all the rights that children and future adults normally have. They don't go to school, they are not protected from abuse and, once they reach sexual maturity, they follow the natural course of reproductive life, becoming mothers whenever they can, biologically speaking.

The marriage is officiated by a priest, even without a civil ceremony. And, when they are ready to bear children, the girls become mothers, no matter their age.

They start having children as early as 12-13 years and, by 15, they are sure to have at least one child. They don't give birth in a hospital unless there are complications. School is not valued in the Săruleşti community of Roma tinkers, as most of them go to school only until they get married. Lack of education is justified by lack of financial means to support [school] *children (they lack notebooks, lunchboxes, footwear, etc.). The illiteracy rate is very high in the community. (Preoteasa, A. M. et al., 2009).*

Although the phenomenon is well known to the authorities and professionals, this is "accepted" because they are traditional Roma. There are almost no laws regulating the rights of children and women that apply in these communities. The persistent lack of action has amplified these

phenomena. As also shown by quantitative research, the number of girls who become mothers before the age of 15 has increased in recent years. The number of births is six times higher among Roma girls than among Romanian girls.

Although several laws on education and child rights protection are being broken, the interventions of the authorities are clearly ineffective since these phenomena are growing.

As highlighted by the discussion held with resource persons from the academic environment, familiar with the situation of the Roma, and with a representative of an organisation working with Roma communities, things are unlikely to change in traditional Roma communities, at least in the current context.

References were made to several factors pertaining to the cultural model of these communities and being – from many perspectives – in total contradiction with current child protection legislation or with Criminal Code provisions on sexual relations with a minor.

Moreover, as our interlocutors explained, the model used offers protection to young mothers, since they are protected by the community based on strict rules and the families are stable (Burtea, 2002).

Such protection is needed and justified in the current context of Romanian society, which discriminates this ethnic group on the labour market. For example, completing a school or learning a trade would not bring real benefits to their lives, as employers hardly ever accept Roma women. As one of the interlocutors mentioned, right now most employers usually pay the minimum wage, which is not motivating enough for them to abandon their current lifestyle.

The Săruleşti community of Roma tinkers is quite large, counting around 400 people, according to the mayoralty's social worker. In the Săruleşti community, girls get married at 10-13. The reason why girls are dragged into early marriages is that their parents see them as "risky investment", the risk of losing their virginity…, the girl's family receives money from the boy's family, which fuels the fear of girls losing their virginity or running away with other men (in which case the money and the goods have to be returned). At the wedding, they usually show proof of the bride's virginity, placing a sheet beneath her during the sexual intercourse. This proof is needed to avoid a scandal between families in the community.

(Preoteasa, A. M. et al., 2009).

The laws that could sanction and, consequently, deter such behaviours have systematically bypassed these communities. According to the professionals who participated in qualitative research, interventions should be implemented by:

1. Social assistance services under local public authorities, during their assessment of these families for the provision of certain benefits;
2. Educational establishments, schools, kindergartens, if the child is not enrolled in school or does not attend school or drops out of school;
3. Child protection services under the County Directorate for Social Assistance and Child Protection, when maternity facilities report adolescent births.

All these institutions should notify the police to investigate neglect, deprivation of liberty, abuse of children placed with other families and sexual relations with a minor, since these are all acts that fall under the Criminal Code. As the representatives of child protection services stated, after notifying the police, they don't hear back from them and don't know whether those who neglected and abused the children have been investigated and convicted. In their opinion, they may not even run an investigation at all, since repeat pregnancies and births are seen in these under-age girls over and over again. Neither the persons nor the institutions involved are monitored or held accountable for their inaction.

Different institutions are responsible for ensuring that laws and procedures are observed, such as the Social Inspection Agency and the Inspection Body of the National Authority for the Protection of Children's Rights and Adoption (NAPCRA).

The Social Inspection Agency checks whether different services have their permits, licences and minimum standards in order, but not whether the interventions related to a case have had an outcome. This happens because no standards are in place to combat neglect and abuse, so the Social Inspection Agency has nothing to check.

The Inspection Body of NAPCRA is the institution authorised to check the content of the interventions implemented following reports of child abuse and neglect. This body either acts on the reports received or runs routine checks, but – as GDSACP representatives stated – this institution has never looked for the root causes of problems.

