

State of adolescents in Romania



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Final report: State of adolescents in Romania

Authors:

Abraham, D. (coord.); Abraham, A.; Dalu, A.M.; Fierbinteanu, C.; Marcovici, O.; Mitulescu, S.; Plaesu, A.; Sufaru, I.

Institutions:

Center for Urban and Regional Sociology

Institute of Education Sciences

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Florentina Furtunescu, MD, MPH, PhD

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARAS	Romanian Anti-AIDS Association
CURS	Centre for Urban and Regional Sociology
DK/NA	Don't know/No answer
EACEA	Education, Audiovisual and Culture Executive Agency
EPA(s)	Educational Priority Area(s)
ESL	Early School Leaving
ESOMAR	European Society for Opinion and Marketing Research
EU	European Union
GDP	Gross Domestic Product
GDSACP	General Directorate for Social Assistance and Child Protection
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IES	Institute of Education Sciences
IQLR	Institute for Quality of Life Research
MARA	Most-at-Risk Adolescents
MLFSPE	Ministry of Labour, Family, Social Protection and the Elderly
MNE	Ministry of National Education
NAA	National Anti-Drug Agency
NGO(s)	Non-governmental organisation(s)
NHIH	National Health Insurance House
NIP	National Interest Programme
NIS	National Institute of Statistics
PSSA	Public Service for Social Assistance
RH	Reproductive Health
SEN	Special Educational Needs
SOP HRD	Sectoral Operational Programme Human Resources Development
STD	Sexually Transmitted Diseases
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAPOR	World Association for Public Opinion Research
WHO	World Health Organisation

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<p>Major weaknesses exist in setting and/or implementing appropriate sanctions, this resulting in somewhat ineffective laws and leaving room for risky behaviours (e.g. selling alcohol and tobacco to the underage, access to drugs, smoking in public places etc.) and in limited access to rights and welfare/protection services (e.g. home education for people with disabilities, accessibility for people with disabilities, welfare services at local level, proximity services for street children, drug addicts and victims of human trafficking/sexual exploitation).</p>	
<p>Weaknesses are also seen in coordination between different sectors or authorities in implementing the legislative provisions (Eg, the Child Protection Law mentions health education as compulsory, to be delivered, but in practice the Health Education remained an optional subject in schools).</p>	
<p>The legislation is underdeveloped in the fields of inclusive education – especially with regard to children with disabilities, of special protection and assistance for children with parents working abroad, special protection for human trafficking victims and drug addicts (in particular harm reduction), of providing fair opportunities for educational advancement to adolescents in the child care system and from poor families and/or poor rural/remote areas. Many other issues – such as the right to autonomy and confidentiality of medical investigations related to adolescents' sex life or ethical issues concerning psychological counselling – remain unaddressed.</p>	
<p>Also new challenges or threats occur in the society in the globalization context and legislation needs to be improved constantly to face and to prevent these threats as possible. For example, increased availability and accessibility of legal and illegal drugs (the number and availability of points of sale, effective means of promotion and distribution, the price, etc.) have contributed to the growing risk of drug use.....</p>	
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<p>Even though there are some relevant programs meant to facilitate the access of adolescents of their fundamental rights – health, education, social protection (e.g. “Second Chance”, “Croissant and Milk”, “Money for High School”), some of them are perceived as too bureaucratic to be accessed by some disadvantaged groups or do not cover some specific subjects (e.g. Second Chance programme doesn't cover the adolescents that dropped-out, but want to come back in schools before the age of</p>	

14), others or are not implemented in uniform manner (drop-out registration) and others are implemented with difficulties or delays. Some programs haven't been evaluated in terms of effectiveness or efficiency.	76
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There is a lack of collaboration between public institutions and NGOs, conducting to insufficient use of the capacities and expertise gained by NGOs, in the context of an insufficient capacity of the public bodies. A poor interconnections between various programmes (provided by public institutions and NGOs) aimed at the same target group can arise, with detrimental efficiency. ...	77
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NGOs show good potential for qualified and effective interventions meant to address the difficulties faced by adolescents, being able to support the public services but their availability at local level is also scarce.	78
A general feature that comes out from our qualitative research is the decreasing specialised staff in public institutions that provide services/assistance to vulnerable adolescents, who has either left for	

better jobs or been dismissed based on administrative criteria as a consequence of staff reduction policies in the public sector and who cannot be replaced due to employment restrictions. Besides, suitable professionals are hard to find as the ones who have left were trained over the years. Moreover, in fields like child protection, education, social assistance, staff turnover has also led to emotional traumas for the assisted children/adolescents who had emotionally connected to their assistants.	79
In the public sector, staff working with vulnerable groups is considered insufficient and chronically unmotivated from a financial standpoint. Things are even worse in rural areas where human resources involved in prevention services lack appropriate professional training. Lately, increasingly fewer resources have been allocated to social services for human resource development.	79
In the case of NGOs, for which high-quality workforce and logistics are usual standards, the problem lies in their financial flows that are unreliable due to either short-term programme funding schemes or lack of support from public bodies responsible for the respective areas of intervention (at least as regards continuity of services), or by both.	79
Those who work in the education system seem to be insufficient and under-prepared to deal with vulnerable adolescents' matters.	79
There are no clear procedures for the integrated intervention of relevant public services in addressing problems faced by adolescents with school adjustment difficulties: adolescents from childcare centres, adolescents with disabilities, drug users, etc.	79
Instead of having a proactive approach, public services are structurally passive mainly due to insufficient human and financial resources and the bureaucratic background of the public sector. Adolescents are reluctant to accessing services offered by public bodies due to the rigid official environment.	79
Information and counselling services for parents are also lacking. This seems to be a major gap as many parents do not know how to approach teenagers in general and in particular how to discourage alcohol, tobacco and drug use or drop-out. This is also a problem for parents of adolescents with disabilities.	79
Bureaucratic barriers do exists in adolescents' access to the basic services (e.g. missing ID paper or missing of the parent consent)	79
There is a lack of information concerning the right of adolescents and their families to access different services, most common in disadvantaged communities.	79
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In many cases, accessing services requires travelling to their location and transportation costs have been mentioned as potential barriers for disadvantaged adolescents.	80
Socio-economic factors are most frequently invoked as reasons for non-participation or school drop-out, these factors being associated with disadvantaged communities and adolescents from poor Roma families. The costs incurred by attending school (school supplies, clothes, shoes, transportation) pose a problem for families living in severe poverty, especially in the current context of rationalisation of educational network.	80
For adolescents in rural areas, access to specialised medical services is difficult; often, the nearest medical centre is many miles away. The dissolution of school dental care units has created an access problem especially for financially challenged teenagers.	80

Adolescents' awareness of the services that are available for them and propensity to use these services vary significantly depending on service type and coverage, as well as on the area of residence and the community of origin. 80

The adolescents from urban areas are generally more aware about the existing services, even though their knowledge of these services is vague and stereotypical, acquired mostly from the media, but also at school. Per contrary, adolescents from rural areas have limited knowledge of child assistance and protection services, generally mediated by television; Adolescents prefer not to seek such services for fear of repercussions, but also because they don't want to make public what they have experienced. 80

Social and cultural practices, as well as social norms, mentalities and associated beliefs also play a significant role in adolescents' accessing available services. In the case of traditional Roma communities, the low level of educational aspirations, parents' lack of interest and information, along with a traditional culture that sets a very low age limit up to which children (especially girls) must attend school often result in a high drop-out rate among Roma adolescents. 80

The social stigma that Roma communities place on those who access services of psychological counselling, reproductive health, testing for sexually transmitted infections exposes Roma adolescents to greater health risks. 80

The stigma associated with drug and alcohol use is the main barrier to accessing services, as recognised by users, their families and the professionals who work with these teenagers. 80

Adolescents are reluctant to accessing services offered by public bodies due to the rigid official environment, excessive bureaucracy, long paperwork and associated costs, lack of confidentiality, parental presence required in certain cases, etc. On the other hand, when public services are the only source, as in the case of substitution treatment for drug addicts, the available facilities cannot cover the demand, which is far greater; to access these services, addicts have to wait for far too long given their condition. 80

With respect to family, the research has revealed that there are still cases of severe neglect and physical abuse, along with little focus on education, lack of understanding, affection and support, and lack of suitable communication with adolescents. Of particular concern are the children and adolescents whose parents work abroad. Besides, research findings suggest that many parents can't keep up with the changes that have occurred during the country's transition to capitalism and democracy in terms of adolescents' values and behaviours and so they are unable to manage their relationships with them. It seems that this also applies to school teachers and the staff of child protection and assistance services. The relationship between school and families has weakened, particularly after primary grades, which makes adolescents more vulnerable to risky behaviours, especially under peer influence, while also leaving the adults in proximity environments more exposed. Yet not automatically leading to drop-out or early school leaving, factors like the learning environment in school, teaching style, lack of teachers' authority along with lack of suitable communication skills and sometimes biased treatment of pupils with learning difficulties (including Roma) may have such effects when associated with low motivation for learning, poor achievements and/or unsuitable influence from peer group or even family. The stigma that many classmates (sometimes teachers as well) place on pupils who are in public care and/or Roma pupils has also been referred to as a reason for dropping out. 80

Entourage, mainly peer groups but also adults with whom they spend their spare time or share a habit (e.g. substance abuse), has a bearing on adolescents. Due to their age-specific curiosity and propensity to experiment, along with the lack of mature judgement, sometimes adolescents can easily fall into the trap of alcohol and drug use, early sexual debut with associated risks (including trafficking), or illegal

conducts. This is amplified by the lack of affordable facilities for instructive/healthy leisure activities (even less so on school premises).	81
The temptation of the virtual space is another influencer of adolescents' behaviours, with severe consequences on the development of their social skills. Besides, e-commerce offers easy access to drugs, making protection measures prescribed by law ineffective. The temptations of the consumer society along with rather aggressive advertisements to tobacco and alcohol (sometimes also associated with sports competitions) are often difficult to resist for adolescents.	81
In general, adolescents show a satisfactory level of information concerning HIV. However, the quantitative research has revealed considerable uncertainty among adolescents, which raises serious doubts about their full understanding of HIV transmission ways. Lapses and uncertainties regarding knowledge of HIV and sexually transmitted diseases, as revealed by the quantitative research, give an indication of how adolescents are educated on these topics: very little and very vaguely by parents and often in unsuitable conditions in the school environment.....	81
Most adolescents have proper knowledge (information) about the risks of alcohol, tobacco, drugs and unsafe sex. Nonetheless, there is also a significant number of respondents whose knowledge (information) is uncertain.	81
Most of the adolescents subject to clinical interviews revealed some mindsets and beliefs about drug use before experimenting and during the initiation phase. Unhealthy behaviours almost always provided real and instant gratification while the likely onset of diseases or other harmful effects was seen as remote and improbable to them. Moreover, most of the interviewed adolescents (18) were unaware of the problems different drugs may cause or the risks of their behaviours; they focused on the short-term perspective and saw these problems and risks as remote and as not concerning them.	81
The survey has also revealed that adolescents' awareness of the risks associated with alcohol use, smoking, drug use and sexual behaviour is higher among adolescents aged 14 years and older. However, it should be noted that younger adolescents are less informed and less aware of these risks, especially with regard to sexual behaviour and drinking.	81
Disability appears to be one of the most important individual features influencing the behaviour of disabled adolescents in relation to peers, school and community. Besides, adolescents with disabilities shoulder the greatest impact of determinants as regards the enjoyment of child rights. They also share with many Roma adolescents and with adolescents brought up in child care centres the burden of feeling different, which often makes them withdraw from peer groups and drop out of school.	81
Low school involvement in preventing such behaviours was identified as a risk factor for drug use initiation, frequency and intensity. On the other hand, there is no evidence that a low degree of school involvement is a predictive factor for drug abuse. The interviewed adolescents revealed a total lack of interest in school and a major disregard of consequences like the lack of education, low chances of employment and many others when they started using drugs. Looking back, they declared that maybe continuing their education could have prevented their drug abuse.....	81
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Wide actions for social recognition and valorisation of adolescents are needed in order to improve the social perception of this age-group. The recognition and valorisation of adolescents should become priorities for the further national strategies and public policies developed at central level.	83
The central authorities should encourage and support the local ones to involve the adolescents in the community life.	83
The adolescents' multidimensional needs and vulnerabilities should be clearly identified and understood based on evidence's research with specific tools and techniques. In this purpose, periodical surveys on the adolescents' knowledge, attitudes and behaviours should be planned, financed and unfolded.	83
Further on, targeted actions for raising public awareness and parents' and caregivers' knowledge of the specific features and needs of this age group and of the ways to relate to adolescents are needed at national and local levels. The authorities (both central and local), the community's elites and the civil society should be mobilised for these actions.	83
Proper approach of vulnerable adolescents that gives due consideration to age specificity, type of vulnerability, specific needs and living context should be ensured. This could be achieved through combined interventions at national and community levels:	83
a. information and education campaigns aimed at combating discrimination and social stigma, and addressed to the general population, to specific communities / groups and families.	83
b. provision of continuous professional training for all the staff working with adolescents in health, education and social protection fields, and specifically for staff working with vulnerable adolescents.	83
c. wide partnerships developed al local level between school, local authorities, other community elites and the civil society sector and targeting to respond to adolescents needs.	83
The public opinion in relation to educational system needs to be improved, through policies and actions aimed to recognize the education as a fundamental social value and to increase the social visibility and public trust in school and school staff.	83
The public authorities (both central and local) should identify those legal responsibilities and stipulations regarding the adolescents rights that are not implemented, to plan feasible mechanisms, time frame and resources for their implementation.	84
The civil society sector could provide support in identifying the uncovered rights and in developing mechanisms for their implementation.	84
The partnership between authorities and the civil society is very necessary in order to use the latter's capacity to provide specific services in hard to reach groups.	84
The central authorities need to develop their institutional capacity in controlling the law's enforcing al all levels.	84
The civil society can assist or support the public bodies in identifying the cases when the law is broken (e.g. identifying cases of underage alcohol or tobacco selling, identifying inadequate or illegal advertising).	84
More coordination is necessary between different sectors at central and local level.	84
For the specific case of Health Education subject, it would be more than beneficial to include this topic in the basic curriculum for all grades. This would assure a coordinated manner to provide health education to all children (including adolescents).	84

New legislation need to be developed by the central authorities in order to properly address to the occurring threats and challenges of the society.	84
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Adolescents may be included mainly in youth and education policies, but also as a mainstream dimension in other policy areas, such as labour, family and social protection, health, transport, tourism, law enforcement, etc.....	84
Further assessment of weaknesses, effectiveness and efficiency of social, educational and health programs is needed, in order to understand their outcomes and added value and to define the further public policies based on evidence.	84
Some very important national strategies are under development during the study time. Given the key findings of this research, adolescence should be included as an area of intervention in the development of these upcoming strategies (National Strategy on the Protection and Promotion of Children's Rights 2014-2020, National health Strategy).	85
Special attention should be given to adolescence when developing the National Youth Strategy for 2014-2020 and national action plans since adolescence is a transition period from childhood to youth and investing in this age group might contribute to breaking the cycle of vulnerabilities. Special attention should be given to vulnerable populations and adolescents with fewer opportunities;	85
Speed up the approval of the HIV/AIDS strategy, reproductive health strategy and anti-drug strategy would be very useful in order to establish the further directions of action in these specific fields. Further investigation on the possibility to develop an alcohol and tobacco control strategy, with special focus on adolescents, is needed in the context of insufficient covering of these issues in the national anti-drug strategy.	85
Clear policies focusing on adolescents living in institutions, with long-term objectives and targeting specifically adolescents' social integration (including labour market aspects) should be defined at national level.....	85
Institutional cooperation at central, regional, county and local levels is a prerequisite for successfully approaching and addressing complex situations that affect adolescents' lives and for providing them with opportunities to achieve successful transition to adulthood.	86
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Moreover, adolescents should be given the chance to participate in programmes meant to empower them.	87
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Considering the scale and complexity of adolescents' needs for assistance and support as they came out from this research, the necessity to increase the availability and capacity of public authorities/services at local level is prominent.	87
In addition to increased availability of local services, the NGOs capacities could be better used through joint actions and resource mobilisation by private and public sectors.	87
Since television, Internet and many other habits and preferences for spare time activities have a significant impact on adolescents' mental and physical development, as well as on their attitudes and behaviours, education and youth policies should pay greater attention to providing more and better opportunities for leisure activities that develop social and communication skills, encourage community participation, improve the understanding and acceptance of differences, raise awareness of transition risks, and smooth adolescent transition to adulthood.	87
Special attention should be paid especially by the local authorities, school staff, and social and health workers from the community, for making the vulnerable families aware about the rights their children have and how those rights can be accessed. Those institutions and professionals could provide support to the disadvantaged parents and adolescents for making the formalities, fulfilling forms and really accessing their rights.....	88
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A solution should be found to ease access for deprived adolescents to educational and health services by covering associated costs (e.g. travel costs, proper wheelchairs, adequate clothes and footwear, supplies).	89
School buses and reimbursement of travel costs are already implemented as support measures, but their implementation needs improvement in term of coverage and assuring financial resources for school buses and in terms of more rapid reimbursement for travel costs.	89
The access to specialised medical services can be facilitated by the local community through providing transportation or subsidies for transportation.	89
In relation to access to education innovative solutions should be found to encourage continuation of schooling/participation in alternative educational schemes among vulnerable groups of adolescents such as dropouts, drug users, pregnant adolescents/underage mothers, human trafficking victims, and adolescents practising commercial sex. Also further research is needed to understand the social	

and economic reasons why adolescents aged 16-18 are neither in education or training nor on the labour market and to inform relevant child and youth policies.	91
As regard of social support and health services addressing to vulnerable groups, lack in continuity affects the beneficiaries trust in those services and consequently their willingness to access the services.....	91
On another hand, discontinuity in some programs (e.g stopping the needles exchange for a short period due to the lack of resources) induce high risks of spreading communicable diseases and ineffectively of the hole investment.....	91
Thus, the programs addresses to adolescents need to be implemented in a systematically manner, with avoiding gaps and discontinuities.	91
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Executive summary

Background:

In recent years, UNICEF Romania has focused on adolescents at risk of HIV infection, highlighting their increased risks compared with the adults and identifying the legislative, budgetary and coordination setbacks which hinder adolescents from realizing their rights to education, health, and protection. The currents study - ‘State of Adolescents in Romania’ (a determinants analysis) – was launched by UNICEF Romania with the intention to deepen the understanding of adolescents, in particular of vulnerable adolescents and to identify the barriers that hamper the realisation of their rights.

The study was carried out by the Centre for Urban and Regional Sociology, with scientific support from a team of experts at the Institute of Education Sciences.

Purpose/Objective:

The purpose of the analysis was to identify programmatic, structural, legislative, social and individual causes impeding the achievement of adolescents’ rights to education, health and protection, with the focus on the most vulnerable ones, in order to make recommendations on ways to address identified problems.

The specific objectives were:

- To evaluate adolescents’ knowledge on: targeted services, determinants influencing whether they access services, HIV, STDs, effects of drug, alcohol and tobacco use;
- To analyse legislation and existing policies; financial allotments and expenditure; management, coordination and partnership; availability, access and quality of public and private services targeting adolescents and vulnerable adolescents;
- To evaluate social and cultural norms which influence adolescents and vulnerable adolescents, including the causes of drug use initiation.

Methodology:

To accomplish the purpose of the study, the research team employed a mixture of methods:

- A quantitative, questionnaire-based survey on a nationally representative sample of 607 adolescents aged 10-18 years. In order to collect more information about vulnerable adolescents, the survey was conducted as well in two additional subgroups of 67 Roma adolescents and 59 adolescents using drugs
- Review of legislation, existing reports and databases.
- In-depth individual interviews with representatives of central, county and community level institutions and NGOs, etc.;
- In-depth interviews and focus groups with adolescents;
- Field visits and observation of existing services;
- Clinical interviews with adolescent drug users in order to identify the causes of drug use initiation (psychotherapists were involved in the process of collecting information – with respect to the existing connection between child trauma and drug use).

The sample used for the quantitative research had a maximum margin of error of +/- 3.9% at a 95% confidence interval and was selected in two stages, being stratified by development region and share of adolescents in each county was used.

The questionnaire was structured in the following sections: demographics; alcohol, tobacco and drug use; knowledge on HIV and Sexually Transmitted Diseases; knowledge on the risks associated with alcohol, tobacco and drug use; sexual behaviour; social capital; mass media and internet usage; social media usage and leisure activities.

The analysis was stratified by two age-groups (10 – 13 and 14-18 years), by gender and by residence areas (urban/rural).

The tools for the qualitative research were designed based on the determinants framework provided by UNICEF Romania that uses the following clustering of the determinants:

- a. “Enabling environment” - including social norms, legislation/policy, budget/expenditure and management/coordination;
- b. “Supply” - including availability of essential commodities/inputs and access to adequately staffed services, facilities and information);
- c. “Demand” - including financial access, social and cultural practices and beliefs, and timing and continuity of use);
- d. “Quality” of care – including adherence to required quality standards as defined by national or international norms). Nevertheless, these determinants are more or less structural since they mostly relate to legal and institutional settings. Therefore, determinants that act at proximity and individual levels and influence adolescents’ behaviours – including the onset of drug use – will be dealt with in the analysis on social and cultural practices and separately in a different chapter on adolescents who use drugs.

As a general rule, in-depth interviews were conducted face-to-face at the interviewee’s place of residence and were audio recorded. In some cases, vulnerable adolescents and their parents were interviewed at the care centres, at the NGOs’ points of service delivery or in schools, according to each case, giving due consideration to privacy and confidentiality requirements.

The qualitative research was conducted in Bucharest and 7 counties: Braşov, Cluj, Constanţa, Dolj, Giurgiu, Iaşi, and Timişoara.

Study limitations

The main limitation of the quantitative component refers to the possibility of generalising some of its findings and conclusions, regarding vulnerable adolescents (Roma and drugs users), because a mixed method was used for their selection.

Also the qualitative research was conducted only in Bucharest City and in seven counties. Beside this, the study captured the opinion of local authorities only to a small extent, because the key institutions targeted for conducting the interviews with experts were located in the county level and little room was left for interviewing local stakeholders.

Scarce availability of some data from public sources limited the analysis, mainly as regards vulnerable groups of adolescents such as drug users, commercial sex workers, human trafficking victims, pregnant adolescents, and teenage mothers.

Other limitations came from the fact that our investigation was run over a short period of time (February – May 2013) and from difficulties in contacting relevant experts and/or groups of adolescents.

Besides, due to ethical but also legal considerations, the parents/legal guardians' consent was obtained prior to interviewing underage people, which might have somewhat altered the reliability of the answers received.

Ethical considerations

The 'child's best interest' as stipulated in the Convention on the Rights of the Child has been the paramount principle in this research: respect for the participants; confidentiality asking for the consent of both adolescents and their parents or legal guardians prior to the interviews.

Before starting any fieldwork, CURS obtained approval from the Ethics Committee at the Institute of Education Sciences (Bucharest, Romania). The ethical standards of ESOMAR/WAPOR were strictly followed in the qualitative research.

Key findings and conclusions on adolescents' risky behaviours

According to national statistics¹, the number of adolescents living in Romania as of July 1, 2011 amounted to 2,012,709, representing 9.43% of the overall population. Of these, 939,538 (46.68%) resided in urban areas and 1,073,171 (53.32%) lived in rural areas. Their make-up by gender was 51.22% male and 48.78% female. Most of Romanian adolescents were enrolled in education (87.36%). As for the rest of 12.63%, statistics don't provide much clarity, further research being necessary.

Participation in education and in the labour market

In our study 93.7% of respondents declared they were attending school, with similar proportions by age-groups (94% in 10 -13 years, compared to 93.6% in 14 – 18 years), but increased proportion in girls (95.0% versus 92.3% in boys) and in urban areas (96% compared to 91.6% in rural).

Very few respondents declared they were working (1%) at the time of the survey, suggesting that the topic of adolescents who are neither in education, nor on the labour market needs to be further explored.

Alcohol consumption

42% of adolescents drank an alcoholic beverage at least once during their lifetime. Having drunk alcohol at least once is more common among older adolescents (more than half having drunk alcohol, compared to 21% of those under 14-year-olds), in boys (57% compared to 27% of girls) and in urban areas (half, compared to 32% in rural). Type and volume of alcohol need further investigation.

Smoking

¹ NIS, TEMPO-Online, <https://statistici.INSSE.ro/shop/>

A quarter (23%) of adolescents smoked at least one cigarette in their lifetime, the proportion being, of course, higher in older adolescents (33% vs. 6% in the younger group), in boys (32% compared to 16% in girls) and in urban areas (28%, compared to 19% in rural).

Drug use

3.8% of all adolescents have already used some kind of drugs, but in adolescents over 14 years old, the percentage goes up to 5.4%.

Sexual behavior

15% of adolescents declared they were sexually active (23% of boys and 11% of girls; 20% in urban areas and 14% in rural ones). By age-groups, one quarter of adolescents over 14 and under 1% of those younger than 14 declared they are sexually active. On average, adolescents had their first sexual relation at the age of 15.5. None of the interviewed adolescents had experienced motherhood/fatherhood at the time of research. At the time of research, sexually active adolescents had had 2.3 partners on average and 68% of them had a steady partner. Only 47% of the adolescents which are sexually active and have a steady sex partner declared they had always used a condom with their steady sex partner in the past month and most of them use it to prevent pregnancy (63%, compared to 19% that used condoms to protect themselves from STDs). 4 in 10 sexually active adolescents said they had had sex with a casual partner in the past 12 months and only 60% of them had used a condom each time

These findings underline a huge need for sexual education, with focus on STDs and on importance of condom use for protection against STDs.

Awareness and knowledge of HIV and other Sexually Transmitted Diseases and effects of drug, alcohol and tobacco use

In general, adolescents have satisfactory information about HIV, but many answered DK/NA registered at some of the questions, might raise some doubts as to adolescents' accurate and full understanding of HIV and its particularities, especially when transmission and protection were brought into discussion.

The risks that HIV poses are better known by older adolescents and by those living in urban areas, but much poorly known by the younger adolescents and by those living in rural. This level of awareness does not differ significantly between boys and girls. Most adolescents had accurate knowledge (information) about the risks of alcohol, tobacco, drugs and unsafe sex, but the younger adolescents are the less informed and less aware of these risks (especially with regard to sexual behaviour and drinking). Only slight differences were found by gender and between urban and rural adolescents.

Social capital

Most adolescents turn to their parents/grandparents for help. They also rely on teachers and friends/colleagues, but other social capital 'actors' in adolescents' lives, such as neighbours, emergency or child helplines, are hardly ever used. The persons to whom adolescents turn when they look for support vary to some extent according to age group and more to the type of issue involved (the younger adolescents confide in their parents and teachers and the older turn usually to their friends). Nearly 9 in 10 adolescents, regardless of their age, rely on their parents when it comes to health-related problems.

Mass media and Internet usage

96% of adolescents watch TV every day and that 50% of them spend over 3 hours a day doing this activity instead of others such as socializing, learning, playing sports, games, etc.

Half of adolescents don't listen to the radio.

88% of adolescents use the Internet, most of them at home (92%), followed by mobile internet (31%) and school (21%). The internet usage is more common in older age-group, in boys (8% of boys versus 15% of girls do not use internet) and in urban areas (only 5% of urban adolescents and 18% of rural teenagers do not use the Internet). The average daily Internet usage was 3.37 hours.

Adolescents make extensive use of some social networks, only 16% of them declaring they are not users. Over 50% of adolescents used those networks for keeping in touch with other individuals and for sending messages to other people, but very few adolescents logged on to social networks to find out about drugs, cigarettes and alcohol (1%). More girls than boys use social networks to get informed and more boys than girls to socialise. However, social media information is not perceived as very reliable, more than half of adolescents either “trust to a certain extent” or “don’t trust at all” the information they find on social networks. Most of the interviewed adolescents did not participate in a debate/discussion about adolescents/youth problems on social networks.

Key findings and conclusions on determinants analysis. Main recommendations

A. Social norms

Despite the opinion of most interviewed adults (experts, parents) that adolescents are a resource rather than a problem for our society, adolescence is an age that is diffusely perceived at societal level. Often, adolescents’ social identity is highly uncertain, leaving their real needs unaddressed. There have been voices saying that public opinion is rather negative, especially towards street children, sex workers and drug addicts, holding them responsible for their conduct. The discrimination that Roma adolescents claim they have experienced in their interaction with teachers and peers have a major influence on how they build their relationship with school, self-segregation being often perceived as a solution to discrimination.

Adolescents with disabilities are pushed to the margins of the education system by the discriminatory attitudes of their peers and parents and by teachers’ unpreparedness to handle the special educational needs of these adolescents, lack of support teachers and school counsellors, and poor accessibility. Wide actions for social recognition and valorisation of adolescents are needed in order to improve the social perception of this age-group, with focus on vulnerable groups. The recognition and valorisation of adolescents should become priorities for the further national strategies and public policies developed at central level. The adolescents multidimensional needs and vulnerabilities should be clearly identified and understood based on evidence’s research with specific tools and techniques.

The central authorities should encourage and support the local ones to involve the adolescents in the community life.

B. Legislation/Policy

The Romanian legislative framework is generally well-developed as regards education and access to quality education, child rights protection, social assistance for vulnerable/disadvantaged groups and healthcare services, but quite inadequate when it comes to laying down relevant obligations so as to ensure that intended beneficiaries have access to and enjoy these rights. Major weaknesses exist in setting and/or implementing appropriate sanctions, this resulting in somewhat ineffective laws and leaving room for risky behaviours (e.g. selling alcohol and tobacco to the underage, access to drugs, smoking in public places etc.) and in limited access to rights for some vulnerable groups.

Legislation is still underdeveloped in some fields (inclusive education for children with disabilities, special protection and assistance for children with parents working abroad, special protection for human trafficking victims and drug users’ fair opportunities for educational advancement to adolescents in the child care system and from poor families and/or poor rural/remote areas). Weaknesses are also seen in coordination between different sectors or authorities in implementing the legislative provisions or in defining, approving and implementing some sectoral strategies.

In some cases, legislation needs to be improved constantly in order to control the new challenges or threats occurring in the society in the globalization context (E.g. Increased availability and accessibility of legal and illegal drugs the number and availability of points of sale, effective means of promotion and distribution, the price, etc. have contributed to the growing risk of drug use).

The public authorities (both central and local) should identify those legal responsibilities and stipulations regarding the adolescents' rights that are not implemented to plan feasible mechanisms, time frame and resources for their implementation. The civil society sector could provide support in identifying the uncovered rights and in developing mechanisms for their implementation. The partnership between authorities and the civil society is very necessary in order to valorise the latter's capacity to provide specific services in hard to reach groups.

C. Budget/Expenditure

Public budgets have proved to be highly insufficient in Romania to fully cover adolescents' needs for protection and assistance/support to fairly benefit from their prescribed rights. On the other hand, the EU funds aimed at supporting Romania's integration have not had a noticeable impact on the improvement of services addressed to vulnerable adolescents, especially in terms of proximity influencers. This deficit used to be compensated to a certain extent by the NGOs specialising in youth work and financed by international donors, but following Romania's accession to the EU, most of the international donors have cut down or cancelled their financial support for direct interventions.

Even though some NGOs are very experienced and proactive in reaching out to vulnerable adolescents than most public services, they have few opportunities to access public funding and the consultations on policy making between public authorities and NGOs seem to be mostly formal.

- Public (human and financial) resources devoted to social assistance and protection are mostly concentrated at central and county levels, while the needs that these resources are aimed to address are found at local level.
- Sufficient public financing should be allocated in order to respond to adolescents' needs, unmet needs having a detrimental impact on the adolescent, but also on the society. Public resources should be distributed and social services should be provided following the real existing needs.
- A better priorities' setting regarding the use of the next coming EU funds and new and more flexible mechanism should be prepared by the public authorities, with real public consultation of all the relevant stakeholders at national and local level, including the dedicated NGOs..

Management/Coordination

Aside from (but related to) insufficient/ineffective legislation, the research has revealed a deficit of mechanisms for coordination between relevant stakeholders on multiple axes (between different central authorities, between county and local authorities, between public institutions and NGOs). Deficient coordination between local and county institutions is also a cause of frequently inefficient responses to adolescent and family needs.. A major deficiency in institutional cooperation in the field of child protection was found at local level, where local advisory bodies are not functional or do not exist. Also an insufficient capacity to address vulnerable adolescents' problems both in terms of diagnosis and adequacy of interventions was pointed out at local level in all the sectors (social protection, health, education)

Institutional cooperation at central, regional, county and local levels is a prerequisite for successfully approaching and addressing complex situations that affect adolescents' lives. Thus, coordination mechanisms for joint and harmonised interventions implemented by governmental and nongovernmental organisations should be established at least by secondary legislation while also including measures to ensure their effectiveness.

The development of the local capacity to address the adolescents vulnerabilities remain the biggest challenge in the context of economic crisis and of national policy to limit the budgetary work places; alternative mechanisms have to be identified and developed among which the cooperation with NGOs (where possible) and the voluntary programs.

D. Availability of essential commodities/inputs

- There are gaps in coverage of adolescents with basic social, educational and health services, especially in rural and deprived areas. NGOs show good potential for qualified and effective interventions meant to address the difficulties faced by adolescents, being able to support the public services but their availability at local level is also scarce.

Many of the proximity social services, acting in the living environment of vulnerable groups, are less developed and inefficient in disadvantaged communities. Services that our respondents have mentioned to be rare or inexistent although much needed are parent education/counselling, day care (after-school programme), sheltered workshops providing jobs to vulnerable adolescents, suitable counselling for adolescents, multi-purpose centres for non-formal education and leisure activities, programmes aiming at health education and education for independent living. Proximity services for at-risk adolescents, provided mostly by NGOs and aiming at harm reduction, have been most frequently named as existing but insufficient services.

A special case is that of children whose parents work abroad and for whom suitable services haven't even been designed yet.

Youth centre services are scarce in Romania despite the great need for such facilities.

Considering the scale and complexity of adolescents' needs for assistance and support, as they came out from this research, the necessity to increase the availability and capacity of public authorities/services at local level is prominent. In addition to increased availability of local public services, the NGOs capacities could be better used through joint actions.

E. Access to adequately staffed services, facilities and information

With regard to adequately staffed and resourced services available to adolescents, research findings suggest that public service providers are faced mostly with quantitative issues rather than qualitative ones. In the public sector, staff working with vulnerable groups is considered insufficient and chronically unmotivated from a financial standpoint. Things are even worse in rural areas where human resources involved in prevention services lack appropriate professional training. In the case of NGOs, for which high-quality workforce and logistics are usual standards, the problem lies in their financial flows that are unreliable due to either short-term programme funding schemes or lack of support from public bodies responsible for the respective areas of intervention (at least as regards continuity of services), or by both.

Information and counselling services for parents are also lacking. This seems to be a major gap as many parents do not know how to approach teenagers in general and in particular how to discourage alcohol, tobacco and drug use or drop-out. This is also a problem for parents of adolescents with disabilities.

Bureaucratic barriers do exist in adolescents' access to the basic services (e.g. missing ID paper or missing of the parent consent) and a legal procedure needs to be developed in order to allow access of adolescents without ID papers to those basic services.

There is a lack of information concerning the right of adolescents and their families to access different services, most common in disadvantaged communities. In this regard, special attention should be paid especially by the local authorities, school staff, and social and health workers from the community, for making the vulnerable families aware about the rights their children have and how those rights can be accessed. Those institutions and professionals could provide support to the disadvantaged parents and adolescents for making the formalities, fulfilling forms and really accessing their rights.

The insufficiency of the public services staff can be addressed either by new employments or by outsourcing some services to qualified providers (e.g. NGOs). Further efforts are needed for providing lifelong learning alternatives for the existing professionals.

F. Financial access

Socio-economic factors are most frequently invoked as reasons for non-participation or school drop-out, but these factors are associated with disadvantaged communities and adolescents from poor Roma families are therefore most at risk of non-participation in education.

In many cases, accessing services requires travelling to their location and transportation costs have been mentioned as potential barriers for disadvantaged adolescents.

For adolescents in rural areas, access to specialised medical services is difficult; often, the nearest medical centre is many miles away. The dissolution of school dental care units has created an access problem especially for financially challenged teenagers.

Covering the associated costs to educational and health services by (e.g. travel costs, proper wheelchairs, adequate clothes and footwear, supplies). Could be a reliable solution to ease access to the basic services for deprived adolescents

G. Social and cultural practices and beliefs

Social and cultural practices, as well as social norms, mentalities and associated beliefs also play a significant role in adolescents' accessing available services.

Adolescents' awareness of the services that are available for them and propensity to use these services vary significantly depending on service type and coverage, as well as on the area of residence and the community of origin, the adolescents from urban areas being generally more aware about the existing services, even though their knowledge is vague and stereotypical,

In the case of traditional Roma communities, the low level of educational aspirations, parents' lack of interest and information, along with a traditional culture that sets a very low age limit up to which children (especially girls) must attend school often result in a high drop-out rate among Roma adolescents.

Adolescents are reluctant to accessing services offered by public bodies due to the rigid official environment, excessive bureaucracy, long paperwork and associated costs, lack of confidentiality, parental presence required in certain cases, etc.

The relationship between school and families has weakened, particularly after primary grades, which makes adolescents more vulnerable to risky behaviours, especially under peer influence, while also leaving the adults in proximity environments more exposed.

All the professionals working with adolescents from social protection, health or educations facilities should be trained to recognize and to consider the social and cultural practices and believes.

Specifically for the Roma communities, the professionals should be trained to understand their particular beliefs and practices. Also the interventions should be unfolded with the support of the community leaders.

H. Timing and continuity of use

As a general matter, we can say that the kind of relationship that the service provider and the beneficiary develop is very important for adolescents in continuing to access available services. This is especially important for drug users/addicts, sex workers and human trafficking victims, who are in great need of harm reduction services but are very reluctant to seeking public services and also suspicious with regard to NGOs' social workers until a trustful relationship is built.

The fact that public welfare services are not delivered where they are most needed and that working methods are not tailored to the profile of intended beneficiary adolescents lead to both restricted access to and ineffectiveness of such services.

In some areas of intervention such as HIV/AIDS, recovery of drug addicts in specialised centres and institutionalised child care, our interviews showed that monitoring mechanisms were in place and continued access to services was ensured in most cases. On the other hand, as far as prevention measures are concerned, things looked different. Besides insufficiently available prevention services, it was revealed that continued use was not only a matter of beneficiaries' choice but also a matter of service provision continuity since in many cases such services were provided (mostly) by NGOs and local public authorities within the limits of available funding and/or the lifespan of relevant projects.

I. Quality of care

As far as implementing quality standards goes, one can say that, generally, public and private providers of educational, medical and social services work either according to legal standards (accredited providers) or according to internally developed procedures, protocols, methodologies of work (especially NGOs). The fulfilment of quality standards in service delivery is monitored both externally and internally, with NGOs feeling a higher pressure when being monitored by the state. Scarce resources and unskilled staff seem to be the main reasons for which quality standards are not implemented.

Chapter 1

Research objectives, design and implementation

1. Context and aim

In recent years, UNICEF Romania has focused on adolescents at risk of HIV infection: drug users, adolescents engaging in commercial sex, and men who have sex with men. Research conducted among MARA (most-at-risk adolescents) has highlighted increased risks of HIV infection compared with the adults from the same group while identifying other legislative, budgetary and coordination setbacks which hinder adolescents from achieving their rights to education, health, and protection.

On the basis of data available with regard to adolescents and of those collected through research carried out in the area of HIV and drug use, UNICEF Romania intends to deepen the understanding of adolescents, in particular of vulnerable adolescents, by conducting a relevant study with the purpose of identifying barriers that hamper the realisation of their rights.

The aim of conducting the current analysis is to identify programmatic, structural, legislative, social and individual causes impeding the achievement of adolescents' rights to education, health and protection, with the focus on the most vulnerable ones, in order to make recommendations on ways to address identified problems.

2. Research objectives

Implemented in the timeframe January to June 2013, the research aimed in particular:

- a. To analyse legislation and existing policies; financial allotments and expenditure; management, coordination and partnership; availability, access and quality of public and private services targeting adolescents and vulnerable adolescents in order to identify:
 - ✓ Difficulties for adolescents, including vulnerable ones, in realising their rights to education, health, and protection;
 - ✓ Existing data gaps in addressing adolescents and vulnerable adolescents;
 - ✓ Lessons learnt and good practices in addressing adolescents and vulnerable adolescents;
 - ✓ Recommendations formulated to address identified difficulties.
- b. To evaluate adolescents' knowledge on:
 - ✓ Targeted services, determinants influencing whether they access services;
 - ✓ HIV, STDs, effects of drug, alcohol and tobacco use;
- c. To evaluate social and cultural norms which influence adolescents and vulnerable adolescents, including the causes of drug use initiation.

3. Research methodology

In order to achieve research objectives, a mixture of methods was employed:

1. A quantitative questionnaire-based study on a nationally representative sample of 607 adolescents, aged 10-18 years. In order to collect more information about vulnerable adolescents, the questionnaire-based survey was conducted as well in two additional subgroups of Roma adolescents and adolescents using drugs.

Fig. 1 Sample structure (age, gender and residence)

	% sample	NIS estimation (July 1 st , 2010)
Gender		
Boys	47.1%	51%
Girls	52.9%	49%
Age		
10-13 years	45.6%	49%
14-17 years	54.4%	51%
Residence		
Urban	49.1%	47%
Rural	50.9%	53%

The quantitative research was carried out on girls and boys from whole population, having a maximum margin of error of +/- 3.9% at a 95% confidence interval. The two-stage probability sample was stratified by development region and share of adolescents in each county. Households and respondents were randomly selected, with all respondents being aged between 10 and 18 years. With a view to staying within child age limits as officially defined, the upper age limit was set to 18 minus one day. Sample locations were randomly selected across the county while the random starting point for the selection of households was a local school. In order to better capture the voice of vulnerable adolescents, 59 adolescent drug users (19 girls and 40 boys) and 67 Roma adolescents (37 girls and 30 boys) were interviewed. The analysis of these two groups should be viewed as significant for the investigated population. Roma adolescents were randomly selected at national level, while adolescent drug users were selected with support from NGOs active in the field. When selecting adolescent drug users for interviews, we took into account their concentration (mostly in big cities) and availability of specific organisations active in the field – some of which were UNICEF partners that CURS could work with to conduct the interviews. Thus, the survey targeting drug users focused on the city of Bucharest.

The questionnaire was structured as follows: demographics; alcohol, tobacco and drug use; knowledge about HIV and other Sexually Transmitted Diseases; knowledge about risks associated with alcohol, tobacco and drug use; sexual behaviour; social capital; mass media usage; internet usage; social media usage and leisure activities.

2. Review of legislation, existing reports and databases at national and European levels. A full list of reviewed documents is included in the annexes;

3. In-depth interviews² (60) with:

- a. representatives of public institutions/services at central, county and local levels;
- b. representatives of NGOs at various levels;
- c. vulnerable adolescents;
- d. parents of vulnerable adolescents;

4. Clinical interviews with adolescent drug users (20) in Bucharest;

5. Focus groups (11) with adolescents and vulnerable adolescents;

6. Field visits and observation of existing services³;

Research tools (in-depth interview guides and focus group guides) were designed based on the determinants framework provided by UNICEF⁴.

² See Annex with interviewed institutions and NGOs

³ See Annex with observed services

⁴ See annexes

As a general rule, in-depth interviews were conducted face-to-face at the interviewee's place of residence and were audio recorded. However, in some cases, vulnerable adolescents (namely adolescents with disabilities, institutionalised adolescents, drug addicts, school dropouts, human trafficking victims and sex workers) and their parents were interviewed at the care centres, at the NGOs' points of service delivery or in schools, according to each case, giving due consideration to privacy and confidentiality requirements. Institutions and NGOs were directly contacted by UNICEF Romania and IES via letters explaining the purpose of the research and asking for support. Vulnerable adolescents were recruited for interviews with the support of either NGOs or educational/child care institutions, based on selection criteria provided by the research team.

Clinical interviews with adolescent drug users were conducted by psychotherapists and the interview guide was so designed as to identify the causes of drug use initiation and the existing connection between child trauma and drug use.

For the observation of existing services (child care, information and counselling, youth services), the observation guide included items like: location and accessibility; availability of necessary commodities; atmosphere; staffing, including gender aspects; types of beneficiaries, including gender aspects; relationship between staff and beneficiaries and among beneficiaries; opportunities for gender-specific initiatives; relationship with beneficiaries' families; relationship with the community; beneficiaries' participation in the functioning of the service; and opportunities for non-formal education.

The qualitative research was conducted in Bucharest and 7 counties: Braşov, Cluj, Constanţa, Dolj, Giurgiu, Iaşi, and Timişoara.

The conclusions and recommendations of this study are based on the data and information collected throughout the research process.

4. Approach of determinants analysis

Determinants analysis is a rather recent approach in social research and policy reviews, so we cannot speak about a generally/largely agreed definition of concepts yet. For the purpose of this study, we shall embrace the definition of social determinants as proposed by the WHO Commission on Social Determinants of Health, namely "the conditions in which people are born, grow, live, work and age"⁵. Developed for analysing health, this definition is comprehensive enough to apply to adolescents' condition and behaviours as well. The authors distinguish two main categories of social determinants⁶: **structural determinants** - fundamental structures of the nation state that generate social stratification, such as national wealth, income inequality, educational status, sexual or gender norms, or ethnic group; and **proximal or intermediate determinants** - the circumstances of daily life, from the quality of family environment and peer relationships, through availability of food, housing, and recreation, to access to education. They also point out that proximal determinants are generated by the social stratification resulting from structural determinants, as well as by cultural, religious, and community factors. In addition, they state that proximal determinants also establish individual differences in exposure and vulnerability to factors that compromise health.

While not denying the influence of such proximal determinants on individual exposure and vulnerability to risk factors, as regards the last statement above we have to emphasise that young

⁵ Russell M Viner, Elizabeth M Ozer, Simon Denny, Michael Marmot, Michael Resnick, Adesegun Fatusi, Candace Curri, "Adolescence and the social determinants of health", in *The Lancet*, Vol 379 April 28, 2012, p. 1641) Available at: <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673612601494.pdf?id=3d35b1b5aa0ec416:58d1b5c9:13be60db275:-3781356778794886> [last accessed on May 24, 2013]

⁶ Ibid., p. 1642

people's actions and behaviours are not mechanical reactions to such determinants, but rather the result of negotiated choices with both individual needs and interests and structural constraints. Therefore, we shall opt for the structure-agency approach embraced by several international youth research studies⁷, which argue that individual actions and behaviours are in most cases the results of an interplay between structural constraints (institutional settings and rules) and individual agency, "regarded as the principle ability of human beings to make choices, to take decisions and to act in an autonomous way."⁸ According to this approach, "agency implies neither the autonomous actor isolated from social influence nor complete freedom of choice but instead implies choice that is restricted by the constraints of social inequalities and differentiations, such as gender, age, social belonging, ethnicity, etc."⁹

Although exploring this "black box" – where structural and proximity choice constraints are being confronted with personal interests and needs, as well as with the subjective assessment of one's own potential to reach the set targets – is beyond the scope of our research, this approach is important for our study because it requires due consideration of individual features as well while discussing the role of social determinants in setting choice constraints and shaping pathways for adolescents to achieve their rights. It is also important when approaching vulnerable adolescents since vulnerability is often associated not only with structural and/or proximity determinants, but also with individual features (which are, to a relevant extent, social constructs as well).

A recent report produced by EACEA¹⁰ approaches in similar terms the determinants of social exclusion, which are highly relevant for our study. Drawing on a UNDP report¹¹, the authors argue that: "On one hand, the aspects of social exclusion describe the social, political, and economic deprivation suffered by marginalised individuals. This deprivation can be read in terms of an imposed inability to enjoy fundamental human rights, such as the right to education, the right to work and to a fair remuneration, the right to health and wellbeing, and the right to vote and to stand for elections", and "on the other hand, the determinants of social exclusion illustrate the confluent economic and social processes, the cumulative effect of which leads to experiencing marginalisation."¹²

When developing interview and focus group guides for the purpose of this study and compiling the information and data collected through our research for this report, we have considered the **determinants framework provided by UNICEF Romania, which does not conflict with our approach as described above, but only uses a different clustering of these determinants**, namely: "Enabling environment" (including social norms, legislation/policy, budget/expenditure and management/coordination); "Supply" (including availability of essential commodities/inputs and access to adequately staffed services, facilities and information); "Demand" (including financial access, social and cultural practices and beliefs, and timing and continuity of use); and "Quality" of care (adherence to required quality standards as defined by national or international norms). Nevertheless, these determinants are more or less structural since they mostly relate to legal and

⁷ E.g. Youth Policy and Participation. Potentials of participation and informal learning in young people's transitions to the labour market. A comparative analysis in ten European regions (YOYO), 2004; Thematic Study on Policy Measures concerning Disadvantaged Youth, 2005; Youth – Actor of Social Change (UP2YOUTH), 2009 (all available at <http://www.egris.eu/projects.html>)

⁸ Walther, Andreas; Stauber, Barbara; Pohl, Axel (2009): UP2YOUTH. Youth – Actor of Social Change. Final report. Tübingen, IRIS, p. 65. Available at http://www.up2youth.org/downloads/task%2cdoc_download/gid%2c113/index.html [last accessed on May 25, 2013]

⁹ Id.

¹⁰ Delhaxhe, A (Managing Editor), Paolini, G (Author), "Youth Social Exclusion and Lessons from Youth Work. Evidence from literature and surveys", Report produced by the Education, Audiovisual and Culture Executive Agency (EACEA), available at: <http://youth-partnership-eu.coe.int/youth-partnership/news/attachments/eurydice-study-social-exclusion-2013.pdf> [last accessed on May 27, 2013]

¹¹ United Nations Development Programme (UNDP), 2007. *Summary of the virtual round table on social exclusion*. [pdf] Available at: <http://hdr.undp.org/en/nhdr/networks/replies/161.pdf> [Accessed on 11 March 2013], apud Ibid. p. 5

¹² Id.

institutional settings. Therefore, determinants that act at proximity and individual levels and influence adolescents' behaviours – including the onset of drug use – will be dealt with in the analysis on social and cultural practices and separately in a different chapter on adolescents who use drugs.

The qualitative research carried out for the purpose of this study, in particular focus groups with adolescents and in-depth interviews with key stakeholders, has brought out a wide range of factors that mark adolescents' condition, their behaviours, strategies and pathways towards achieving the desired social status and their rights, including coping strategies regarding risk factors and social constraints. However, since several aspects relating to the determinants framework referred to above have been already analysed in previous studies commissioned by UNICEF and/or carried out by their partner organisations, we will present these determinants looking only at the aspects that are most relevant to the purpose of this study.

5. Determinants analysis limitations

The main limitation of the quantitative component refers to the possibility of generalising some of its findings and conclusions, regarding vulnerable adolescents (Roma and drugs users). The results are not representative for the subgroups analysed and must not be reflected as representative for the populations investigated. This is so because we have employed a mixed method for selecting the respondents. To draw the Roma respondents from the overall population of adolescents, we have employed a stratified random probability sampling method. The sampling and stratification scheme for this group was designed based on the latest official statistics regarding the population structure of the country. In the case of adolescents using drugs, we employed a non-random sampling method. For instance, with the help of key informants we visited the places where adolescent drug users were known to congregate. In other cases, we relied on the support provided by various NGOs to contact and interview adolescents using drugs. Resorting to a non-random sampling method was the only option because nationwide sampling frames were unavailable in the case of vulnerable adolescents.

In spite of having conducted a large number of in-depth interviews and focus groups, budgetary and time constraints made it impossible to cover the whole country and only Bucharest City and seven counties were eventually selected for the qualitative research. Since the key institutions targeted for conducting the interviews with experts were located in the county seat of the selected counties, little room was left for interviewing local stakeholders, which means that our findings captured the opinion of local authorities only to a small extent.

Also, availability of data from public sources further limited our analysis, mainly as regards vulnerable groups of adolescents such as drug users, commercial sex workers, human trafficking victims, pregnant adolescents, and teenage mothers. Besides, the latest issue of the Statistical Yearbook contains data for the year 2009, while the online database made available by the National Institute of Statistics (Tempo-online) offers some data up to the year 2011. Since our sample survey was carried out among adolescents in the spring of 2013, caution should be taken when comparing our quantitative findings with data from public statistics.

Other limitations came from the fact that our investigation was run over a short period of time (between February and May) and from difficulties in contacting relevant experts and/or groups of adolescents. Besides, due to ethical but also legal considerations, we had to get parents/legal guardians' consent prior to interviewing underage people, which might have somewhat altered the reliability of the answers received. In order to minimise this risk, the quantitative survey questionnaire included a separate section with questions about alcohol, tobacco and drug use and sex life which respondents could fill in themselves.

Surveying adolescents in their households (in the presence of their parents/guardians) might have affected their openness and honesty, especially about sex, smoking, drinking, and drug use. Likewise, it is possible that the fact that vulnerable adolescents were primarily reached through NGOs and in

some cases through school teachers and/or school mediators affected the levels of knowledge and behaviours/practices of these adolescents (e.g. HIV testing among vulnerable adolescents could be due to the fact that those reached have regular contact with NGOs).

6. Participation of UNICEF in the research

From the very beginning of the research process, UNICEF team provided support to identify relevant documentary sources and design research tools, as well as feedback on the proposed methodological approach. Throughout the research work, the research team stayed in contact with officials appointed by UNICEF who made suggestions regarding the development of certain research stages, facilitated contacts with institutions and organisations and were even involved in the field research at certain times. Later on, the draft report was submitted for analysis to the UNICEF team, which provided feedback and guidance for the final research report.

7. Ethical considerations

The ‘child’s best interest’ as stipulated in the Convention on the Rights of the Child has been the paramount principle in our research on adolescents and vulnerable adolescents: respect for the participants; asking for the consent of both adolescents and their parents or legal guardians prior to conducting the interviews; every participant was assured that their personal data and image would remain fully confidential and their identity would be protected; interviewers and focus group moderators explained to all interviewees the role they had in the research and pointed out how important their contribution was to the success of our undertaking.

Before interviewing adolescents, we obtained approval from their parents or legal guardians. To select interviewees from among vulnerable adolescents who were living in specialised institutions, we got the approval of the persons in charge of such institutions. In all cases, aside from the permission given by parents and other legal guardians, we also received the informed consent of adolescents themselves prior to interviewing them.

Adolescents participating in the interviews were informed that discussions would be audio recorded and they were asked for their consent.

Due to the sensitive nature of some of the topics in our questionnaires (e.g. underage alcohol use, smoking, drug use, sexual behaviours), we assured our adolescent respondents that their answers would remain fully confidential and anonymous.

Above all, before starting any fieldwork, CURS obtained approval from the Ethics Committee at the Institute of Education Sciences (Bucharest, Romania). Also, we strictly observed the ethical standards of ESOMAR/WAPOR guide to opinion polls.

Chapter 2

Adolescents in Romania

Adolescence lacks an official definition in both international treaties and Romanian legislation. Public policies usually refer to either children or youth, but sometimes children and youth are jointly addressed (e.g. The Netherlands). The consequence of this policy approach is that responsible (inter)governmental agencies have been in most cases so designed as to focus on either child or youth policies. Social research that aims to inform public policies, largely dependent upon public funding, has followed the same pattern; hence, we have excellent studies on children and outstanding studies on youth, but little research evidence to inform child and youth policies, except for maybe on transition to adulthood and education.

Things are quite different when it comes to vulnerable adolescents; not because adolescents have been better targeted by research and policy reports, but because vulnerability has been extensively analysed, especially in the past 15 years, for both scientific and political purposes. A report commissioned by the Youth Directorate at the Council of Europe¹³ looked into the vulnerability of young people. The authors proposed two definitions for vulnerability: a more sociological one as “the scarce response capacity of certain persons and groups inside society to confront, adapt or cope with specific economic, social, cultural and political challenges to which they are permanently exposed”¹⁴ and a more policy-adapted one as “severely restricted opportunities for secure employment, social and economic advancement and personal fulfilment”¹⁵. The second definition actually refers to disadvantage – which is a result of vulnerability, among other things – rather than to vulnerability itself. From a socio-economic perspective, the disadvantage ranges in-between vulnerability and structural constraints while also bearing the influence of the daily life context. This approach is backed by a reference study commissioned by the European Commission – DG Employment and Social Affairs and carried out by an international team of experts: “What does ‘disadvantage’ mean in terms of youth transitions? One may refer to young people as disadvantaged if the central prerequisites for a standard biographical transition process – following the perspective of structure and agency – are lacking. (...) The relationship between the two may be summarised as a lack of accessibility, manageability and relevance of education, training and employment opportunities.”¹⁶

The Romanian law on social assistance/welfare defines vulnerable groups as “persons or families who run the risk of losing the capacity to meet their daily living needs because of circumstances such as illness, disability, poverty, drug or alcohol addiction, or of other situations that lead to economic and social vulnerability”¹⁷. Further references to vulnerable groups in the body of the law (e.g. most vulnerable groups of persons, vulnerable elderly) associate the benefits that such groups are entitled to with the disadvantage they are faced with as a consequence of their vulnerability.

¹³ Furlong, A (Editor), Stalder, B, Azzopardi, A, “EUROPEAN YOUTH TRENDS 2000 - Vulnerable youth: perspectives on vulnerability in education, employment and leisure in Europe”, International expert report, Council of Europe Publishing, 2000. Available at: http://www.coe.int/t/dg4/youth/Source/Resources/Documents/2000_European_youth_trends_en.pdf [last accessed: May 26, 2013]

¹⁴ Ibid. p.9

¹⁵ Id.

¹⁶ Walther, A & Pohl, A (Coord.), “Thematic Study on Policy Measures concerning Disadvantaged Youth”, p. 35. Available at http://ec.europa.eu/employment_social/social_inclusion/docs/youth_study_en.pdf [Last accessed on May 30, 2013]

¹⁷ Article 6(p) of Law No. 292 of 20 December 2011

Defining vulnerability and vulnerable groups in legal/policy documents is very important for further steering intervention measures since focus on disadvantage as an outcome of the interplay between individual vulnerability and social constraints may result in overlooking the preventive dimension of policy interventions and, so to speak, focusing on effects rather than on causes.

Therefore, we will use the legal/policy-adapted approach to address groups/categories of adolescents, without however disregarding the sociological approach especially when discussing determinants that influence adolescents' behaviours.

The study focuses on persons aged 10-18, which largely fits into the UN approach (i.e. 10-19 years old¹⁸) and makes it easier to explore laws and services targeting children and adolescents up to their 18th birthday.

According to national statistics¹⁹, the number of adolescents living in Romania as of July 1, 2011 amounted to 2,012,709, representing 9.43% of the overall population at the same date. Of these, 939,538 (46.68%) resided in urban areas and 1,073,171 (53.32%) lived in rural areas. Their make-up by gender was 51.22% male and 48.78% female. Most of Romanian adolescents were enrolled in education (87.36%). As for the rest of 12.63%, statistics don't provide much clarity. A slight overestimation of the officially reported population at 1 July is possible, compared to the census, but we may assume that many of the adolescents aged 14-18 are neither in school, nor on the labour market, a topic that should be further investigated.

Statistics also tell us that in 2011 almost 20,000 children were attending special education and some 19,000 were living in child care centres²⁰.

According to a recent document published by the Directorate for the Protection of Persons with Disabilities at the Ministry of Labour, Family, Social Protection and the Elderly²¹, as of December 31, 2012 there were 29,405 persons with disabilities in the 10-17 years age group, of whom 13,009 were girls (44%). Almost all of these adolescents were living with their families (only 15 were institutionalised, out of which 9 were girls).

¹⁸ "The State of the World's Children 2011. Adolescence: An Age of Opportunity", p. 8. Available at http://www.childinfo.org/files/SOWC_2011.pdf

¹⁹ NIS, TEMPO-Online, <https://statistici.insse.ro/shop/>

²⁰ Id.

²¹ Ministry of Labour, Family, Social Protection and the Elderly, Statistical Bulletin for 2012, Chapter 6: Protection of Persons with Disabilities, p. 9

Chapter 3 Research findings

1) Adolescents and risky behaviours

In the following subchapters, the research report will look at the key results of the quantitative survey on adolescents, boys and girls, aged 10 to 18 years, which will allow us to formulate preliminary recommendations and suggest a course of action for relevant stakeholders in the area of health and not only.

The questionnaire applied to adolescents helped us to analyse participation in education and in the labour market, as presented below, and briefly indicate potential means of action in these areas.

Participation in education

Adolescents do attend school. 93.7% of respondents in our adolescent sample declared they were attending school, while only 6.3% stated the opposite. Taking into account 2011 figures reported by NIS, our results suggest a better school attendance. However, taking into consideration the margins of error set for our survey ($\pm 3.9\%$), we notice that a large number of adolescents continue to be out of school.

Among adolescents who are in school, girls declared to a larger extent than boys that they were attending school (95.0% girls as compared to 92.3% boys). Considering the slight prevalence of boys in the adolescent population of Romania, we can assume that girls are more likely to attend school than boys.

School attendance among adolescents is slightly higher in the 10-13 years age group (94%) than in the 14-18 years age group (93.6%). According to our survey data, more adolescents go to school in urban areas than in rural areas (96% and 91.6%, respectively).

Participation in the labour market

Very few respondents declared they were working (1%) at the time of the survey, suggesting that the topic of adolescents who are neither in education, nor on the labour market needs to be further explored.

Risky behaviours

A significant part of the questionnaire aimed to assess: adolescents' behaviour, knowledge and awareness of alcohol, cigarettes and drugs, HIV, sexually transmitted diseases (STDs). In fact, all these matters were merged into a separate sub-questionnaire which was either completed by interviewers or self-completed by the respondents when they felt more comfortable to answer those questions (respondents were given the option to fill in the questionnaires in privacy).

Alcohol consumption

According to the survey data, 42% of adolescents drank an alcoholic beverage at least once (Fig. 1.1., Annex 1). Alcohol use is more prevalent in boys than girls: 57% of boys consumed alcohol at least once in their lifetime compared to only 27% of girls.

31% received comments from people around them about their drinking (out of which 35% boys and 26% girls).

These data are also supported by the figures indicating the average quantity of alcohol teenagers drink. Thus, the average quantity of alcohol that boys drank in the past 30 days when they had a drink (out of those who had at least one drink in their lifetime) was 513 millilitres, whereas girls drank less than half of boys' quantity (204 millilitres).

Alcohol consumption is more common among older adolescents, with more than half of the teenagers aged 14 years and older having drunk alcohol compared to 21% of under 14-year-olds. It is quite a warning sign if one correlates these figures with those showing that 33% of the former category (i.e. 14 years and older) and 20% of the latter received comments about their alcohol use behaviour.

The percentage of rural adolescents who consumed alcohol at least once is lower than that of urban adolescents. Thus, half of the adolescents living in urban areas drank alcohol at least once in their lifetime compared to only 32% of those residing in rural areas. Rural adolescents usually drink a higher quantity (almost double) than adolescents in urban settings. Data show that in the past 30 days when they had a drink rural adolescents drank 560 millilitres on average whereas urban teenagers drank almost half of that quantity (approx. 300 millilitres). 31% of urban adolescents and 30% of rural adolescents received comments about their alcohol use behaviour.

Details related to frequency of alcohol consumption by type of alcohol are shown stratified by age-group, gender and rural/urban area in Annex 1.

Smoking

A quarter (23%) of adolescents smoked at least one cigarette in their lifetime (Fig. 1.2., Annex 1). Approximately 32% of boys and 16% of girls smoked, even if it was just 1-2 smokes. Moreover, the two categories show a slightly different pattern of taking up smoking on a daily basis: at the age of 14 in boys and at the age of 15 in girls.

Smoking habit starts at a very young age unfortunately and spreads very much latter. As data show, around 6% of adolescents less than 14 years of age already smoked in their lifetime and 33% of those who were older.

In the past 30 days, younger smokers smoked 12 days a month and 10 cigarettes daily on average, while older smokers smoked 20 days a month and 20 cigarettes daily, on average.

Like alcohol use, the smoking habit is more widespread among urban adolescents. Around 28% of adolescents living in urban areas smoked, even if it was just 1-2 smokes, compared to 19% of those from rural areas. This can be linked to the financial resources adolescents have, on the one hand, and to the general public acceptance of this behaviour, on the other. It's common knowledge that in small communities people are generally less tolerant towards adolescents who transgress morally acceptable norms (and smoke).

There is, however, no difference with regard to the age at which both groups start smoking on a daily basis – namely, at the age of 14 on average.

The prevalence of smoking in the past 30 days shows no difference between the two groups of adolescents. Thus, urban teenage smokers smoked 21 days over the past month and 20 cigarettes daily on average, while rural teenager smokers smoked 18 days out of 30 in the last month and 22 cigarettes daily on average.

Drug use

3.8% of adolescents have used some kind of drugs. If we take into consideration only the adolescents who are over 14 years old, the percentage goes up to 5.4%. These data seem to be comparable with surveys conducted by NAA. Data of the National Agency indicate that the percentage of adolescents aged 16 years having used drugs at least once in their lifetime is 10%. But we should keep in mind that the survey was carried out in high schools which are mostly located in urban areas. If we want to compare the data from the two surveys (CURS and NAA), we should take into account urban adolescents aged 14 years and older (the number of 16-year-olds included in the sample is too small for data comparison). Thus, the percentage of adolescents aged 14 years and older from urban areas

that have ever used drugs is 7.5% – comparable, within the tolerated margin of error, with the 10% resulting from NAA’s 2011 survey²².

2.3% of adolescents declared they had used cannabis, 1% used ecstasy, 1% used ‘new substances with psychoactive effects’ (also known as ‘ethnobotanical’ substances), 1% took sleeping pills, 1% sedatives, 1% hallucinogens, and 1% inhalants.

Drug use seem to be more widespread among boys, especially hard drugs, while the use of pills is more common to girls. Girls seem also to start using drugs at an older age than boys. (Table 2)

Table 2. Proportion of adolescents using drugs by drug type and by gender. Age of first use.

Types of drugs	Use		Age of first use	
	boys	girls	boys	girls
Inhalants (nitrites, glue, etc.)	1%	0%	14	-
Crack/pasta	0%	0.3%	-	N/A
Cocaine	0.3%	0%	N/A	-
Amphetamines or Speed	0%	0%	-	-
Hallucinogens	1%	0%	N/A	-
Heroin	0.3%	0%	N/A	-
Opiates	0%	0%	-	-
Sedatives/tranquilisers	0.3%	0.6%	14	16
Sleeping pills	0.3%	0.9%	11	17
Antidepressants	0.3%	0.3%	13	15
New psychoactive substances (ethnobotanical substances)	2.1%	0.3%	14.5	15

Data show that drugs’ consumption is lower among younger teenagers. The survey, however, captures to some extent the use of new psychoactive substances. (Table 3).

Table 3. Proportion of adolescents using drugs by drug type and by age-group. Age of initiation

Types of drugs	Use		Age of first use	
	Less than 14 years old	14 years old and over	Less than 14 years old	14 years old and over
Inhalants (nitrites, glue, etc.)	0%	0.8%	-	14
Crack/pasta	0.5%	0%	12	-

²² Source: www.ana.gov.ro/studii/sinteza, Results of the national school survey on alcohol, tobacco and drug use, ESPAD 2011, conducted on a sample of 16-year-old high school students

Cocaine	0%	0.3%	-	15
Amphetamines or Speed	0%	0%	-	-
Hallucinogens	0%	0.8%	-	14
Heroin	0%	0.3%	-	14
Opiates	0%	0%	-	-
Sedatives/tranquilisers	0%	0.8%	-	15
Sleeping pills	0.5%	0.8%	11	15
Antidepressants	0%	0.5%	-	14
New psychoactive substances (ethnobotanical substances)	0%	1.8%	-	15

Anyway, none of the adolescents less than 14 years of age and only 0.3% of the older adolescents injected illicit drugs.

The analysis by area of residence shows that drug use is quite uncommon to rural adolescents (Table 4). Moreover, no rural adolescent injected illicit drugs, while 0.3% of the urban ones did. In the past 30 days, 2.3% of urban adolescents used marijuana 1 to 3 times while none of the rural adolescents tried it.

Table 4. Proportion of adolescents using drugs by drug type and area of residence. Age of initiation

Types of drugs	Use		Age of first use	
	Urban	Rural	Urban	Rural
Inhalants (nitrites, glue, etc.)	1%	0%	14	-
Crack/pasta	0.3%	0.3%	N/A	N/A
Cocaine	0%	0.3%		N/A
Amphetamines or Speed	0%	0%	-	-
Hallucinogens	1%	0%	N/A	-
Heroin	0.3%	0%	N/A	-
Opiates	0%	0%	-	-
Sedatives/tranquilisers	0.7%	0.3%	16	14
Sleeping pills	0.7%	0.6%	17	11
Antidepressants	0.3%	0.3%	15	13
New psychoactive substances	2%	0.3%	14.5	N/A

1% of urban adolescents tried ecstasy and they were 13 (for adolescents under 14 years of age) or 16 (for adolescents older than 14) when they first used it whereas none of the rural adolescents experienced it.

Sexual behaviour

15% of adolescents declared they were sexually active (23% of boys and 11% of girls). By age-groups, one quarter of adolescents over 14 and just under 1% of those younger than 14 were sexually active. On average, adolescents had their first sexual relation at the age of 15.5. At the time of research, sexually active adolescents had had 2.3 partners on average and 68% of them had a steady partner. None of the interviewed adolescents had experienced motherhood/fatherhood at the time of research.

When asked how often they had used a condom with their steady sex partner in the past month, almost half (47%) of the adolescents who were sexually active said they had always used a condom. 20% of adolescents stated having used a condom with their steady sex partner most of the times. The share of adolescents saying they had used a condom with their steady partner only sometimes or rarely was however quite high (17%). 16% of adolescents had never used this particular method of contraception and protection with their steady partner (Fig. 2.1., Annex 2). Adolescents said they had used a condom mainly to prevent pregnancy (63% of adolescents) and to protect themselves from diseases (19% of adolescents). Of those who said they hadn't used a condom with their steady sex partners in the past month, 47% of adolescents said they hadn't used it because of the discomfort it created, 20% because they hadn't had one and 7% for another reason (Fig. 2.2., Annex 2).

Out of those who were sexually active, some 4 in 10 said they had had sex with a casual partner in the past 12 months (Fig. 2.3., Annex 2). These adolescents had 1.9 casual partners on average in the past 12 months and only 60% of them used a condom each time.

5% of sexually active adolescents said they had had sexual relations with a commercial/paid sex partner in the past 12 months and all of them had used a condom the last time they had sexual contact with a commercial sex worker.

At the end of the questionnaire, there were two sets of specific questions for girls or boys alone. When asked if they had ever been pregnant, very few teenage girls said they had been at least once in their lifetime (6%) and none of them declared to have ever had an abortion.

Moving forward to the set of questions for boys alone, 1% of teenage boys said their girlfriend had been pregnant at least once by the time of the survey, 22% of them said their girlfriend had never been pregnant while 77% of adolescent boys said their girlfriend hadn't had their sexual debut yet (Fig. 2.4., Annex 2). Just one adolescent in the 14 years and older age group experienced a pregnancy situation with his girlfriend having an abortion – a decision they had both agreed on.

At the time of research, 84% of sexually active girls said they had a steady partner as compared to 60% of boys. The age of their first sexual contact was 15, with a marginal difference between boys and girls (in months). Moreover, girls seem to be more careful when it comes to protection, more than half of them using always condoms with their steady partner as compared to 43% of boys (Fig. 2.5., Annex 2). The two groups use condoms for different reasons. Girls are more pushed by fear of pregnancy (81% vs. 51%), while boys are more concerned with protection itself (25% of boys and only 10% of girls mentioned that they were using condoms for protection).

Casual sex is rather common among boys. Around 49% of sexually active boys and 20% of girls had sex with a casual partner in the past 12 months while 53% of these boys and 71% of these girls used a condom each time.

Over the past 12 months, 2% of the older adolescents traded sex for material gains and 5% engaged in commercial sex.

Moreover, over the past year, 2% of the older adolescents showed signs of STIs and one quarter of them did nothing to address the matter, another quarter sought treatment to a private health facility and 12% turned to their parents, went to the pharmacy or resorted to self-medication.

The survey shows a moderate level of awareness as regard the places from where to buy condoms. One third (32%) of adolescents didn't know or didn't answer where they could get/purchase condoms in their neighbourhood. Boys seemed better informed compared to girls (Fig. 2.6., Annex 2), older adolescents better informed compared to the younger ones (Fig. 2.7., Annex 2) and adolescents from urban areas better informed compared to those from rural respectively (Figure 2.8., Annex 2).

Taking into account the figures above and adolescents' tendency for casual sex, there is a need to step up health awareness campaigns.

The share of sexually active adolescents is higher in urban settings: 20% of adolescents from urban areas had their sexual debut, with 71% of them currently having a steady sex partner, while only 14% of those living in rural areas had sexual encounters and 65% of them had a steady partner. Both adolescent groups stated they had their first sexual contact at the age of 15.

It is worth mentioning that more rural adolescents use always a condom with their steady partner than urban teenagers (Figure 2.9., Annex 2), which can mean that their sex life is more planned (as resulting from the answers given by adolescents themselves). Thus, 7 in 10 rural adolescents mentioned they used a condom "to reduce the probability of pregnancy", while only 5 in 10 urban adolescents came up with this reason. However, none of the rural adolescents mentioned using condoms "for protection" while this was the reason named by one quarter of urban adolescents.

Over the past 12 months, just over 1% of urban adolescents had sex for material gains (gifts and other incentives) and 5% of urban and rural adolescents experienced commercial sex (received or paid money for sex).

While sex for material gains is exclusively an urban experience since only urban adolescents stated they had traded sex for material gains, casual sex is more common among rural adolescents. Around 45% of sexually active adolescents living in rural areas and 33% of those living in urban areas had sex with a casual partner over the past 12 months and nearly 55% of them used a condom each time.

Awareness and knowledge of HIV and other Sexually Transmitted Diseases and effects of drug, alcohol and tobacco use

HIV and other Sexually Transmitted Diseases

In general, adolescents have satisfactory information about HIV. Answering the question "What does HIV mean to you?", most adolescents in our sample associated it with a disease, a serious/fatal disease, a sexually transmitted disease or a virus, which means that they have accurate knowledge of the matter while not discerning well between HIV and AIDS.

In order to assess adolescents' awareness of factors that may ease HIV transmission, the questionnaire included a list of statements and respondents were asked to express agreement or disagreement with these according to their views. The list included connections between the risk of HIV transmission and different kind of behaviours: being picked by a mosquito, eating at the same table with somebody who is infected, practising unsafe sex (without a condom), not using a clean/unused needle for injecting drugs. The answers to these questions have revealed that adolescents are mostly aware of the risks related to unsafe sex/not using condoms and of the fact that you can't tell from someone's appearance (healthy/not healthy) whether they are HIV-positive or not.

Most adolescents know something about HIV. They strongly or somewhat agree with the statements that show how inappropriate management of sexual relations can lead to HIV transmission.

However, we noticed that many answered DK/NA at some of the questions, which might raise some doubts as to adolescents' accurate and full understanding of HIV and its particularities, especially when transmission and protection were brought into discussion.

Thus, even if adolescent respondents have shown a good understanding of most HIV-related statements, some doubts arise from the wrong answers (more common with regard to the last three statements which go into more detail about the virus) and from the quite high shares of DK/NA cases (ranging from 24% to 39%). These point to considerable uncertainty among adolescents and leave serious doubts about their full understanding of HIV transmission ways.

The level of awareness regarding the risk factors for HIV transmission varied consistently among age-groups (Figure 3.1., Annex 3). The risks that HIV poses are well known by older adolescents, but much poorly known by the younger ones. This is partially due to the fact that in most secondary schools HIV risks are not tackled at all. Adolescents aged 14 years and older are more informed and seek various sources of information, thus acknowledging better the means of HIV infection.

This level of awareness does not differ significantly between boys and girls (Figure 3.1. – 3.2, Annex 3).

Not many adolescents believe that HIV can be transmitted by mosquito bites or by eating at the same table with an infected person. Nevertheless, the fact that 10.6% of our respondents aged 10-13 years and 18.2% of those aged 14-18 believe that eating at the same table with an HIV-infected person poses a risk suggests that specific education on the topic is still needed. It is important to note the differences between rural and urban adolescents with respect to their awareness of HIV risks. Urban adolescents are more aware of the risks and acknowledge them to a higher degree than rural teenagers (Figure 3.3., Annex 3). Just like younger adolescents, rural adolescents are less informed about sensitive issues than they should be at their age.

Infectious diseases pose major concerns and are better known by girls than boys. Just one boy had an HIV test compared to four girls; 2.4% of boys and 2.8% of girls got tested for Hepatitis B while 1.7% of boys and 2.2% of girls for Hepatitis C. Two boys and two girls had a syphilis test.

Since sexual behaviour is more common among urban adolescents, they have more experience with various STD tests. Therefore, around 2% of urban adolescents and none from rural areas had an HIV test, 4.4% had a Hepatitis B test compared to only 1% in rural areas, 3.5% of the former and 0.6% of the latter were tested for Hepatitis C, and 0.7% of the adolescents living in urban areas and 0.6% of those from rural areas had a syphilis test.

The level of information about the places where a HIV test can be taken was reduced, most of the adolescents indicating the hospitals. One of five adolescents (21%) did not know/didn't answer where he could get an HIV test in the neighbourhood (Figure 3.4., Annex 3). Younger adolescents seem less informed about health facilities that run HIV tests than older teenagers. (Figure 3.5., Annex 3), but no relevant differences were found by gender (Figure 3.5., Annex 3). Rural and urban teenagers are also differently aware of the places where they could be tested for HIV, with more adolescents in rural areas not knowing where to go for an HIV test (Figure 3.6., Annex 3).

Effects of drug, alcohol and tobacco use

Most adolescents had accurate knowledge (information) about the risks of alcohol, tobacco, drugs and unsafe sex. But in this case also, there is a significant share of respondents whose knowledge (information) is uncertain: about 20% are not convinced that condom use reduces the risk of sexually transmitted diseases and only 77% are aware of occasional drug use dangers.

The amount of information and the variety of information sources adolescents have access to nowadays seem to have a positive impact as well. Thus, adolescents' awareness of the risks associated with drinking, smoking, drug use and sexual behaviour is very high, especially among adolescents aged 14 years and older. However, it should be noted that the younger adolescents are, the less informed and less aware of these risks they are, especially with regard to sexual behaviour and drinking (Figure 3.8., Annex 3).

Awareness levels with regard to the risks posed by drinking, smoking and sexual behaviour are only slightly different by gender and between urban and rural adolescents, which means that they are equally aware of the side effects of such habits and the risks they might be exposed to by adopting them (Figures 3.9. – 3.10, Annex 3).

Social capital

From the social capital perspective, most adolescents turn to their parents/grandparents for help. They also rely on teachers and friends/colleagues (Table 5).

Table 5. Proportion of adolescents using different social capital 'actors'

	Parents /grandparent	Teachers	Friends/ colleagues	Social assistant	Neighbour hood	Emergency	Child phone	Someone else?	DK/DA
1. learning problems	60%	26%	9%	0%	0%	0%	0%	1%	4%
2. problems with colleagues	42%	30%	23%	0%	0%	0%	0%	1%	4%
3. problems with parents	36%	6%	32%	2%	1%	0%	1%	7%	15%
4. problems in love	39%	0%	40%	0%	1%	0%	0%	3%	17%
5. health problems	88%	0%	3%	1%	0%	2%	0%	3%	3%
6. else, what?	8%	0%	1%	0%	0%	0%	0%	1%	90%

The other social capital 'actors' in adolescents' lives, such as neighbours, emergency or child helplines, are hardly ever used.

The persons to whom adolescents turn when they look for support vary to some extent according to age group and more to the type of issue involved. Thus, the majority of younger adolescents confide in their parents and teachers when they have problems.

Friends or one of the parents or grandparents are the persons to whom young adolescents turn for parent-child problems, although many older adolescents talk to their friends and many younger adolescents to one of the parents or grandparents. For love problems, many younger adolescents confide in their parents, while half of the older ones turn to their friends.

Nearly 9 in 10 adolescents, regardless of their age, rely on their parents when it comes to health-related problems.

Mass media and Internet usage

TV audience data show that 96% of adolescents watch TV every day and that 50% of them spend over 3 hours a day doing this activity instead of others such as socializing, learning, playing sports, games, etc (Figure 4.1., Annex 4).

The most watched TV channels are Pro TV, Antena 1, Acasa, Kanal D and Disney Channel, with movies and cartoons as top choices among broadcasts (Figure 4.2., Annex 4). Two times more girls than boys (5% vs. 2%) do not watch television.

Half of adolescents don't listen to the radio (Figure 4.3., Annex 4). Among those who do listen, the daily mean is 1.8 hours. With regard to favourite music, adolescents under 14 prefer hip-hop and soft music and those over 14 prefer house, 'manele' [Turkish-derived genre], and pop music. 98% of urban adolescents who tune in to the radio listen to music and prefer pop, soft and 'manele' music while 94% of rural adolescents who tune in to the radio listen to music but many more of them prefer 'manele'.

88% of adolescents use the Internet, most of them at home (92%), followed by mobile internet (31%) and school (21%) (Figure 4.4a., Annex 4). 5% of urban adolescents and 18% of rural teenagers do not use the Internet. A double percentage of girls do not use the Internet as compared to boys (15% vs. 8%), but there is no gender-based difference when it comes to the time spent daily surfing the Internet (around 45% of both genders spend less than three hours daily surfing the web) or to the place where they get online (Figure 4.4b-d., Annex 4). The average daily Internet usage was 3.37 hours, with adolescents aged below 14 years using the Internet in a smaller proportion than those over 14. Daily, adolescents spend 1.93 hours on average playing video games. Video games seem to be boys' 'cup of tea' since only 29% of boys and 67% of girls do not play them.

The conclusion is that the adolescents spend about seven hours every day involved in these types of activities: television, Internet, and video games. Half of them are involved daily in all three types of activities, spending over eight hours every day. This should have a significant impact on other activities they could do and, of course, on their development. It may as well be that children lack other means of spending their free time and socialising with peers.

Adolescents make extensive use of some social networks, only 16% of them declaring they are not users (Figure 4.5a., Annex 4). Social media are used to a greater extent by adolescents over 14 (9% of not users, compared to 23% not users among adolescents under 14) (Figure 4.5b., Annex 4). The percentage of girls who do not use social media is higher than that of boys (19% versus 13%) (Figure 4.5c., Annex 4). Three times more adolescents living in rural areas (23%) do not use social networks as compared to those living in urban areas (9%) (Figure 4.5d, Annex 4). 78% of adolescents log on to Facebook and 32% on Youtube while more than 8% of adolescents use Twitter, Hi5 and blogs. Over 50% used them for keeping in touch with other individuals and for sending messages to other people (Figure 4.6., Annex 4). The main topics adolescents searched for on social networks were: movies (33%), entertainment (29%), games (26%), ways to spend one's spare time (24%) and meetings/friendship, love (17%). Very few adolescents logged on to social networks to find out about drugs, cigarettes and alcohol (1%). Data show that more girls than boys use social networks to get informed and more boys than girls to socialise (Figure 4.7., Annex 4). Girls pay more attention to the web pages of NGOs and other organisations/institutions dealing with child/youth issues. The topics that interest girls are extremely diverse, whereas boys are more into games when it comes to what they follow or engage in on blogs/forums/social networks.

To adolescents, social media information is not very reliable. Survey data show low levels of trust in social networks. More than half of adolescents either "trust to a certain extent" or "don't trust at all" the information they find on social networks (Figure 4.8., Annex 4). Rural adolescents are more confident in the information they get from social media as compared to urban ones (31.7% vs. 23.5%).

As regards adolescents' preferred sources for the information they need, very few would like to get it from social media. Most of them want to get it from their parents and friends. However, parents and social media are the main sources of information for younger adolescents while older ones turn to their parents, friends, and social media to receive the information they need.

ADOLESCENT DRUG USERS

The analysis below is based on 59 structured interviews conducted among adolescents who use drugs (19 girls and 40 boys) and should be viewed as significant for this specific category.

Risky behaviours

This study reveals once again that drinking, smoking and drug use are interconnected. The highest drinking and smoking numbers were recorded among adolescent drug users.

Alcohol consumption

Almost all of the interviewed adolescent drug users reported they had consumed alcohol at least once in their lifetime. Adolescents who had at least one drink in the last month drank 2,891 millilitres on average over the last 30 days. Moreover, nearly half of them received comments from other people regarding their alcohol use behaviour.

Smoking

All drug-using adolescents reported having smoked at least once in their lifetime and they started smoking at the age of 12 on average. The frequency of smoking in the last 30 days shows us that this is a rather daily habit than an occasional one. The survey found that in the last month interviewed smokers smoked for 27 days out of 30 on average and the average number of smoked cigarettes per capita was on average 24 sticks per day.

Drug use

Most interviewed teenage drug users prefer 'legal highs', heroin and inhalants. The age of first use is the lowest for inhalants, but what is of particular concern is the age of first use for heroin and 'legal highs'. (Table 6).

Table 6. Number of adolescents using drugs by drug type. Age of initiation

Types of drugs	Use	Age of first use
	Counts	– mean -
Inhalants (nitrites, glue, etc.)	28	11.7
Crack/pasta	0	-
Cocaine	5	15.8
Amphetamines or Speed	3	15.7
Hallucinogens	3	16
Heroin	30	13.9
Opiates	9	14.6

Sedatives/tranquilisers	2	14
Sleeping pills	4	14
Antidepressants	2	15.5
‘Legal highs’ (ethnobotanical substances and other ‘legal’ drugs)	42	14.2

The survey found that more than half of the interviewed adolescent drug users injected heroin and/or ‘legal’ drugs into their system at least once in their lifetime. These adolescents used the drugs intravenously over the last month in 19.8 days out of 30, on average. Furthermore, more than half of adolescent drug users stated they had smoked marijuana and the average age of first use for marijuana was 15.

Use of ecstasy is less widespread among interviewed adolescent drug users, only 6 of them reporting to have tried this type of drug at least once in their lifetime and in just 1.5 days out of 30 in the last month, on average. The average age of first ecstasy use was 15.7, as survey data show.

The greatest concern is that more than half of adolescent injecting drug users reported having used needles and syringes that had been previously used by other persons or by themselves on some other occasion. We might conclude that, like in the case of alcohol use and cigarette smoking, adolescent drug users are at a great risk of developing drug use-related health problems. The risk is highly amplified by vulnerable adolescents’ preference for ‘legal highs’ (the drug of choice for our questionnaire respondents) which are cheaper and easier to procure but come with unknown long-term effects and a very high risk of HIV infection because many drug users inject this type of drugs using, as in the case of heroin, non-sterile needles or syringes which have sometimes been utilised before by other drug users. The input and information we got from the field also point out the fact that many ex-heroin users now prefer to inject ‘legal highs’ because they are cheaper and easier to find, with some still being available in sex shops in certain areas – such as Ferentari or Rahova in Bucharest – even if they have been recently banned by law. However, unlike heroin, these drugs have much shorter-lasting effects and users need to take the drug much more frequently, leading to larger overall daily doses. This may also increase juvenile crime among adolescent drug users because they need to somehow procure the money to buy their next dose.

Sexual behaviour

Sexual activity is very common among our interviewed adolescent drug users, 52 out of 59 reporting to have had their sexual debut and, according to their answers, this happened at the average age of 13.5. Stability is not these adolescents’ most frequent choice when it comes to their sex life. Interviewees reported having had 9.9 sex partners on average by the time of the survey, while less than half of sexually active adolescents who used drugs had a steady partner at the time of research. However, their steady relationships lasted for less than one year (8.6 months), on average. Anyway, for what is worth, only a quarter of them “always” use a condom with their steady sex partner while almost half of them use a condom with their sex partner “most of the times” (Figura 5.1., Anexa 5). Three of them stated they had never used a condom with their steady partner (see the chart below).

Most adolescent drug users use a condom as a precaution against STD transmission and as a measure to prevent pregnancy. Almost all are aware from where to buy a condom and they indicated the social workers as a source in a higher proportion compared to the overall adolescents population (Figure 5.2, Annex 5)

The data above regarding sexually active adolescents are consistent with these teenagers’ attitude to casual sex. Thus, around two thirds of drug-using adolescents who were sexually active had casual sex in the last 12 months with 3 different sex partners on average. Of particular concern is the fact that

more than half of the drug-using adolescents who had casual sex over the past 12 months reported not having used a condom with these casual partners.

Anyway, a good thing is that commercial sex is marginally recorded amongst teenage drug users, with only 3 adolescents reporting to have had sex for material gains in the last 12 months and 2 of them used condoms on these occasions.

Among drug-using adolescent girls, pregnancy can be regarded as an alarming issue. 5 girls out of 19 reported having got pregnant at least once in their life. The average number of pregnancies that drug-using teenage girls experienced in their lifetime is two. Just one of the five girls kept the child whereas all the others had an abortion. Two drug-using girls had a miscarriage.

Only 5 drug-using boys reported that their girlfriends had been pregnant and decided to have an abortion – a decision both partners agreed on.

Awareness and knowledge of HIV and other Sexually Transmitted Diseases and effects of drug, alcohol and tobacco use

The level of awareness regarding the risks of drinking, smoking, drug use and unsafe sex is roughly average to low (Figure 5.3 Annex 5). What is important to note is that these adolescents are more informed about the risks of STI transmission, which may be explained by their exposure to HIV prevention services, and less informed about the dangers of tobacco smoking. Moreover, it is worth mentioning that they seem to have a quite tolerant attitude towards occasional alcohol and drug use.

With regard to the means by which HIV infection can be transmitted, adolescent drug users' level of awareness is quite high, as the survey revealed (Figure 5.4., Annex 5).

There is some uncertainty though that comes out from the high share of DK/NA answers to the questions in this section. These point to considerable uncertainty among teenage drug users and leave serious doubts about their full understanding of HIV transmission ways. Unfortunately, even if most drug-using adolescents seem to be aware of the risk of HIV transmission through previously used needles/syringes, those who inject drugs continue to use non-sterile needles/syringes to a great and very dangerous extent, as previously mentioned.

Almost all adolescents drug users are aware about where to have a HIV test in the neighbourhood and almost one third indicated the outreach services as a possible provider (Figure 5.5., Annex 5).

Social capital

Ultimately, the social capital of adolescent drug users narrows down mostly to their friends. Teenage drug users' relationships with their friends are very solid and significant for this group. Thus, when they need a piece of advice or other type of information most of them turn to their friends.

The vast majority of adolescent drug users turn to their parents only for health-related issues; in all other situations (i.e. classmates-related issues, love-related issues, parents-related issues, etc.), these adolescents turn to their friends for help, advice or consolation. Thus, if we consider the possibility of running a recovery campaign, the main question would be how we could replace parents' problem-solving assistance for these vulnerable adolescents.

Mass media and Internet usage

Almost one third of adolescents drug users don't watch TV and those who watch TV like especially movies (Figure 5.6., Annex 5)

They are connected to internet in the same places (home, mobile phone, school) as the other adolescent and more than half are connected to Youtube and/or Facebook (Figures 5.7, 5.8., Annex 5) generally they use the social networks for the same purposes as the other adolescents (Figures 5.9a, b., Annex 5).