The interventions of child protection services are normally limited to providing these young mothers with cash benefits or services and allowances, which fail to prevent repeat pregnancies. Instead, as a benefit recipient, an under-age mother becomes attractive for she brings money.

Therefore, attempts to discourage early maternity through family planning programmes alone do not make sense as far as these communities are concerned.

Women under 35 years of age resort to contraceptive methods – birth control pills, tubal ligation – or to abortion. However, they avoid talking about it because their men forbid them to use such methods. (Preoteasa, A. M. et al., 2009).

The young age of first sexual experience, the relatively high proportion of adolescent girls who get pregnant or have a child before the age of 15 and the high prevalence among uneducated, Roma and socio-economically disadvantaged girls highlight the populations that should be targeted by public policies meant to contain undesirable phenomena among children.

CHAPTER 6.
CONCLUSIONS

6. Lack of a coherent policy and standards of practice in the field of reproductive health for the professionals involved in adolescent work

- At present, policy measures on adolescent health and teenage pregnancy prevention are dispersed among different authorities, without *demarcated roles and aligned responsibilities.*
- There are no *standards for providing contraceptive counselling to adolescents in general and to socially disadvantaged teenagers in particular* and no responsibilities and boundaries have been set at institutional or professional level.
- *Responsibilities for the prevention of unintended pregnancies are ambiguously assigned to a large number of professionals* (community health nurses, social workers, health mediators, general practitioners, gynaecologists, family planning doctors, DPH doctors), who *don't seem to be in tune or sufficiently aware of their professional complementarity*.
- There is a lower number of *trained professionals* available to provide family planning counselling to adolescents because the network of family planning doctors is quite

disorganised, general practitioners have left the system and the number of community health nurses and health mediators is *small*.

- *Postgraduate training* on specific topics for professionals working in the area of *adolescent* reproductive health, with a different basic training (teachers, nurses, midwives, physicians, psychologists, social workers and community health nurses), is not encouraged or supported as a means to *harmonise their activitie*s.
- *There are no information materials* on sexual and reproductive health, *appropriate to different age groups and levels of education, including for functionally illiterate adolescents.*

7. **Lack of a coherent health education programme for adolescents**
    - For adolescent girls who become mothers after the age of 15, pregnancy could be prevented through education and *family planning programmes tailored* to the sociocultural context in which these adolescent girls live.
    - Health education is currently optional in schools and does not successfully provide information meant to promote non-risky sexual behaviours and prevent adolescent pregnancy.
    - As shown by quantitative and qualitative research, *under-age mothers are not a compact group sharing the same characteristics and needs.*
    - According to the professionals interviewed in this research,
        - Low participation,
        - Poor organisation of the activities by
        - Staff with insufficient competencies or skills (homeroom teacher, biology teacher, school doctor),
        - *Lack of performance standards, and*
        - *Lack of a communication strategy targeted at the opponents of sex education* – parents, teachers, religious leaders,

    these are all factors that make these actions reach unsatisfactory outcomes.
8. **One-dimensional approach to under-age mothers across social services, focused on financial support**

- Child protection services usually focus their interventions on the provision of *cash benefits or services*/*allowances* to these young mothers, *yet these actions fail to prevent repeat pregnancies.*
- Most under-age mothers have dropped out or leave school when they become mothers. Therefore, setting measures for *their school integration and access to education and training* is an absolute must in order to provide new families with a socio-economic framework *that allows their children to develop*.
- No *educational measures* are being implemented *for socially disadvantaged adolescents and early school leavers*, who are largely excluded from information and education activities, thus heightening the risks of inappropriate sexual behaviours and unintended pregnancies.
- What is missing is *a network of psychologists – integrated into social assistance services* – that can *develop and implement support programmes for under-age mothers*.