In conclusion, drug users' foreseeable behaviours, habits and attitudes were confirmed by this survey as follows:

- Higher incidence of alcohol abuse, smoking and drug use;
- A more unhealthy and risky sexual behaviour;
- Social capital limited to the influence of their peer group, entourage and other drug users;
- Early transition to adulthood as a consequence of drug addiction that pushes adolescents to finding financial resources to procure the needed drugs.

ROMA ADOLESCENTS

The analysis below is based on 67 structured interviews conducted among Roma adolescents (37 girls and 30 boys) who were randomly selected nationwide. The results are not representative at national level.

Risky behaviours

Alcohol use, smoking and especially drug abuse are not high among Roma adolescents.

Alcohol consumption

Almost half of interviewed Roma adolescents reported having drunk alcohol at least once in their lifetime and less than 50% received comments about their alcohol use behaviour. The average alcohol quantity reported by those who drank in the last month was 375 millilitres over the last 30 days.

Smoking

One third of Roma adolescents reported having smoked at least once in their lifetime and according to their statements they started smoking at the average age of 13.3. As in the case of other adolescents, smoking is a rather daily habit than an occasional one since, over the last month, Roma adolescent smokers declared they smoked 22.5 days out of 30 and an adolescent smoked 51 sticks on average per day.

Drugs use

Drug abuse is low among Roma adolescents. (Table 7).

Table 7. Number of Roma adolescents using drugs, by drug type. Age of initiation

Types of drugs	Use	Age of first use
	Counts	– mean -
Inhalants (nitrites, glue, etc.)	1	12
Crack/pasta	0	-
Cocaine	1	16
Amphetamines or Speed	0	-
Hallucinogens	0	-
Heroin	0	-

Opiates	0	-
Sedatives/tranquilisers	1	14
Sleeping pills	2	14
Antidepressants	1	14
‘Licit’ drugs (ethnobotanical substances, natural drugs/herbs)	1	14

None of the Roma adolescents has ever used heroin intravenously; only 2 Roma adolescents have tried marijuana and they did it for the first time at the age of 16, whereas only 1 has tried ecstasy and that first happened at the age of 14. Anyway, over the last 30 days, none has used such drugs/substances.

Sexual behaviour

One third of interviewed Roma adolescents declared having had their sexual debut. They became sexually active at the age of 14, according to their statements. Stability is something that characterises Roma adolescents who reported in great numbers having a steady partner and stable relationships that lasted for a year (11.8 months), on average. Of great concern is the fact that more than half of them have never used a condom with their steady partner, while those who have were primarily concerned about preventing pregnancy (Figure 6.1., Annex 6). Moreover, half of them were not able to indicate a place from where to buy a condom in the neighbourhood (didn’t know / didn’t answer) (Figure 6.2., Annex 6).

Casual sex incidence is quite high among Roma adolescents, half of those who were sexually active reporting to have had casual sexual relations over the last 12 months with 7.8 different sex partners on average and half of them stated they hadn’t used a condom with these casual partners.

Sex for material gains is a marginal behaviour among Roma adolescents, with only two reporting to have engaged in such behaviour.

Half of sexually active Roma girls got pregnant 1.2 times on average. Almost all of them kept the babies. Abortion was experienced by two Roma girls for one time only, while miscarriage was experienced once by only one Roma girl.

As far as Roma boys are concerned, 3 out of 11 (who were sexually active) declared that their girlfriends/partners got pregnant at least once and two of them decided to have an abortion. This decision was made by the boy in one case and by both partners in the other.

Awareness and knowledge of HIV and other Sexually Transmitted Diseases and effects of drug, alcohol and tobacco use

Roma adolescents’ awareness of the risks posed by drinking, smoking and drug abuse is quite good. (Figure 6.3, Annex 6) They lack, however, information about STD transmission risks, toxic substances contained in cigarettes and the side effects of direct and second-hand smoke. Nonetheless, Roma adolescents show a quite tolerant attitude towards occasional drinking and synthetic drug use .

What should be of most concern is the low level of HIV awareness among Roma adolescents. When asked what HIV meant, half of Roma adolescents didn’t know how to describe it and most of them associated it with “AIDS” and a “terminal disease”. Roma adolescents’ awareness of HIV risks and the measures that can be taken in order to prevent HIV infection is very low (Figure 6.4., Annex 6).

Furthermore, Roma adolescents have little information about where an HIV test can be taken, with many of them naming “the hospital” just like for any other disease, most likely because the only thing they know about it is that it is a disease (Figure 6.5., Annex 6).

Social capital

As to the social capital of Roma adolescents, they mostly trust and confide in parents, teachers and friends when they have problems with their classmates, with school, with their parent-child relationship or health-related problems.

Mass media and Internet usage

Only 10% of Roma adolescents don’t watch TV and those who watch TV like especially series movies and cartoons (Figure 6.6., Annex 6)

They are connected to internet in the same places (home, mobile phone, school) as the other adolescent (Figure 6.7., Annex 6). Almost half are connected to Facebook and one in five connected to Youtube (Figures 6.8., Annex 6). Generally they use the social networks for the same purposes as the other adolescents (Figures 6.9a, b., Annex 6).

2) Determinants analysis

This subchapter lays out the determinants bearing an impact on the realisation of adolescents' rights to protection, health and education. The analysis was carried out in the field of child protection, health (with a focus on reproductive health, including HIV; tobacco, drug and alcohol use), and education.

a) Enabling environment

i) Social norms

Norms in every culture create conformity that allows for people to become socialised to the culture in which they live²³ and it is unquestionably assumed that there is a strong correlation between people's normative beliefs and their behaviour²⁴. This social influence is conceptualised in terms of the pressure that people perceive from important others to perform, or not to perform, certain behaviour²⁵.

Adolescents' behaviour is shaped, more than adults', by what relevant people around them consider appropriate and desirable. Their groups internalise norms by accepting them as reasonable and proper standards for behaviour within peer groups, family and with significant others.

Often, general social norms are subject to negotiation and it is not unusual that smaller groups endorse norms separate or in addition to cultural or societal expectations²⁶.

When we talk about securing the realisation of adolescents' rights to education, health and social protection, both generally accepted social norms and norms shared by the age group or vulnerable group become relevant.

Despite the opinion of the adults (experts, parents) interviewed for the qualitative research that adolescents are a resource rather than a problem for society, adolescence is an age that is diffusely perceived at societal level.

Often, adolescents' social identity is highly uncertain, leaving their real needs unaddressed. In this context, adolescents themselves have a mixed perception of their identity. Some of them believe their problems are ignored by society and some perceive themselves as children or, on the contrary, young adults with associated responsibilities (this is mostly the case with Roma adolescents).

"A teacher treats a teenager as a student; a parent treats him or her as a child, an employer as a disciple. Nobody sees them as teenagers..." (Expert, government agency)

Adolescents' problems are also ignored in the family. The latter is more interested in the child's condition at younger ages and much less during his or her teen years. Teachers noted that parents' interest in their children's academic record dropped significantly once they passed the first grades. This is also the result of a more recent social norm – shared by education beneficiaries (parents and adolescents) – according to which school is no longer able to motivate students or their parents. Public opinion is quite critical of the education system, with drop-out or non-participation in education being ascribed to the fact that school fails to provide a guarantee for employment and for social success in general.

"I think that, first of all, we don't know very well what adolescents need and what we want from these kids. We want to keep them in school, why? We want to get them to high school, why? We want to give them a professional degree... that's very good, but employers come and say... it's OK, but what skills does this cover? In the end, I think it all comes down to the educational offer that we make to them." (Expert, NGO)

²³ Marshall, G. (Ed.) (1988): *Oxford Dictionary of Sociology*, Oxford University Press

²⁴ Bicchieri, C. and Muldoon, R. (Spring 2011): *Social Norms*, The Stanford Encyclopedia of Philosophy

²⁵ Rivis, A., Sheeran, P. (2003): *Descriptive Norms as an Additional Predictor in the Theory of Planned Behaviour: A Meta-Analysis*, in *Current Psychology*, Volume 22, Issue 3, pp. 218-233

²⁶ Jackson, J. (1965): *Structural characteristics of norms*, in I.D. Steiner & M. Fishbein (Eds.), *Current studies in social psychology* (pp. 301-309), New York: Holt.

Adolescents' opinions are also quite strong with regard to the weak capacity of the formal education system to motivate them to participate or perform well in school. Students appear to be more stimulated by school as a socialising medium rather than a learning environment.

Poorly motivated teaching staff, the low attractiveness of the teaching career, the lack of real professionalization of human resources in public education, the poor vision for flexible inclusive education are frequently mentioned as reasons for the students' lack of motivation and even drop-out.

"We raise kids 'too smart', overloaded with knowledge but unprepared for life; they don't know how to cope with life". (Interview)

The discrimination that Roma adolescents claim they have experienced in their interaction with teachers and peers has a major influence on how they build their relationship with school. Self-segregation is often perceived as a solution to discrimination. Despite legislation, ethnic segregation seems to be a hidden norm and practice in the schools that serve communities with a high number of Roma children.

"I saw many situations where segregation was covered up. For example, there are schools that say: ... we do not segregate students by ethnicity. And you go to fifth grade A and see that they are all Roma and then you go to fifth grade B and see that they are all Romanian and ask yourself why is that." (Expert, public institution)

Adolescents with disabilities are pushed to the margins of the education system by the discriminatory attitudes of their peers and parents, teachers' attitudes and unpreparedness to handle the special educational needs of these adolescents, lack of support teachers and school counsellors, and poor accessibility.

"Schools ... that run inclusive education projects and that ... are very open to integrating children with disabilities, even those schools feel the need for more training, more specific strategies, information on the types of disabilities, given that even where integration is desired, there is a lack of information and training of teachers. So, there are very few schools that currently have an inclusive culture. Hence, it is clear that drop-out is almost imminent for some categories [of students]." (Expert, public institution)

The social stigma that Roma communities place on those who access services of psychological counselling, reproductive health, testing for sexually transmitted infections exposes Roma adolescents to greater health risks; under these circumstances, local health mediators play a very important role and can contribute to changing the social norms according to which accessing these services is not a desirable behaviour within the community.

Though they are provided decent material living conditions, institutionalised adolescents are exposed to risks that originate in the very heart of the system. The struggle to develop their sense of belonging and identity, living in an environment that is characterised by multiple separations leading to trauma and attachment disorders (e.g. due to a high staff turnover, etc.), the social stigma associated with institutionalisation are merely some of the systemic setbacks that affect these adolescents' right to a normal life.

ii) Legislation/Policy

Many interviewees from key institutions and organisations have stressed that the Romanian legislative framework is well-developed as regards education and access to quality education, child rights protection, social assistance for vulnerable/disadvantaged groups, healthcare provision – including special measures for HIV/AIDS and drug addiction, but quite inadequate when it comes to laying down relevant obligations so as to ensure the realisation of intended beneficiaries' rights. This results in somewhat ineffective laws, leaving room for risky behaviours (e.g. selling alcohol, tobacco and drugs to the underage) and limited access to rights and welfare/protection services (e.g. home education for people with disabilities, accessibility for people with disabilities, welfare services at

local level, proximity services for street children, drug addicts and victims of human trafficking/sexual exploitation).

“... I’d like to say that, while speaking about the performance of a legal framework, one cannot avoid discussing its correlation with the resources that make it possible to put it into practice to the fullest extent.... Hence, there is an inherent connection between the performance of the legal framework and the extent to which it is efficient in practice.” (Head of a regional agency)

Nevertheless, it has been mentioned that legislation is underdeveloped and inadequate in the fields of inclusive education – especially with regard to children with disabilities, of special protection and assistance for children with parents working abroad, special protection for human trafficking victims and drug addicts (in particular harm reduction), of providing fair opportunities for educational advancement to adolescents in the child care system and from poor families and/or poor rural/remote areas.

The *Child Protection Law*²⁷ defines children as persons aged 0 to 18 years and states their rights, including adolescent rights, as laid down in the UN Convention on the Rights of the Child. Special provisions are prescribed for authorities to take into account the opinion of the adolescent (aged 10, 14, or 16) in different situations such as the application of special protection measures, religious options, and the choice of an academic path.

The Child Protection Law mentions health education as compulsory, to be delivered by *“specialised bodies of the central government, local authorities and any other public or private institutions with responsibilities in the field of health [which] are required to take all necessary measures ...[for].... systematically implementing school programmes aimed at education for life, including sex education for children, in order to prevent sexually transmitted diseases and teenage pregnancy [Article 43(3)(i)]”*.

If fully applied, such a provision would lead to children, including adolescents, being better informed on health topics in school. In the context of an overloaded curriculum – “40% of teachers say that the main problem with Romanian education is the high volume of information”, the motivation for both teachers and adolescents for focusing on health education curricular or extracurricular activities is reduced. At the same time, as prescribed by law, there are other institutions or professionals empowered to conduct preventive interventions on health-related matters targeting the overall population, including children and adolescents (district public health authorities, school doctors and nurses, family doctors and nurses, community nurses and health mediators.– However, in the context of health competences decentralization, the capacity of these instances to conduct health education interventions decreased. (Only few communities have employed community nurses or health mediators - in 2007, only 21.8% of all communes in the country had a community health mediator) and thus health education is delivered sporadically and with limited impact.

The qualitative research indicates that the legislation aimed at preserving health should target adolescents, with emphasis on discouraging risk behaviours. Although legal frameworks are in place for alcohol and tobacco selling, they are either incomplete or ineffective. In the opinion of a government agency expert: *“the rules regarding selling alcohol to the underage are not complied with. With reference to existing laws, the state lacks the capacity to enforce them ... for example, smoking in public places: in many restaurant you may go you will see that smoking and non-smoking areas are divided by nothing but a line.”*

Thus, although a legal framework is in place as regards age requirements for purchasing alcohol and tobacco, it is not enforced. On the other hand, the law allows alcoholic beverages to be advertised on TV and tobacco products in public spaces.

²⁷ Law No. 272 of 2004 (updated in 2008) on the protection and promotion of children’s rights

“In theory, tobacco companies cannot offer their products to young people, but in reality there is no doubt that it happens ... as long as promotion is allowed, promotional campaigns will target adolescents.” (Expert, ministry)

Specific harm reduction rules, especially for minors, are missing too: *“There is no legal framework ... because it is difficult for decision makers to acknowledge that there are children who use drugs...”* (Expert, NGO)

For any medical interventions, including access to reproductive health care, parental consent is needed. Only in specific cases, the medical staff may intervene without the parental consent. Under the law, the adolescent doesn't have an active role and is limited to asking for health care if the parent(s) or legal guardian does not agree or take the required steps. This is especially relevant when adolescents seek reproductive health services.

*Youth Law*²⁸ targets “citizens aged 14 to 35 years” and offers them special protection and assistance for the realisation of their rights. This law also mentions vulnerable youth groups – identified as rural youth, youth in institutional care, youth in conflict with the law, young people who use drugs, alcohol and tobacco – in order to mitigate the impact of risk factors. The provisions of this law are not further reflected in a national youth strategy.

The *National Education Law*²⁹ mentions the state support provided to children and youth, including to those with multiple vulnerabilities. In addition, it states that special education and special assistance are the means for complex educational, social and medical integration. In practice, it turns out that such provisions are difficult to implement in the absence of technical and human resources that schools need in order to provide such complex assistance.

As for students who need to travel to another city or village in order to attend school, while the law states that *“they will either be reimbursed for travel costs... or will receive free accommodation and meals in boarding schools ...”*, funds are often missing or reimbursement is delayed.

The shortcomings identified in the implementation of the provisions aimed at vulnerable adolescents are also mentioned with regard to adolescents with disabilities. Although the law requires public facilities to place ramps for persons with disabilities, these are only partially available. The rules for integrating adolescents with disabilities in public schools are not applied due, among other factors, to deficient infrastructure and school staff reluctance:

“...schools place a ramp at the entrance, but inside the school the mother has to carry her child in her arms up to the 3rd floor.” (Leader, NGO)

The secondary legislation on education fails to regulate matters for adolescents aged 14-15 who have completed compulsory education. They lack support for continuing their studies while being unable to access the labour market because the legislation forbids it before the age of 16. So, they remain in a grey area.

The “Second Chance” programme methodology does not target children and adolescents under 14 who have dropped out of school since they cannot be enrolled until they are 14 (for example, a 12-year-old who has dropped out in the first grade cannot be enrolled in the second chance programme before s/he turns 14).

The drop-out registration methodology is deficiently implemented. At school level, we have different understandings of the same phenomenon. Therefore, different drop-out figures are reported for similar situations.

On the other hand, the standpoint that the school's mission is not (any longer) limited only to the institution itself has started to gain more ground. One official said that *“the focus is too much on*

²⁸ Law No. 350/2006

²⁹ Law No. 1/ 2011

children and too little on family ... children are provided a lot in school only to go home to unsupportive parents". In other words, social programmes with an educational component should be given more priority.

Strategies concerning adolescents

The reviewed strategic documents³⁰ contain very few references to adolescents, including vulnerable adolescents. However, some of the official documents lead to the idea that teenagers are a special group deserving special attention. The Anti-Drug National Strategy stresses that, although drug use has a relatively low incidence in the overall population of Romania compared to the European average, it has reached higher levels in certain age groups, especially among young people. While the National Anti-Drug Agency is concerned with teenage drug use, it only investigates drug use among students aged 16 years.³¹

Educational programmes and strategies

According to a European Commission report³², Romania's early school leaving (ESL) rate³³ is above the EU average of 13.5%, reaching 17.5% in 2011 while the EU target for 2020 is 10%. More than two in five children aged 15 do not have the appropriate reading, math or science skills they need for adult life. A major challenge for Romania concerns ESL in rural areas and among Roma population. In terms of investment in education, Romania allocates the lowest GDP percentage to education, already affected by the economic crisis.

The Ministry of Education carries out several programmes – Croissant and Milk, Second Chance, Educational Priority Areas, Money for High School – that we discussed with officials from various institutions, representatives of NGOs, and adolescents.

The "Croissant and Milk" programme (implemented since 2002) is best known for involving schools in reducing disadvantaged children's social vulnerability. The "Second Chance" programme is a literacy catch-up programme and, according to experts' opinion, it reflects the deficiencies of prevention programmes. In the opinion of NGO representatives, the potential beneficiaries of the Second Chance Programme are discouraged to participate by bureaucratic requirements: *"...You must submit many documents ... sometimes the family quits because of the costly paperwork ... they simply don't know what to do... to access scholarships ... to access aid...."* (Leader, NGO)

As for the "Money for High School" programme (initiated in 2004), official data provided by the Ministry of Education³⁴ show that in 2012 a significant number of high school students (over 118,000) received RON 180 each month. Generally, grants are awarded to all eligible applicants. In addition, students are provided accommodation and transportation.

The desk review and qualitative research indicate that few evaluations have been conducted on the effectiveness, efficiency and impact of the above-mentioned programmes, which means that further research might be needed.

The situation of adolescent migrants raises concerns and requires further investigation to develop appropriate legislative measures. Interviewed specialists brought up the issue of adolescents returning to Romania and facing difficulties in getting their grades recognised or with school reinsertion.

³⁰ e.g. The Strategy on the Protection and Promotion of Children's Rights 2008-2013, the National Anti-Drug Strategy 2013-2020; the Strategy on Roma Inclusion 2012-2020

³¹ The National Anti-Drug Strategy 2013-2020, available at www.mai.gov.ro/Documente/Transparenta/decizionala/Strategie_SNA2013-2020 (last accessed on June 18, 2013)

³² Council Recommendation on Romania's 2013 national reform programme and delivering a Council opinion on Romania's convergence programme for 2012-2016

³³ The share of the low-educated population aged 18-24 years, who did not attend any form of education or training in the four weeks prior to the interview, in the total population aged 18-24 years

³⁴ <http://banideliceu.edu.ro/Rapoarte2012/jfile/Judete/index.html>

Our qualitative research has pointed out several initiatives that are sporadically run either by state institutions or NGOs, such as: the after-school programme (considered by respondents as promising for reducing early school leaving); parenting programmes (considered by respondents as relevant especially in the case of vulnerable adolescents). While interviewed specialists believe that such programmes are highly efficient, such opinions should be backed up by future evaluations.

Health programmes and strategies

The National Health Strategy is currently under development and it is an ex-ante conditionality that Romania has to meet in order to gain access to European Funds in 2014-2020.

The Ministry of Health addressed adolescents with previous strategies. For instance, the Strategy on Family, Woman and Child Health 2002-2006 targeted the health of adolescents and youth through the lens of reproductive health. Adolescents and their health are also targeted by the Reproductive Health Strategy 2012-2015 and the HIV/AIDS Strategy 2011-2015, both strategies still pending for approval. The National HIV/AIDS Strategy sets six expected results, one of which concerns *“the decrease in HIV transmission among vulnerable adolescents and youth population living in institutions and street children”*. Even if today there are few cases of HIV infection among adolescents, the risk persists, especially for adolescents who inject drugs: *“in absolute figures, there aren’t many HIV cases among IDUs. What is frightening is that the number is skyrocketing. For example, in the last years, we registered about 16-20 HIV-positive IDUs and now we’ve reached 150-200 nearly 300 HIV-positive cases in IDU population because of the use of ethnobotanical substances”³⁵* (Expert, central institution)

Pending for approval, the National Anti-Drug Strategy for 2013-2020 develops the national policy framework needed for the proactive implementation of all measures against the use of drugs, alcohol and tobacco. The strategy sets out special provisions for drug use prevention and assistance to adolescents and youth. In the opinion of interviewed experts, alcohol and tobacco matters are insufficiently tackled in the National Anti-Drug Strategy and National Action Plans, while the National Mental Health Programme only addresses the *“tip of the iceberg”* in experts’ opinion, targeting only chronic patients. This leaves alcohol and tobacco use unaddressed and diluted across national policies. The solutions proposed by interviewed specialists were either to develop specific strategies in both fields – *“Romania is one of the few states in the EU that has neither a national strategy, nor an action plan, nor a national programme on alcohol use.”* (Expert, NGO); *“State authorities need to cooperate so as to develop a strategy for combating smoking in agreement with the existing European Strategy for Tobacco Control.”* (Expert, ministry) –, or to develop normative measures meant to address alcohol and tobacco use in the general population, including adolescents.

Anyhow, even if all previous strategies mentioned above included relevant measures aimed at adolescents and youth policies, their adoption was much delayed and their approval should be accelerated. At the same time, given the National Health Strategy for 2014-2020 currently under development, the opportunity to address the aforementioned gaps should be analysed.

Social protection programmes and strategies

The National Strategy on the Protection and Promotion of Children’s Rights 2008-2013 was developed so as to fully cover child rights issues across all sectors, being designed for the first time at such a scale. For strategy implementation, three action plans were developed. The National Strategy on child rights takes into consideration adolescents in light of the UN definition of children, and special reference is made to adolescents living in institutions and drug use prevention in the same population. The strategy for 2008-2013 stressed the need *“to increase the capacity of children and youngsters to make decisions on career development based on strengths and preferences”*.

With regard to a special focus on adolescents within national policies, experts’ opinions are divided. On the one hand, some believe that there is no need to place a special focus on adolescents since

³⁵ New psychoactive substances

current policies are already targeting adolescents through the lens of children: “....*the problem is not the legislative framework, but rather the insufficient development of services*” On another hand, in the opinion of some medium-level representatives, adolescents should have their own strategy or at least a proper secondary legislation.

Another recommendation made by local experts pertains to the development of clear policies focusing on adolescents living in institutions, policies which should have long-term objectives and specifically target adolescents’ social integration (including labour market aspects). In experts’ opinion, the current approach is characterised by short-term objectives and leads to harmful habits in adolescents (e.g. dependence on the system).

Youth programmes

In the last eight years, Romania hasn’t had a youth strategy. The newly established Ministry of Youth and Sports has set the target for this year to develop a 2014-2020 youth strategy.

So far, several ongoing programmes (e.g. youth centres, national grants for local projects or youth research) have been implemented, but their efficiency hasn’t been evaluated yet which means that further research is needed. Anecdotal data indicates that several programmes implemented by youth NGOs have proved that adolescents can be engaged in the activities (e.g. volunteering, mentoring, and youth exchanges).

Policies, programmes and services for youth are about to be reconsidered under a new strategy that is in its stage of completion and special attention should be paid to adolescents aged 14-18 years.

iii) Budget/Expenditure

With respect to adolescents’ need for protection and assistance/support in (fairly) realising their rights, public budgets in Romania have proved to be highly insufficient as indicated by the qualitative research.

In connection with both legal/institutional frameworks and resource allocation policies, a key determinant that impacts adolescents’ realisation of their rights and their perspectives for a better life is poverty. According to a European recommendation, 49.1% of children in Romania were at risk of poverty and social exclusion in 2011 (exceeding the rate for the whole population, which was 40.3%)³⁶. As the first European Youth Trends report commissioned by the Youth Directorate at the Council of Europe pointed out in 1998, it is currently largely accepted that early exposure to welfare deficit is the main risk factor of exclusion whose effects can hardly be repaired at later stages in life³⁷. This has also been emphasised in the recent UNICEF report on the state of the world’s children: “Poverty is one of the biggest threats to adolescent rights. It catapults young people prematurely into adulthood by pulling them out of school, pushing them into the labour market or forcing them to marry young.”³⁸

Due to the economic crisis, public funds available for social protection have experienced a slight decrease in Romania between 2010 and 2012 and seem to return to the previous level of 2010 only in 2013-2014³⁹. In the opinion of an interviewed expert, the national budget allocated to the social

³⁶ Council Recommendation on Romania’s 2013 national reform programme and delivering a Council opinion on Romania’s convergence programme for 2012-2016, p. 4

³⁷ European Youth Trends, Council of Europe, Youth Directorate, 1998, p.3. Available at http://www.coe.int/t/dg4/youth/Source/Resources/Documents/1998_Youth_Trends_en.pdf [Last accessed on May 26, 2013]

³⁸ UNICEF, “The State of the World’s Children 2011”, p. 72. Available at http://www.childinfo.org/files/SOWC_2011.pdf [Last accessed on May 26, 2013]

³⁹ MLSP spending on social assistance decreased from RON 14,099 million in 2010 to RON 13,784 million in 2012 and it will reach the level of 2010 only in 2013 (expected – RON 14,429 million), Annex of MLSP budget available at http://www.mmuncii.ro/pub/imagemanager/images/file/Minister/Informatii_Publica/buget%202012.pdf

protection of children covers 70% of the needs. The desk review indicates that public (human and financial) resources devoted to social assistance and protection are mostly concentrated at central and county levels, while the needs that these resources are aimed to address are found at local level. This weakens the effectiveness of welfare services, which results in the persistence of vulnerabilities and undesirable proximity factors that lead to risky behaviours among adolescents (and not only).

Another consequence of the resource allocation system is that decision making is assigned to upper levels in the administrative/political hierarchy, which diminishes responsibilities at lower levels while leaving social problems that occur at the ground level unaddressed. As revealed by a report on the social protection system in Romania, *“When it comes to resources, one may distinguish two trends in the social assistance legislation: on the one hand, central structures benefit from a detailed description of the resources they use and of the sources they access, and on the other hand county structures (to a smaller extent) and local ones (to a great extent) are given only some guidelines which hardly ever offer a real answer to the questions <from where?> and <how much?>”*⁴⁰.

“We have been speaking about decentralisation for a long time now, but we haven’t done anything to achieve clear decentralisation, at least in the field of social assistance; it’s no good to be a mammoth institution like we are, with more than one thousand employees and 20,000 files to work with each month ... which is anything but efficient. As long as we don’t travel to local communities, speak with mayors, set up a day care centre ... for marginalised children, for children at risk, for vulnerable children. ... Let’s go there and provide them with a warm meal, maybe the next day we can talk about after-school activities, to keep them there but let them spend the night with their families without isolating them from society, because if they stay in our system the costs are three times higher and they get separated from society. ... In education, funding follows the pupil ... that is the principle; why shouldn’t we follow the same principle in social assistance? Funding should follow the child. That is ... the money should go where the day care centre is. So, funds would be available but not distributed/thought as they currently are; they would follow the beneficiary and go where the beneficiary is located...” (Expert, county agency)

The state budget remains the main source of funding for health programmes while European funds and funding from countries like Norway or Japan cover financial needs only to some extent. Hence, sustainability is low and activities often stop after funds run out despite their clearly positive impact.

Officials in the education system believe that a series of programmes (projects) could improve things, but most of them are implemented for a short period of time and in limited areas, which affects the sustainability of interventions.

Additional resources used to be provided by international donors, especially via NGOs, before Romania’s accession to the European Union⁴¹. In the context of the economic crisis which hit the country in 2009, some of the international donors have cut down or cancelled their financial support for direct interventions.

On the other hand, as our interviewees revealed, the EU funds made available to Romania once the country joined the EU proved to be a rather difficult instrument. In the opinion of NGO leaders, the allocation of funds was not based on a solid needs assessment but only on formal consultations with the civil society. This erratic allocation along with hypertrophic bureaucracy led to a low absorption rate and to growing discrepancies in the targeted areas. At the same time, NGO leaders regret the retreat of international donors (especially in the area of HIV/AIDS) which used to base their funding on results rather than on bureaucratic procedures, all the more so as specific programmes for HIV prevention in most-at-risk populations lack national ownership.

⁴⁰ Magheru, M, “Decentralisation of the Social Protection System in Romania”, UNICEF Romania, 2010, p. 9. Available at <http://www.unicef.ro/wp-content/uploads/descentralizarea-protectiei-sociale-in-romania-ro-.pdf> [last accessed on June 18, 2013]

⁴¹ Analysis of mechanisms providing direct funding from the state budget to non-governmental organisations in Romania, FDSC, 2007

In spite of NGOs being more proficient and proactive in reaching out to vulnerable adolescents than most public services, they have few opportunities to access public funding. The APADOR-CH report shows that in 2009 14% of county or local governments granted subsidies to NGOs that set up or managed social assistance services.⁴²

As for subsidies granted (by the Ministry of Labour, Family, Social Protection and the Elderly) to the NGOs that provide social services, they have increased in absolute terms (from RON 13,101,700 in 2008 to RON 19,715,426 in the first 9 months of 2012⁴³). This increase can be ascertained in both the number of beneficiary NGOs (subsidies were granted to 134 NGOs in 2008 and to over 180 organisations in 2012) and the amount allocated to each NGO (from RON 97,773 to RON 109,530). Despite this slight increase, the perception of NGO representatives is that these funds are increasingly insufficient. This perception can be explained by the rising inflation and higher quality standards which incur additional costs.

Regarding child protection NIPs, a change has been made to the detriment of NGOs: if before 2007, they were the only eligible applicants (under GO 532/2006), starting with 2008 the programmes were implemented by County Directorates for Social Assistance in partnership with NGOs and after 2010 only by these Directorates. *“Foundations have survived... Some closed their operations after 2007, others have survived by changing their programmes in the sense that they deliver fewer or no direct services to beneficiaries and offer coaching, experience-sharing instead...”* (Leader, NGO)

However, allocation mechanisms seem to be the main problem. Recommendations have been made for implementing clear, consistent, transparent procedures. Recently, another analysis of the welfare system has found persistent weaknesses in public funding mechanisms: *“... Resources, especially the human and financial means to access them, are not always clearly explained.... The social service funding mechanism is insufficiently detailed ...”*⁴⁴

In the case of drop-out, existing programmes have no clear financing sources: *“I think we lack the means to make real all these legal provisions... For example, the school after school programme. Good. Now, the question that arises is what resources are there to do this job???”* (Leader, NGO)

Changes in the financing of national health programmes (shift away from NHIH funds towards state budget funds coordinated by the Ministry of Health, as expected from this year) created some incertitude within the health system. This shift was seen as a mechanism to assure the sustainability of these programs through the state budget, but the real impact will be seen in few years. Lack of funding and national ownership can affect HIV prevention programmes. Even if health budget allocations for treatment amounts to more than USD 71,000,000/year, interviewed experts think that prevention programmes aimed at the most vulnerable populations (IDUs, SWs, MSMs) are currently underfunded.

Stakeholders in the fields of alcohol and tobacco control underline the lack of constant budgetary allocation, especially for primary and secondary prevention.

Management/Coordination

Our statements above regarding structural determinants such as legal framework and budgetary/resource allocation are consistent with the findings of a more specific study on the Romanian social protection system commissioned by UNICEF Romania in 2010.⁴⁵ They are further supported by a recent document of the European Commission containing recommendations on Romania's 2013 national reform programme, which states, *inter alia*, the need to “strengthen

⁴²APADOR-CH, Sustainability and continuity of social services, 2010, available at http://www.apador.org/publicatii/durabilitate_servicii_sociale.pdf

⁴³ MLSP data available at www.mmsf.ro

⁴⁴ Magheru, M, “Decentralisation of the Social Protection System in Romania”, UNICEF Romania, 2010, pp. 2-3; 8-9. Available at <http://www.unicef.ro/wp-content/uploads/descentralizarea-protectiei-sociale-in-romania-ro.pdf> [last accessed on June 18, 2013]

⁴⁵ Magheru, op. cit.

*governance and the quality of institutions and the public administration, in particular by improving the capacity for strategic and budgetary planning, by increasing the professionalism of the public service through improved human resource management and by strengthening the mechanisms for coordination between the different levels of government*⁴⁶.” The Report on the decentralisation of the social protection system also mentions among its conclusions that “*not all institutions and their mandates are clearly defined...*” and there is a need “*... to ensure complementarity and consistency of all actors, who don’t always benefit from the most appropriate procedures and mechanisms for cooperation*”⁴⁷.

Regarding central level cooperation, the qualitative research revealed several divergences between different institutional actors that act on the same target group or area of intervention.

Some interviewed social protection professionals raised the issue of schools’ inefficiency in providing appropriate training for proper employment to certain groups of vulnerable adolescents (in particular to adolescents living in institutions): “*school and child care seem to pursue divergent goals*”. (Social protection expert)

The collaboration between the General Directorate for Social Protection (Ministry of Labour, Family, Social Protection and the Elderly) and the National Anti-Drug Agency has highlighted the need to correlate certain legislative issues to better respond to social needs: “*In recent years, we have indeed discussed it.... with our colleagues at NAA that their legislation is not consistent with our law (on social protection) or the health law.*” (Expert, central institution)

The cooperation between NAA and the Ministry of Health in preventing and reducing drug use among adolescents “*features some ambiguity and overlapping*” (expert, central institution) and it should be strengthened: “*Authorities should become aware of the fact that alcohol is a major public health problem, including among adolescents, and therefore it is necessary to create a framework for cooperation and coordination between actors in the areas of alcohol, tobacco and drugs, such as inter-ministerial committees.*” (Expert, ministry)

For the successful implementation of the National Health Education Programme in schools, a good collaboration between health and education systems is essential. The difficulty is to make room for the health education course syllabus in the actual curriculum. In terms of time restrictions, which are difficult to overcome, the health education programme has to be included in the curriculum based on the school’s decision or as part of extracurricular education which is quite vague. Therefore, the education system becomes a relatively unreliable partner for the health education programme as pointed out by public health officials.

The interviews conducted with education and child protection experts have showed that coordination between the two systems is hard to achieve because of poorly defined functional roles for the institutions involved. The same opinion is shared by NGO experts: “*School does not have the necessary means to solve these problems (A/N: adolescents in vulnerable circumstances), but at the same time it cannot be replaced and should work together with child protection bodies on the diagnosis and get involved in the community advisory board. There is a lack of training and necessary means at school level.*” (Expert, NGO) “*...school is often forced to take on more responsibilities and venture into the area of child protection. But we have hardly ever seen [...] child protection institutions venturing into the area of prevention*”. (Expert, NGO)

⁴⁶ European Commission, Recommendation for a COUNCIL RECOMMENDATION on Romania’s 2013 national reform programme and delivering a Council opinion on Romania’s convergence programme for 2012-2016 {SWD(2013) 373 final}, p. 7 Available at http://ec.europa.eu/europe2020/pdf/nd/csr2013_romania_en.pdf [last accessed on June 9, 2013]

⁴⁷ Ibid, p. 44

Working groups, committees and commissions were mentioned during the qualitative research, but very few of them seemed to have effective mechanisms in place for defining and setting roles, sharing responsibilities and implementing synergic interventions under an integrated action plan.

Cooperation between the public system and NGOs is also difficult. Public consultations on draft laws carried out mainly with the NGOs active in the respective field could create the conditions for collaboration between public institutions and civil society. In fact, the interviews conducted with NGO representatives have pointed out that the consultation process is mostly formal (only because the law requires it), usually involving a few NGOs that are readily available. Thus, legitimacy is ensured, but real collaboration continues to be nothing more than wishful thinking. *“There are policies and strategies; I haven’t seen any mechanisms that truly work.”* (Leader, NGO)

The perception of poor institutional cooperation in the field of alcohol, tobacco and drug use was identified at the level of both public institutions and NGOs, as well as the lack of inter-institutional committees to develop a framework for cooperation and to manage the specific role of each party. *“I think we should shift away from informal and personal relationships towards the inter-institutional level in order to set up inter-institutional committees with the representatives of state institutions and NGOs concerned.”* (Expert, NGO)

The qualitative research has also raised the question of poor interconnections between various programmes (provided by public institutions and NGOs) aimed at the same target group: *“What we lack is not necessarily social services since they are in place, but they are not interconnected, which means that it so happens that a certain group of beneficiaries may receive social benefits or food aid but not counselling, for example.... And the Directorate doesn’t have the money for it. An organisation could step in and offer these services free of charge, but somehow interventions are not interconnected.”* (Expert, NGO)

Vertical coordination

Deficient coordination between local and county institutions is also a cause of frequently inefficient responses to adolescent and family needs.

County experts’ assessments on social assistance and child protection converge in supporting the idea that local authorities leave the necessary interventions to county directorates and avoid taking on any specific role in providing social protection services.

Staff shortages and lack of resources limit the interventions of experts from the Public Services for Social Assistance (PSSA) at the level of mayoralities, experts who focus on paying social benefits and allowances.

In the field of education, central and local public authorities should cooperate more and local authorities’ capacities need to be built up in order to be able to diagnose and develop local strategies for better educational inclusion of disadvantaged adolescents (leading to decreased drop-out rates among adolescents).

Cooperation at local level

In the field of child protection, a major deficiency in institutional cooperation is that local advisory bodies are not functional or do not exist although the obligation for local authorities to establish such bodies is explicitly stated in the law on the protection and promotion of children’s rights.

Instead of and complementary to institutionalised collaboration, informal relationships are brought into play at this level: *“I assure you that we solve more than half of the problems in the system (A/N the social protection system) and between us as institutions based on our personal relationships, on our mutual understanding, on the people we know.”* (Expert, county service)

The absence at local level of integrated services designed to meet vulnerable adolescents’ needs reduces the efficiency of disparate and incoherent approaches across the social protection system. “...

There's this problem, [in our system] you need to give [people] 200,000 directions: <go there, then go there>, services are all disparate and that's a problem; someone (A/N: certain categories of vulnerable adolescents such as drug users) tries to access them, but doesn't reach the assigned counter or fails to pass the guardian ... A place is needed where people are welcome, where they can discuss things, where they can get a feasible intervention plan, where there are resources for them, so that they don't feel that <we've talked and now I get kicked out in street; maybe it's November or December and it's cold, where can I go, what will happen to me?>” (expert, NGO)

The desk review and qualitative research converge to the conclusion that local capacities to address vulnerable adolescents' problems are weak both in terms of diagnosis and adequacy of interventions.

b) Supply

i) Availability of essential commodities/inputs

This subchapter runs an analysis on essential commodities available in social protection, health and education, based on desk review inputs and findings of the qualitative research conducted with central and local authorities, NGO representatives, and adolescents. The research looked into services available at central and local levels, distribution of basic and specialised commodities available for all children, with a focus on adolescents and vulnerable adolescents. For the purposes of this research, essential commodities represent the set of social protection, education and health commodities necessary for the realisation of adolescent rights.

This subchapter explores the following commodities:

- Basic social services available at local level and specialised services (for adolescents living in institutions, adolescents with disabilities, adolescents who are victims of trafficking, etc.);
- Education commodities available at community level, especially for Roma adolescents;
- Basic health services provided by community health workers and specialised services (at the crossroads of medical and social interventions – for adolescent drug users, adolescents with disabilities).

a. Social services ⁴⁸

During our field research, many voices have stressed the fact that social services are not close to beneficiaries at local/community level where the needs are actually located: *“Lack of local services causes great damages”* (expert, county level). Assessments made by social service experts working for public providers such as General Directorates for Social Assistance and Child Protection (GDSACP), Public Social Services and private providers (NGOs) have shown that the social service system may sometimes feature shortcomings: social services are insufficient to meet existing needs. Even though the needs of beneficiaries are identified in the community, services are available mainly at municipality or county level. In rural areas, the only existing social services are public services whose reach is extremely limited. Proximity public social services, acting in the living environment of vulnerable groups, are less developed due to limited resources: *“...a secondary paragraph [of Law No.292 on Social Assistance] allows for an exception: in case they [local authorities] do not have financial and human resources to set up such services, these may be staffed by only one person. This is the element that brought the entire structure down – a simple paragraph in a framework law.”* (Expert, county public service) Following the same pattern, NGOs are usually established in urban settings and lack the capacity to develop services in rural areas, providing thus no solution to the current situation.

⁴⁸ Law 292/2011 on social assistance – the Social Assistance Law sets out the overall framework for the establishment, operation and funding of the national welfare system in Romania. The law defines and categorises social services based on several criteria: purpose, groups of beneficiaries, etc. Under the law, social services stand for any activity or set of activities carried out to cover social and special needs of individuals, families and groups so that they can cope with difficult situations, to prevent and combat social exclusion, and to increase the quality of life.

However, things look different when we assess the extent to which existing specialised services meet the needs of beneficiaries, according to experts' opinions. With regard to children and adolescents with disabilities, social services, such as day care centres, are scarce in urban areas and totally lacking in rural areas. Another problem related to services aimed at adolescents with disabilities concerns insufficient or lack of rehabilitation services in the villages, with adolescents and their families having to travel sometimes hundreds of miles to get to such a centre. Interviewed experts have brought up the lack of specialised centres and integrated services for adolescents who are victims of trafficking. The same has been mentioned with respect to pregnant adolescents for whom health and social services have not yet been defined as a package of interventions.

From the perspective of our interlocutors, social services for adolescents should work not only with the adolescent but with the family too, and they should be proactive and shift focus onto the areas where special groups of adolescents live.

The weak link between local social services – in particular prevention services – comes from a lack of resources to develop services designed for local needs. The direct consequence of this is that additional pressure is placed on protection services at county level while more specialised services are needed for specific groups of vulnerable adolescents (e.g. street children).

Educational services

Interviewed experts believe that the few hundred school mediators currently working in the Romanian schools are insufficient compared to the needs.⁴⁹

Given the challenges of adolescence, an age that – psychologists say – is a “time of search”, adolescents have a real “social need for guidance” in education. By the standards of the Romanian education system, one educational counsellor is available to 800 students or 400 children in kindergarten⁵⁰. Interviewed experts have mentioned that counsellors cannot provide effective interventions since their workload is overwhelming. Rural communities are particularly short of school counsellors. The qualitative research has indicated that since some school counsellors work as both a counsellor and a teacher, they may need to fill the shoes of conflicting figures. Thus, beneficiaries (students) see them as teachers and don't trust them (anymore). A county inspector reported cases where students “*had an issue that needed to be addressed and preferred to go to a counsellor in a different school*” (expert, county level).

With regard to persons with disabilities, in rural areas support teachers are way too few compared to the needs. “... *We cannot talk about the integration of adolescents with disabilities in rural areas unless support teachers and adapted curricula are available; otherwise, there's nothing to talk about.*” (Expert, public institution) The need for day care centres and specialised recovery centres for adolescents with disabilities has been underlined as an alternative to the state allowance for a personal caregiver – in most cases one of the parents, which would allow the parent to go to work.

For adolescents with disabilities, the education system needs to improve its target as identified by experts: “...*once adolescents complete their education, they have no marketable skills. The products of the education system don't match the labour market demand; there is a need to teach students the skills expected by employers...*” (Official, central institution)

The lack of free opportunities like after/before school activities is perceived as a gap especially for adolescents in vulnerable groups (e.g. from families dealing with alcohol abuse; with migrant parents). School should also become a centre for both formal and non-formal lifelong learning targeting the parents and other community members (including teenagers) who need it, a place to

⁴⁹ Elena Raducanu, Effectiveness of a public service under threat - school mediators in Bucharest, available at <http://www.doctorat.snsa.ro>

⁵⁰ Framework for setting up and running psycho-pedagogical assistance centres at county/Bucharest level (http://www.isj.gl.edu.ro/html/sub_noutati/2011-2012/METODOLOGII%20NOI/25.%20OMECTS%205555%202011%20pentru%20aprobarea%20Regulamentului%20privind%20organizarea%20si%20functionarea%20CJRAE.pdf)

practise hobbies and spend one's free time in a useful and pleasant way. *"...I think school could be a lifelong learning facility! Serving the community as a whole. It is abnormal that in a small village school closes at 12."* (Expert, public institution)

Adolescents who have dropped out of school or are at risk of dropping out are mainly targeted by the educational programme called the "Second Chance". Whilst the programme is considered extremely useful, its coverage is limited. There are counties where, despite high drop-out rates, there are very few providers authorised to carry out activities under this programme. As indicated by the qualitative research, for this type of services to meet the needs of beneficiaries, the methodology has to be revised both in terms of the documents that must be completed by potential beneficiaries (complaints have been made about the bureaucracy that one has to deal with when applying for this programme) and in terms of the minimum age requirements for enrolling in this programme, namely 14 years. Related to support services for programme participants, like providing/facilitating transport to/from "Second Chance" centres or providing meals to these pupils, these are insufficiently developed.

Health services

Whilst in Romania healthcare is free of charge until the age of 18, many services are still insufficiently available.

With the healthcare infrastructure located mainly in urban areas, rural communities have a much lower coverage in terms of medical staff and health facilities. In the opinion of interviewed experts, the number of community health nurses and health mediators is completely insufficient. Also school doctors and nurses completely lack in rural areas, their responsibilities being fulfilled in a various degree by the family doctors.

Interviewed experts have talked about a shortage of harm reduction services. The absence of private or public funding for harm reduction interventions, especially in the areas where such interventions are most needed (like Bucharest), is a serious concern. According to the documents of the National Anti-Drug Agency, needle exchange services are insufficient to cover existing needs⁵¹. As regards adolescent drug users, socio-psycho-medical services are delivered by public and private providers that offer both information and counselling at county level. Substitution treatment services are available in the cities, but they are insufficient compared to the needs. The qualitative research has identified waiting lists for drug users and delays in treatment initiation which jeopardise the efficiency of such treatment. Professionals who work directly with this group of beneficiaries have stressed that these services should be more flexible and closer to the drug users' psychological profile, which requires going to the drug users' community (outreach work).

Youth services

There are 33 Departments of Youth and Sports in Romania, under the coordination of Ministry of Youth and Sports. The role of the departments is to ensure the implementation of the policies in the field of youth and sports at local level. We may assume that in lack of a youth strategy to guide the interventions of those centres at county level, the effectiveness of the interventions was rather deficient. A potential line of intervention in this area, in order to ensure effectiveness of Youth Departments at county and at local level, it might be related in the first place on the assessment of resources (financial and human) of those departments. This is especially relevant in the context of the development of youth strategy for 2014-2020 and in the context of new European funds programmatic preparedness.

ii) Access to adequately staffed services, facilities and information

The situation is particularly alarming in rural areas. There, human resources involved in prevention services are rarely skilled professionals with higher education (73% of employees don't hold a higher

⁵¹ The State of Drugs in Romania in 2012 available at <http://www.ana.gov.ro/rapoarte%20nationale/Sinteza%20ANA%202013.pdf>

education degree in social work)⁵². Lacking qualified staff, local social assistance services can only do as much as to refer the cases to county social protection departments that will establish protection measures instead of delivering early counselling services and support to the family at local level.

Lately, increasingly fewer resources have been allocated to social services for human resource development. An official from a specialised social service has recalled that *“in the last two years the County Council has not allocated funds for staff training in social care.”* Staff training has become a secondary concern for employers as proved by GDSACP budgets where the amounts for training have been cutback and in most cases suppressed. In the period 2010-2013, MLFSPE hasn't implemented any NIP on staff training in social care and hasn't published any guidelines and training handbooks for PSSA staff since 2005.

Also, healthcare is affected by a shortage of medical staff. Finding qualified staff is a real problem that takes a toll on the proper functioning of the health system⁵³.

With respect to those who work in the education system, it is believed that school staff are often insufficiently prepared to deal with adolescents and definitely not motivated. Due to these shortcomings and to their focus on covering the curriculum, they neglect the relationship with adolescents and their parents, thus leaving a serious gap in the development of adolescents' personality. Therefore, adolescents do not enjoy attending school and tend to find alternative ways of spending their time outside school. Many activities could be carried out to make the adolescent feel valued and encouraged.

In this respect, the “Second Chance” programme should also avoid involving the same type of teachers whom adolescents have rejected: *“It is about how comfortable they [programme participants] feel in school - and they don't - because we don't have real inclusion strategies ...”* (Expert, public institution)

Teaching methods are too traditional and curriculum overload sets a barrier to achieving effective teacher-adolescent communication.

The Ministry of Education has not promoted teacher training programmes that put emphasis on the cooperation between the staff from its own system and the personnel from other complementary systems, health and social care, etc.⁵⁴ According to the quoted study conducted by IES, continuing teacher training predominantly targets specific aspects of the educational process and more or less or never related areas such as integration of minority children, interculturality, school violence, or Roma ethnicity. This was noticed by the teachers who participated in a group interview conducted by the cited authors. Our research team has found that things haven't changed in many Romanian schools.

Access to facilities and information

Staff training deficiencies in public services could impact their intervention methods.

In the view of interviewed experts, instead of having a proactive approach public services are structurally passive due to the bureaucratic background of the public sector. Some public service approaches are opposed to those of NGOs. NGOs have a more proactive approach going towards beneficiaries and providing them with services in the community where they live. They can do this

⁵² Presidential Commission on Social and Demographic Risk Assessment, Risks and Social Inequities in Romania, available at http://www.presidency.ro/static/CPARSDR_raport_extins.pdf

⁵³ Documentary analysis on health http://www.fonduri-ue.ro/res/filepicker_users/cd25a597fd-62/2012-2020/Dezbateri%20parteneriale/Rezultatele%20analizei%20documentare/03.06.2013/8.Health%20and%20social%20services_22%20mai.pdf

⁵⁴ Jigau, Mihaela, (coordinator), Continuing training in Romania, Institute of Education Sciences, Bucharest 2008

because they have more flexible internal rules compared to the more rigorous internal framework of state institutions. This approach is rather relevant for the services delivered by NGOs to hidden populations, such as drug users. *“Those who work for public entities also have to take their work out in the streets; counselling can be provided to drug users in the street, at the corner of a building, near a pole or a tree, wherever the drug user hangs out; by doing so, results will show up ... you have to go out, to build and maintain a relationship with the drug user.”* (Expert, NGO) The problems raised are met in practice at some extent.

The need to tailor interventions to the specific adolescent age group (a teenage-friendly approach that is adapted to their age, gender, and needs) was underlined by most respondents. Some vulnerable adolescents are reluctant to accessing services offered by public institutions because of the rigid official environment. As regards access to substitution treatment, drug users mentioned waiting lists and the delayed start of the treatment for addiction. *“Public bodies will always be full of rules, surveillance cameras, internal provisions... you cannot put the drug user in a corner... you have to adapt your methods to his lifestyle.... It is very important that more addicts have access to free substitution treatment... to vulnerable people, the amount of about RON 600 a month is too much to pay for this kind of treatment.”* (Expert, NGO)

A specific issue for vulnerable groups (drug users, the homeless, commercial sex workers) is the lack of identity documents, which makes them unable to exercise their rights to health, social protection and education. All public bodies and NGOs that are funded from structural or public funds are required to provide personal data (ID card serial number, social security number, etc.). On the other hand, given that many vulnerable adolescents don't have parents or a legal representative that may consent to the services delivered to them, their access to some services is practically denied. *“... You cannot be hospitalised if you are not from that area, if you don't have a social security number, if your parents are not there to sign for your admission or surgery... unless it is an emergency and they collapse in the street and somebody calls the ambulance, they cannot benefit from healthcare which in theory is guaranteed by law.”* (Leader, NGO)

Other times, there are bureaucratic barriers:

“For certain groups of beneficiaries, access is difficult because they don't have a legal guardian or a parent to come and consent to you as a service provider that you can include him or her in your records ... this clearly restricts their access ... in terms of regulations making it easier or not, it's a bit hard for me to make a difference when the law does not explicitly focus on these groups and states that for any kind of service delivered to children, a parent or legal guardian must come and give their consent and only then can they benefit from the full range of services. If in the absence of a guardian or parent they have no one, they are basically denied any service or you can choose to deliver services to them as a service provider at your own risk.” (Expert, NGO)

Adolescents' exposure to the major risks tackled by the research is equally due to socioeconomic factors affecting the family of origin and the deficit of social services targeting disadvantaged families and communities.

“Social services in Romania work on effect management, not on cause management; the Romanian social worker does not align with the family so as to influence the adolescent's life, but merely tries to restrain the effects he or she faces....” (Expert, government agency)

The lack of information concerning the right of adolescents and their families to access services is most common in disadvantaged communities, especially in rural areas, where information and prevention programmes are rather accidental. This is also proved by our quantitative research findings, showing that rural adolescents seem underprivileged as regards information about issues that are sensitive at their age.

Information and counselling services for parents are also lacking. This seems to be a major gap as many parents to whom we have talked do not know how to approach teenagers in general and in

particular how to discourage alcohol, tobacco and drug use or drop-out or they do not know how to behave with an adolescent with disabilities.

c) Demand

i) Financial access

Generally, financial barriers to adolescents' access to their rights have been mentioned less frequently. Most frequent references have been made to the costs of transportation to the place where certain services are available. However, we have identified a number of economic and financial issues that are obstacles to the demand.

Education

Several rationalisation measures in the educational network (such as closing down schools with a small number of children) imposed by budgetary constraints have affected once again the access to education of children and adolescents from disadvantaged communities in rural areas. Distance to/from school, difficult transportation, or boarding costs associated with secondary education have increased drop-out risks for rural adolescents.

Socio-economic factors are most frequently invoked as reasons for non-participation or drop-out, but these factors are associated with disadvantaged communities and adolescents from poor Roma families are therefore most at risk of non-participation in education.

Roma adolescents are faced with multiple vulnerabilities. The costs incurred by attending school (school supplies, clothes, shoes, transportation) pose a problem for families living in severe poverty. On the other hand, because of economic challenges adolescents have to get involved in work inside their own household, such as looking after younger siblings, or in activities that generate an income for their family, which may cause academic failure or drop-out.

'Time costs' have also been mentioned as barriers to enrolling vulnerable adolescents in the "Second Chance" programme or similar programmes devoted to dropouts. Extensive paperwork is required and the cost and complexity of such paperwork often make parents give up: *"... Certainly, for many access to this programme, and to others, support and protection are limited by the need to meet formal procedures. You must submit many documents ... sometimes the family quits because of the costly paperwork ... they simply don't know what to do... to access scholarships ... to access aid...."* (Leader, NGO)

Health

According to legislation, adolescents are guaranteed access to free healthcare. However, for adolescents in rural areas access to specialised medical services is difficult; often, the nearest medical centre is many miles away.

Free dental care is difficult to access and rather scarce, so these services may be accessed by adolescents, in most cases, at a charge. The dissolution of school dental care units has created an access problem especially for financially challenged teenagers.

The complex health services that adolescent drug users need are generally included in the offer of public and private medical centres, hospitals, Anti-Drug Centres for Prevention, Evaluation and Counselling and of the few NGOs that provide services to this category of patients. The interviews and focus groups that we have conducted with drug users have revealed that public service coverage is low and the cost of private services is high for this group of beneficiaries. While more active, services provided by NGOs have some cost barriers: *"Sure, services are in place but they are obviously delivered at a charge because the organisations which offer them must find a way to survive since funds are scarce."* (Expert, NGO)

Adolescents with disabilities face the biggest problems in accessing specialised medical and rehabilitation services given that the coverage of these services is very low. Parents of adolescents with disabilities are too often guided away from free public services towards paid services which they can hardly afford: *“When you get the certificate, you are given a recovery plan whose implementation however is left up to you. And the family has to find a place in the country where they can go for recovery”* (parent of an adolescent with disabilities). Or some procedures require trips to evaluation committees in county seats or Bucharest hospitals.

In terms of access to healthcare, things look most challenging for adolescents confronted with multiple vulnerabilities, for example those with disabilities who come from disadvantaged families and rural communities. They face a major risk of academic and social failure while social services that could improve their circumstances are unavailable or ineffective.

Finally, there is a group of adolescents who are completely denied access to healthcare: those who lack identity documents. Whether they are street children or they come from extremely poor families and communities, these adolescents can only access emergency medical services. Although access to healthcare is guaranteed by law for all adolescents, not having a social security number, parents or guardians prevents them from getting the services they need.

ii) Social and cultural practices and beliefs

“Soft” determinants of adolescents’ behaviour are placed at the interplay of social beliefs, cultural values and practice. Beliefs represent an individual’s perceptions of reality; they can be specific to an activity or institution and, as such, be more directly related to behaviours. Cultural values imply some level of stable shared meaning, of a commonality in the way in which behaviour is evaluated. However, an individual’s behaviour at any given moment “may or may not be congruent with ‘shared’ cultural meanings, and personal desires may be incompatible with cultural norms.”⁵⁵

Social and cultural practices are patterns of social interactions and behaviours. Practices represent the knowledge of “what to do, when and where” and how to interact within a particular culture. Cultural practices involve the use of products, be they tangible (material commodities) or intangible (laws, public service systems, education).

This research investigated only some of adolescents’ social and cultural practices and beliefs, namely those that influence access to education, healthcare and social protection.

Knowledge of services

Adolescents’ awareness of the services that are available for them and propensity to use these services vary significantly depending on service type and coverage, as well as on the area of residence and the community of origin. Social assistance and protection services are generally known to urban and vulnerable adolescents, yet their knowledge of these services is vague and stereotypical, acquired mostly from the media, but also at school.

Rural adolescents’ knowledge of child assistance and protection services (including the Child Helpline) is mediated by television; they have not been in a situation where they had to use such services and do not know anyone to have used them. Adolescents prefer not to seek such services for fear of repercussions, but also because they don’t want to make public what they have experienced.

“ ... When I was abused by my mother, I came to school covered in bruises and child services did nothing. They said I’d got drunk and hit myself. The second time, same thing happened; I was in Constanta and I asked for child services. The gentleman asked me to give a statement, which I did. That was just to find out my name and call my Mom. But the police didn’t help me either. They took me and hit my head against the chair because I wouldn’t give them my last name. And I explained that

⁵⁵Rohner, R.P. (1984): “Toward a conception of culture for cross-cultural psychology”, *Journal of Cross-Cultural Psychology* 15(2): 111–138.

I didn't want to tell them because my mother would beat me up at home." (Victim of trafficking in human beings)

Most groups of adolescents approached by this research show lack of confidence in child assistance and protection services and share the view that these services resort very easily to institutionalising children with family problems.

In some disadvantaged Roma communities, social assistance is perceived as providing social support as well as threatening to remove the child from the family. In these communities, those who access counselling services (psychological counselling, reproductive health counselling), but also certain types of medical services (STD testing and treatment) are socially stigmatised and therefore these services are avoided or, when necessary, secretly sought away from the community.

Vulnerable adolescents who benefit from assistance and protection services have more knowledge of available services, but they too stay sceptical when it comes to accessing them due to the unfriendly climate and treatment provided by those services.

Institutionalised adolescents have the most positive attitude towards services provided by the social assistance and protection system and they best perceive the necessity and benefits of psychological counselling services that are available to them.

Adolescents, including those from disadvantaged communities, have stereotypical information about counselling services and, even when their necessity is well understood, the fear of being labelled stands as a barrier to accessing them.

"I think that adolescents generally need to be heard, advised and guided to take the right path! So, to this end, some services are probably needed, something like counselling. It's just that in our country it's very difficult to change someone's mentality and to make them see a psychotherapist and explain to them that it's actually something normal. Because even in the best environments if you say that you've seen a shrink people ask you if you're crazy." (Adolescent)

Specific services addressed to certain categories of vulnerable adolescents are generally known among those teenage groups, but the extent to which these are accessed, the motivation and the confidence in them vary.

Urban adolescents with disabilities are generally well informed about the medical, recovery and counselling services to which they are entitled and are eager to access them, but these services have a very low coverage, with the exception of county seats and Bucharest. For those who live in rural areas, things are different: information about services is vague and fragmented and access to proximity services is virtually nonexistent. For both urban and rural adolescents, support teachers and home schooling are almost unknown alternatives.

Adolescent drug users who benefit from specific public or private services are generally informed about the range of available services. As regards detoxification services, users share stereotypes that make them refuse such treatment, such as:

"I heard ... that they take users, tie them up and keep them on pills and perfusions." (Adolescent drug user)

Family environment and family relationships

Family is the smaller social environment in which adolescents live and develop life concepts and coping strategies, which may fit in with community's and/or society's standards or not. In most cases, this is also the social setting where adolescents' identity and reference system of values are being constructed alongside their main support.

As regards key family-related determinants, interviewees from institutions and NGOs have mentioned severe neglect and physical abuse, along with little focus on education, lack of understanding, affection and support, and lack of suitable communication with adolescents. Of particular concern are the children and adolescents whose parents work abroad.

“... the way in which families ... play their role, because with lack of time and information parents choose to prohibit things and later on when the child or the youngster carries on with the same behaviour it’s worthless to say ‘no’; in most cases things get worse and one can’t come up with a logical argument to help him or her get over this phase; even less so when the parent has a drinking problem which s/he has never been able to keep under control.” (Expert, NGO)

“My dad is in jail and my mom left ... I don’t know, she left for Italy and abandoned us...” (FG, Roma adolescents)

Relationships between adolescents and parents, especially at their extremes (excess of authority/laissez-faire), have been referred to by some adolescents, as well as by other interviewees, as factors that pushed them to take up risky behaviours such as drug and alcohol use and/or commercial sex.

“Mostly when I was younger, I would wrangle with them [parents] because I wasn’t allowed to do anything and when I grew up I didn’t have to anymore because I went out into the wide world and they couldn’t tell me what to do anymore...” (FG, drug addicts)

“Some people happen to have everything; when they grow up, nothing is good enough for them and they end up dead from an overdose of 5 intravenous drugs. One can be very rich and turn into a big loser just like it might happen to a very poor guy.” (FG, drug addicts)

Several interviewees from institutions and NGOs have argued that many parents can’t keep up with the changes that have occurred during the country’s transition to capitalism and democracy in terms of adolescents’ values and behaviours and so they are unable to manage their relationships with them. There have been voices saying that this also applies to school teachers and the staff of child protection and assistance services.

“... I mean, I’ve noticed that other children can’t communicate with their own parents ... and I saw this happen to a girl who had a problem and couldn’t speak to her mother and ... I have no clue what happened. Maybe she was embarrassed or ashamed, but she was unable to overcome that problem and ran away from home for three days; and when they found her, she was sick and they got her to a hospital; and only there did she tell [her mother] what the problem was. And this is a tragic story.” (FG, Roma)

“Adolescents’ problems may have several causes; like the fact that they don’t get along with their parents or lack of communication...” (FG, Roma)

School and school environment

The relationship between school and families has also been referred to as weakening, particularly after primary grades, which makes adolescents more vulnerable to risky behaviours, especially under peer influence, while also leaving the adults in proximity environments more exposed.

“While in the early grades parents come to school all day long, as the child grows up they kind of break away from school or the school breaks away from them and they both break away from the child; this is the problem.” (Expert, NGO)

“I think that parents have broken away from school in the last years ... contacts with parents are often vague... Think about it, when the parents are gone [abroad], with whom could the school cooperate?” (Expert, county public service)

The school environment itself has been included among the influencers of adolescents' choices and behaviours relating to school attendance and educational achievement. Among these we find the learning environment in the classroom, the lack of teachers' authority along with lack of suitable communication skills and sometimes biased treatment of pupils with learning difficulties (including Roma), or boring teaching style.

These factors do not automatically lead to drop-out or early school leaving, but when associated with low motivation for learning, poor achievements and/or unsuitable influence from peers or even family, they may have such effects.

"Some causes [of drop-out] are ... linked to the fact that a lot of children don't feel comfortable at school and don't find a friendly environment in school... Too rarely does one succeed – and this is a goal that many countries haven't reached yet – ... to adapt the educational offer to children's development pace, and [in the absence of that] one will surely have to deal with dropouts." (Expert, NGO)

"There are teachers who don't have any authority over their class and this creates an environment that is not suitable for learning; ... and this may not be a problem for some pupils, but there are also pupils who want to pay attention to and who are really interested in what is being taught, and so it is a pity when this happens. They might have potential but in time, because of the teachers, they get lost along the way..." (FG, institutionalised adolescents)

School climate that is dominated by mistrust, poor communication with peers and teachers, manifestations of various forms of violence – all these also stand as barriers to the adolescent-school relationship, especially in disadvantaged communities.

"... in dealing with children, it is scary how much insult is used, but also bantering and all these acts of power for establishing authority. But today's adolescents don't buy that anymore. So, if you fail to win their respect and appreciation, authoritarianism won't work because these kids don't respond to strictly authoritarian attitudes anymore." (Expert, county public service)

Participation in education is affected by the belief that the educational offer is not adapted to adolescents' level of development and the imposed performance standards exceed students' capacity. This opinion is consistently reported by adolescents and experts and is perceived as a cause leading to poor academic results and even drop-out.

With regard to what the education system actually provides to adolescents, data highlight the perception of decreased school capacities to guarantee the social and professional integration of young people.

The qualitative research has revealed that, for many Roma families from disadvantaged communities, the role of school is virtually reduced to minimal literacy that allows them to get a driving licence in order to transport scrap metal on their own, following their family tradition.

"They go to school mainly for the [driving] licence. In order to collect metal, since they won't do anything else!" (Roma adolescents)

According to the qualitative research carried out in some communities with high shares of Roma disadvantaged members, low educational aspirations, parents' lack of interest and information, a traditional culture that sets a very low age limit up to which children (especially girls) must attend school, all these build a cultural background that contributes to a high drop-out rate among Roma adolescents.

The stigma that many classmates (sometimes teachers as well) place on pupils who are in public care has also been referred to as a reason for dropping out. It has been argued that adolescents from child care institutions develop a 'double identity' – one which they use in school and during activities with

classmates and another one while at the child care centre. Hence, when their real identity is disclosed they often ask to be moved to another school or even drop out.

“This stigma (placed on those who come from a child care centre) ... raises major problems. ... At some point, they develop a dual behaviour. They hide the fact that they are in public care. When we have to monitor their academic record or ... negotiate some aspects with schools and they find out that we have been to their school and that it has been discovered at school where they come from, it often happens that they actually leave school.” (Expert, county public service)

Peer pressure

Another determinant revealed by our research is adolescents' entourage, mainly peer groups but also adults with whom they spend their spare time or share a habit (e.g. substance abuse). Due to their age-specific curiosity and propensity to experiment, along with the lack of mature judgement, sometimes adolescents can easily fall into the trap of alcohol and drug use, early sexual debut with associated risks (including trafficking), or illegal conducts. Cases have been reported where adolescents brought up in the country (with less temptations and stronger community control), who moved to big cities for further education or their parents' work, have become easy victims of a wrong entourage with negative consequences on their behaviours, ending up leaving school and becoming drug addicts or getting involved in commercial sex. This is amplified by the lack of affordable facilities for instructive/healthy leisure activities (even less so on school premises). Some have blamed the community itself for being unable to see the importance of providing adolescents and young people with safer and healthier leisure alternatives and subsequently mobilising resources to this end.

“Once you've got in, you start going around in circles and can't get out anymore. If you had a baby now, you would quit the habit one way or another. You need a reason ... and you need somebody to push you from behind. It should be something more challenging than that dose. If you want to, you can make it. But again, it all comes down to the entourage; when we don't have money, we make it together and we spend it together...” (FG, drug addicts)

“When I was two years old my parents got a divorce. I can't say that my childhood was very happy. When I came to the city and I found the entourage ...” (FG, drug addicts)

“There are youngsters who get here [to the city] ... and are very naive. Probably the way things are in the countryside, where all children are good and kiss everybody's hands ... [makes them vulnerable]. And many of them change. I mean from a good child, they get here ... [to the city], and that's it: they change; they start smoking, taking up drugs... Not all of them, but the naive ones do.” (FG, Roma)

Virtual space and consumer society

The temptation of the virtual space has been identified as another influencer of adolescents' behaviours, with severe consequences on the development of their social skills. Besides, e-commerce offers easy access to drugs, making protection measures prescribed by law ineffective.

The temptations of the consumer society along with rather aggressive advertisements to alcohol (sometimes also associated with sports competitions) and, when possible, to tobacco, are often difficult to resist for adolescents.

“I think that one problem is access; the fact that it is very easy to buy alcoholic beverages; the fact that we don't have any regulations regarding the audiovisual, that advertisements to alcoholic beverages may be broadcast at any time, without any restrictions; the fact that we have sports competitions, namely the national football championship, which is sponsored by an alcoholic beverage producer; the fact that it is somehow culturally accepted by families that it's OK to drink alcohol, mainly in the case of boys ...” (Expert, NGO). Some of the above mentioned facts happen into practice, even though there are regulation in place concerning the alcohol advertising.

“... On the other hand, the tobacco industry resorts to all sort of stratagems; these stratagems are known and they are especially intended for youth.” (Expert, ministry)

iii) Timing & continuity of use

Along with continuity of provision/delivery, continuity of use is a key prerequisite for the effectiveness of a service or other intervention measure. This has been addressed in our research by a special question in the interview/focus group guides, but many respondents avoided providing any estimates about this and argued that it was a matter of monitoring and evaluation by responsible authorities/institutions – which unfortunately is not common practice in Romania.

The qualitative research has highlighted that monitoring systems are underdeveloped. In the case of services targeting prevention among drug users (harm reduction interventions) and addiction treatment (substitution therapy), interviewed experts and adolescent drug users have indicated that services were discontinuously delivered through the years and especially in 2013. This bears an impact on drug users' exposure to HIV infection and on the success of their recovery.

We further present some continuity aspects relating to adolescents' use of available services, as revealed by our research findings.

As a general matter, we can say that the kind of relationship that the service provider and the beneficiary develop is very important for adolescents in continuing to access available services. This is especially important for drug users/addicts and sex workers who need harm reduction services.

“First of all, you can give her what she needs right away: a clean syringe, a condom... This doesn't necessarily mean that you want to let her stay in that situation.” (Expert, NGO)

The experience that somebody had (or heard about) with services is also an influencer of further access. With regard to school psychologists, both positive and negative experiences have been reported.

“Regarding the school psychologist, in secondary school I had a friend who went to the psychologist; I don't know why and for what, but what I do know is that he told me that he had gone there with an idea and got out more confused. I mean, he didn't know what to do next, whether what he was thinking he should do was good or not...” (FG, Roma adolescents)

“As regards the school psychologist, I can speak from my own experience because I went to see him and it was very good; I mean, those meetings were supposed to last a certain amount of time that we would exceed at every session because I just liked being there and I'd come out [of the office] with positive thoughts and I was always happy after that.” (FG, Roma adolescents)

Sometimes, a service may be accessed out of constraint and is no longer sought once the constraint is over.

“I'm in the national anti-drug programme. I'm doing this kind of counselling. I do it because I have to, not because I want to. At some point, I had to choose between two options: go to Bucharest for a 3-month detoxification treatment or accept this sort of counselling twice a week and so I chose counselling.” (FG, drug addict)

“The (drug) user is a person with an unpredictable behaviour ... you can't set a schedule with him/her. For example, the way in which methadone substitution centres work in Bucharest, where acceptance in the programme and getting the methadone pill is somehow conditioned upon attending a counselling session at the centre on a given day. The user goes there by constraint; it is an indirect constraint not a direct one, but once there, one has to play by the rules of the centre. But... when we're not talking about substitution treatment how can you constrain somebody? You can't. This [accessing the service] depends upon his/her condition, upon the relationship that has been established.” (Expert, NGO)

Cases have been reported where services were not continuously accessed due to lack of financial resources, especially when such services were not located in the proximity of potential beneficiaries. Although services provided by public institutions and NGOs are usually free of charge, transportation costs are significant.

“...In my project, I noticed that such difficulties existed and so we focused some of our subsidies on covering transportation costs incurred by going to school, to counselling services, to interviews with employers...” (Expert, NGO)

Several adolescents told us that they would access health services more frequently if they were available in schools.

We have also explored the use of the “Child Helpline”. Several interviewed adolescents told us that they knew about it, especially from TV, but hadn’t used it. This was because, on the one hand, they had heard that they would have to identify themselves when calling and were not sure that confidentiality would be ensured (especially when reporting parental abuse) and, on the other hand, they were not confident that it would help them sort out the reported problem. Some of them also associated the “Child Helpline” with the “Emergency Helpline” (112).

“Some don’t call out of fear; they say: if I call I might get beaten up again.” (FG, rural adolescents)

“... I cannot call anonymously and say that I’ve seen an incident and so on, you must give details, where I am, what relationship I have with that family and until they reach the poor kid ... Or if my mom beats me up and I call child services, my mother will beat me up three times more before they come. My mother finds out and asks why I called ...” (FG, adolescents)

Adolescents who use drugs refrain from accessing services since a parent or a legal guardian has to be present or informed about his/her drug user status and fear of consequences restricts their access to such services.

Adolescent victims of human trafficking are not aware of specific public services (the adolescent girls that we have surveyed access these services at the NGO managing the centre that houses them) and are sceptical about general services that provide assistance and social protection.

In the case of both drug users and human trafficking victims, low self-confidence and self-esteem make them reluctant to seeking public services, which are deemed too inflexible and unfriendly.

“... You can’t go out on the street and tell someone <Come with me, I have a centre and I’ll help!> ... No, first you need to give out sandwiches, make friends with them, let them gain confidence in you ... I mean, let them know they can trust you, because some of them don’t trust anyone. It’s very hard for them.” (Victim of trafficking in human beings)

The stigma associated with drug and alcohol use is the main barrier to accessing services, as recognised by drug users, their families and the professionals who work with these adolescents. Drug users who assume their status and associated label are only interested in harm reduction services offered by NGOs and in substitution treatment. Psychological counselling is most often accessed alongside the necessary medical services or substitution treatment and the benefits of such counselling are perceived as irrelevant.

“It doesn’t matter, being a drug addict and not attending school doesn’t mean that s/he’s a good-for-nothing who will never earn a living and is going to be a parasite; it’s not just like this. But s/he is instantly labelled as underworld and addressed as such. What chance does s/he stand for being otherwise?” (FG, drug addicts)

The lack of information and limited access of adolescents at risk of dropping out to after-school programmes, counselling services and remedial support may further their vulnerable status.

Adolescents from vulnerable groups mentioned poor living conditions, lack of footwear and clothing (especially for school) and having to work from an early age not only inside their household but also to collect recyclable materials (in the case of Roma), which resulted in their not going to school or dropping out at early stages. Nevertheless, some adolescents from rural areas (including Roma) stated that their family's poor living conditions acted as an incentive for them to achieve higher education levels so as to escape poverty and provide a better life for their children in the future.

"... because we don't have shoes, clothes and what we need for school ... We don't have [the right] conditions." (FG, Roma adolescents)

"...but we can't come to school because we have work to do at home." (FG, Roma adolescents)

Finally, the fact that public welfare services are not delivered where they are most needed and that working methods are not tailored to the profile of intended beneficiary adolescents lead to both restricted access to and ineffectiveness of such services.

d) Quality of care

Looking at quality standards for the provision of educational, health and social services, the existing normative documents – laws, government decisions, ministerial orders, protocols, methodological guides – refer to both general standards of quality and specialised service standards.

For educational services to be considered optimal, service providers should operate in accordance with GD No. 1534/2008 *approving reference standards and performance indicators for evaluation and quality assurance in higher education*, the Government Emergency Ordinance No. 75/2005 *on the quality of education*, approved by Law No. 87/2006, as subsequently amended. Quality standards in education are divided into the following areas: <institutional capacity>, <educational effectiveness> and <quality management >, with each of these areas having associated criteria, performance indicators and descriptors of quality.

Health services have protocols and procedures specific to each type of medical service, but also procedures, standards and accreditation methodologies for hospitals, approved by the Minister of Health.

For the accreditation of social service providers, the legislation provides both general quality standards (Ministry of Labour Order No. 383/2005 *approving general quality standards for social services and the means for providers to assess performance against these standards*, Law No. 197/2012 *on social service quality assurance*) and certain minimum standards for the specific fields in which they operate.

General quality standards for accredited social service providers, as stated by the Ministry of Labour Order No. 383/2005, are based on the principles developed in the European model of quality (organisation and administration, rights, ethics, comprehensive approach, focus on the person, participation, partnership, focus on results and continuous improvement), which they reflect from different perspectives – approach, deployment, and results. The fulfilment of general quality standards by accredited service providers is monitored and evaluated by the Ministry of Labour through its county directorates.

With regard to providers of social services for children, including vulnerable adolescents, several types of standards are set out⁵⁶ responding to a wide range of needs.

On the other hand, private service providers who do not receive subsidies under Law No. 34/1998 *on awarding grants to Romanian associations and foundations with legal personality that establish and run social assistance units* have developed their own procedures, protocols or working methodologies on service quality.

Interviewed experts' opinions on the existence and implementation of quality standards for providers of educational, medical and social services converge to the idea that the work is done based on quality standards, with different focuses depending on the sector in which they operate.

Public service providers mention that their work is done according to these standards since accreditation is received if standards are met as required by law.

Interviewed experts revealed that private service providers may run their activity either according to quality standards stipulated by the legislation in force⁵⁷ or may develop their own procedures, protocols and methodologies for working with beneficiaries. The latter case is common among non-governmental organisations and it reflects from an NGO perspective a client-centred approach and flexibility of interventions.

The assessments run by several civil society experts, directly involved in service delivery, on the quality standards required by law highlight the fact that they *<have to be reasonable, flexible, with realistic demands, which doesn't always happen >*. Another issue raised concerns the fact that standards are usually based on a material perspective and there is a *<lack of emotional standards>* (expert NGO) in services addressing vulnerable adolescents.

Areas not covered by regulations, procedures, current methodologies for social service accreditation have been reported, namely social art and mobile units for social service provision, areas in which NGOs need to use their own methodologies that are not recognised by the state.

⁵⁶ *Minimum mandatory standards for case management in the child protection field* (Ministry of Labour Order no. 288/2006); *Minimum mandatory standards for the protection of children in foster care* (Ministry of Labour Order no. 35/2003); *Minimum mandatory standards for day care centres* (Ministry of Labour Order no. 24/2004); *Minimum mandatory standards for services aimed at the development of independent living skills* (Ministry of Labour Order no. 48/2004); *Minimum mandatory standards for internal adoption procedures* (Ministry of Labour Order no. 45/2004); *Minimum mandatory standards for maternity centres* (Ministry of Labour Order no. 101/2006); *Minimum mandatory standards for residential child care services* (Ministry of Labour Order no. 21/2004); *Quality standards for social services aimed at the protection of domestic violence victims* (Ministry of Labour Order no. 383/2004); *Minimum mandatory standards on the emergency reception centres for abused, neglected and exploited children* (Ministry of Labour Order no. 89/2004, Order no. 177/2003); *Minimum mandatory standards for parent and child counselling and support centres* (Ministry of Labour Order no. 289/2006); *Minimum mandatory standards for training and support centres for child reintegration or family integration* (Ministry of Labour Order no. 287/2006). As regards street children, accredited social service providers must meet *minimum mandatory standards on services for the protection of street children* (Ministry of Labour Order no. 132/2005). Providers of specialised services for drug users must follow the national standards set for healthcare, psychological and social care, as regulated in their concerned field by the Anti-Drug Agency. The National Anti-Drug Agency approved by Decision no. 23/2006 minimum quality standards for drug use prevention in schools and prevention activities carried out among students are based on these provisions. Accredited providers of social services for people with disabilities have to meet specific quality standards in their centres for people with disabilities (Ministry of Labour Order no. 651/2008) and minimum mandatory standards in their day care centres for children with disabilities (Ministry of Labour Order No. 25/2004).

⁵⁷ Law 34/1998 on awarding grants to Romanian associations and foundations with legal personality that establish and run social assistance units

Insufficient resources and deficient staff skills appear to be among the main reasons why quality standards are not implemented, although more rarely mentioned.

With regard to the monitoring of standard fulfilment, the perception emerges that private service providers are more often and carefully verified than public service providers *<which, once accredited, are relieved of the pressure of monitoring visits that become occasional>* (expert, NGO).

3) Determinants that influence adolescents' behaviours - causes of drug use initiation

Today's adolescents are facing multiple dangers, including the risk of and exposure to drug abuse. Addressing the causes which lead to initiation of drug use and drug addiction is essential when developing and implementing programmes. One of the goals of this part of the research was to offer a better understanding of drug use causes in order to prevent its onset and propose recommendations for further actions.

For a comprehensive explanation of adolescent behaviour, all the major components of a human being – biological, psychological and socio-cultural ones – need to be taken into account. The biological component refers to the human being's organic structure and its biological functioning via its senses, organs and innate biological or other characteristics that have been interacting with its psychological and social parts throughout its life. The psychological component concerns the way in which adolescents understand and deal with the world based on their reality, perceptions, norms, mindsets, and beliefs. The socio-cultural component refers to the context in which the adolescent was born, has learned, has developed skills and currently lives (this means that they have learned things within a specific culture, that they have a conception of the world different from that of other social groups, and that they interact with the world using the values and beliefs of that culture).

Given the methodological approach and need to cluster results on categories of determinants, the main research findings are organised around selected determinants: social norms, legislation and policies, budget and expenditure, social and cultural practices and beliefs. Within these determinants, special attention was given to family context and other influencers which added value to research findings.

a) Peer pressure

Drug use in the peer group is one of the risk factors associated with individual drug use initiation. More than half of the interviewed adolescents (13) cited peer pressure as one of the reasons they started to use drugs. Adolescents' need to belong, to be appreciated and recognised as a member of a group made them vulnerable to the pressure exerted by the other members to change their attitudes, values or behaviours so as to conform to group norms.

b) Mass media

It has been scientifically proven that there is a direct relationship between media coverage of social behaviours and conducts favourable to drug use or violence and the development of aggressive and violent behaviour, especially among children and young people. Firstly, children can learn from media content that violent behaviour is a strategy for solving problems (through violence). Secondly, violence and antisocial behaviours covered by the media seem to adversely affect children and youth's attitudes and reactions to this type of behaviour. Likewise, some personalities/role models presented by mass media disclose unhealthy behaviours such as drug use, thus furthering the tolerance and acceptance of this type of conduct. Seven interviewed adolescents have mentioned mass media as a factor that influences their behaviour ("it's on TV, it's ok and cool" and "the American that won several Olympic medals smokes weeds and he's a winner").

c) Legislation and policies

Increased availability and accessibility of legal and illegal drugs (the number and availability of points of sale, effective means of promotion and distribution, the price, etc.) have contributed to the growing risk of drug use. The easier it is to get drugs, the more likely adolescents are going to use them. This also influences the type of drugs adolescents use. One of the absolutely necessary preconditions for drug use is availability of drugs. Interviewed adolescents declared they had easy access to drugs either through friends or family members.

d) Extreme poverty

Four of the interviewed adolescents are homeless. They became homeless due to overwhelming circumstances combined with the lack of a family support structure. A couple of these adolescents ended up in this situation due to an actively hostile, abusive and non-supportive family environment. They were systematically abused – physically and emotionally – until they ran away from their abusers, choosing homelessness over continued abuse. Another one comes from a very poor family of 5 members (single mother of 4) that lost their main source of income when the father died; they were eventually forced to live on the streets since their earnings were less than sufficient to maintain decent accommodation.

e) Social and cultural practices and beliefs

Most of the interviewed adolescents revealed some **mindsets and beliefs** about drug use before experimenting and during the initiation phase. They admitted to having disregarded (when they first started using drugs) the consequences of harmful behaviours in favour of the gratifying (reinforcing) nature of drugs. Unhealthy behaviours almost always provided real and instant gratification while the likely onset of diseases or other harmful effects was seen as remote and improbable to them. Moreover, most of the interviewed adolescents (18) were unaware of the problems different drugs may cause or the risks of their behaviours; they focused on the short-term perspective and saw these problems and risks as remote and as not concerning them.

f) Early antisocial behaviours

Low school involvement in preventing such behaviours was identified as a risk factor for drug use initiation, frequency and intensity. On the other hand, there is no evidence that a low degree of school involvement is a predictive factor for drug abuse. The interviewed adolescents revealed a total lack of interest in school and a major disregard of consequences like the lack of education, low chances of employment and many others when they started using drugs. Looking back, they declared that maybe continuing their education could have prevented their drug abuse.

g) Criminal environment

Through the example it sets, family can contribute to the development of permissive attitudes towards crime in general, which develop into antisocial and/or unhealthy behaviours and drug abuse. In our case, this determinant was explicitly mentioned by 9 adolescents who reported that they were familiar with a criminal environment – either a friend or a family member had been in jail or in trouble with the police during their childhood. Growing up in the presence of criminal behaviour and disregard of the law, they become prone to misbehaviour. Their need and achieving their goal (usually getting money for drugs) is more important to them than respecting the norms, values and regulations of the society.

h) Family management and context

Lack of parents or guardians able to provide positive emotional support to children, the absence of strong affective ties with the family may be related to the development of behaviours like initiation of drug use and abuse. 14 adolescents gave details about their family background that featured: parents' divorce/separation, death of a parent and/or brother/sister, abandonment.

i) Trauma – emotional, physical and sexual abuse

Most of the interviewed adolescents went through traumatic experiences as children. Aggressive and abusive parenting styles led to conflicts within the family while lack of landmarks and family values contributed to the emergence of maladaptive behaviours and the risk of drug use onset.

Drugs were used to cope directly with the emotional pain of the abuse or with the subsequent self-derogation based on low self-esteem and poor self-image. 18 of the interviewed adolescents declared they had started to use drugs due to a variety of stressful or traumatic psychological factors rather than physical ones. They wanted to escape or forget reality, avoid difficult decisions, have fun, make friends, or come across as risk takers.

In most of the cases, adolescents reported emotional or physical abuse by parents or other authority figures. Interviewed adolescents identified such behaviours as common among parents or other important relatives and as normal behaviours that they later imitated, marking their development and probably the way they behave later in life. The void created by parents' failure to fulfil children's most basic needs led to anxiety, craving for acceptance, suicidal tendencies, disregard of own health, including initiation of drug use, etc.

j) Drugs and history of dependence

Adolescent users said that in their case it mattered that closed family members were dealing with addiction and it was something they grew up with. 12 adolescents declared having one or more family members addicted to drugs or alcohol.

k) Transition and displacement

Four adolescents reported having lived in 3 different cities during their childhood and adolescence. Another 7 moved around a lot during the same period. The key risk periods for drug abuse occur during major transitions in a child's life. Some of these transitions that may increase young people's vulnerability to drugs are puberty, changing homes, divorce, leaving the security of the home and entering school. These transitions generate adjustment issues for some of them and are associated with an increased prevalence of drug use, academic failure and drop-out and antisocial and/or unhealthy behaviours.

Chapter 4 Conclusions and recommendations

Conclusions

Enabling environment

Social norms

Most of the interviewed adults (experts, parents) believe that adolescents are a resource rather than a problem for our society, but adolescence remains an age that is diffusely perceived at societal level.

Often, adolescents' social identity is highly uncertain and their problems are ignored or not understood by themselves, by the family (more interested in the child's condition at younger ages), but also by the society. As a consequence, their real needs remain unknown and/or unaddressed.

There are specific categories of adolescents having increased vulnerability – Roma, adolescents with disabilities or those institutionalised. There are also social norms and beliefs, in certain communities, that represent real barriers for the adolescents' access to the services that could respond to their needs.

There have been voices saying that public opinion is rather negative, especially towards street children, sex workers and drug addicts, holding them responsible for their conduct. However, the NGO approach has been quasi-unanimously regarded as positive and supportive in terms of policies and programmes aimed at addressing vulnerabilities among adolescents.

The educational system is perceived by public opinion and by adolescents themselves as unable to motivate them for good performance or to guarantee their further employment or social success. School appears to be considered by adolescents rather as a socialising medium than a learning environment.

Legislation/Policy

The Romanian legislative framework is generally well-developed as regards education and access to quality education, child rights protection, social assistance for vulnerable/disadvantaged groups and healthcare services – including special measures for HIV/AIDS and drug addiction, but quite inadequate when it comes to laying down relevant obligations so as to ensure that intended beneficiaries have access to and enjoy these rights.

Major weaknesses exist in setting and/or implementing appropriate sanctions, this resulting in somewhat ineffective laws and leaving room for risky behaviours (e.g. selling alcohol and tobacco to the underage, access to drugs, smoking in public places etc.) and in limited access to rights and welfare/protection services (e.g. home education for people with disabilities, accessibility for people with disabilities, welfare services at local level, proximity services for street children, drug addicts and victims of human trafficking/sexual exploitation).

Weaknesses are also seen in coordination between different sectors or authorities in implementing the legislative provisions (Eg, the Child Protection Law mentions health education as compulsory, to be delivered, but in practice the Health Education remained an optional subject in schools).

The legislation is underdeveloped in the fields of inclusive education – especially with regard to children with disabilities, of special protection and assistance for children with parents working abroad, special protection for human trafficking victims and drug addicts (in particular harm reduction), of providing fair opportunities for educational advancement to adolescents in the child care system and from poor families and/or poor rural/remote areas. Many other issues – such as the right to autonomy and confidentiality of medical investigations related to adolescents’ sex life or ethical issues concerning psychological counselling – remain unaddressed.

Also new challenges or threats occur in the society in the globalization context and legislation needs to be improved constantly to face and to prevent these threats as possible. For example, increased availability and accessibility of legal and illegal drugs (the number and availability of points of sale, effective means of promotion and distribution, the price, etc.) have contributed to the growing risk of drug use.

We cannot speak of either legislation or policies and programmes that address adolescents as such, except for some notable initiatives by UNICEF Romania meant to support programmes for adolescents. The legal framework, policies, programmes and services (where they exist) are designed for children and (young) adults and do not take into account adolescence as a specific transition period requiring dedicated framework, especially as regards programmes and services.

Even though there are some relevant programs meant to facilitate the access of adolescents of their fundamental rights – health, education, social protection (e.g. “Second Chance”, “Croissant and Milk”, “Money for High School”), some of them are perceived as too bureaucratic to be accessed by some disadvantaged groups or do not cover some specific subjects (e.g. Second Chance programme doesn’t cover the adolescents that dropped-out, but want to come back in schools before the age of 14), others are not implemented in uniform manner (drop-out registration) and others are implemented with difficulties or delays. Some programs haven’t been evaluated in terms of effectiveness or efficiency.

There are many sectoral strategies or policies in focusing on specific issues (HIV, drugs, reproductive health) that include adolescent among other target populations, but a certain lack of coordination between their actions and difficulties in implementation can be seen.

Some strategies are under development and others are still pending for approval at different ministries.

Special protection measures are limited to at short-term objectives (addressing emergencies, daily care) and create harmful habits (dependence on the system).

The research has also identified groups of adolescents, such as convicted juveniles or school-aged migrant adolescents returning from abroad, for whom social policies have not yet been developed.