9. Inadaptability of family planning services to the needs of adolescents, especially of those from disadvantaged families

- *The policy on the monitoring and evaluation of the mother and child health strategy* and of the family planning programme *does not include indicators related to adolescent reproductive health.* Given its current disorganisation, the family planning network can no longer provide the necessary framework for contraceptive counselling and care in general, which incidentally restricts adolescents' access to these services in both urban and rural areas. In rural communities, contraceptive care is provided by general practitioners, who are few in number and overloaded with other activities; many of them have left the family planning network.
- *Adolescents in general are not regarded as a priority across strategic documents* on reproductive health and the "National Programme for Women's and Children's Health" includes them in the broad group of beneficiaries under pregnancy prevention through access to family planning services.
- *Adolescents' access to family planning services* is hampered by the fact that those services do not offer *a friendly and confidential environment.*

- Health policies do not grant socially disadvantaged adolescents equal access to family planning services and modern contraceptives, as those teenagers have to deal with lack of information, stigma, cultural and religious barriers, making them more vulnerable to unintended pregnancies.
- *Contraceptives can no longer be obtained for free,* which experts think makes young people, in particular those from socially disadvantaged groups, seek family planning services and use contraception considerably less.

10. Low adolescent involvement in positive changes

- *Sustained community awareness campaigns* focused on adolescent sexuality, the risks of unintended pregnancies and ways to prevent them are sporadic and lack financial support from the government.
- No feedback is given with regard to the information shared by service providers for decisions within the health system.
- Policies and current social practices refer almost exclusively to under-age mothers, yet all adolescents should be included, as some of them are the *fathers of the children* born to under-age mothers, the latter's future partners or support people who are the closest to under-age mothers and their children.
- *Stigma,* as a psychological or social event, is a barrier to adolescents' access to family planning services and reproductive health counselling. It is also the cause of *their non-participatory attitude when it comes to changing things for the better*.

6. Lack of an information system regarding adolescent reproductive health

- The information system regarding reproductive health, including youth reproductive health, does not benefit from a coherent policy. Therefore, the 2016 Reproductive Health Survey is not representative for the entire youth population.
- The data collected are not systematically analysed and *there is no data sharing policy*. As a result, *such data are rarely used for planning and making policy decisions at system level.*
- There is a lack of funding for *studies and research* meant to identify the specific needs and expectations of Romanian adolescents and to inform both policies and standards of practice in the field.

- ❖ Adolescent pregnancy studies conducted so far focus on *under-age mothers while neglecting male adolescents*. Initiating such research projects, along with education can prevent not only a number of pregnancies or the stigma against under-age mothers but also diseases that affect reproductive health, namely sexually transmitted diseases.

CHAPTER 7.
RECOMMENDATIONS

7.1. Health policies

1. Start legislative and administrative reforms to break down the barriers that restrict children's access to sexual and reproductive health information and services, by *revising and adapting the legal framework for reproductive health policies*. A key component of these reforms is the integration of sexual and reproductive health activities into comprehensive social and health programmes for youth, *with the active involvement of young people* in the organisation and implementation of sexual and reproductive health activities that do not require parental consent to participation.
2. Include the issues of reproductive health and *adolescent pregnancy prevention* in the *National Health Strategy 2021-2025*. Within the *National Health Strategy*, adolescent sexual and reproductive health should be a standalone component aimed at addressing inequalities in adolescent care, based on objectives and a plan of appropriate measures for age-relevant issues in the field.
3. The principles of the Strategy should be based on *social and ethical values*, such as:
    a. Right to confidentiality,
    b. Participation,
    c. Gender equality,
    d. Equity,
    e. Non-discriminatory care and prevention, and
    f. Assistance to socially, educationally or culturally disadvantaged groups.

4. Develop viable and sustainable programmes and projects for promoting adolescent sexual and reproductive health and for preventing inequalities in education and care for socially disadvantaged adolescents, implemented with the collaboration and participation of schools, local leaders, local authorities and community leaders.
5. Extend the reproductive health policy evaluation system to include mandatory *indicators measuring inequalities in health care, social assistance and access to education*.

7.2. Interinstitutional cooperation

1. To address the reproductive health needs of adolescents and youth, a *multi-dimensional, complex approach* is needed, *as part of integrated public policies regarding:*
    a. *Sex education,*
    b. *Community awareness of specific needs in the field, and*
    c. *Provision of services tailored to adolescents' psychological and emotional profiles*.
2. Develop *interinstitutional cooperation networks with a view to establishing cross-cutting measures* for the prevention of adolescent pregnancies, with the participation of – among others – the Ministry of Health, the Ministry of Education, the Ministry of Interior (the police), universities, mayoralties, NGOs, associations assisting Roma communities and with a clear definition of roles and responsibilities.
3. Set up a *communication and cooperation network* in the field and address inequalities in adolescent care for reproductive health through *sustainable projects*.
4. *Develop partnerships between governmental institutions and NGOs* for initiatives that address the needs of young people and adolescents in the field of reproductive health in general and in the area of pregnancy prevention in particular.