Budget/Expenditure

Although statistics fail to provide specific data on adolescents, the fact that almost half of Romania’s children were at risk of poverty or social exclusion in 2011 is worrying because poverty and social exclusion denote not only lower income, but also very limited access to many key services or areas of life. Besides, early exposure to welfare deficit is known to be the main risk factor of exclusion whose effects can hardly be repaired at later stages in life.

Public budgets have proved to be highly insufficient in Romania to fully cover adolescents’ needs for protection and assistance/support to fairly benefit from their prescribed rights.

Also the mechanisms that allocate funds to local social services or to different fields of intervention are not very clear and transparent.

Consultations on policy making with NGOs seem to be mostly formal and limited to minimum legal requirements, involving in most cases a few NGOs readily available; thus, legitimacy is ensured while systemic problems remain unaddressed.

Public (human and financial) resources devoted to social assistance and protection are mostly concentrated at central and county levels, while the needs that these resources are aimed to address are found at local level. This results in ineffective welfare services, on the one hand, and in the persistence of vulnerabilities and undesirable proximity factors that lead to risky behaviours among adolescents (and not only), on the other hand.

The EU funds aimed at supporting Romania's integration have not had a noticeable impact on the improvement of services addressed to vulnerable adolescents, especially in terms of proximity determinants. Also the mechanisms of accessing and use of these funds are quite bureaucratic and not easy to understand and fulfil. Several NGOs have reported bad experiences with EU-funded projects which, in some cases, have pushed proficient NGOs out of business.

This deficit used to be compensated to a certain extent by the NGOs specialising in youth work and proximity services for vulnerable groups, including adolescents. These NGOs and programs used to be financed by international donors, but following Romania's accession to the EU, most of the international donors have cut down or cancelled their financial support for direct interventions.

Some programmes and services rely on external funding which has limited term and ceases after a while, thus affecting their sustainability.

In spite of NGOs being more experienced and proactive in reaching out to vulnerable adolescents than most public services, they have few opportunities to access public funding. In recent years, subsidies for NGOs that deliver social services have somewhat decreased and the access of non-governmental organisations to child protection NIPs has been limited. Mechanisms that allocate funds to local social services are not very clear and transparent.

Management /Coordination

Aside from (but related to) insufficient/ineffective legislation, the research has revealed a deficit of mechanisms for coordination between relevant stakeholders on multiple axes. Thus, there is a well-recognised lack of coordination between different central authorities, inducing difficulties or even gaps in implementing of the legislations or of various policies and programs at national levels.

On another hand, there is a lack of vertical coordination and complementarity between county and local authorities in the social protection field, the formers having a limited capacity of intervention at local level and the latter expecting to receive decisions and solutions from the county level.

There is a lack of collaboration between public institutions and NGOs, conducting to insufficient use of the capacities and expertise gained by NGOs, in the context of an insufficient capacity of the public bodies. A poor interconnections between various programmes (provided by public institutions and NGOs) aimed at the same target group can arise, with detrimental efficiency.

There is an ineffective formal collaboration of different institutions/professionals at local level (non-functioning or inexistent local advisory bodies, despite the existing legislative provision) in areas that require joint interventions, such as assistance/support for adolescents with disabilities, adolescents from poor/disrupted families (including Roma), adolescents engaging in risky behaviours, etc.

Moreover, political instability – especially at high decision-making levels, but also among middle and local managing positions – hampers the development and follow-up of strategic visions and sometimes programme implementation continuity; the lack of vision often results in interventions that target the effects rather than the causes of adolescents' vulnerabilities.

An insufficient capacity to address vulnerable adolescents' problems both in terms of diagnosis and adequacy of interventions was pointed out at local level in all the sectors (social protection, health, education)

Supply

Availability of essential commodities/inputs

There are gaps in coverage of adolescents with basic social, educational and health services, especially in rural and deprived areas.

NGOs show good potential for qualified and effective interventions meant to address the difficulties faced by adolescents, being able to support the public services but their availability at local level is also scarce.

Proximity social services, acting in the living environment of vulnerable groups, are less developed and insufficient in disadvantaged communities. These services could identify potential risks (drop-out, substance abuse, neglect) at an early stage, thus avoiding radical measures later on, such as adolescent and family separation.

Proximity services for at-risk adolescents, aiming at harm reduction, are provided mostly by NGOs (like ARAS, ALIAT, and other). They have been most frequently named as existing but insufficient.

Services that our respondents have mentioned to be rare or inexistent although much needed are parent education/counselling (a notable example in this field is Save the Children's network of centres that almost equally address adolescents' needs), day care (after-school programme), sheltered workshops providing jobs to vulnerable adolescents, suitable counselling for adolescents, multi-purpose centres for non-formal education and leisure activities, programmes aiming at health education and education for independent living.

A special case is that of the children whose parents work abroad and for whom suitable services haven't even been designed yet.

The poor development of psychological counselling services and their total absence in rural areas, as well as the insufficient professional training of social workers deployed in disadvantaged communities leave the problems facing families and adolescents unaddressed, exposing them to risks such as violence and abuse, economic exploitation, substance use or even human trafficking.

Adolescents with disabilities face the biggest problems in accessing specialised medical and rehabilitation services given that the coverage of these services is very low in general and completely absent in rural areas. They are too often guided away from free public services towards paid services which they can hardly afford. They are missing also appropriate education alternatives (stipulated by law) due to the lack of professionals.

The education system has difficulties in adapting its educational offer to children's development pace and this also contributes to drop-out. Some very effective programs (Second Chance) are perceived as bureaucratic and failed to cover all the needs.

Free time opportunities like after/before school activities are missing. This affects in particular vulnerable adolescents who don't have the means to access paid services. In parallel, Romanian adolescents spend a large amount of their spare time watching TV and on the Internet. These factors may be detrimental for leisure activities, such as practising sports, engaging in civic activities, socialising at youth centres and participating in cultural events.

In poor communities, medical services are scarce and insufficiently correlated with social services; community health workers are insufficient as well. Family physicians are not sufficiently involved in referring vulnerable teenagers to specialised services even when they are aware of unhealthy behaviours in the community.

Youth centre services are scarce in Romania despite the great need for such facilities.

Access to adequately staffed services, facilities and information

A general feature that comes out from our qualitative research is the decreasing specialised staff in public institutions that provide services/assistance to vulnerable adolescents, who has either left for better jobs or been dismissed based on administrative criteria as a consequence of staff reduction policies in the public sector and who cannot be replaced due to employment restrictions. Besides, suitable professionals are hard to find as the ones who have left were trained over the years. Moreover, in fields like child protection, education, social assistance, staff turnover has also led to emotional traumas for the assisted children/adolescents who had emotionally connected to their assistants.

In the public sector, staff working with vulnerable groups is considered insufficient and chronically unmotivated from a financial standpoint. Things are even worse in rural areas where human resources involved in prevention services lack appropriate professional training. Lately, increasingly fewer resources have been allocated to social services for human resource development.

In the case of NGOs, for which high-quality workforce and logistics are usual standards, the problem lies in their financial flows that are unreliable due to either short-term programme funding schemes or lack of support from public bodies responsible for the respective areas of intervention (at least as regards continuity of services), or by both.

Those who work in the education system seem to be insufficient and under-prepared to deal with vulnerable adolescents' matters.

There are no clear procedures for the integrated intervention of relevant public services in addressing problems faced by adolescents with school adjustment difficulties: adolescents from childcare centres, adolescents with disabilities, drug users, etc.

Instead of having a proactive approach, public services are structurally passive mainly due to insufficient human and financial resources and the bureaucratic background of the public sector. Adolescents are reluctant to accessing services offered by public bodies due to the rigid official environment.

Information and counselling services for parents are also lacking. This seems to be a major gap as many parents do not know how to approach teenagers in general and in particular how to discourage alcohol, tobacco and drug use or drop-out. This is also a problem for parents of adolescents with disabilities.

Bureaucratic barriers do exist in adolescents' access to the basic services (e.g. missing ID paper or missing of the parent consent)

There is a lack of information concerning the right of adolescents and their families to access different services, most common in disadvantaged communities.

Demand

Financial Access

In many cases, accessing services requires travelling to their location and transportation costs have been mentioned as potential barriers for disadvantaged adolescents.

Socio-economic factors are most frequently invoked as reasons for non-participation or school drop-out, these factors being associated with disadvantaged communities and adolescents from poor Roma families. The costs incurred by attending school (school supplies, clothes, shoes, transportation) pose a problem for families living in severe poverty, especially in the current context of rationalisation of educational network.

For adolescents in rural areas, access to specialised medical services is difficult; often, the nearest medical centre is many miles away. The dissolution of school dental care units has created an access problem especially for financially challenged teenagers.

With the low coverage of public services for drug addicts, private services don't provide an alternative for this group of beneficiaries either because of their high costs.

Social and cultural practices and beliefs

Adolescents' awareness of the services that are available for them and propensity to use these services vary significantly depending on service type and coverage, as well as on the area of residence and the community of origin.

The adolescents from urban areas are generally more aware about the existing services, even though their knowledge of these services is vague and stereotypical, acquired mostly from the media, but also at school. Per contrary, adolescents from rural areas have limited knowledge of child assistance and protection services, generally mediated by television; Adolescents prefer not to seek such services for fear of repercussions, but also because they don't want to make public what they have experienced.

Social and cultural practices, as well as social norms, mentalities and associated beliefs also play a significant role in adolescents' accessing available services. In the case of traditional Roma communities, the low level of educational aspirations, parents' lack of interest and information, along with a traditional culture that sets a very low age limit up to which children (especially girls) must attend school often result in a high drop-out rate among Roma adolescents.

The social stigma that Roma communities place on those who access services of psychological counselling, reproductive health, testing for sexually transmitted infections exposes Roma adolescents to greater health risks..

The stigma associated with drug and alcohol use is the main barrier to accessing services, as recognised by users, their families and the professionals who work with these teenagers.

Adolescents are reluctant to accessing services offered by public bodies due to the rigid official environment, excessive bureaucracy, long paperwork and associated costs, lack of confidentiality, parental presence required in certain cases, etc. On the other hand, when public services are the only source, as in the case of substitution treatment for drug addicts, the available facilities cannot cover the demand, which is far greater; to access these services, addicts have to wait for far too long given their condition.

With respect to family, the research has revealed that there are still cases of severe neglect and physical abuse, along with little focus on education, lack of understanding, affection and support, and lack of suitable communication with adolescents. Of particular concern are the children and adolescents whose parents work abroad. Besides, research findings suggest that many parents can't keep up with the changes that have occurred during the country's transition to capitalism and democracy in terms of adolescents' values and behaviours and so they are unable to manage their

relationships with them. It seems that this also applies to school teachers and the staff of child protection and assistance services. The relationship between school and families has weakened, particularly after primary grades, which makes adolescents more vulnerable to risky behaviours, especially under peer influence, while also leaving the adults in proximity environments more exposed. Yet not automatically leading to drop-out or early school leaving, factors like the learning environment in school, teaching style, lack of teachers' authority along with lack of suitable communication skills and sometimes biased treatment of pupils with learning difficulties (including Roma) may have such effects when associated with low motivation for learning, poor achievements and/or unsuitable influence from peer group or even family. The stigma that many classmates (sometimes teachers as well) place on pupils who are in public care and/or Roma pupils has also been referred to as a reason for dropping out.

Entourage, mainly peer groups but also adults with whom they spend their spare time or share a habit (e.g. substance abuse), has a bearing on adolescents. Due to their age-specific curiosity and propensity to experiment, along with the lack of mature judgement, sometimes adolescents can easily fall into the trap of alcohol and drug use, early sexual debut with associated risks (including trafficking), or illegal conducts. This is amplified by the lack of affordable facilities for instructive/healthy leisure activities (even less so on school premises).

The temptation of the virtual space is another influencer of adolescents' behaviours, with severe consequences on the development of their social skills. Besides, e-commerce offers easy access to drugs, making protection measures prescribed by law ineffective. The temptations of the consumer society along with rather aggressive advertisements to tobacco and alcohol (sometimes also associated with sports competitions) are often difficult to resist for adolescents.

In general, adolescents show a satisfactory level of information concerning HIV. However, the quantitative research has revealed considerable uncertainty among adolescents, which raises serious doubts about their full understanding of HIV transmission ways. Lapses and uncertainties regarding knowledge of HIV and sexually transmitted diseases, as revealed by the quantitative research, give an indication of how adolescents are educated on these topics: very little and very vaguely by parents and often in unsuitable conditions in the school environment.

Most adolescents have proper knowledge (information) about the risks of alcohol, tobacco, drugs and unsafe sex. Nonetheless, there is also a significant number of respondents whose knowledge (information) is uncertain.

Most of the adolescents subject to clinical interviews revealed some mindsets and beliefs about drug use before experimenting and during the initiation phase. Unhealthy behaviours almost always provided real and instant gratification while the likely onset of diseases or other harmful effects was seen as remote and improbable to them. Moreover, most of the interviewed adolescents (18) were unaware of the problems different drugs may cause or the risks of their behaviours; they focused on the short-term perspective and saw these problems and risks as remote and as not concerning them.

The survey has also revealed that adolescents' awareness of the risks associated with alcohol use, smoking, drug use and sexual behaviour is higher among adolescents aged 14 years and older. However, it should be noted that younger adolescents are less informed and less aware of these risks, especially with regard to sexual behaviour and drinking.

Disability appears to be one of the most important individual features influencing the behaviour of disabled adolescents in relation to peers, school and community. Besides, adolescents with disabilities shoulder the greatest impact of determinants as regards the enjoyment of child rights. They also share with many Roma adolescents and with adolescents brought up in child care centres the burden of feeling different, which often makes them withdraw from peer groups and drop out of school.

Low school involvement in preventing such behaviours was identified as a risk factor for drug use initiation, frequency and intensity. On the other hand, there is no evidence that a low degree of school

involvement is a predictive factor for drug abuse. The interviewed adolescents revealed a total lack of interest in school and a major disregard of consequences like the lack of education, low chances of employment and many others when they started using drugs. Looking back, they declared that maybe continuing their education could have prevented their drug abuse.

Lack of parents or guardians able to provide positive emotional support to children, the absence of strong affective ties with the family may be related to the development of behaviours like initiation of drug use and abuse.

Information received from both quantitative and qualitative research has indicated that many ex-heroin users now prefer to inject 'legal highs' because they are cheaper and easier to find, with some still being available in sex shops in certain areas – such as Ferentari or Rahova in Bucharest – even if they have been recently banned by law. However, unlike heroin, these drugs have much shorter-lasting effects and users need to take the drug much more frequently, leading to larger overall daily doses. Besides the higher risk of HIV infection, this may also increase juvenile crime among adolescent drug users because they need to somehow procure the money to buy their next dose. Representatives of the NGOs that helped us with the quantitative data collection from adolescent drug users believe that this is already a national problem which needs to be assessed and addressed as soon as possible.

Timing & continuity of use

Providing the service in time and assuring its' continuity of use are key prerequisites for the effectiveness of a service/intervention..

The kind of relationship that the service provider and the beneficiary develop is very important for adolescents in continuing to access available services. This is especially important for drug users/addicts and sex workers who need harm reduction services.

In the case of services targeting prevention among drug users (harm reduction interventions) and addiction treatment (substitution therapy), interviewed experts and adolescent drug users have indicated that services were discontinuously delivered through the years and especially in 2013. This bears an impact on drug users' exposure to HIV infection and on the success of their recovery.

In some areas of intervention such as HIV/AIDS, recovery of drug addicts in specialised centres and institutionalised child care, our interviews showed that monitoring mechanisms were in place and continued access to services was ensured in most cases. On the other hand, as far as prevention measures are concerned, things looked different. Besides insufficiently available prevention services, it was revealed that continued use was not only a matter of beneficiaries' choice but also a matter of service provision continuity since in many cases such services were provided (mostly) by NGOs and local public authorities within the limits of available funding and/or the lifespan of relevant projects.

Quality

Quality of care

There is legislation in place establishing general standards of quality and also standards for the specialised service in all the fields of interest for the study.

The quality standards have to be reasonable, flexible, with realistic demands, but there are voices claiming this doesn't always happen.

The quality standards are usually based on a material perspective.

Areas not covered by regulations, procedures, current methodologies for social service accreditation have been reported, namely social art and mobile units for social and medical service provision, areas

in which NGOs need to use their own methodologies.

As far as implementing quality standards goes, public and private providers of educational, medical and social services work either according to legal standards (accredited providers) or according to internally developed procedures, protocols, methodologies of work (especially NGOs). The fulfilment of quality standards in service delivery is monitored both externally and internally, with NGOs feeling a higher pressure when being monitored by the state.

Scarce resources and unskilled staff seem to be the main reasons for which quality standards are not implemented.

Recommendations

Enabling environment

Social norms

Wide actions for social recognition and valorisation of adolescents are needed in order to improve the social perception of this age-group. The recognition and valorisation of adolescents should become priorities for the further national strategies and public policies developed at central level.

The central authorities should encourage and support the local ones to involve the adolescents in the community life.

The adolescents' multidimensional needs and vulnerabilities should be clearly identified and understood based on evidence's research with specific tools and techniques. In this purpose, periodical surveys on the adolescents' knowledge, attitudes and behaviours should be planned, financed and unfolded.

Further on, targeted actions for raising public awareness and parents' and caregivers' knowledge of the specific features and needs of this age group and of the ways to relate to adolescents are needed at national and local levels. The authorities (both central and local), the community's elites and the civil society should be mobilised for these actions.

Proper approach of vulnerable adolescents that gives due consideration to age specificity, type of vulnerability, specific needs and living context should be ensured. This could be achieved through combined interventions at national and community levels:

- a. information and education campaigns aimed at combating discrimination and social stigma, and addressed to the general population, to specific communities / groups and families.
- b. provision of continuous professional training for all the staff working with adolescents in health, education and social protection fields, and specifically for staff working with vulnerable adolescents.
- c. wide partnerships developed at local level between school, local authorities, other community elites and the civil society sector and targeting to respond to adolescents needs.

The public opinion in relation to educational system needs to be improved, through policies and actions aimed to recognize the education as a fundamental social value and to increase the social visibility and public trust in school and school staff.

The educational system's principles and expected outcomes should be redefined in accordance to the exigencies of the further employers and also in accordance to the expectations of the society, parents and its direct beneficiaries - the adolescents. The educational process should be focused on providing useful knowledge and on creating real abilities in adolescents, for their further life and career. The educational system needs also to continue to develop flexible mechanisms able to respond to specific adolescents' needs (eg. Drop-out, disabilities, pregnancy or parenting during school process etc).

Legislation/Policy

The public authorities (both central and local) should identify those legal responsibilities and stipulations regarding the adolescents rights that are not implemented, to plan feasible mechanisms, time frame and resources for their implementation.

The civil society sector could provide support in identifying the uncovered rights and in developing mechanisms for their implementation.

The partnership between authorities and the civil society is very necessary in order to use the latter's capacity to provide specific services in hard to reach groups.

The central authorities need to develop their institutional capacity in controlling the law's enforcing at all levels.

The civil society can assist or support the public bodies in identifying the cases when the law is broken (e.g. identifying cases of underage alcohol or tobacco selling, identifying inadequate or illegal advertising).

More coordination is necessary between different sectors at central and local level.

For the specific case of Health Education subject, it would be more than beneficial to include this topic in the basic curriculum for all grades. This would assure a coordinated manner to provide health education to all children (including adolescents).

New legislation need to be developed by the central authorities in order to properly address to the occurring threats and challenges of the society.

The civil society sector could also provide support in defining the necessary legislation, through relevant public consultations, especially on the unaddressed needs or on the implementation ways.

It is important to consider that lack of legislation in some specific issues does not mean necessary lack of action. Local policies and (flexible) models of intervention could be developed in order to answer to unmet needs of adolescents

In order to develop suitable policies, strategies and programmes addressing adolescents' needs, this specific group of population should be acknowledged in the legal and official programmatic documents.

Adolescents may be included mainly in youth and education policies, but also as a mainstream dimension in other policy areas, such as labour, family and social protection, health, transport, tourism, law enforcement, etc.

Further assessment of weaknesses, effectiveness and efficiency of social, educational and health programs is needed, in order to understand their outcomes and added value and to define the further public policies based on evidence.

Some very important national strategies are under development during the study time. Given the key findings of this research, adolescence should be included as an area of intervention in the development of these upcoming strategies (National Strategy on the Protection and Promotion of Children's Rights 2014-2020, National health Strategy).

Special attention should be given to adolescence when developing the National Youth Strategy for 2014-2020 and national action plans since adolescence is a transition period from childhood to youth and investing in this age group might contribute to breaking the cycle of vulnerabilities. Special attention should be given to vulnerable populations and adolescents with fewer opportunities;

Speed up the approval of the HIV/AIDS strategy, reproductive health strategy and anti-drug strategy would be very useful in order to establish the further directions of action in these specific fields. Further investigation on the possibility to develop an alcohol and tobacco control strategy, with special focus on adolescents, is needed in the context of insufficient covering of these issues in the national anti-drug strategy.

Clear policies focusing on adolescents living in institutions, with long-term objectives and targeting specifically adolescents' social integration (including labour market aspects) should be defined at national level.

New legislation and especially coordinated policies and programs are necessary to respond to the specific needs of these vulnerable groups.

Budget/Expenditure

The exposure to poverty can be diminished on medium and long term, through general programs of economic and social development. This belongs to macroeconomic policy developed by the central authorities. The local authorities can encourage and support local investments and local economic initiatives aiming to create working places and welfare for the community.

Complementary, public investment in proximity services, able to respond rapidly and properly to the specific needs of different vulnerable groups may contribute to breaking the cycle of poverty. Also public investments in adolescents at local level – social support, health education programs, involvement in the community life and working places can provide to young people motivation and trust in a successful future.

Public allocation should be sufficient to respond to adolescents' needs because unmet needs have a detrimental impact on the adolescent, but also on the society, on long term. The social and economic consequences that can arise from this insufficient coverage with services are much more expensive. Additional financial resources need to be identified for responding to the needs. Beside financial resources voluntary work and small incentives can be considered in the communities. Priorization of the existing needs using relevant criteria (in order to respond firstly to most risky situations) can be relevant and useful.

The process of public consultation of the authorities with relevant stakeholders at national and local level should be improved in order to better prioritize the needs and to allocate properly the financial resources.

Public resources should be distributed and social services should be provided based on actual needs and giving due consideration to where intended beneficiaries are located. This requires a good understanding of the needs and of their geographical spreading, which can be achieved through systematic research in the field. This also requires strengthening the capacity of local authorities to address problems within respective communities as directly and promptly as possible.

While setting the priorities regarding the use of EU funds in the next budgetary cycle (2014 – 2020), the Government should undertake in-depth consultations with all relevant stakeholders, including academic sector and NGOs working in social/youth and child rights areas and ensure that funding schemes from structural funds also respond to youth and adolescents' needs for assistance and support. The mechanism of accessing and using these funds could be analysed to become more operationally.

A special attention should be paid by both central and local authorities to support the relevant local stakeholders willing to engage in social work in understanding the financial mechanism, in accessing and spending them efficiently. The capacities and mechanisms developed through such programs should be taken over by the state institutions and by local authorities.

Special consideration is needed for the transfer of those programs' outputs (good practice models, new services, or new mechanisms to respond to vulnerabilities) towards stable stakeholders (either public structures or NGOs), able to continue the actions and to add social value after the ending of the programme. This includes the collaboration with the specialised NGOs and their financing from the state/local budget for specific services.

NGOs show great potential for rapid, qualified and effective interventions meant to address the difficulties faced by adolescents at least in urban areas, which should be put to better use by outsourcing to such organisations any services exceeding the capacity of public institutions. New and more flexible funding mechanisms for NGOs at central and local level need to be developed and implemented in order to facilitate a meaningful contribution alongside the interventions of public bodies.

Management/Coordination

Institutional cooperation at central, regional, county and local levels is a prerequisite for successfully approaching and addressing complex situations that affect adolescents' lives and for providing them with opportunities to achieve successful transition to adulthood.

Hence, we recommend that coordination mechanisms for joint and harmonised interventions implemented by governmental and nongovernmental organisations should be established at least by secondary legislation while also including measures to ensure their effectiveness.

At central level, the inter-ministerial committees should become more operational, by defining roles and responsibilities for each authority in order to completely implement the legislation and policies focused on adolescents' rights.

As regard the lack of vertical coordination between county and local authorities, this is a normal risk of the decentralization. The deficiencies in coordination and the gaps in covering the defined responsibilities need to be identified and addressed through secondary legislation, but also by providing models of good practice.

The coordination between public institutions and NGOs has to be developed through promoting partnership and through developing mechanisms for financing these bodies from the state/local budget.

The collaboration at local level should also be promoted, enforced and monitored by the county and central authorities.

As regard the political instability, each next coming government should consider to create and maintain a technical level of professionals, not involved in politics and able to implement any public policy.

Moreover, adolescents should be given the chance to participate in programmes meant to empower them.

Supply

Availability of essential commodities/inputs

Considering the scale and complexity of adolescents' needs for assistance and support as they came out from this research, the necessity to increase the availability and capacity of public authorities/services at local level is prominent.

In addition to increased availability of local services, the NGOs capacities could be better used through joint actions and resource mobilisation by private and public sectors.

The proximity social services need to be developed in terms of **number** and training of human resources. They should collaborate to the existing NGOs from urban areas. They also should focus both on adolescent and on their families. .

Harm reduction programs need to be developed in such a manner to cover all the needs.

Innovative and more effective solutions should be found for counteracting the increasing use of legal highs among adolescents;

New services or new roles and competences for the existing services need to be developed to cover all the needs and vulnerabilities (parents counseling , services for children whose parents work abroad, etc).

Special attention should be paid to adolescents with disabilities which face much more difficulties in accessing the necessary services, especially in rural areas (not covered with rehabilitation services, missing professionals for education support etc)

As it was mentioned before, the educational system's principles and expected outcomes should be redefined in accordance to the expectations of the society, parents and its direct beneficiaries - the adolescents, being focused on providing useful knowledge and real abilities in adolescents, for their further life and career. The parents should be more involved in the educational process, acting as real school supporters.

The effective programs should be analyzed and expanded/improved, in order to cover all the vulnerabilities.

Since television, Internet and many other habits and preferences for spare time activities have a significant impact on adolescents' mental and physical development, as well as on their attitudes and behaviours, education and youth policies should pay greater attention to providing more and better opportunities for leisure activities that develop social and communication skills, encourage community participation, improve the understanding and acceptance of differences, raise awareness of transition risks, and smooth adolescent transition to adulthood.

Increase availability of friendly services and free time opportunities for adolescents, especially in the proximity of their living environment could lead to a healthier orientation to sports or other educational activities, instead of remaining vulnerable to health risks like tobacco, alcohol or drugs.

Considering the difference in coverage with health services among rural and urban communities, the barriers in access to medical services revealed by this research and the recent decentralization of some public health competences and staff (community nurses, health mediators and school doctors and nurses) the schools health policy needs to be redesigned, with focus on unmet needs of children and adolescents and on primary prevention services.

The capacity of county youth departments should be assessed and a plan should be designed to increase the capacity of professionals working at county level.

Further investigation of the role of Youth Departments as a source of adolescent participation could be useful.

Access to adequately staffed services, facilities and information

The insufficiency of the public services staff can be addressed either by new employments or by outsourcing some services to qualified providers (e.g. NGOs). Due to the economical situation new employments are difficult to achieve, so it depend on the community to find alternatives to this lack of staff.

Another direction of action is to develop local strategies to maintain the existing staff (not to leave, especially in rural deprived areas), by valorisation and intrinsic motivation.

Further efforts are needed for the professional training of staff working in educational, social and health services especially with regard to the specific features of vulnerable adolescents, approach techniques, working methods, and communication style.

Procedures for integrated intervention of relevant public services in addressing problems faced by adolescents with school adjustment difficulties need to be developed at both national and local level.

Changing the approach and the working methods in public services is possible on medium term, by redefining the working methods and staff training.

Information and counselling services for parents need to be developed in communities, in order to help them to approach teenagers in general, but also in relation to some specific health risks like alcohol, tobacco and drug use or drop-out.

A legal procedure needs to be developed in order to allow access of adolescents without ID papers to basic social protection, education and especially to health services.

Even though the Health Insurance House has the obligation to inform the insured persons about their rights to health and all the adolescents are insured, this information doesn't reach to all the people, especially to the deprived ones. Also information related to social or education rights can miss to those people, being inaccessible or difficult to be understood by them.

Special attention should be paid especially by the local authorities, school staff, and social and health workers from the community, for making the vulnerable families aware about the rights their children have and how those rights can be accessed. Those institutions and professionals could provide support to the disadvantaged parents and adolescents for making the formalities, fulfilling forms and really accessing their rights.

Demand

Financial access

A solution should be found to ease access for deprived adolescents to educational and health services by covering associated costs (e.g. travel costs, proper wheelchairs, adequate clothes and footwear, supplies).

School buses and reimbursement of travel costs are already implemented as support measures, but their implementation needs improvement in term of coverage and assuring financial resources for school buses and in terms of more rapid reimbursement for travel costs.

The access to specialised medical services can be facilitated by the local community through providing transportation or subsidies for transportation.

Unfortunately, the dissolution of school dental care units remains a difficult problem to face to. Oral health is a very serious problem of public health problem in Romania, especially in children and adolescents and currently neither the WHO indicators measuring oral health in children are not anymore known or reported. Accessing the oral health services is a challenge for every persons, but in younger age is essential to keep your teeth healthy. Even though since 2008 it was created the legal frame for the local communities to employ health workers for schools (including dentists), the result of this legislative stipulation is not known. Thus, assuring the oral health in adolescents through providing free prophylactic and curative services is an objective that needs to be included in the revised School Health Policy previously mentioned.

With the low coverage of public services for drug addicts, private services don't provide an alternative for this group of beneficiaries either.

Specific public programs should be developed by NAA, Ministry of Health and Ministry of Education (in strength coordination), or by their subordinated units, in order to provide the necessary assistance for the drug users.

Additionally, but not of less importance, primary prevention services consisting in health education for preventing the drugs consume and initiation should be provided in all the school units, starting from young age, in order to create awareness on this expanding health risk.

Social and cultural practices and beliefs

Based on these findings, the access of adolescents to the essential support services should be facilitated considering their specific believes and the area of residence.

All the professionals working with adolescents from social protection, health or educations facilities should be trained to recognize and to consider the social and cultural practices and believes.

Specifically for the Roma communities, the professionals should be trained to understand their particular believes and practices. Also the interventions should be unfolded with the support of the community leaders.

As regarding the stigma associated with drugs and alcohol users, this can be addressed through awareness campaigns for the general population, parents' counseling and through specific training of the professionals working with adolescents in all fields/levels.

As it was mentioned before, the public services need to change their approach, mainly by staff training.

The collaboration with NGOs specialized in hard to reach people is more than necessary and needs to be developed and encouraged at both central and local level.

Services/facilities for parents' counseling should be developed at the community level.

Schools need to develop policies focused on increasing the parent involvement in the educational process and in the child/adolescent life.

The parents and the school need to be able to prepare the adolescent for avoiding exposure to health risks in entourage

In this purpose counseling programs for parents can be very useful..

As for schools, they should apply routinely primary prevention programs of health education.

Providing alternatives for healthy spending of leisure time (e.g. sports facilities) is very useful in minimizing the exposure of health risks in peer groups.

The temptation of the virtual space can be influenced by providing healthier attractive alternatives for leisure activities and by encourage communication and social skills. This can be achieved in family, in school and also at community levels. Dedicated NGOs could contribute in supporting the free time activities in adolescents, in developing programs for adolescents and in giving to them the ownership of these programs.

The e-commerce and advertising need to be better regulated and controlled by the public authorities.

The adolescents have the legal right to access health education services. The most feasible alternative to provide adequate health education in respect of the equity principle seem to be the development of such a program in schools. Thus all adolescents enrolled have equal access to health education. Currently the Health Education is an optional subject, having a comprehensive curriculum approved at national level. It is however implemented at the discretion of each school. The experts recommendation was to introduce the Health Educations in the basic curriculum for all grades, despite the complexity and overload of this curriculum.

Of course, additional interventions, beside the health education program, are needed for adolescents at high risk.

Special attention should be paid to adolescents with disabilities with a view to ensuring their full integration and participation in society. The inclusiveness of the education system should be further improved so as to allow participation of adolescents with disabilities in all forms and at all levels according to their intellectual potential and without any prejudice relating to their physical aspect or capacity.

The national policies and legislation addressing the adolescents with disabilities should be improved.

Also local good practice models can be developed (e.g. providing travel subsidies, building access balusters by voluntary work in community).

Family and school are the most important instances able to prevent drug use initiation and abuse. They need to fulfill their mission. The parents need to be aware about this role and to have adequate skills and information for addressing it. On another hand, the schools supposed to provide an adequate and learning environment for adolescents, but also psychological support when needed.

Secondary prevention programs for drug users should increase in coverage and availability, especially for those ex-heroin users that now prefer to inject 'new substances with psychoactive effects'. These programs should provide counselling, treatment and syringe exchange in order to minimize the risk of infection. They are expected to cover all the drug users and to be implemented systematically.

In consideration of the role that social and cultural practices, social norms, mentalities and associated beliefs play in the shaping of adolescents' behaviours, including with regard to accessing available services, as well as in the functioning of coordination mechanisms for joint interventions, we

recommend that UNICEF and its partner organisations, both governmental and non-governmental, should design and implement knowledge-based public information and social dialogue programmes targeting both children and youth and decision makers at national, regional and local levels, with a view to improving the level of knowledge and understanding of human rights, equity and gender equality approaches in all policies, programmes and intervention measures addressing children and youth issues. This should also aim at better acknowledging adolescents as a specific category of people in transition to adulthood, with specific features and needs, as well as with the great potential of contributing to social and economic development.

Timing & continuity of use

In relation to access to education innovative solutions should be found to encourage continuation of schooling/participation in alternative educational schemes among vulnerable groups of adolescents such as dropouts, drug users, pregnant adolescents/underage mothers, human trafficking victims, and adolescents practising commercial sex. Also further research is needed to understand the social and economic reasons why adolescents aged 16-18 are neither in education or training nor on the labour market and to inform relevant child and youth policies.

As regard of social support and health services addressing to vulnerable groups, lack in continuity affects the beneficiaries trust in those services and consequently their willingness to access the services.

On another hand, discontinuity in some programs (e.g stopping the needles exchange for a short period due to the lack of resources) induce high risks of spreading communicable diseases and ineffectively of the whole investment.

Thus, the programs addresses to adolescents need to be implemented in a systematically manner, with avoiding gaps and discontinuities.

Quality

Quality of care

The feasibility of the quality standards should be analysed prior to their approval through legislation/consensus protocols.

In developing or revising quality standards as prescribed by law – regular revision is required – a real consultation process should take place, involving all stakeholders, especially public and private service providers, so that the resulting quality standards can be the best fit for each field.

The material perspective is very important, but additional indicators measuring the psychological/emotional dimensions should be defined as minimal quality criteria.

New regulations, procedures and methodologies should be developed for those areas which are currently not covered by social service accreditation (e.g. social art, mobile units for social service and medical provision).

Quality assessment is usually done in internal and external evaluation processes. In external evaluations, uniform procedures for quality assessment should be used for all the service providers from a specific field.

Continuous quality improvement should be a goal for each organization providing medical, educational and social services. This implies to identify the deviations from standards, to understand the reasons for those deviations and to take action to minimize the deviations.

Annexes

1. Quantitative research tables and figures.
2. List of interviewed institutions and NGOs;
2. List of services provided by NGOs;
3. Bibliography;

Annex 1. Findings on alcohol and tobacco consumption

Fig. 1.1.

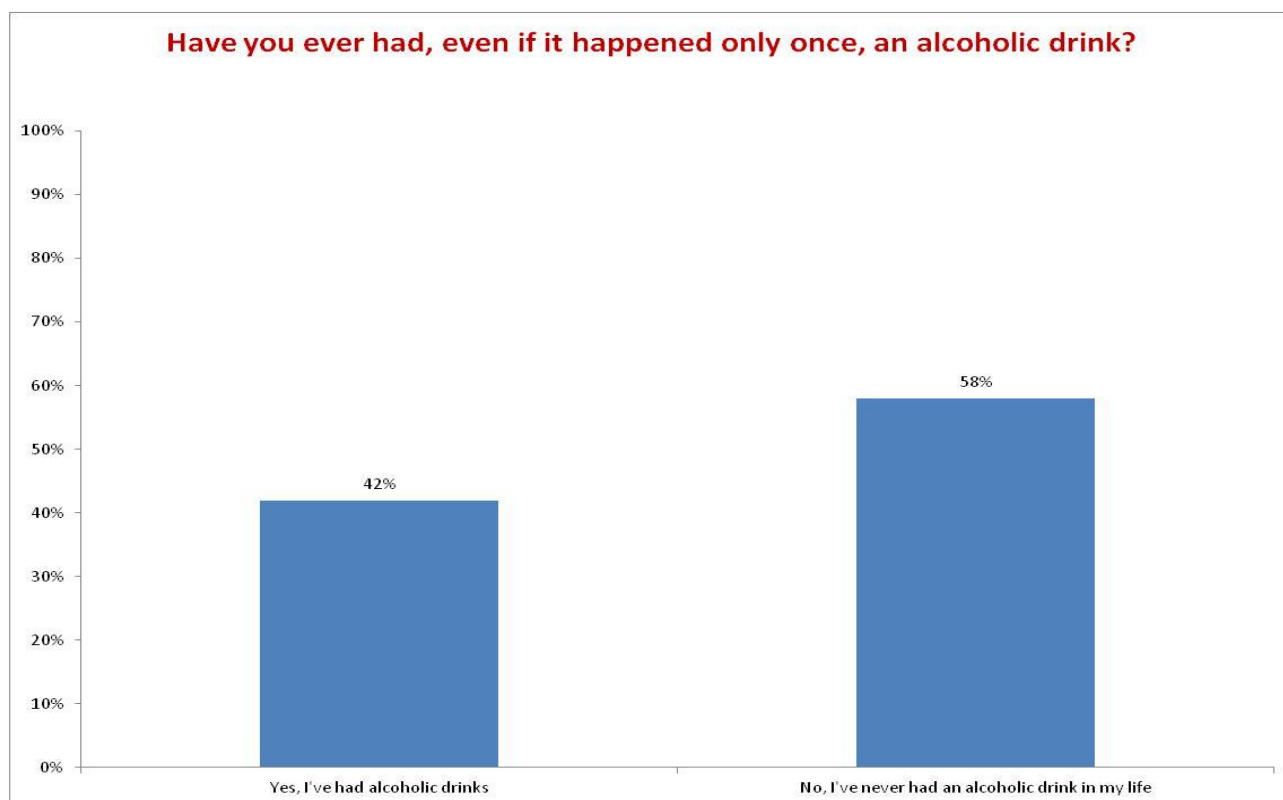


Table 1.1. Drinking habit in the past 30 days by age-groups

Drink habits in the past 30 days		4-5 times a week	2-3 times a week	Once a week	1-3 times a month	Once a month	I didn't drink alcohol over the past 30 days
Wines	less than 14 years old	2.2%		2.2%	4.4%	6.7%	84.4%
	14 years old and over	2.4%	4.3%	5.3%	7.2%	15.9%	64.7%
Beer	less than 14 years old	6.7%		2.2%	6.7%	26.7%	57.8%
	14 years old and over	2.9%	4.3%	14.5%	10.1%	16.9%	51.2%
Spirits	less than 14 years old	-	-	2.2%	-	-	97.8%
	14 years old and over	1%	1.4%	1.9%	7.2%	10.6%	77.8%
Cocktails	less than 14 years old	-	-	-	-	-	100.0%
	14 years old and over	-	3.4%	3.9%	6.8%	12.1%	73.9%
Other	less than 14 years old	-	-	-	-	-	100.0%
	14 years old and over	1.4%	1.4%	0.5%	0.5%	6.3%	89.9%

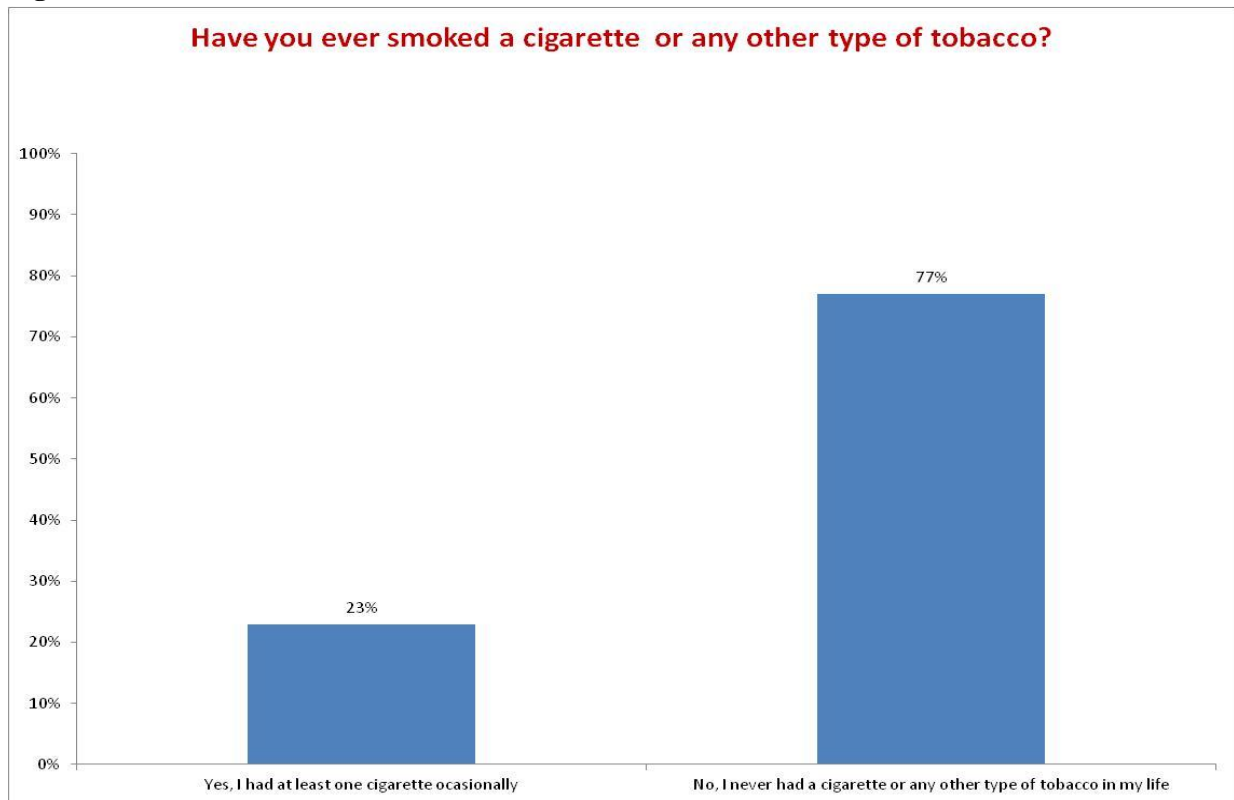
Table 1.2. Drinking habit in the past 30 days by gender

Drink habits in the past 30 days		4-5 times a week	2-3 times a week	Once a week	1-3 times a month	Once a month	I didn't drink alcohol over the past 30 days
Wines	Boys	2%	3%	7%	8%	13%	67%
	Girls	2%	5%	1%	5%	16%	72%
Beer	Boys	3%	6%	15%	10%	21%	45%
	Girls	1%	2%	7%	8%	15%	67%
Spirits	Boys	1%	1%	2%	7%	7%	81%
	Girls	-	1%	1%	3%	13%	82%
Cocktails	Boys	-	2%	3%	6%	8%	82%
	Girls	-	5%	3%	6%	14%	73%
Other	Boys	2%	2%	-	1%	4%	92%
	Girls	-	-	1%	-	7%	92%

Table 1.3. Drinking habit in the past 30 days by area of residence

Drink habits in the past 30 days		4-5 times a week	2-3 times a week	Once a week	1-3 times a month	Once a month	I didn't drink alcohol over the past 30 days
Wines	Urban	1.3%	2%	5.2%	3.9%	15.7%	71.9%
	Rural	4%	6.1%	4%	11.1%	12.1%	62.6%
Beer	Urban	2%	2.6%	9.8%	7.8%	22.2%	55.6%
	Rural	3%	8.1%	16.2%	12.1%	13.1%	47.5%
Spirits	Urban	-	1.3%	0.7%	5.2%	9.8%	83%
	Rural	2%	1%	4%	7.1%	7.1%	78.8%
Cocktails	Urban	-	3.3%	2.6%	6.5%	9.2%	78.4%
	Rural	-	2%	4%	4%	11.1%	78.8%
Other	Urban	-	0.7%	-	0.7%	4.6%	94.1%
	Rural	-	3%	2%	1%	6.1%	87.9%

Fig. 1.2.



Annex 1. Findings on alcohol and tobacco consumption

Fig. 1.1.

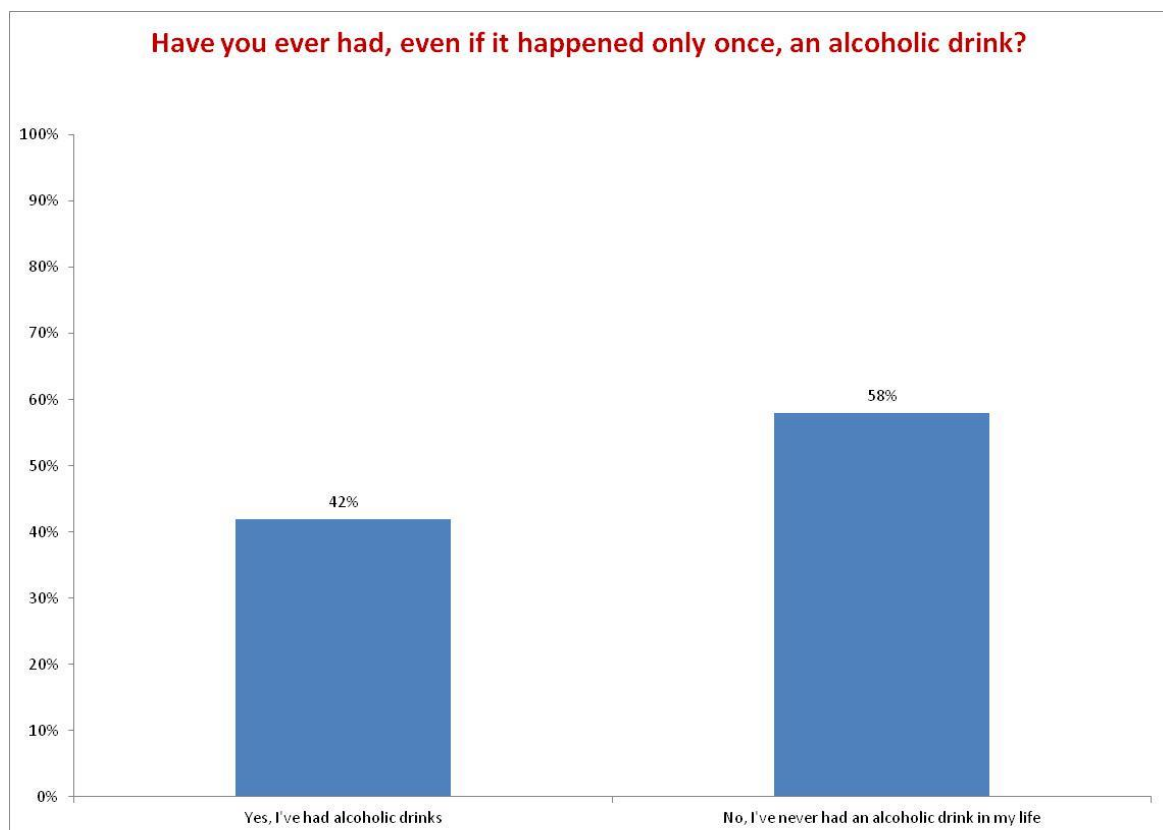


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	14 years old and over	2.9%	4.3%	14.5%	10.1%	16.9%	51.2%
Spirits	less than 14 years old	-	-	2.2%	-	-	97.8%
	14 years old and over	1%	1.4%	1.9%	7.2%	10.6%	77.8%
Cocktails	less than 14 years old	-	-	-	-	-	100.0%
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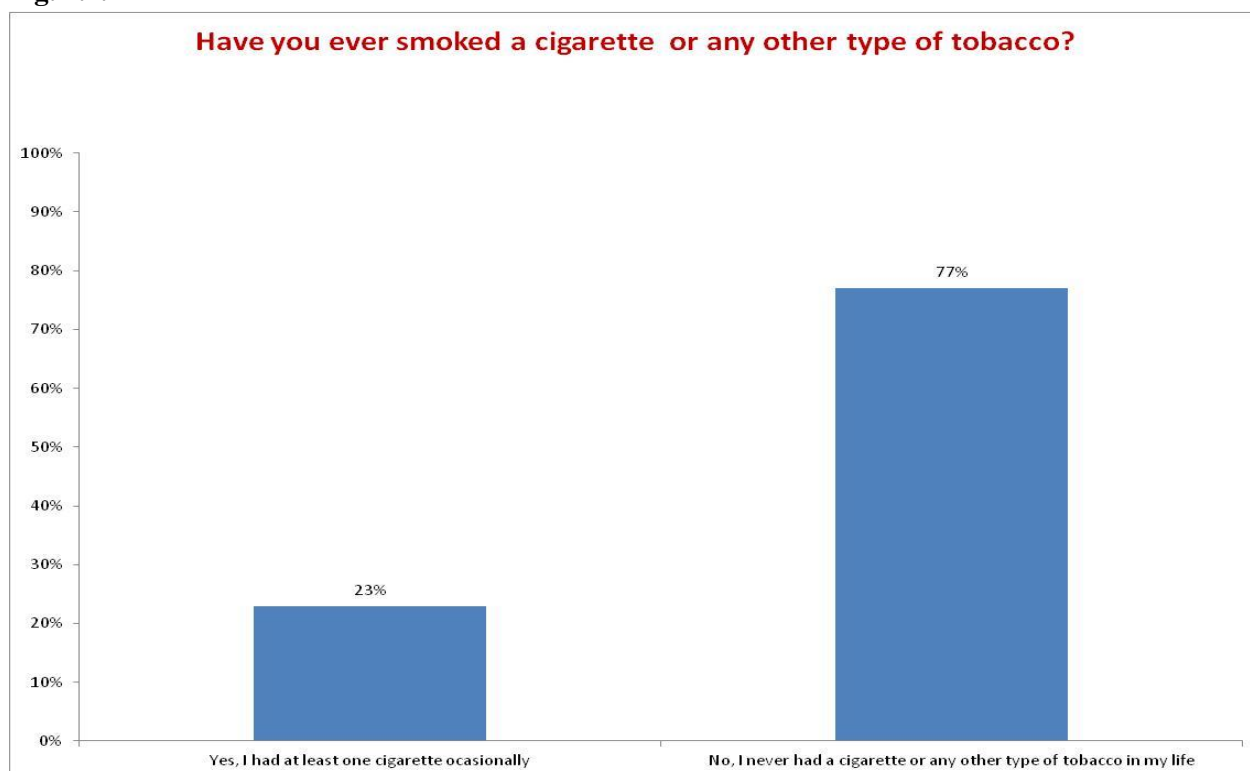
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Other	Urban	-	0.7%	-	0.7%	4.6%	94.1%
	Rural	-	3%	2%	1%	6.1%	87.9%

Fig. 1.2.



Annex 3. Awareness and knowledge of HIV and other Sexually Transmitted Diseases and effects of drug, alcohol and tobacco use

Fig. 3.1*.

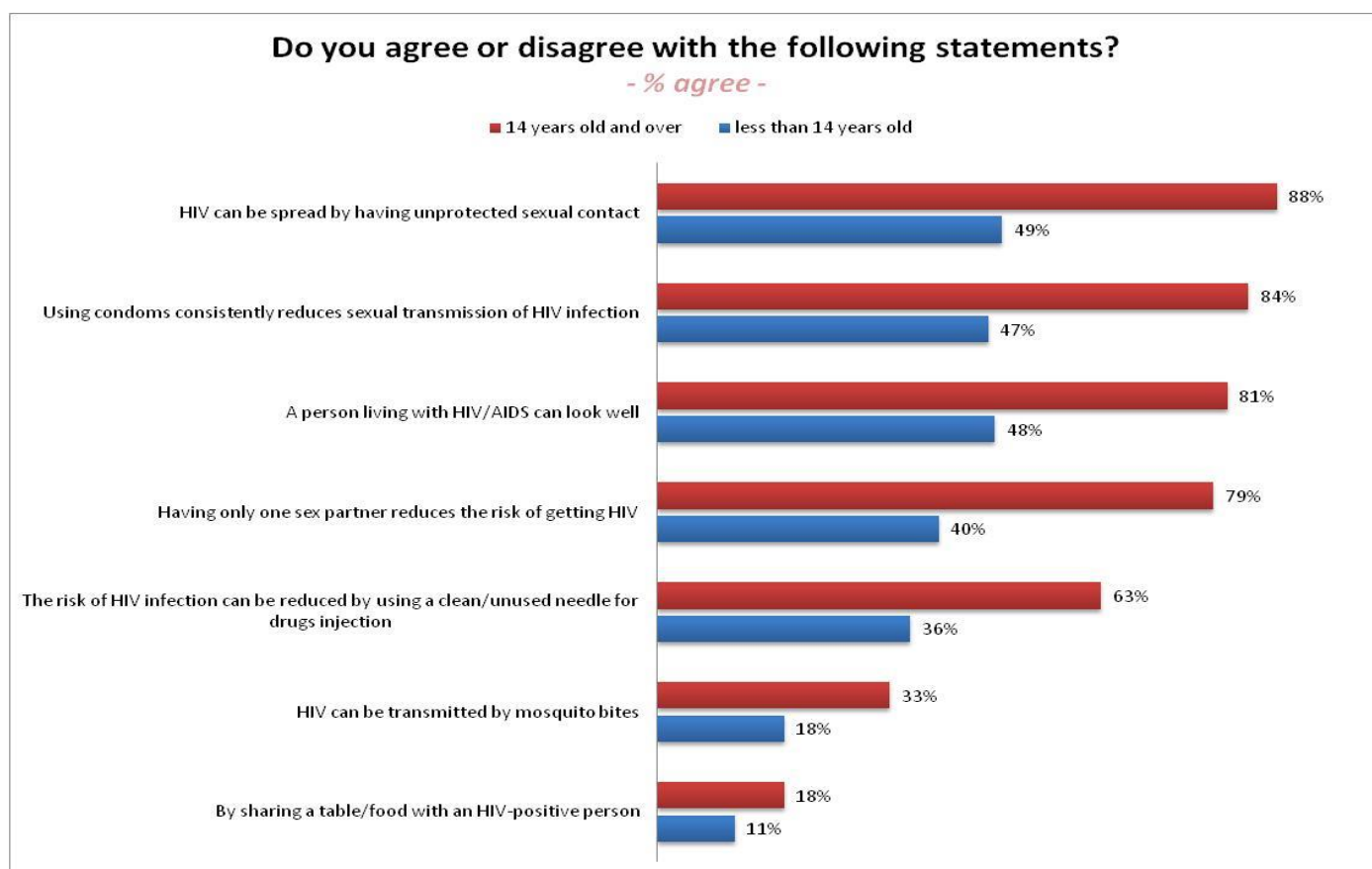


Fig. 3.2*.

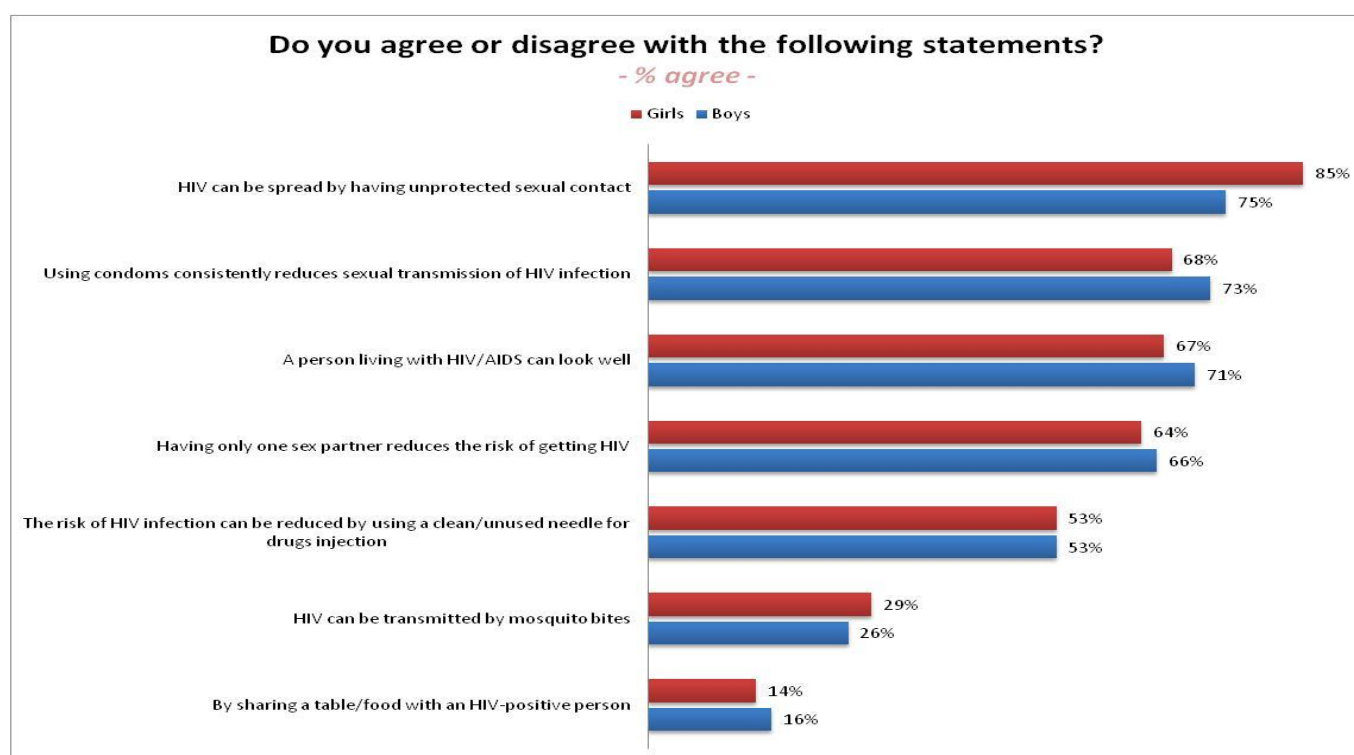


Fig. 3.3*.

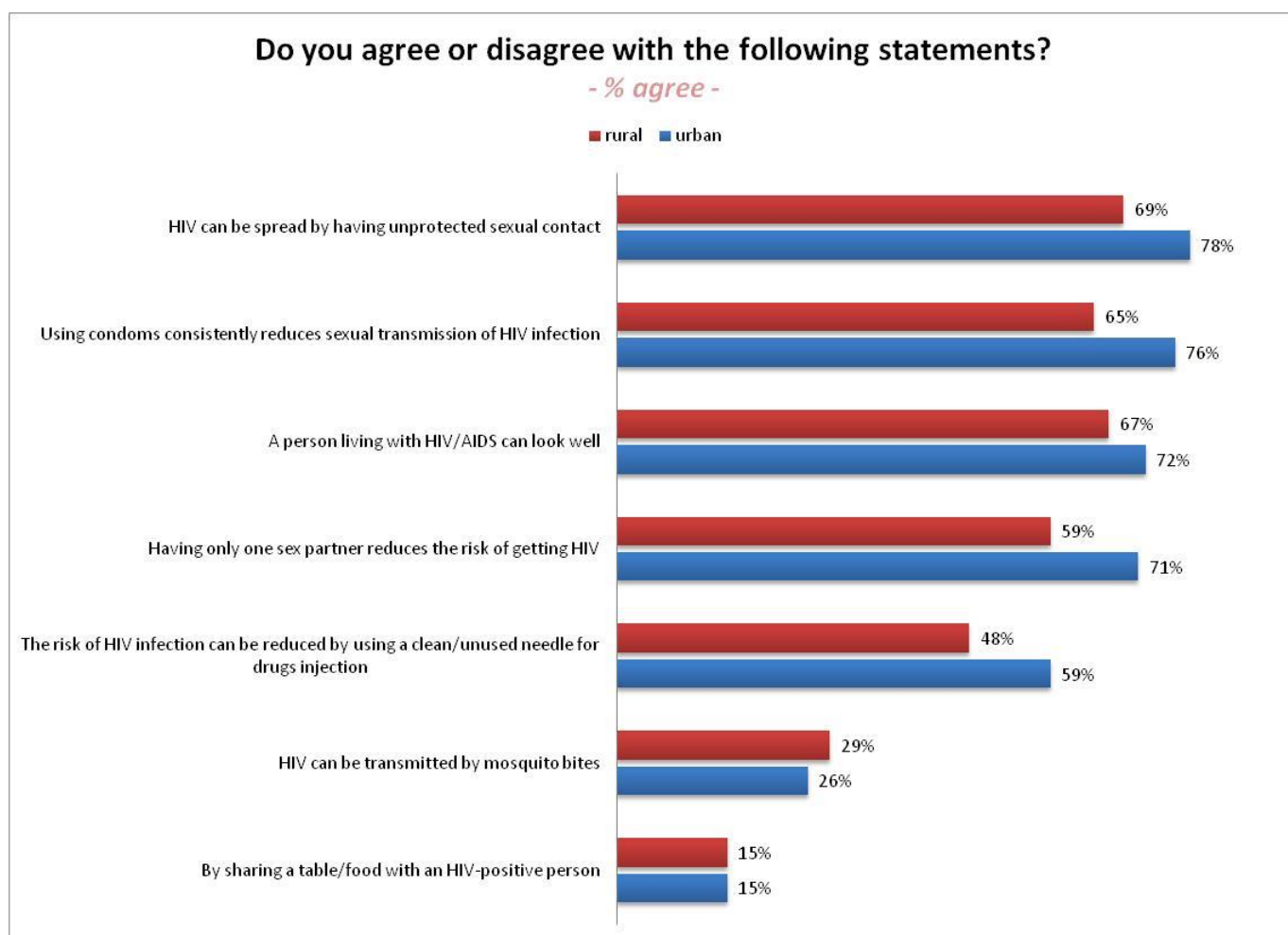


Fig. 3.4.

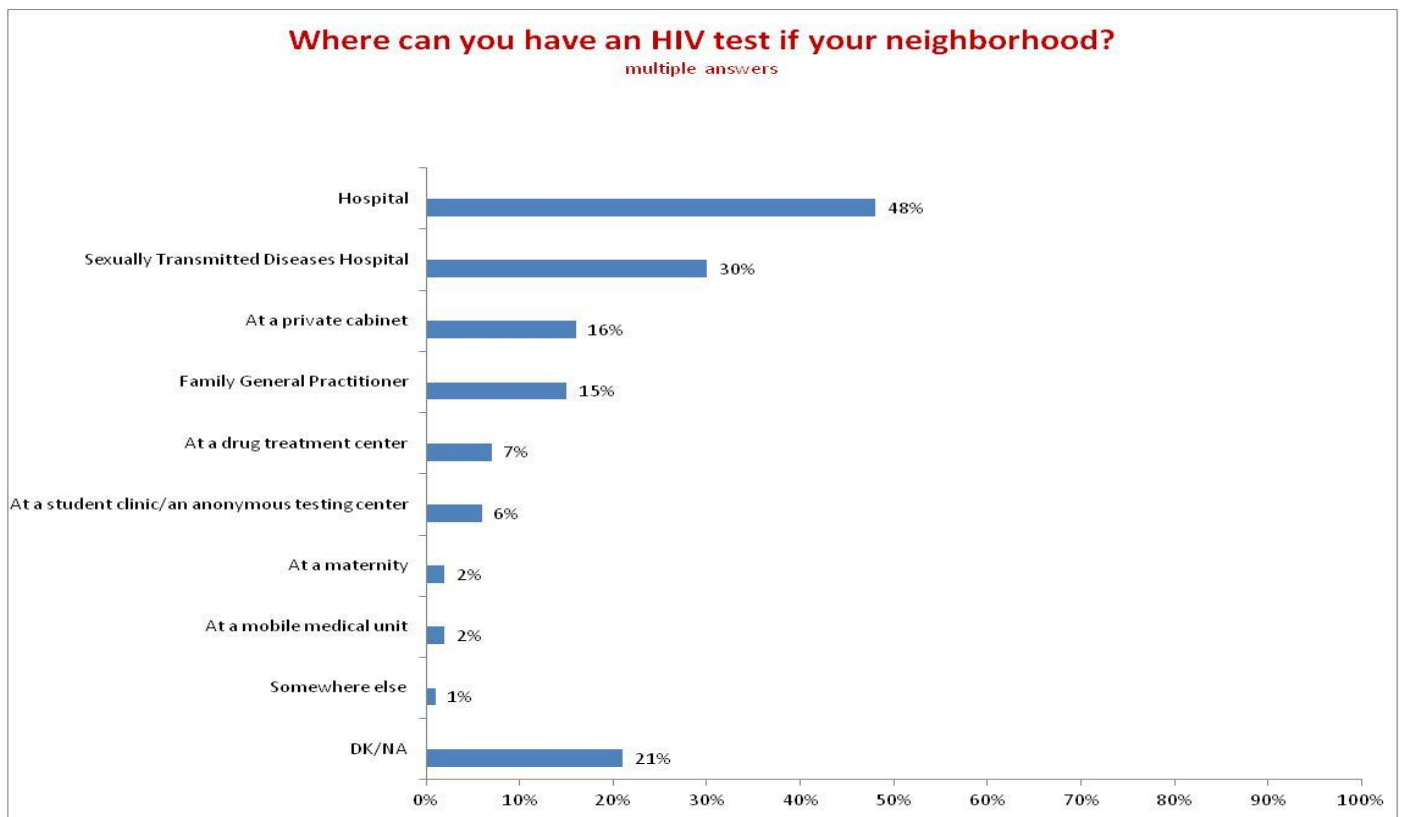


Fig. 3.5.

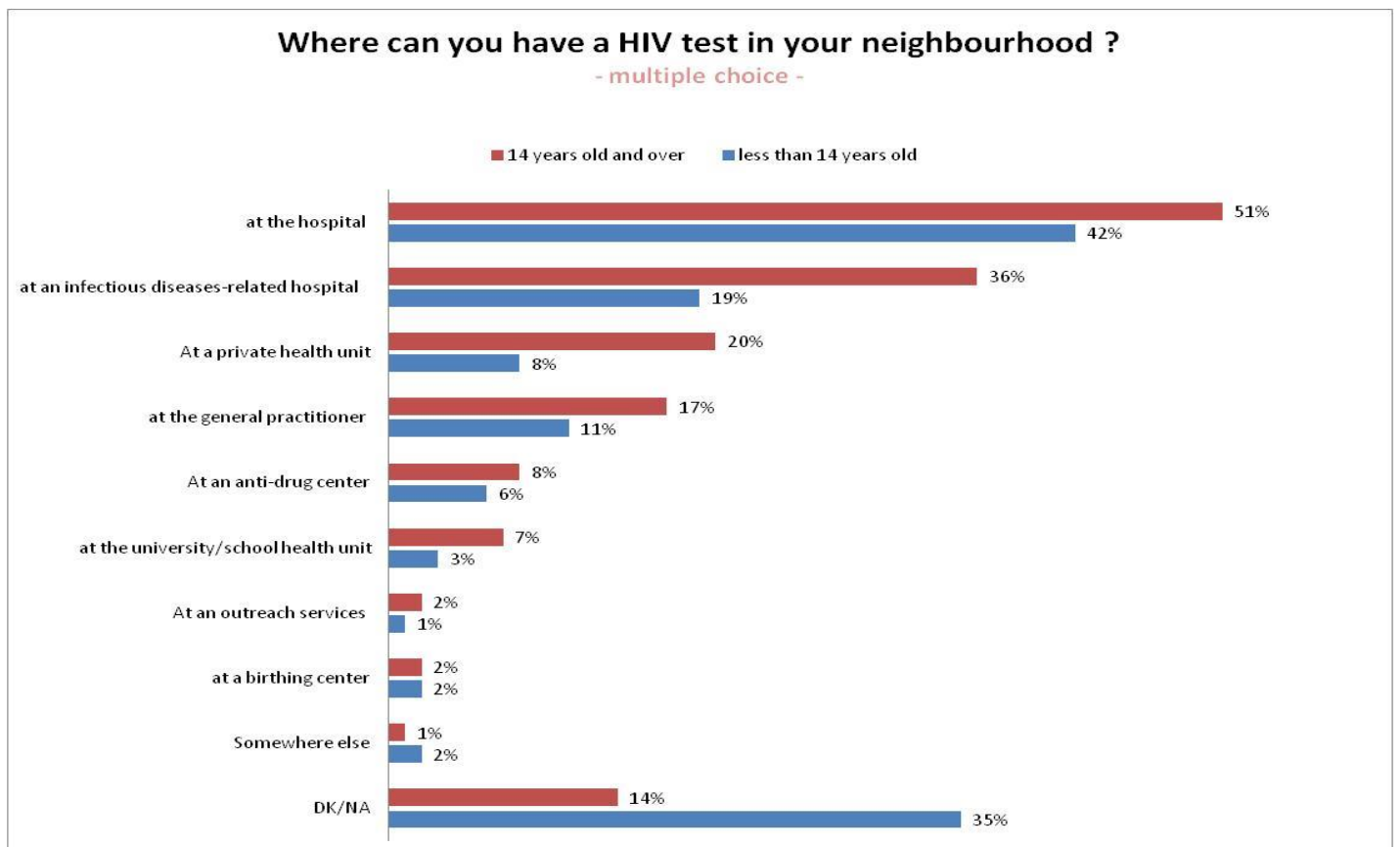


Fig. 3.6.

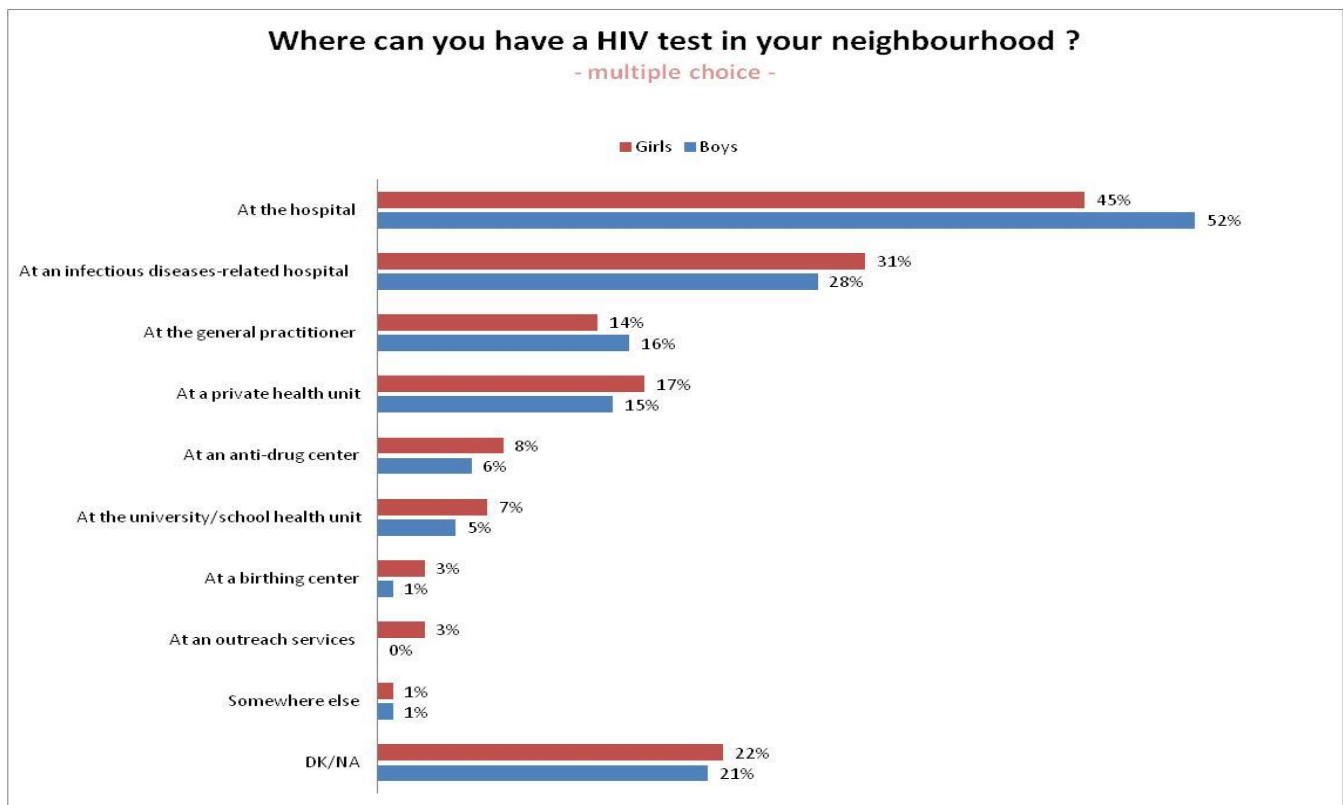


Fig. 3.7.

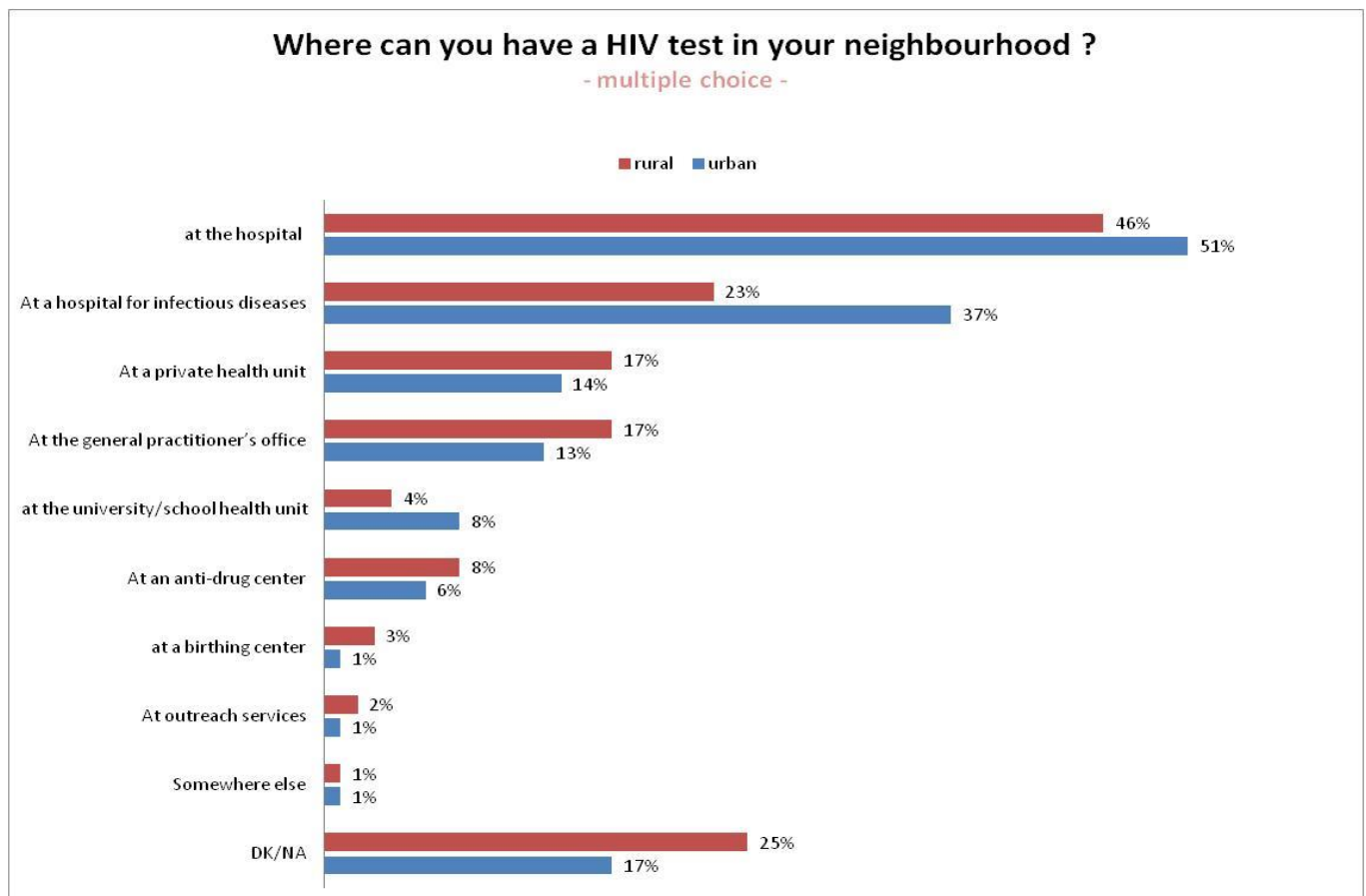


Fig. 3.8.

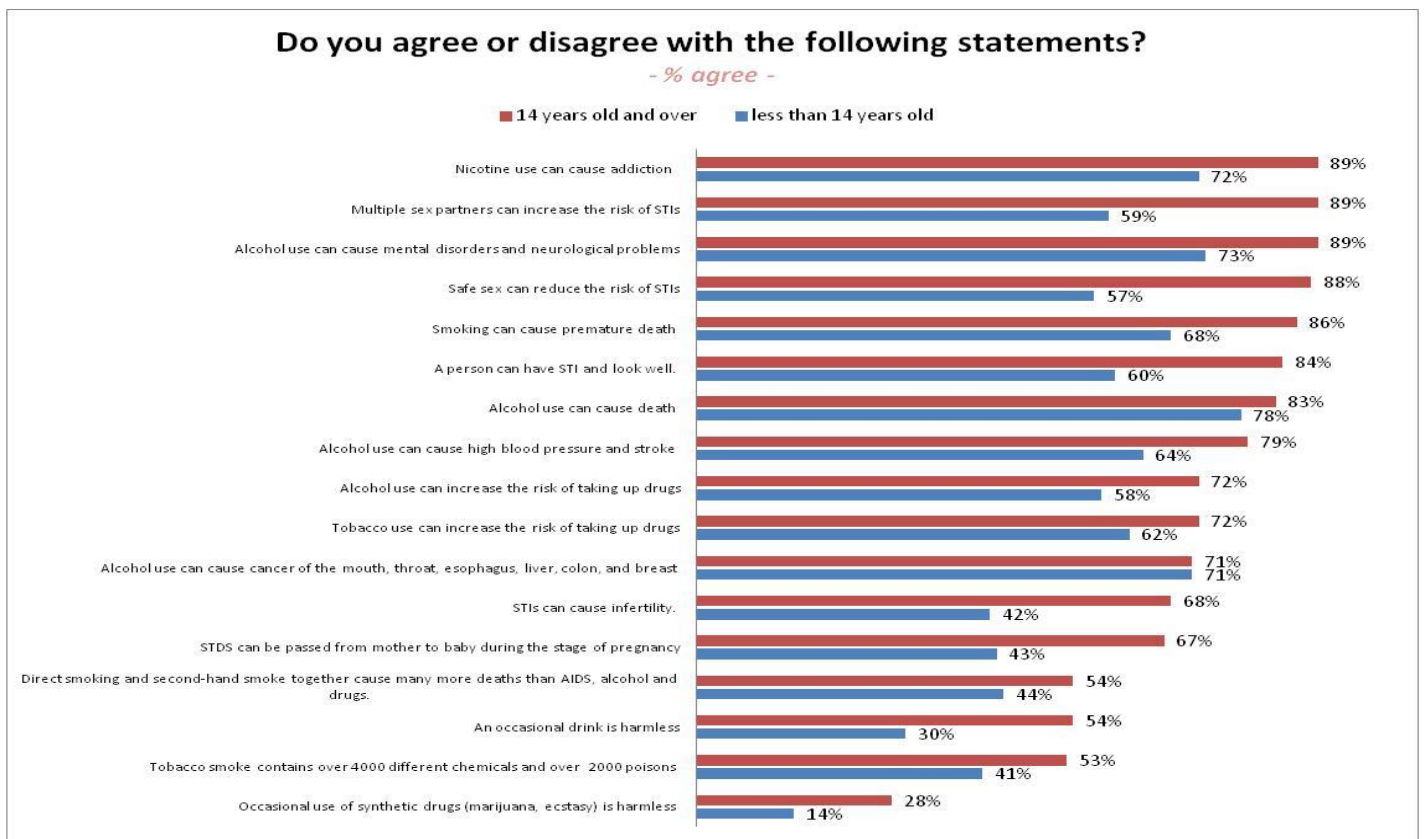


Fig. 3.9.

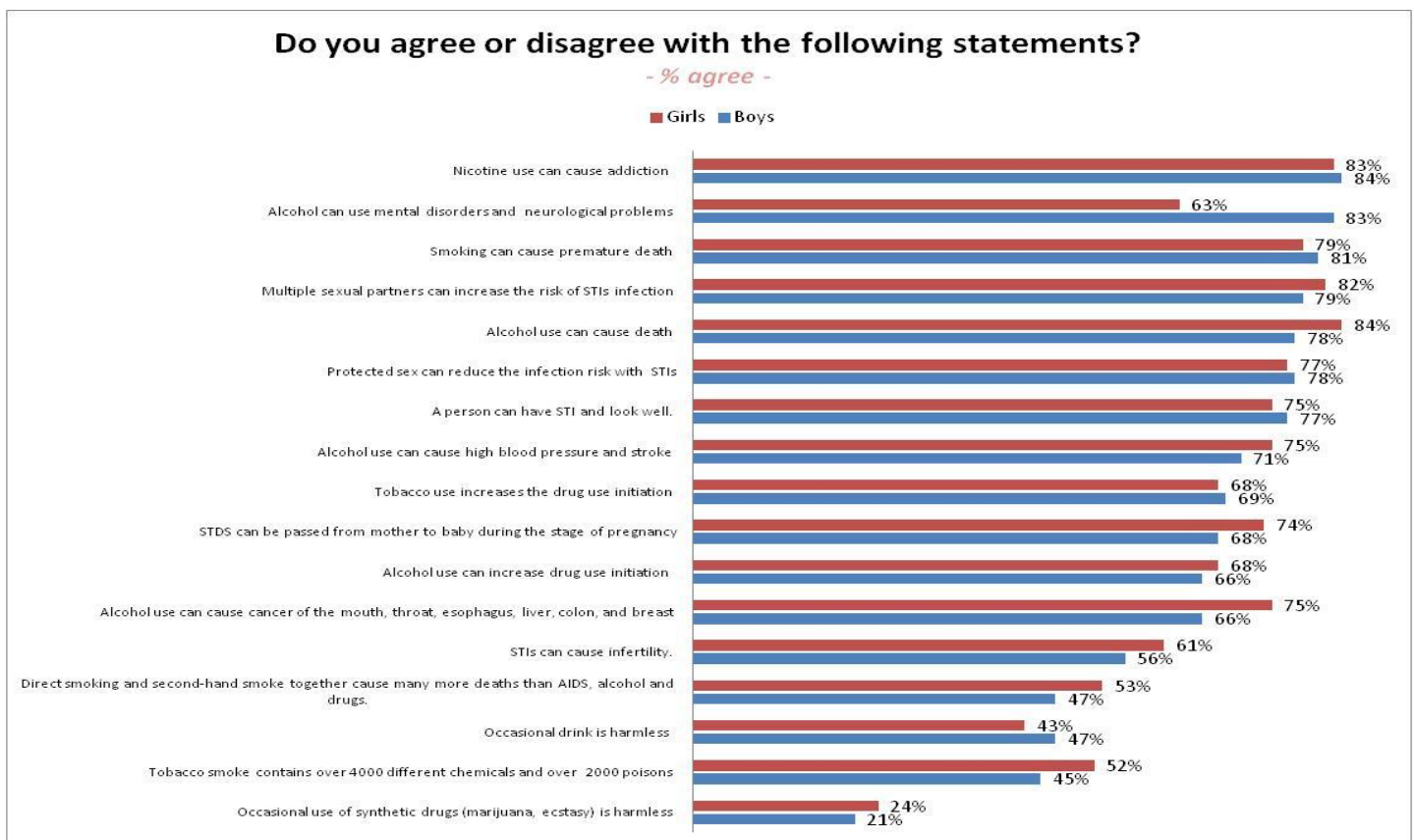
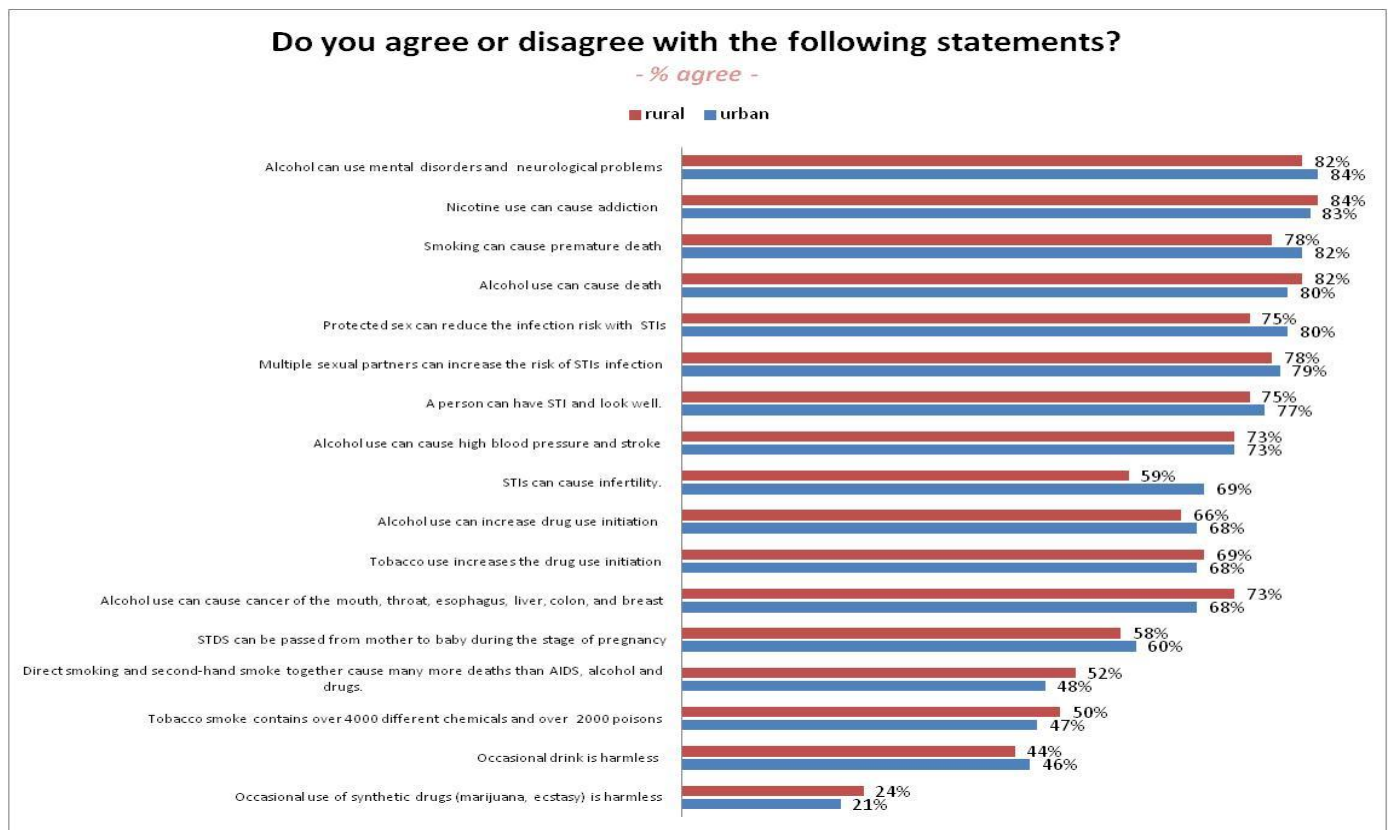


Fig. 3.10.



Annex 4. Mass media and Internet usage

Fig. 4.1.

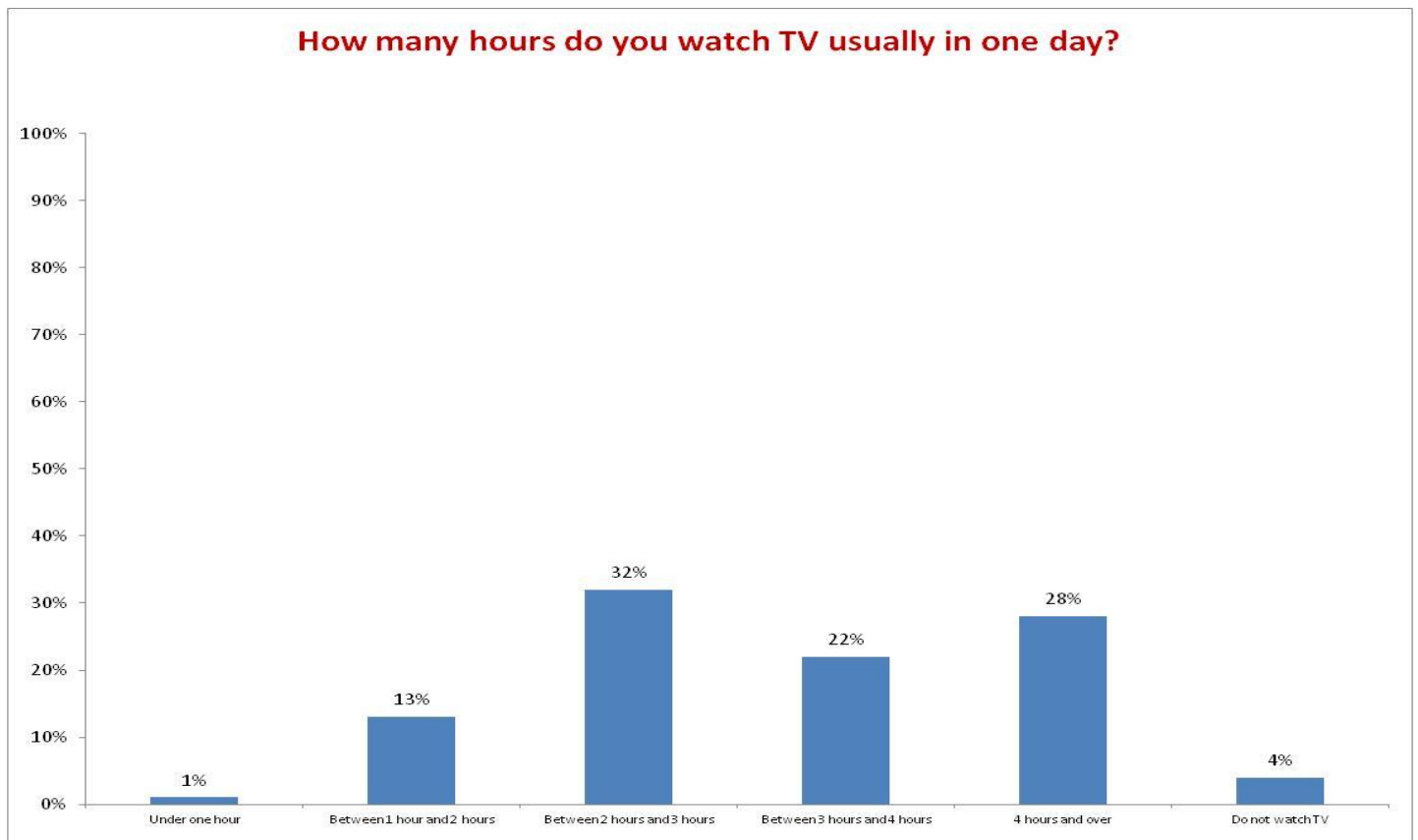


Fig. 4.2.