7.3. Evidence-based policy development

1. Carry out *quantitative and qualitative research* on the sexual behaviours of young girls and boys so that relevant data can be used to develop and improve adolescent reproductive health and pregnancy prevention services for young people.

2. Conduct *adolescent and youth reproductive health surveys* on a regular basis; collect data based on nationally representative samples; process and analyse sexual and reproductive health data to inform future policy decisions.
3. Run *comparative analyses and forecasts and develop alternative strategies to address youth sexual and reproductive health issues*.
4. Assess *cultural and motivational factors contributing to pregnancies among adolescent and under 15-year-old girls and develop specific interventions for different age groups*.
5. Create *educational programmes* addressing the cultural factors identified as well as specific interventions for different cultural groups (the Roma, vulnerable populations living in rural areas and poor urban communities, etc.), targeting both young people and parents, community leaders, etc.

7.4. Provision of tailored educational and reproductive health services to adolescents

a. Sex education

1. Include *sexual and reproductive health education* in the syllabus as a *compulsory subject matter*, in line with international standards, and focus programmes on values and on creating responsible behavioural habits.
2. *Create content that is appropriate to the child's age, issues* and level of understanding and teach it starting with the early stages of school; include *equality- and non-discrimination-based* approaches in IEC programmes implemented for adolescents in the field of reproductive health.
3. *Develop a communication strategy* and ensure the transparent provision of sex education in schools for all stakeholders: parents, teachers, community leaders.
4. Organise *adult education programmes* for parents and teachers so that they can acquire the skills needed to offer adolescents information and guidance on safe and responsible sexual behaviours.
5. Set administrative standards to ensure the collaboration of different stakeholders involved in assisting adolescents in school (school doctor, nurse, psychologist, social worker, teacher), allowing them to participate in sex education classes.

6. Develop *educational programmes/projects for adolescents who have left school and for those who are functionally illiterate*, adjusting the methods used in order to share information via community health nurses and health mediators.
7. Hold *training activities for the staff* delivering sex education in schools and in the community, based on a training curriculum and teaching methods that are in line with international standards.

b. Friendly family planning services

1. Reorganise family planning services by *setting up adolescent- and youth-friendly services* and identifying opportunities to restore the network of family planning/sexual and reproductive health services, thus providing access to rural populations. Choose youth-populated areas (university campuses) as locations for such services.
2. Set up *youth information centres* focusing on sexual and reproductive health, with a friendly atmosphere, and/or create reproductive health-related websites for young people.
3. Set *standards for family planning services targeting adolescents*, based on the development of *clinical guidelines* with a dedicated chapter on adolescents, in line with international standards and WHO documents.
4. Ensure the *provision of free contraceptives to adolescents* in general and to disadvantaged ones in particular, by:
    a. Adding contraceptive products to the list of essential medicines in order to ensure their centralised purchasing via health programmes;
    b. Distributing condoms, contraceptives and other birth control products for free to underprivileged groups via health programmes;
    c. Providing access to a wide range of contraceptives according to the needs, especially to disadvantaged adolescent girls.
5. Review the roles and motivations of general practitioners for the provision of sexual and reproductive health services, including adolescent- and youth-friendly services.
6. Involve nurses from general practices, school-based medical offices or specialist outpatient clinics and midwives and encourage community health nurses and health mediators to engage in family planning activities, according to their competencies, as well as in health promotion and health education activities.

7. Reactivate pre-abortion and post-abortion contraceptive counselling for adolescent girls and refer them to family planning offices for counselling.
8. Carry out health promotion activities for adolescents.