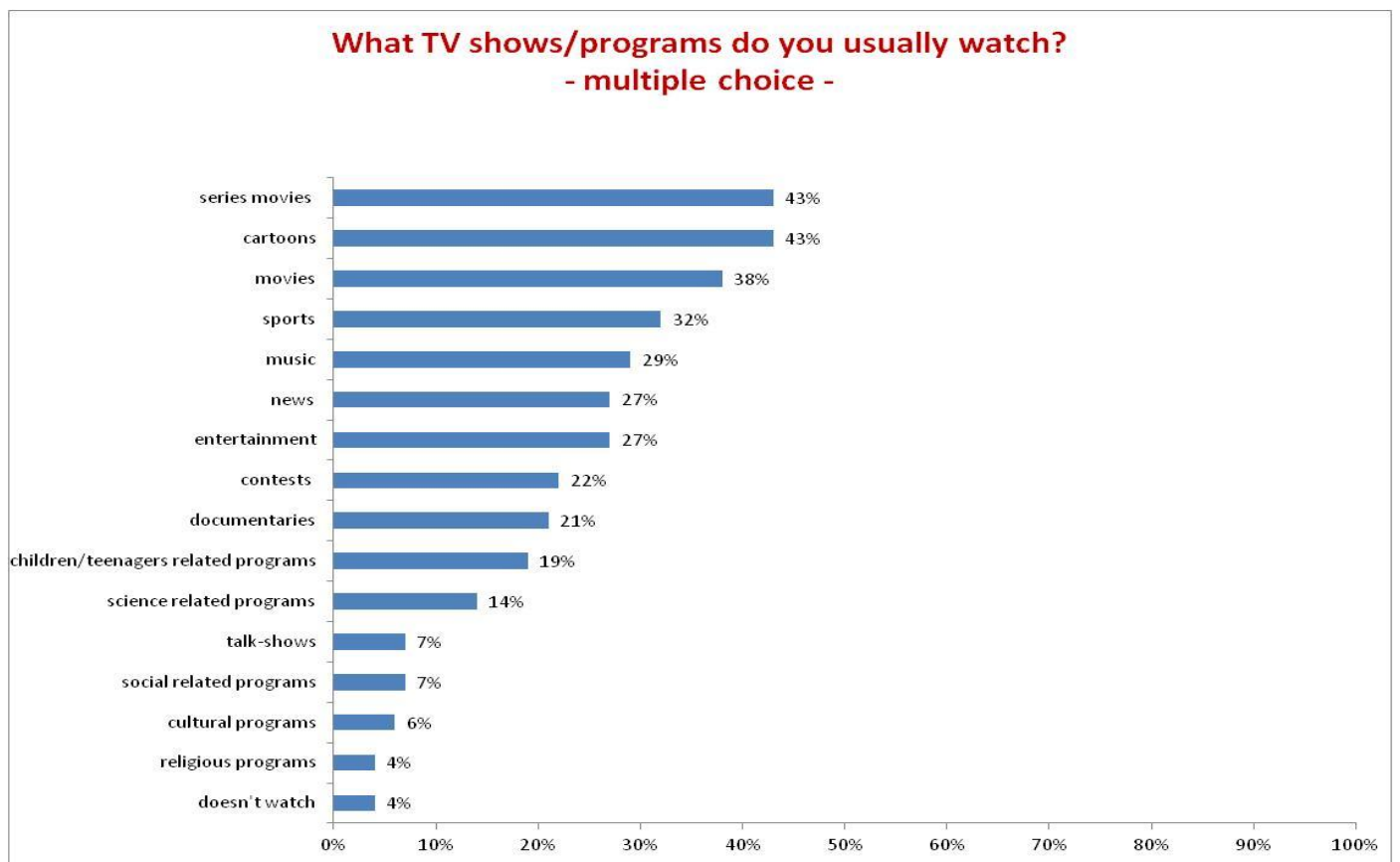


Fig. 4.3.

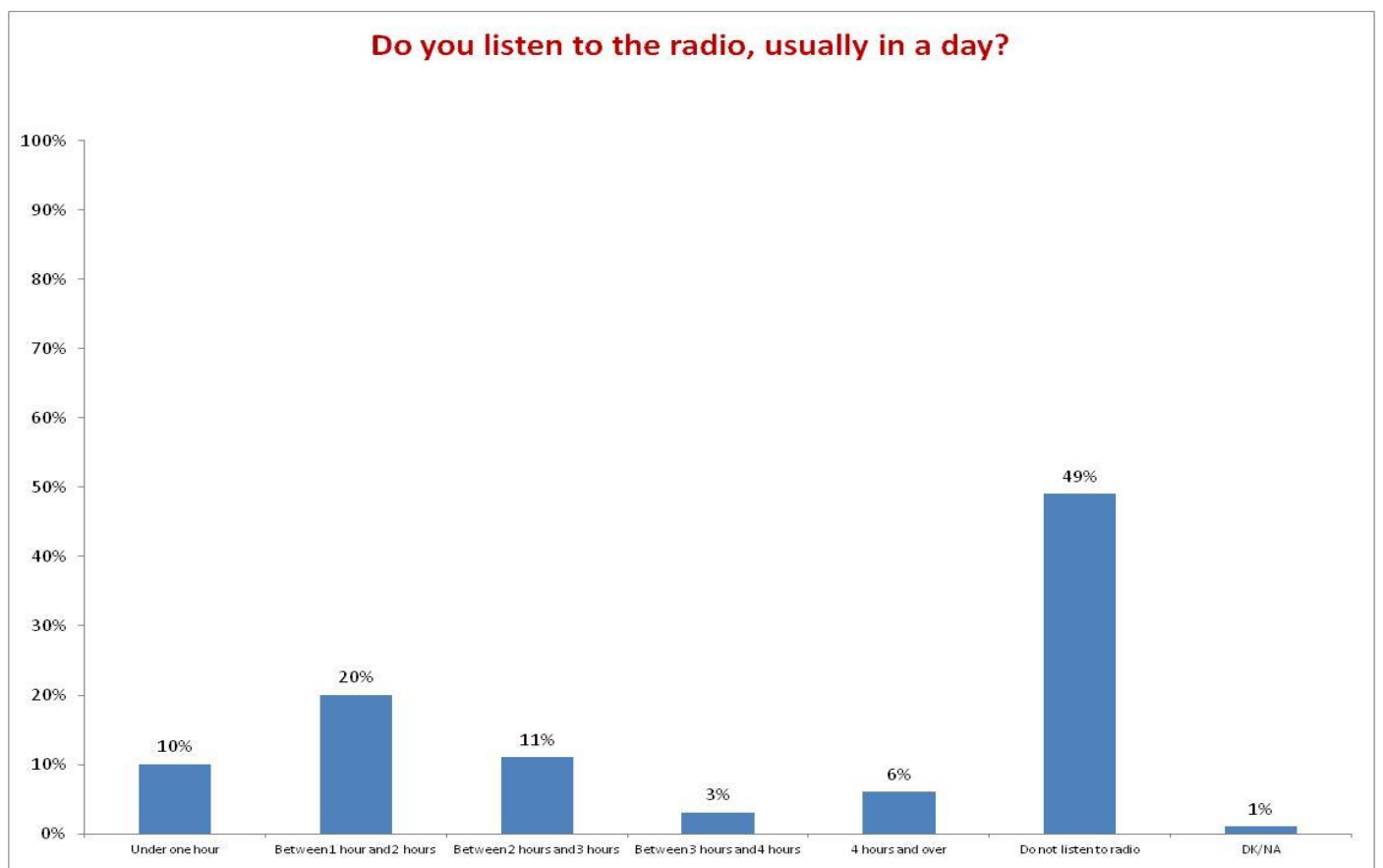


Fig. 4.4a. Place of internet using

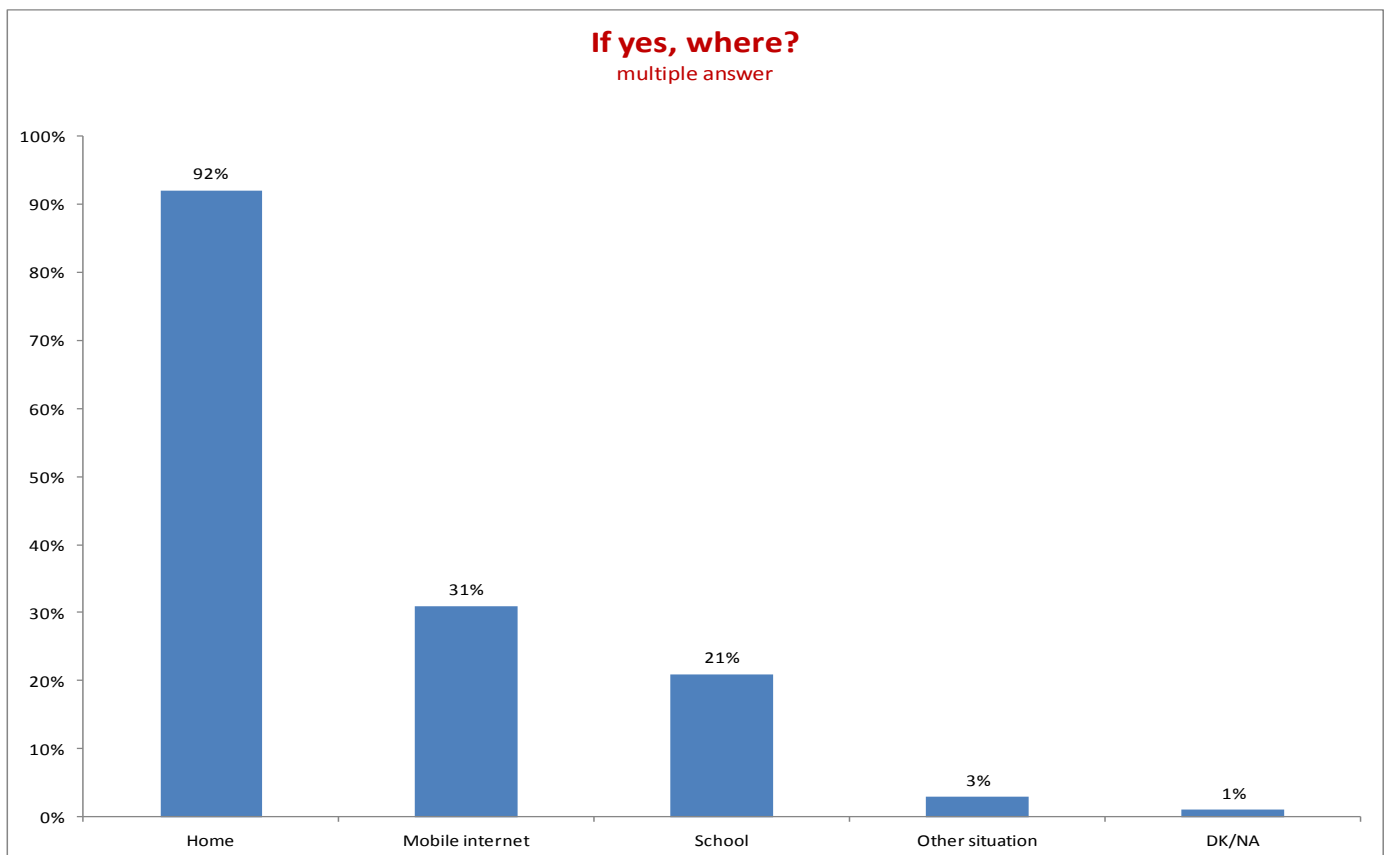


Fig. 4.4. b

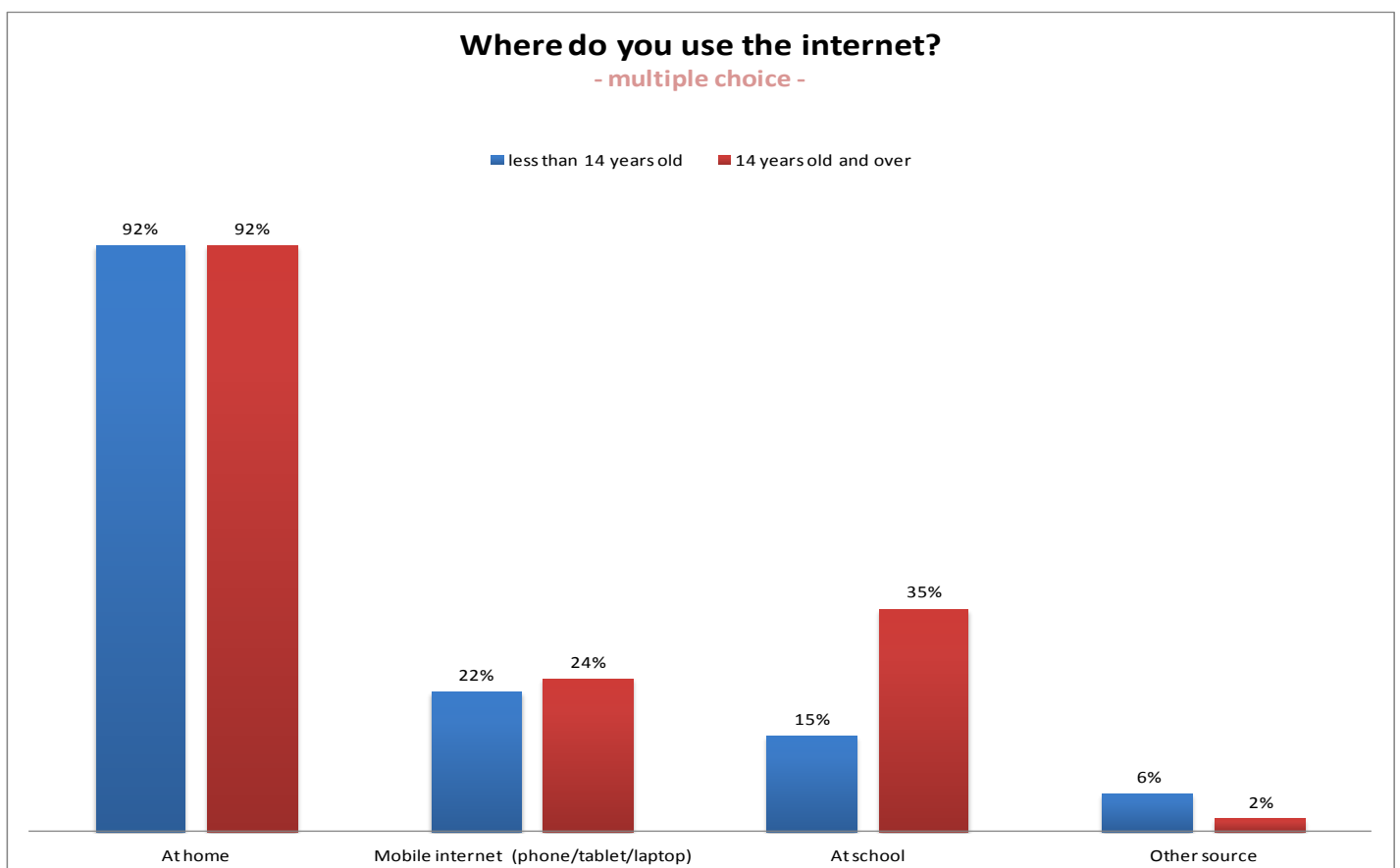


Fig. 4.4. c

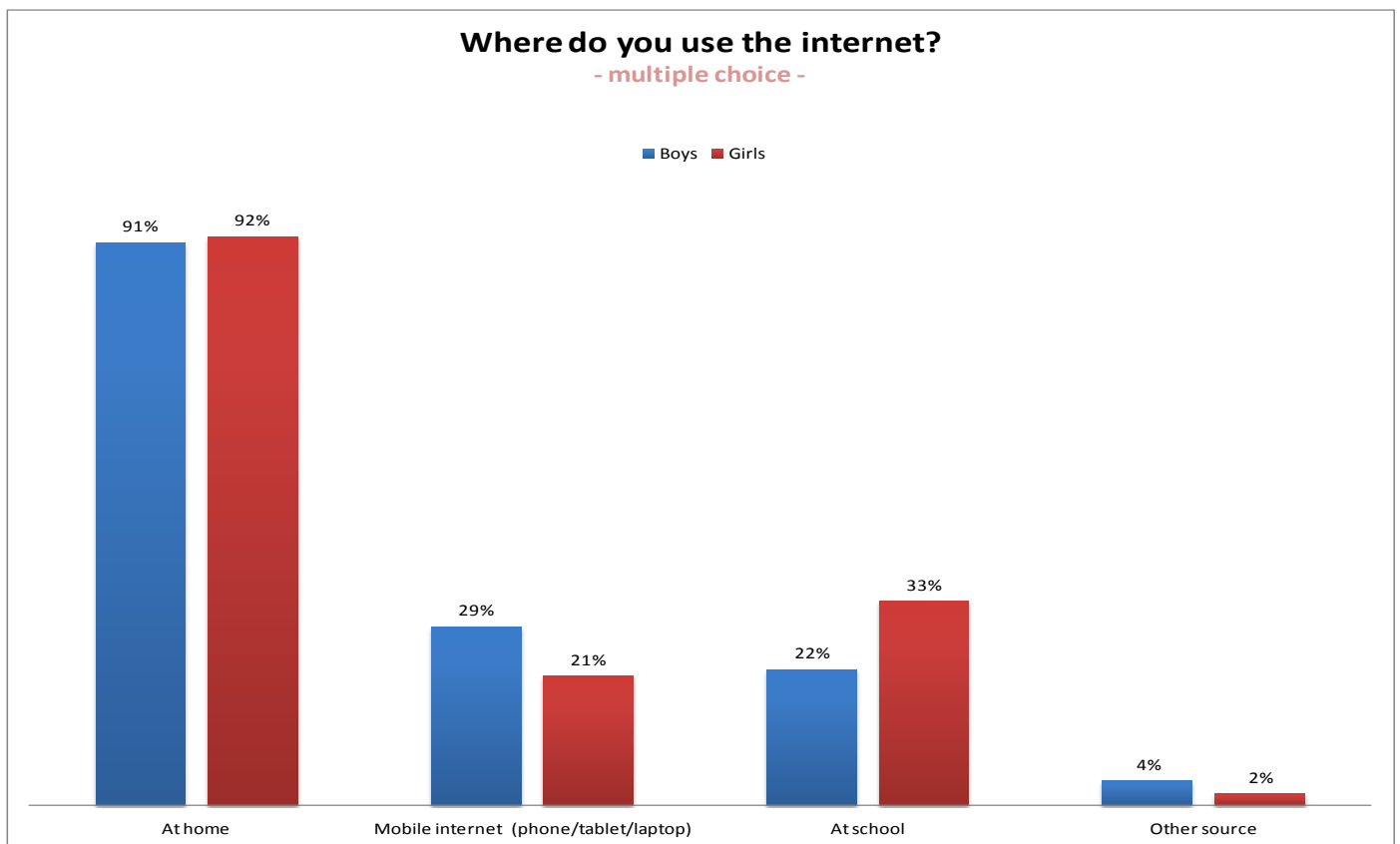


Fig. 4.4. d

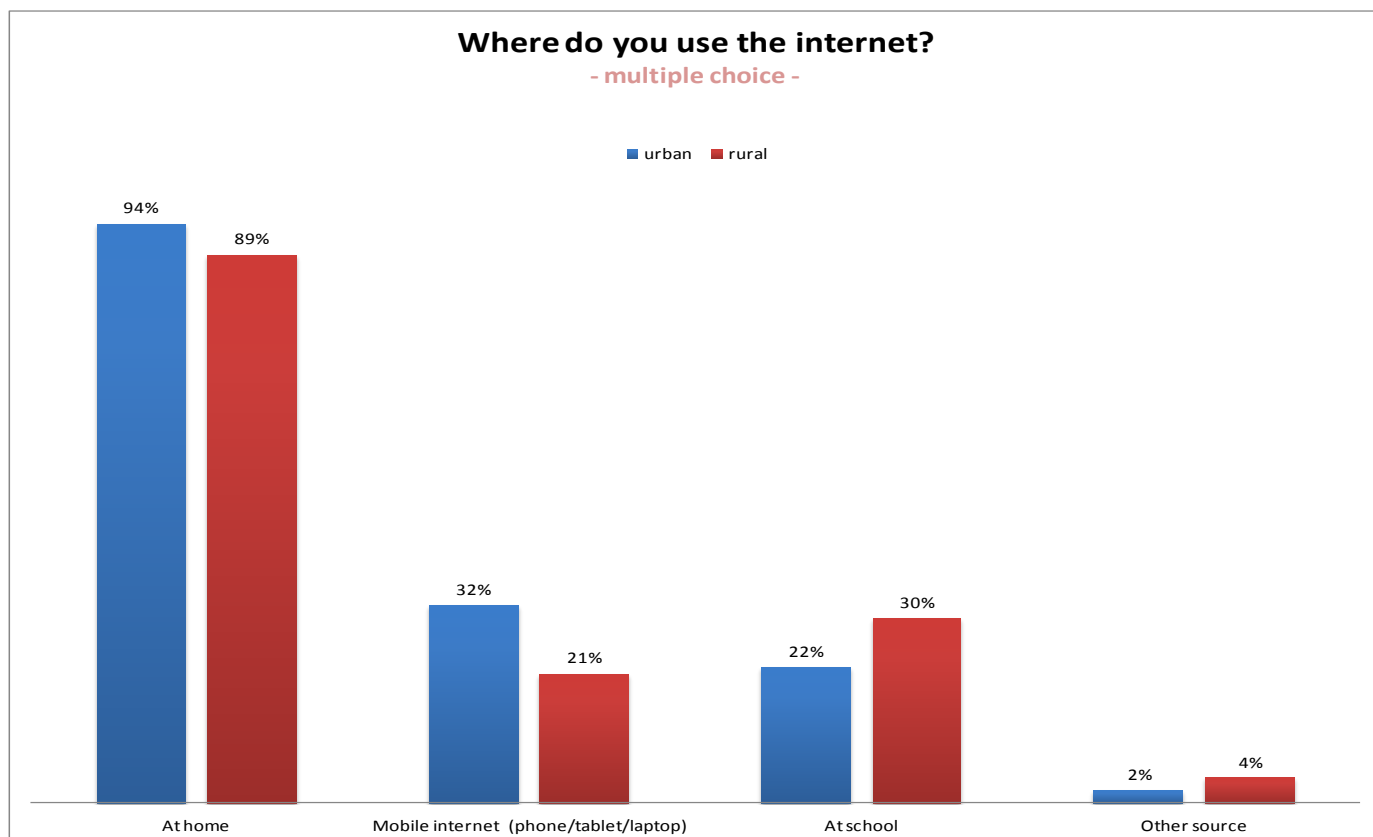


Fig.4.5a. –

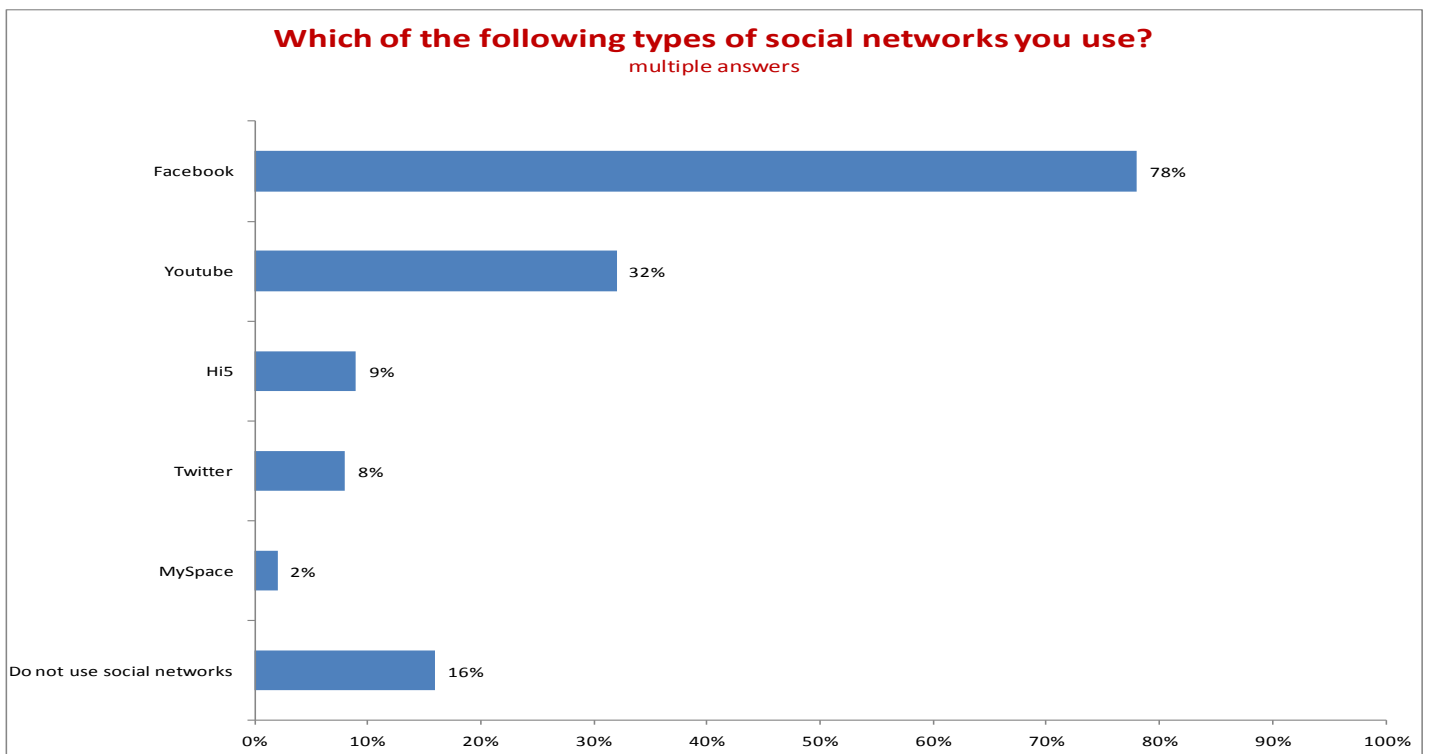


Fig. 4.5b.

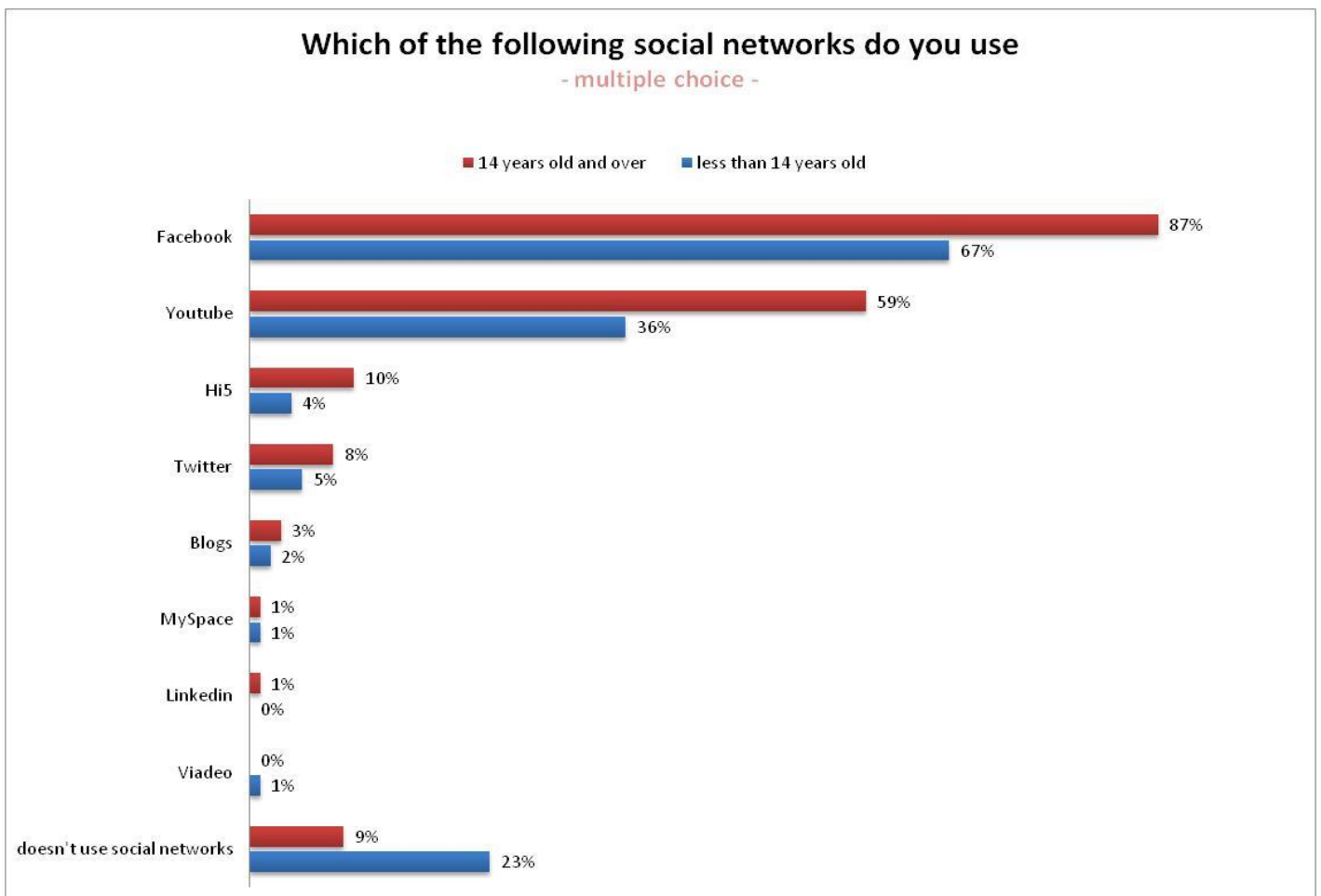


Fig. 4.5c.

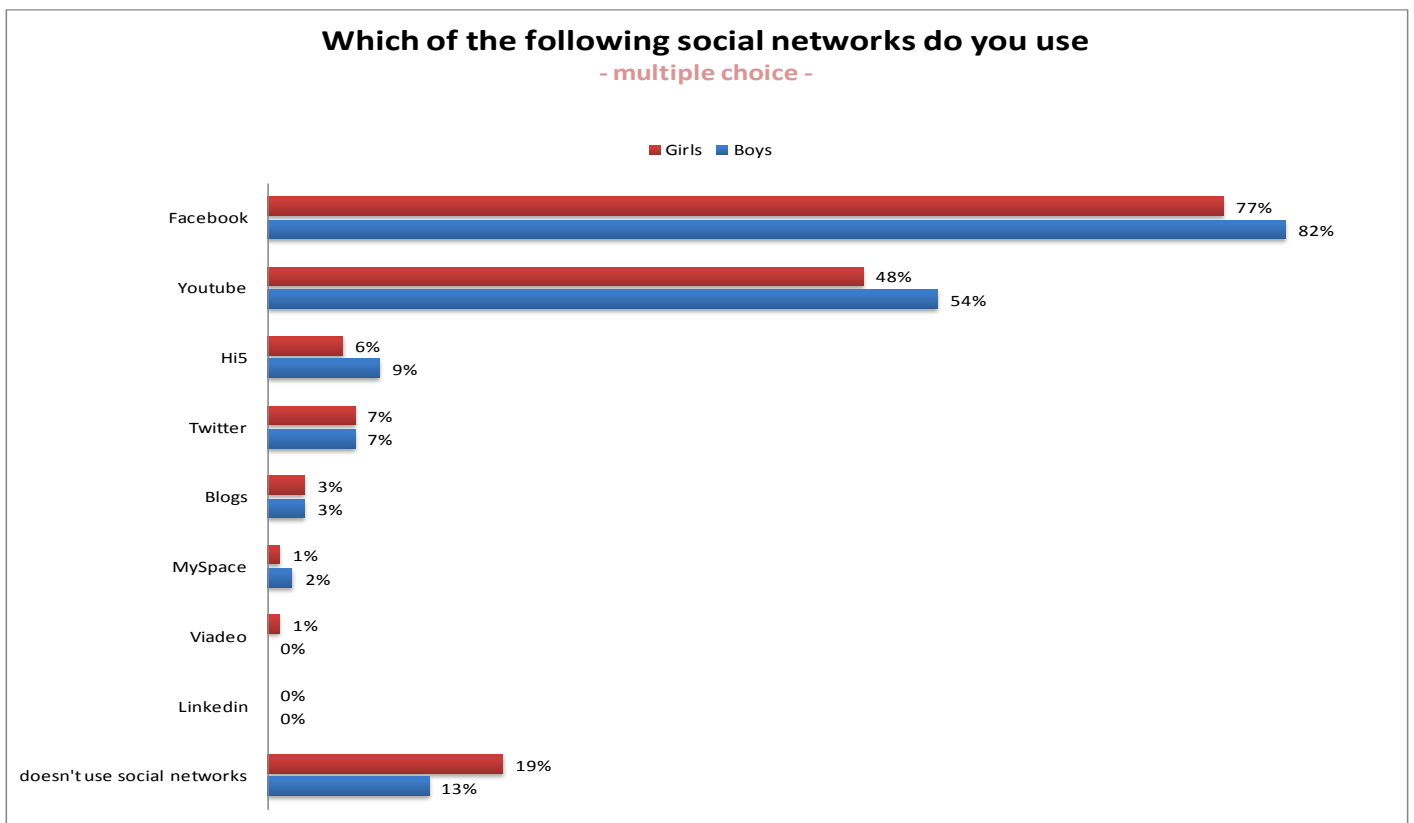


Fig. 4.5d

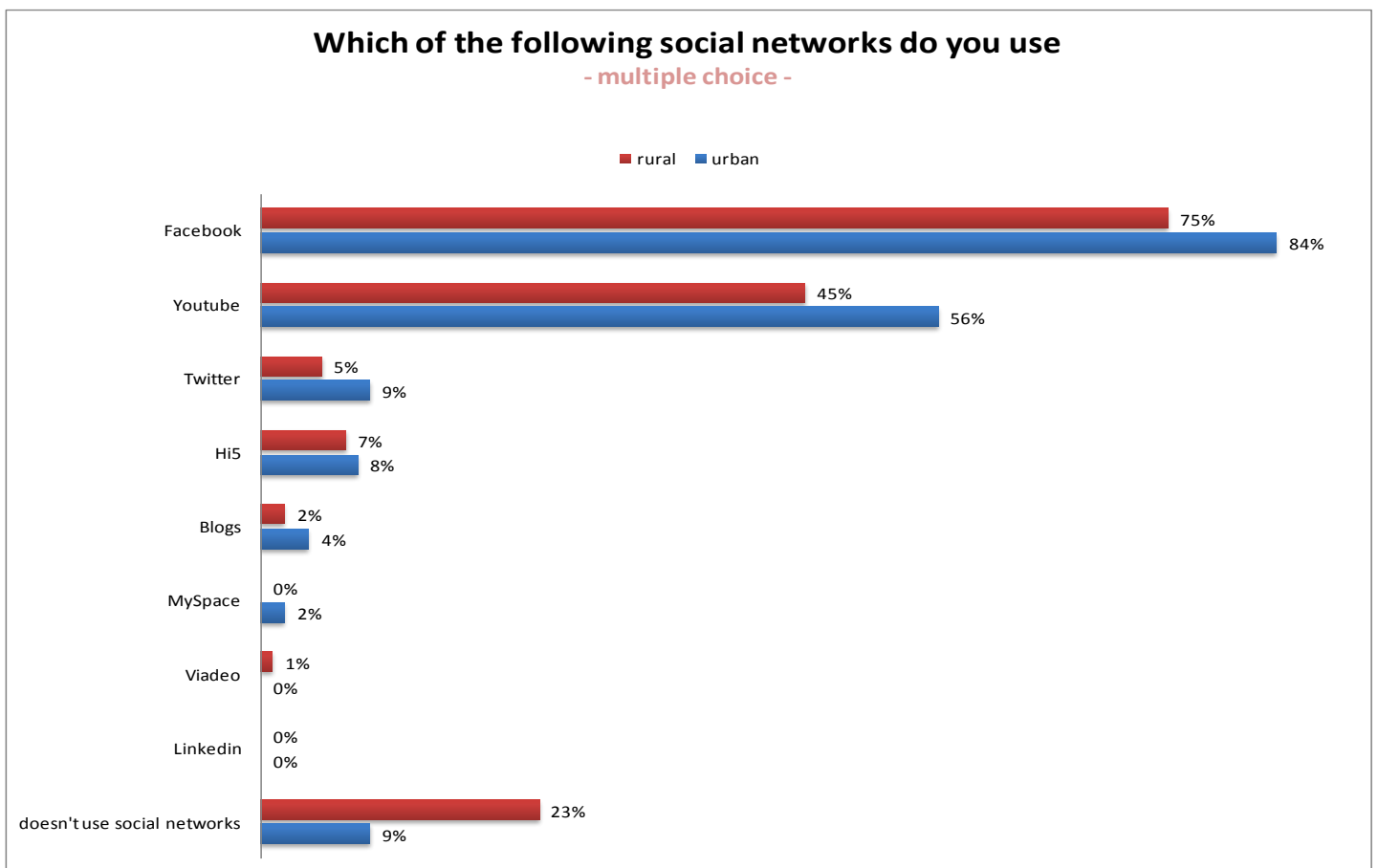


Fig. 4.6

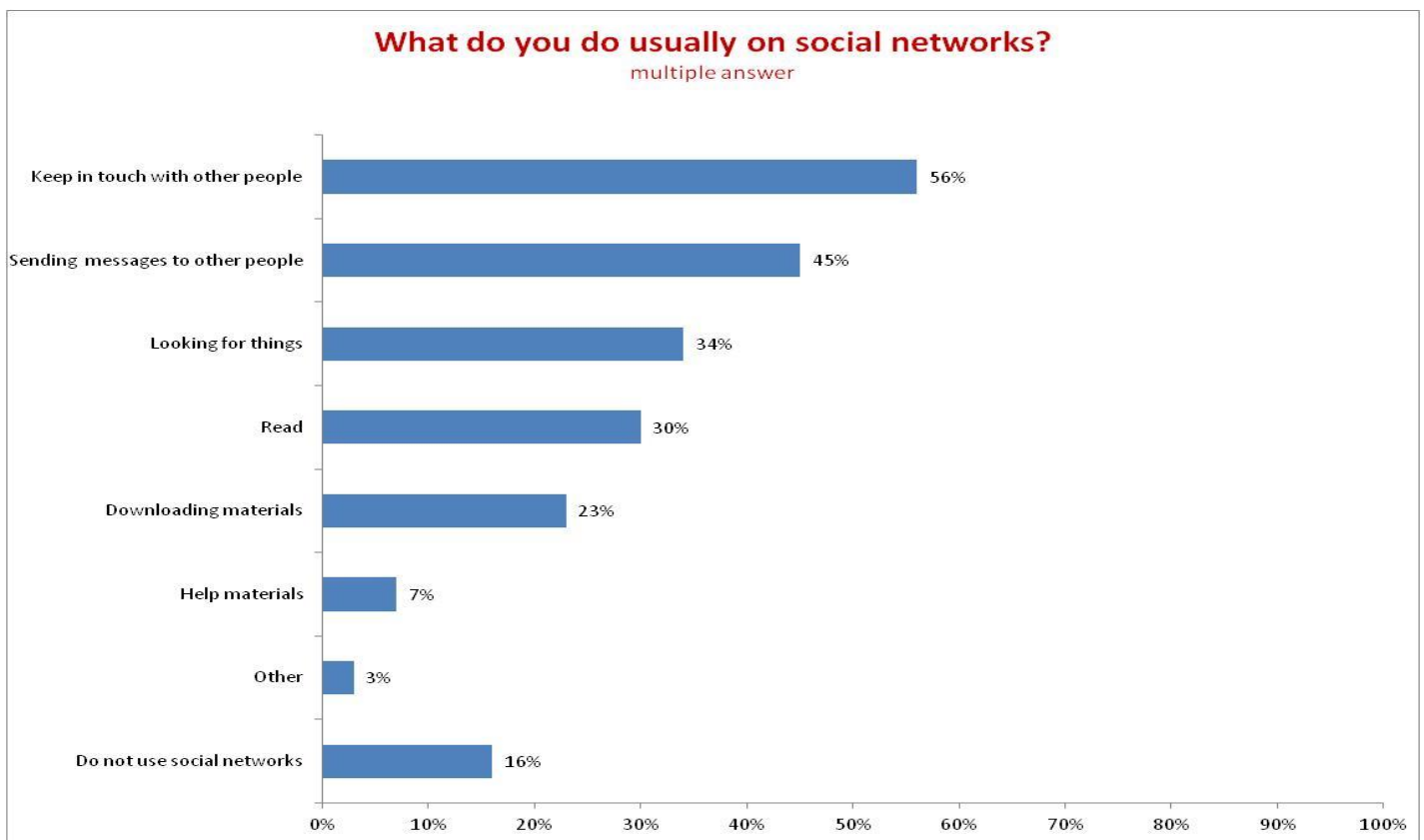


Fig. 4.7.

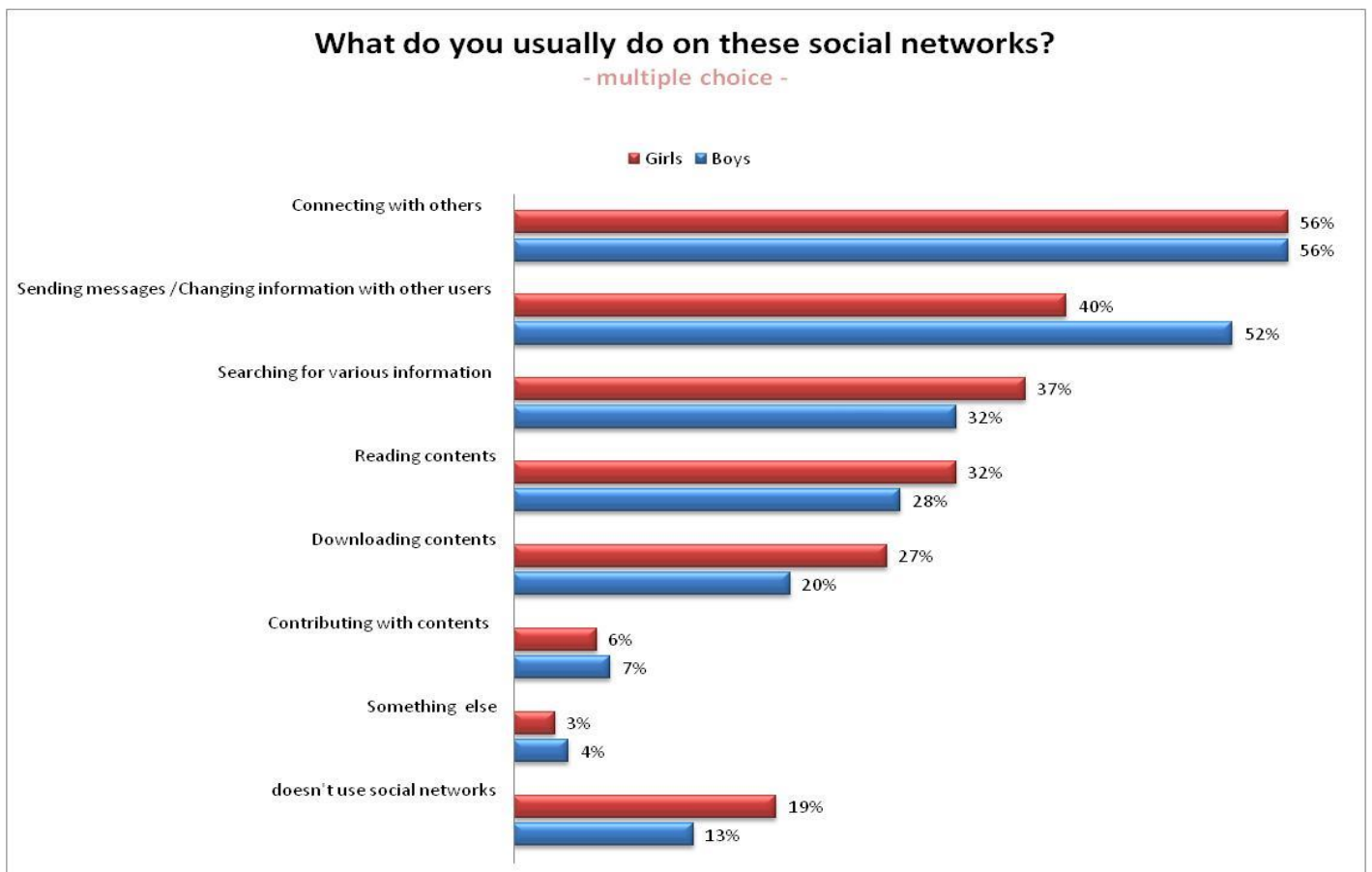
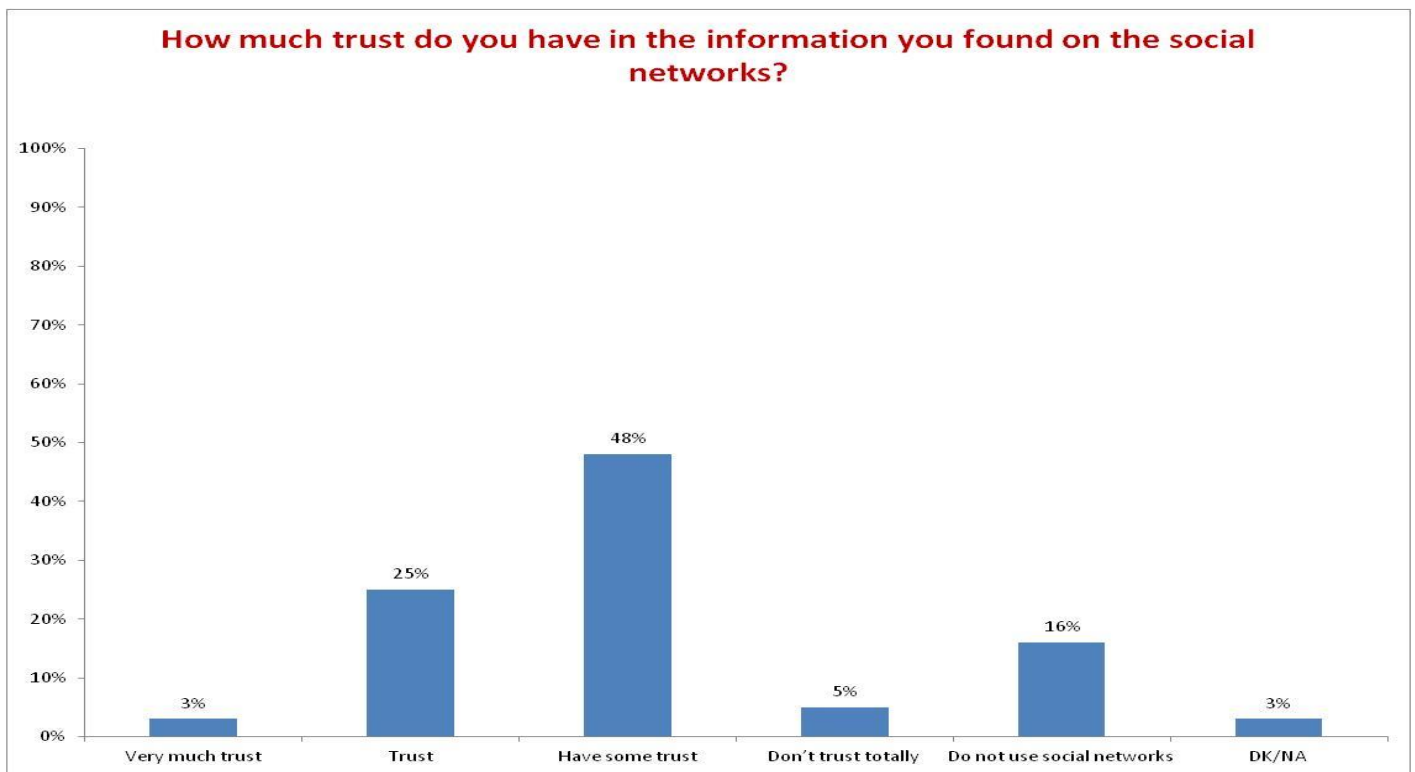


Fig. 4.8.