7.5. Training of staff from adolescent reproductive health services

1. Increase the number of professionals working in the field of adolescent and youth sexual and reproductive health through training, staff recruitment or redeployment of existing staff – family planning doctors, general practitioners, school doctors and nurses, community health nurses, employment of community health nurses/health mediators/social mediators, etc.
2. Train the staff from health, educational, social services and other relevant areas on how to provide sexual and reproductive health information and advice to youth and adolescents; *develop a training curriculum and educational materials in accordance with international standards*.
3. Organise continuing education activities for health workers and other professionals, based on their training and professional roles, in order to deliver quality reproductive health services that offer the confidentiality that youth and adolescents need.
4. Enhance these educators' access to information materials and free contraceptives to be distributed in the community with the help of community health nurses, health mediators, midwives.
5. Reconsider the roles of nurses and midwives, promote and include these qualified and lower-cost professionals in the health education services delivered by family planning offices.

7.6. Community awareness

1. Develop an *advocacy strategy on youth reproductive rights* to raise decision-makers' awareness of reproductive health so as to consider it a national priority.
2. Initiate *education programmes for parents* so that they can offer adolescents guidance on safe sexual behaviours; multidisciplinary and interinstitutional cooperation. Find creative

ways of using mass media and social media to provide appropriate information to young people.

3. Spur collaboration with the community, *involving community leaders*, the church and the media.
4. Use *mass media and social media* to share information between relevant political actors, stakeholder institutions and the community.
5. Rolling out a *media campaign* aimed at *sharing information about school-based sex education*, its objectives and topics approached, before it is introduced in the syllabus, would help community members understand the proposed intervention and would facilitate getting parents' consent.
6. *Improve* the way in which different public and private institutions *share information* on current youth reproductive health policies, programmes and projects, according to their specific duties.
7. *Promote the roles of family planning offices* to the population, general practitioners, community health nurses, health mediators, with a focus on the importance of family health.
8. *Draw up and distribute information materials* on sexual and reproductive health that are appropriate to different age groups and communities, including socially disadvantaged ones.

7.7. Social policies

1. Revise social policies in order to fulfil children's right to reproductive health and prevent abuses of children and women in poverty-stricken communities and in traditional Roma communities.
2. Ensure more responsible interventions from stakeholders with a remit to identify and condemn child sexual abuse, by evaluating their work on a regular basis.
3. Provide *psychological support* to children from broken families, with migrant parents and other vulnerable groups.
4. Implement dropout prevention policies on a large scale, with a focus on rural areas and the Roma.

5. Enhance access to reproductive health services for children from placement centres/adoptive families.
6. Implement reproductive health measures at community level, including access to free contraception for adolescents from vulnerable families.

ANNEXES

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SELECTIVE BIBLIOGRAPHY

1. Ana Maria PREOTEASA, Sorin CACE, Gelu DUMINICĂ - coordinators - STRATEGIA NAŢIONALĂ DE ÎMBUNĂTĂŢIRE A SITUAŢIEI ROMILOR: VOCEA COMUNITĂŢILOR (2009) [National Strategy for Improving the Situation of the Roma: The Voice of Communities], editura Expert
2. Ana Penman-Aguilar[1], Marion Carter, M Christine Snead, Athena P Kourtis Socioeconomic Disadvantage as a Social Determinant of Teen Childbearing in the U.S., Public Health Reports, Mar-Apr 2013; 128(Suppl 1):5-22., doi: 10.1177/00333549131282S102.
3. Burtea, Vasile, The Romanies in the synchrony and diachrony of the contact populations, LUMINA LEX, BUCHAREST, 2002
4. Decision on the approval of national health programmes for 2013 and 2014, Decision no. 124/2013 of 27 March 2013: http://www.dspcovasna.ro/files/legis/hotarare124din2013.html
5. Decision-making tool for family planning clients and providers – A resource for high-quality counselling, WHO, 2005: http://www.who.int/entity/reproductivehealth/publications/family_planning/9241593229/en/index.html
6. Europe 2020 strategy, WHO Regional Office for Europe
7. Family planning: a global handbook for providers, WHO, update 2011: http://whqlibdoc.who.int/publicatons/2011/9780978856373_eng.pdf
8. Hobcraft, J., & Kiernan, K. (2001). Childhood poverty, early motherhood and adult social exclusion. *The British Journal of Sociology*, *52*(3), 495-517.
9. Imamura, M., Tucker, J., Hannaford, P., Astin, M., Oliveira da Silva, M., Bloemenkap, K. W. M., Karro, H., Olsen, J., & Temmerman, M. (2006). REPROSTAT 2: A systematic review of factors associated with teenage pregnancy in the European Union. Retrieved on August 10, 2015 http://ec.europa.eu/health/ph_projects/2003/action1/docs/2003_1_27_frep_en.pdf

10. Iorga, M., Socolov, R.V., Socolov, D.G. (2016). An 8 Years Analysis of Pregnancies and Births among Teenagers in a University Hospital in North-Eastern Romania. Revista de Cercetare şi Intervenţie Socială [Review of Research and Social Intervention], 54, 55-65.
11. Law approving Government Order no. 137/2000 on the prevention and sanction of all forms of discrimination, Law no. 48/2002, 16 January 2002: http://legislatie.resurse-pentru-democratie.org/48_2002.php
12. Law on equal opportunities for women and men, Law no. 202/2002, 19 April 2002: http://legislatie.resurse-pentru-democratie.org/legea/202-2002.php
13. Law on health insurance, 10 July 1997: http://www.cmb.legislatie/legeaAsig/#_Toc453326165
14. Law on paternity leave, Law no. 210 of 31 December 1999
15. Law on patient rights, Law no. 46/2003: http://dreptonline.ro/legislatie/legea_drepturilor_pacientului.php
16. Lawlor, D. A., & Shaw, M. (2002). Too much too young? Teenage pregnancy is not a public health problem. *International Journal of Epidemiology*, *31*(3), 552-553.
17. Markovitz, B. P., Cook, R., Flick, L. H., & Leet, T. L. (2005). Socioeconomic factors and adolescent pregnancy outcomes: distinctions between neonatal and post-neonatal deaths – *BMC Public Health*, *5*1-7. doi:10.1186/1471-2458-5-79
18. Medical Eligibility for Contraceptive Use, 4th edition, WHO, 2010: http://whqlibdc.who.int/publications/2010/9789241563888_eng.pdf
19. National Institute of Statistics, 2017, Population, www.insse.ro
20. National Programme for Women's and Children's Health: https://insmc.ro/Programe-de-sanatate-finantate-de-MS/Programe-de-sanatate-finantate-de-MS/50
21. National Strategy on Sexual and Reproductive Health 2012-2015, Ministry of Health: http://particip.gove.md/public/documente/140/anexe/ro_1006_1.-Strategia-v-f-29.07.13.docx
22. Nicolae Suciu, Michaela Nanu, Ecaterina Stativa, Cornelia Novak, G. Mihailescu, Studiul Sănătăţii Reproducerii în Romania [Romanian Reproductive Health Survey], Oskar Print, Bucureşti, 2019
23. Regional strategy on sexual and reproductive health, 2001, WHO Regional Office for Europe

24. Regional strategy on sexual and reproductive health, 2001, WHO Regional Office for Europe, Copenhagen, Denmark
25. Robson, K., & Berthoud, R. (2003). Teenage Motherhood in Europe: A Multi-Country Analysis of Socioeconomic Outcomes. *European Sociological Review*, *19*(5), 451-466.
26. Selected practice recommendations for contraceptive use, 2nd edition, WHO, 2004; http://whqlibdoc.who.int/publications/2004/9241562846.pdf?ua=1
27. Strategy on Sexual and Reproductive Health, Ministry of Health and Family, 5 December 2001: http://gov.ro/fisiere/programe_fisiere/13-07-30-02-08-443.pdf
28. Sustainable development in Europe – leaving no one behind, 2016, WHO Regional Office for Europe
29. Technical rules for implementing national curative healthcare programmes 2013-2014, Order no. 358 of 29 May 2014 issued by the Director of the National Health Insurance House: http://www.cnas.ro/post/type/local/ordin-nr-358-29-05-2014-norme-tehnice-de-realizare-a-programelor-nationale-de-sanatate-curative-2013.html Decision on the approval of service packages and of the Framework Contract regulating healthcare provision under the health insurance system for the years 2014-2015: http://www.cashr.ro/files/download/contr2014/legi/hg400.pdf
30. UNFPA's Total Market Approach: http://eeca.unfpa.org/topics/total-market-approach
31. WHO Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_12-en.pdf
32. World Health Organisation (2011). Early marriages, adolescent and young pregnancies. Retrieved on August 10, 2015