Annex 5. Drug users

Fig. 5.1.

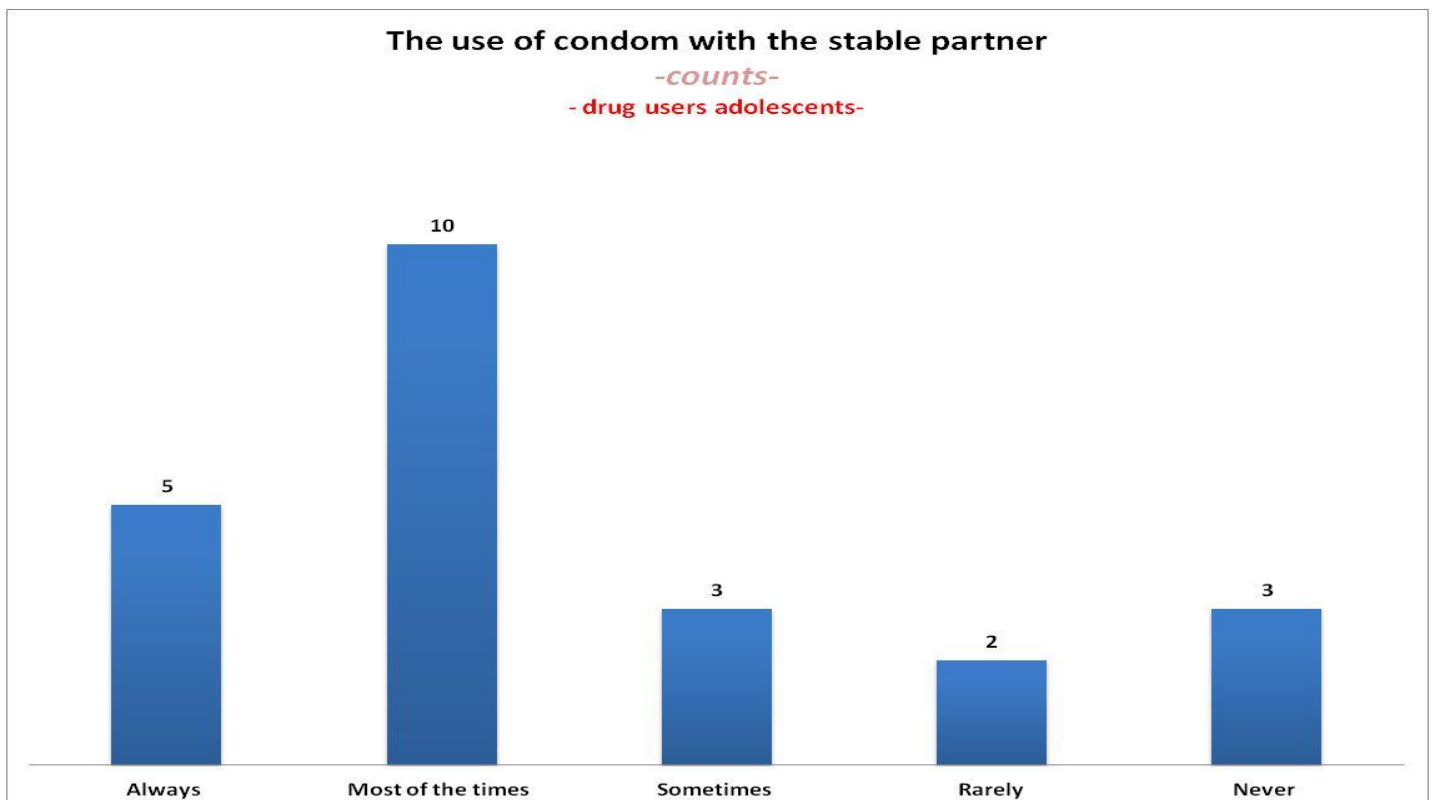


Fig. 5.2.

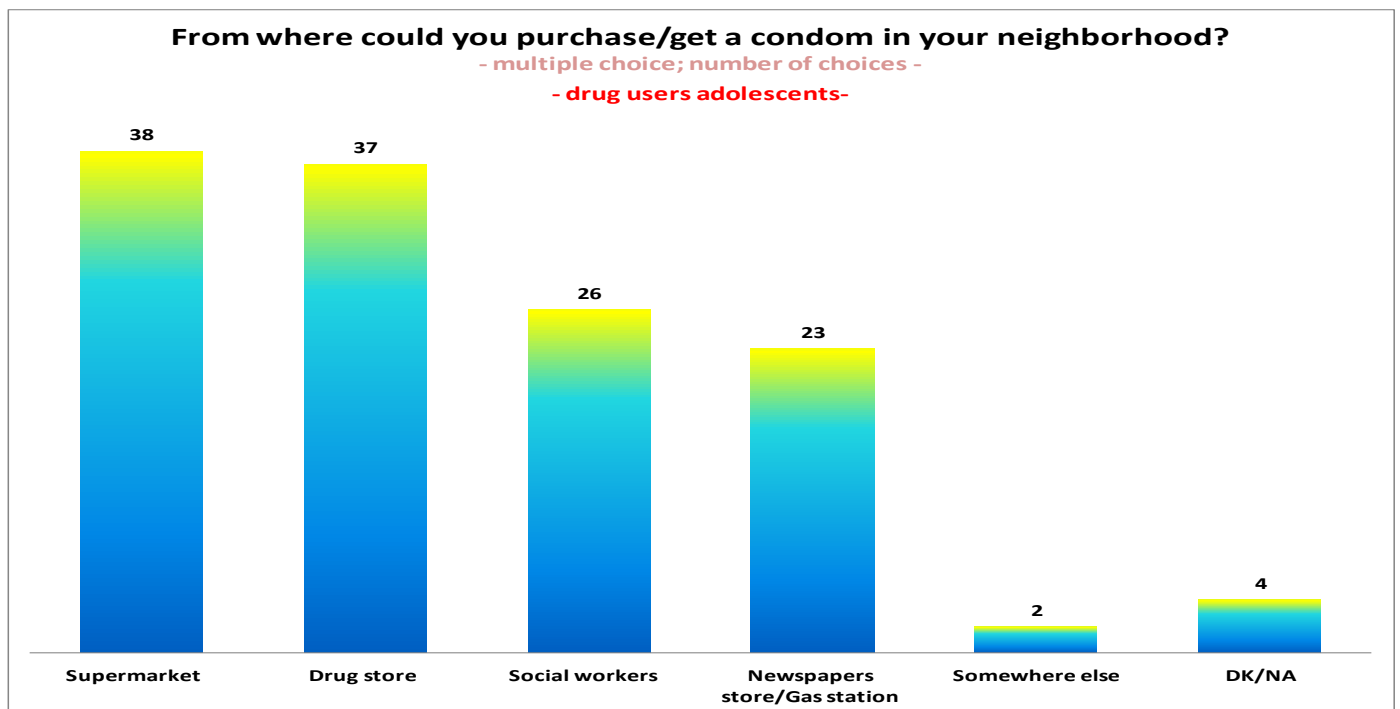


Fig. 5.3.

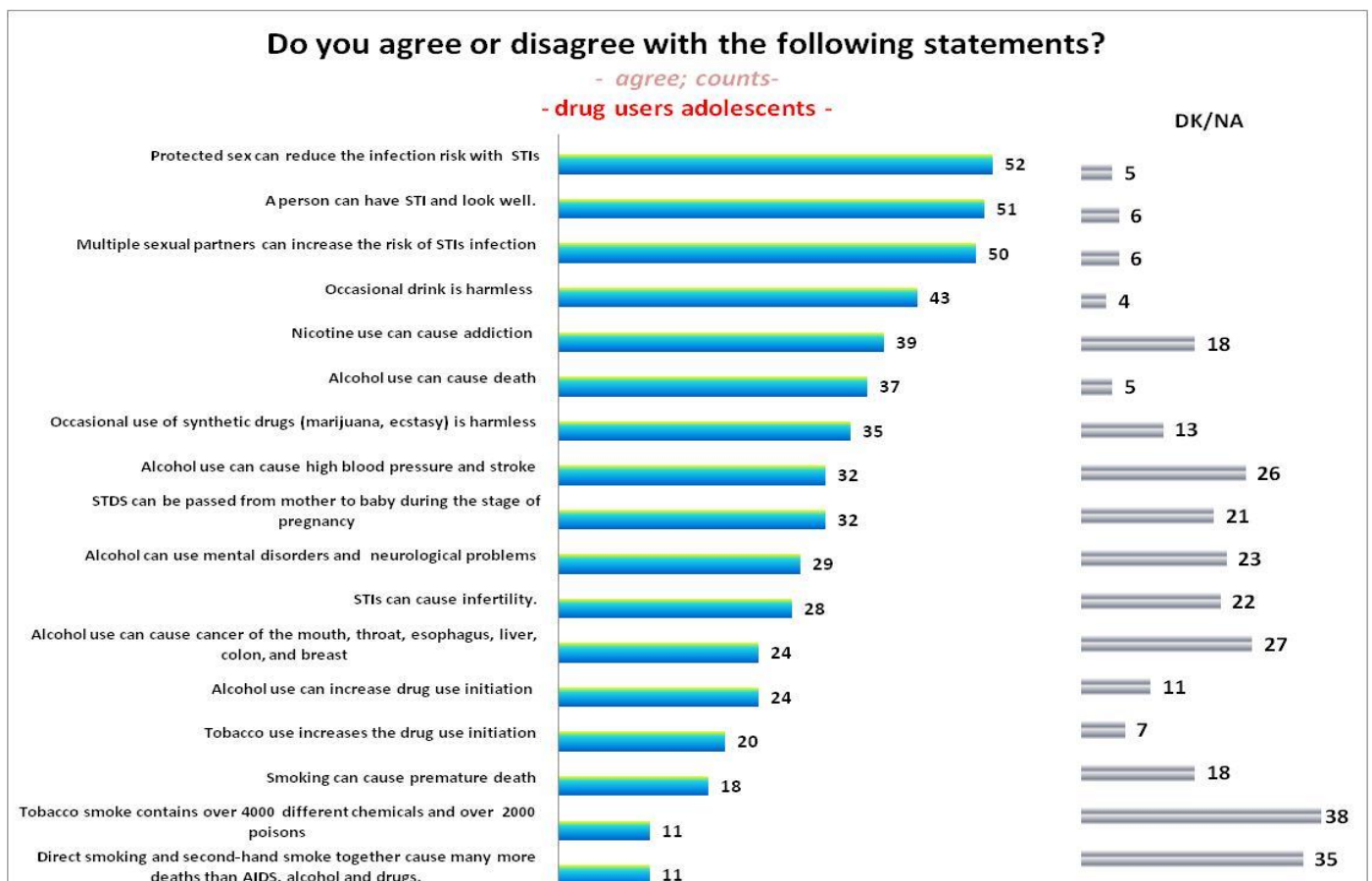


Fig. 5.4.

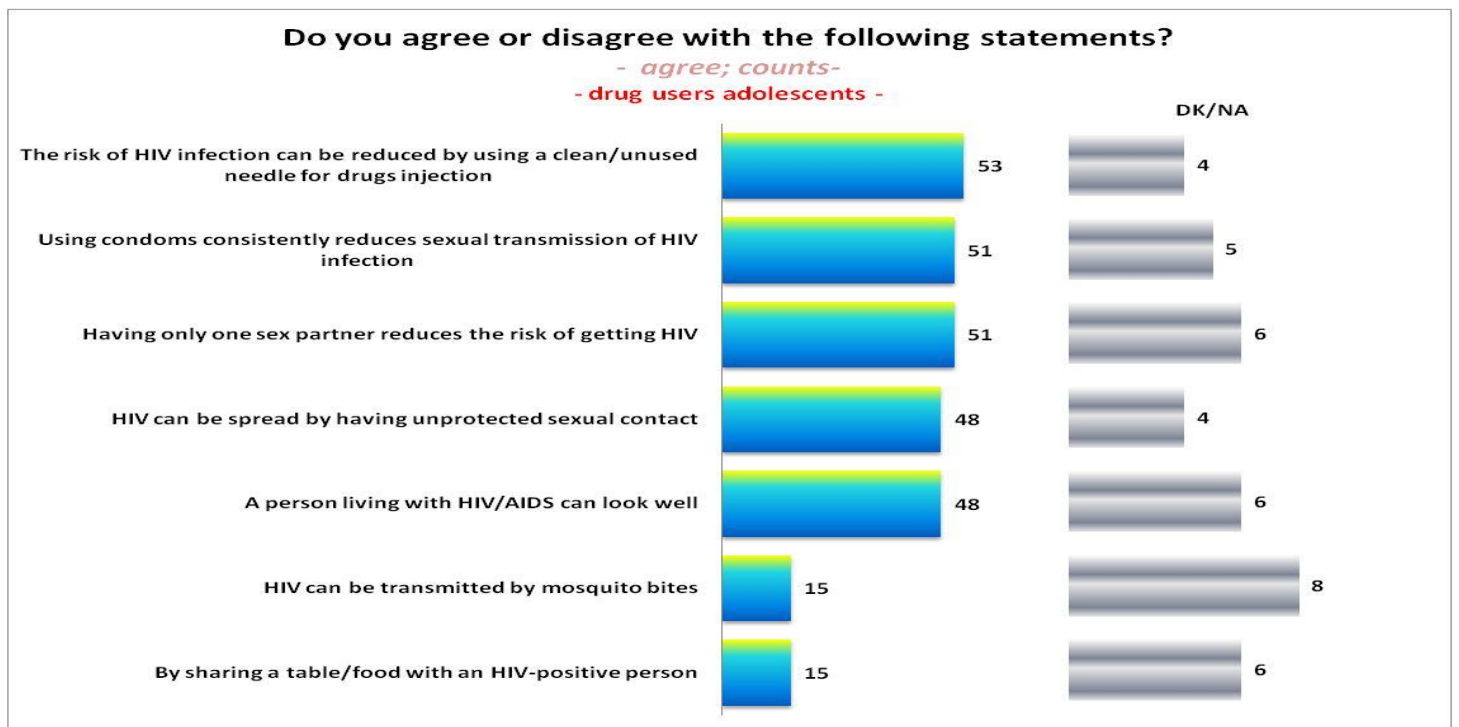


Fig. 5.5.

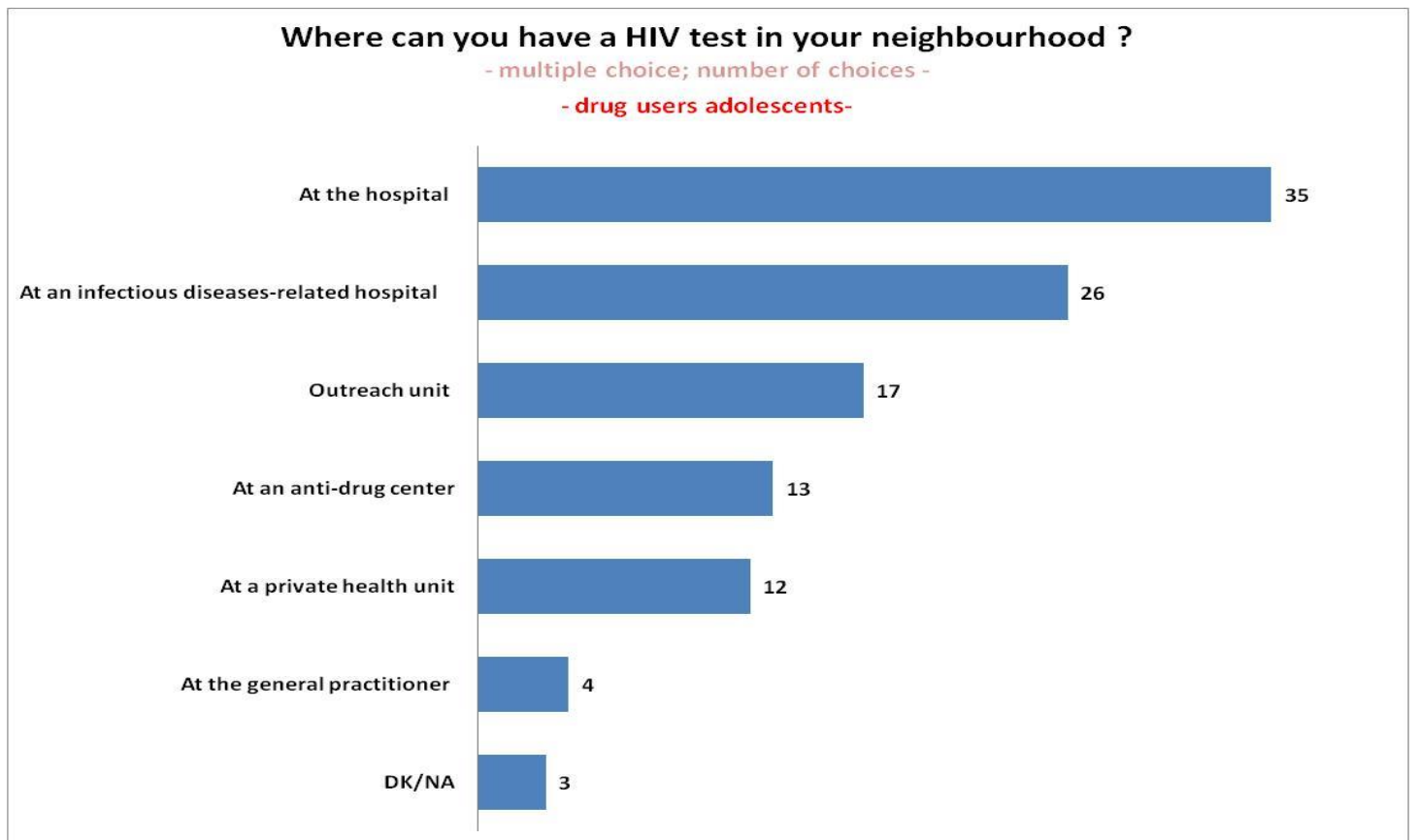


Fig. 5.6.

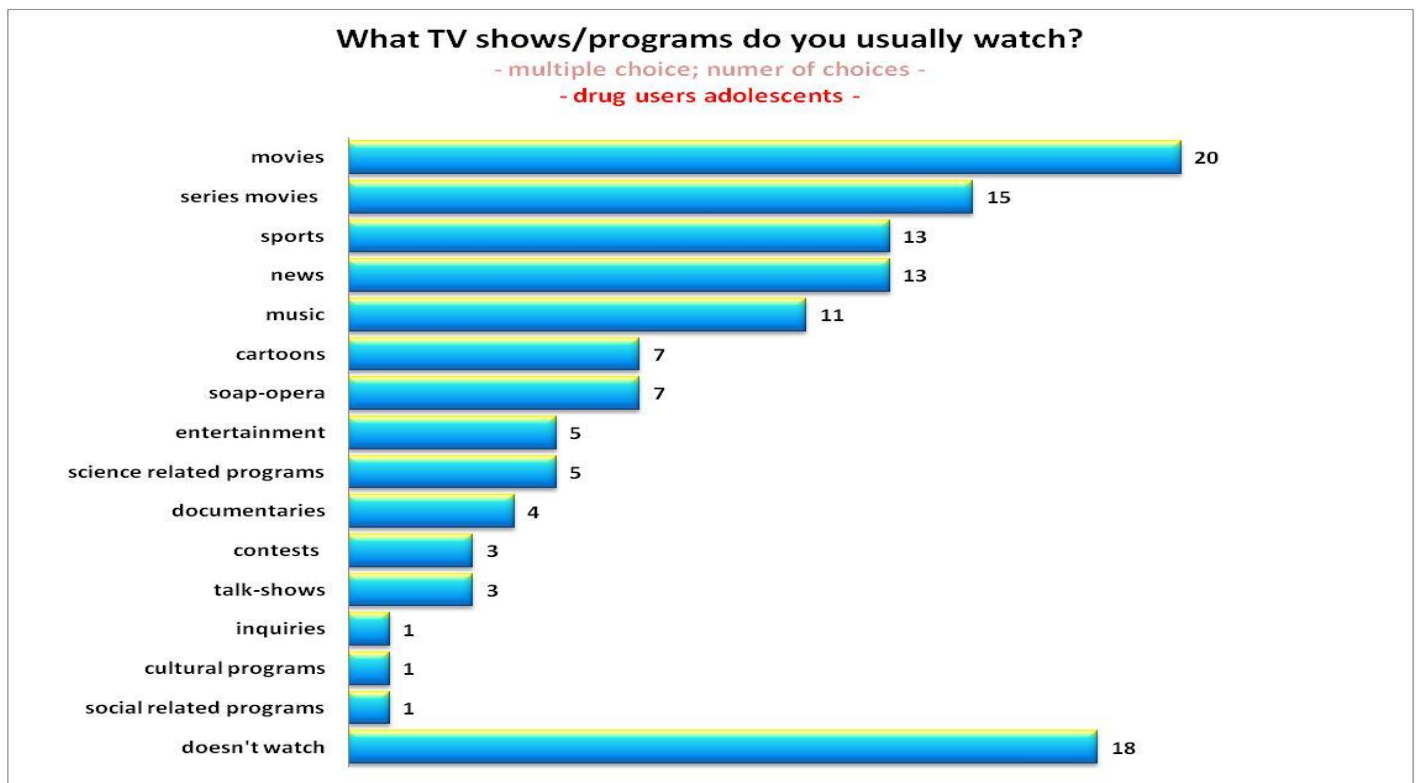


Fig. 5.7.

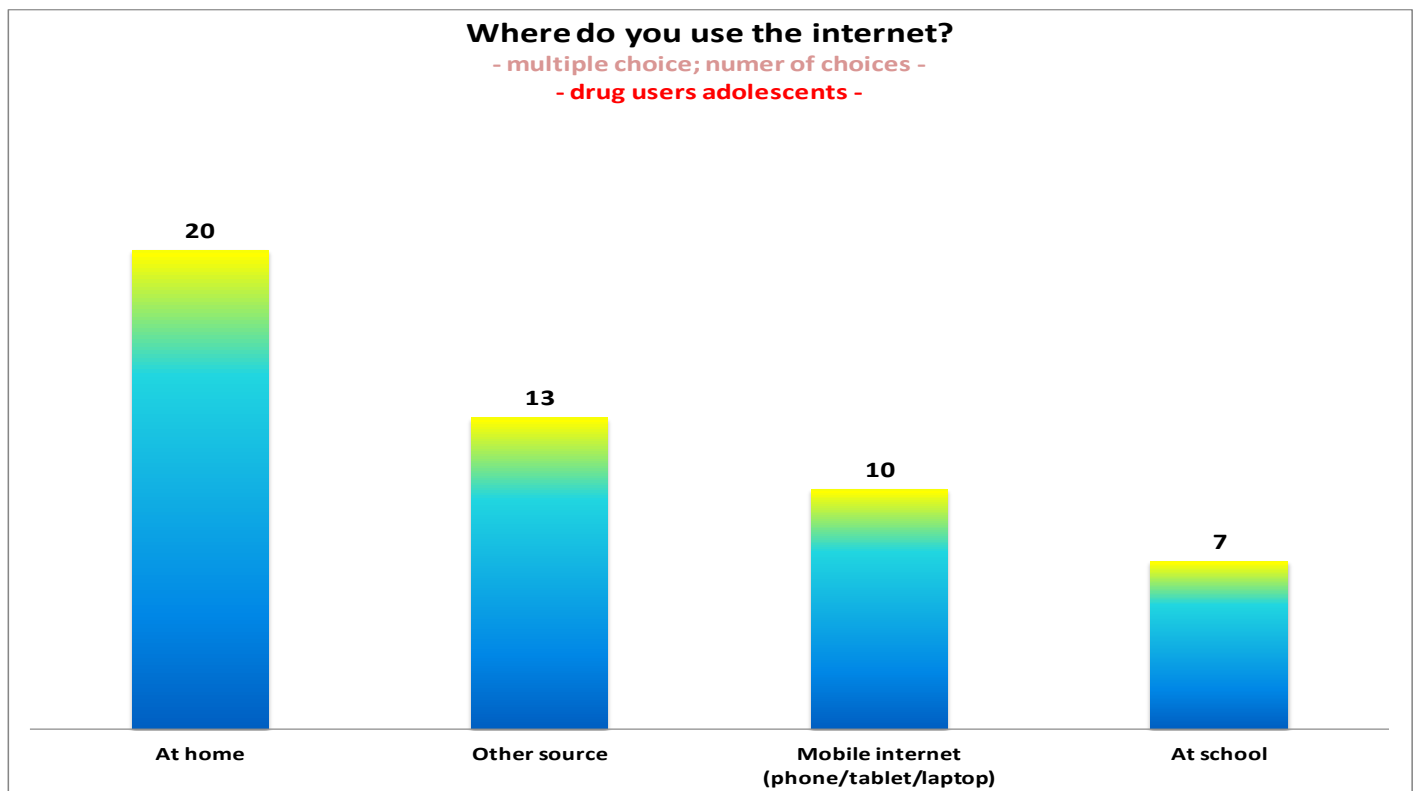


Fig. 5.8.

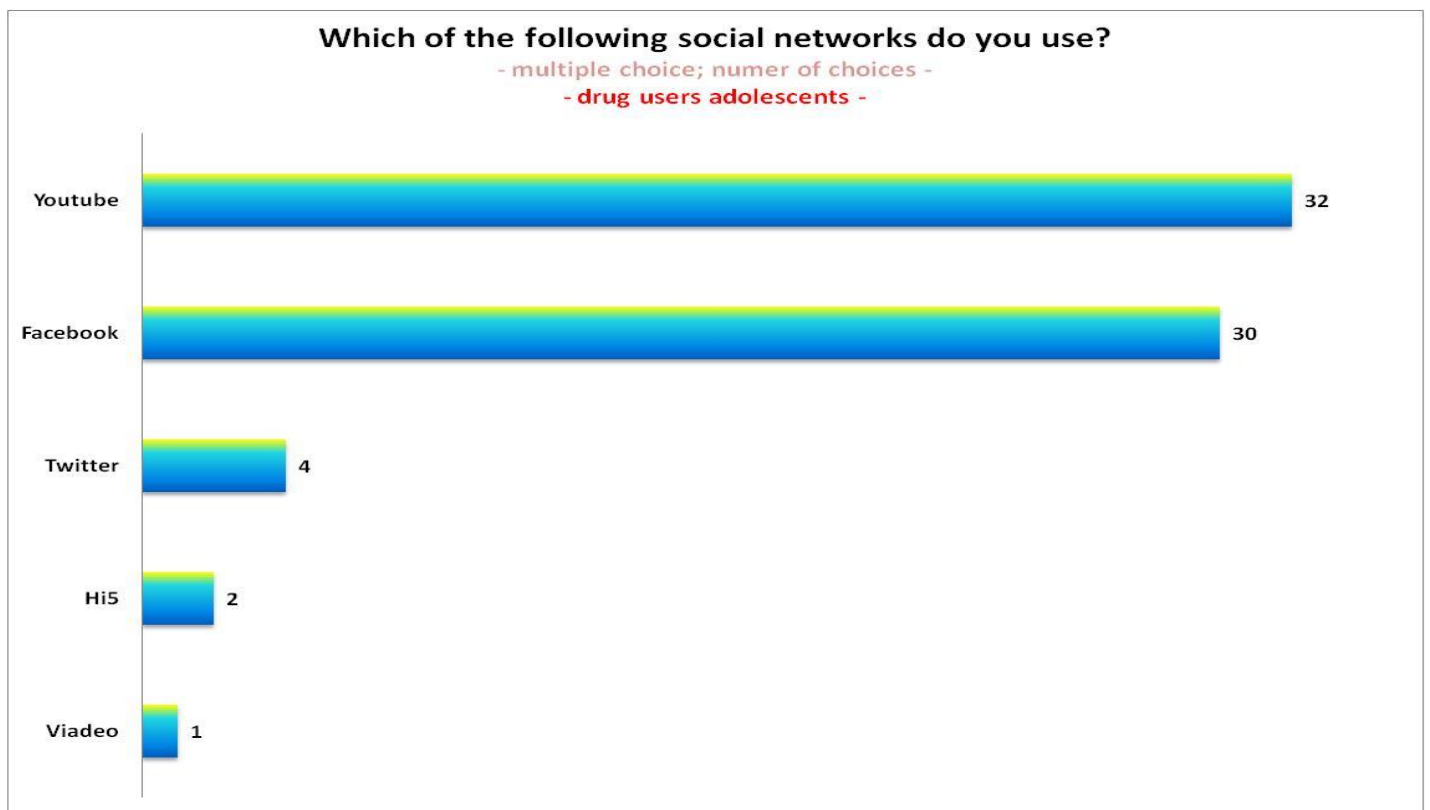


Fig. 5.9a.

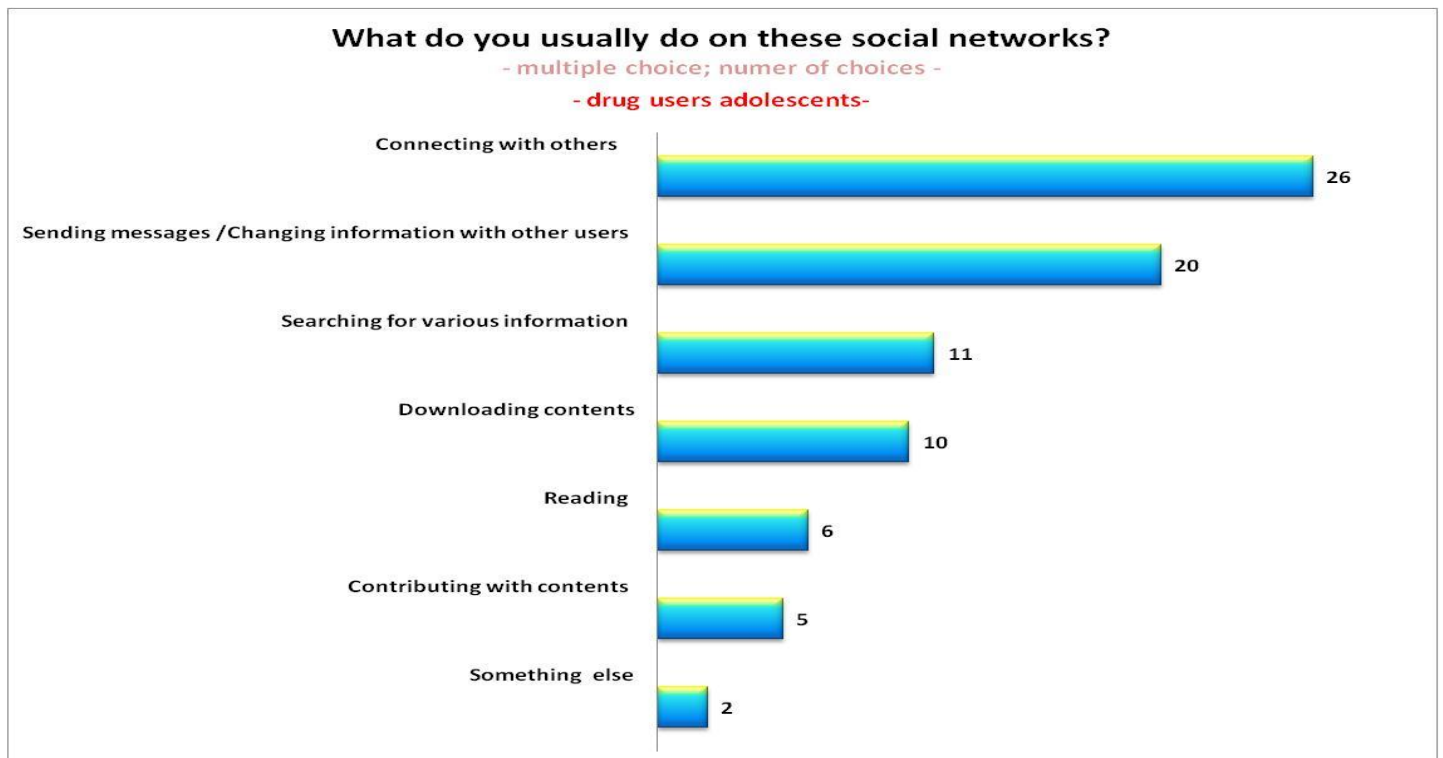
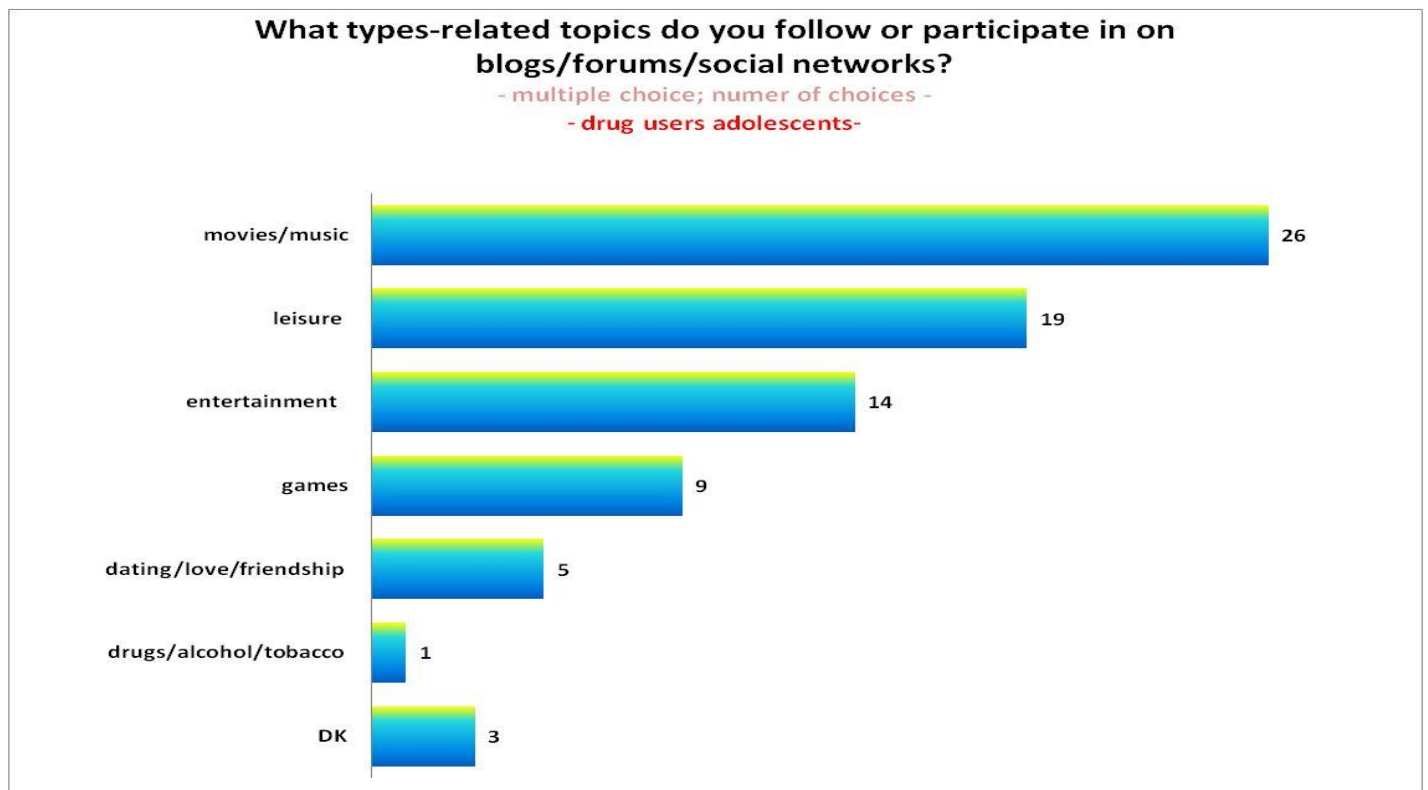


Fig. 5.9b.



Annex 6. Roma adolescents

Fig. 6.1.

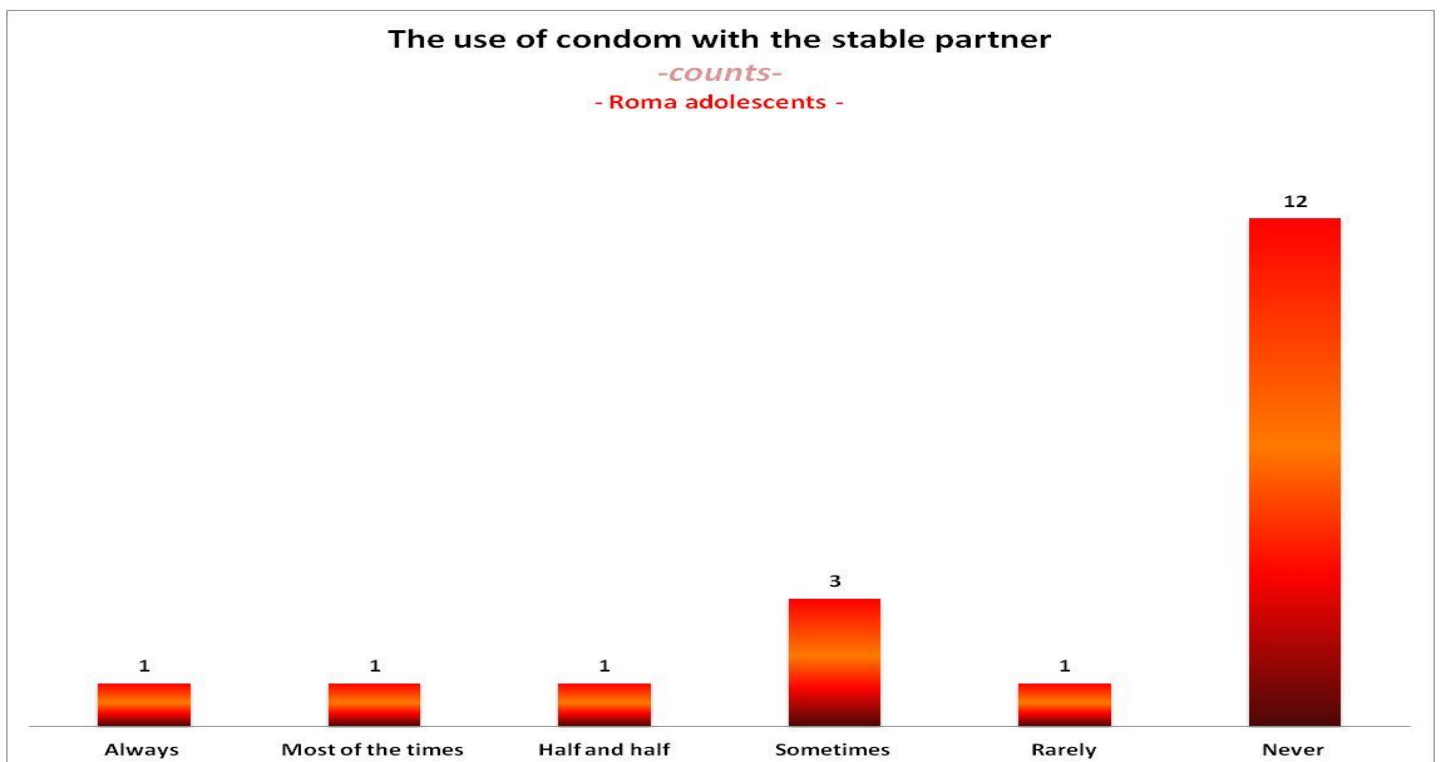


Fig. 6.2.

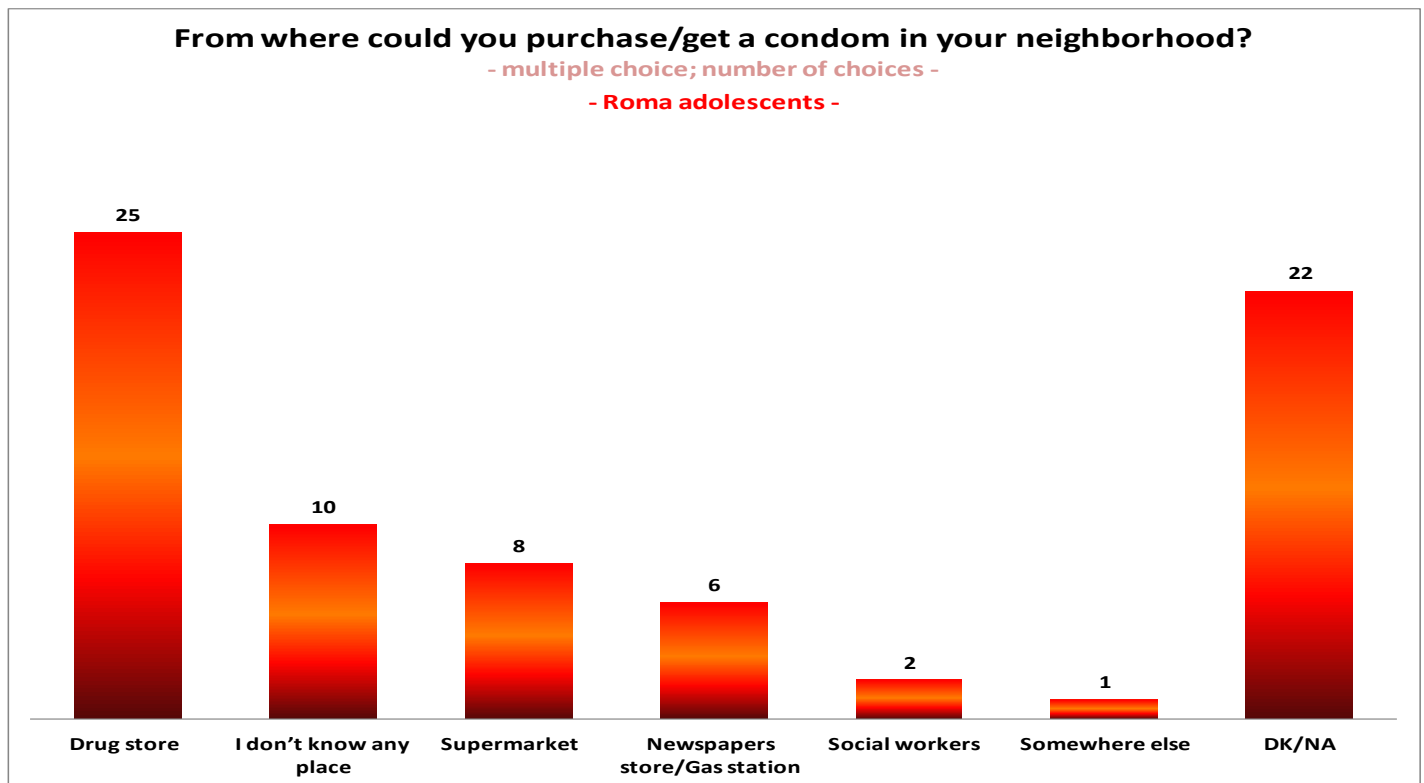


Fig. 6.3*.

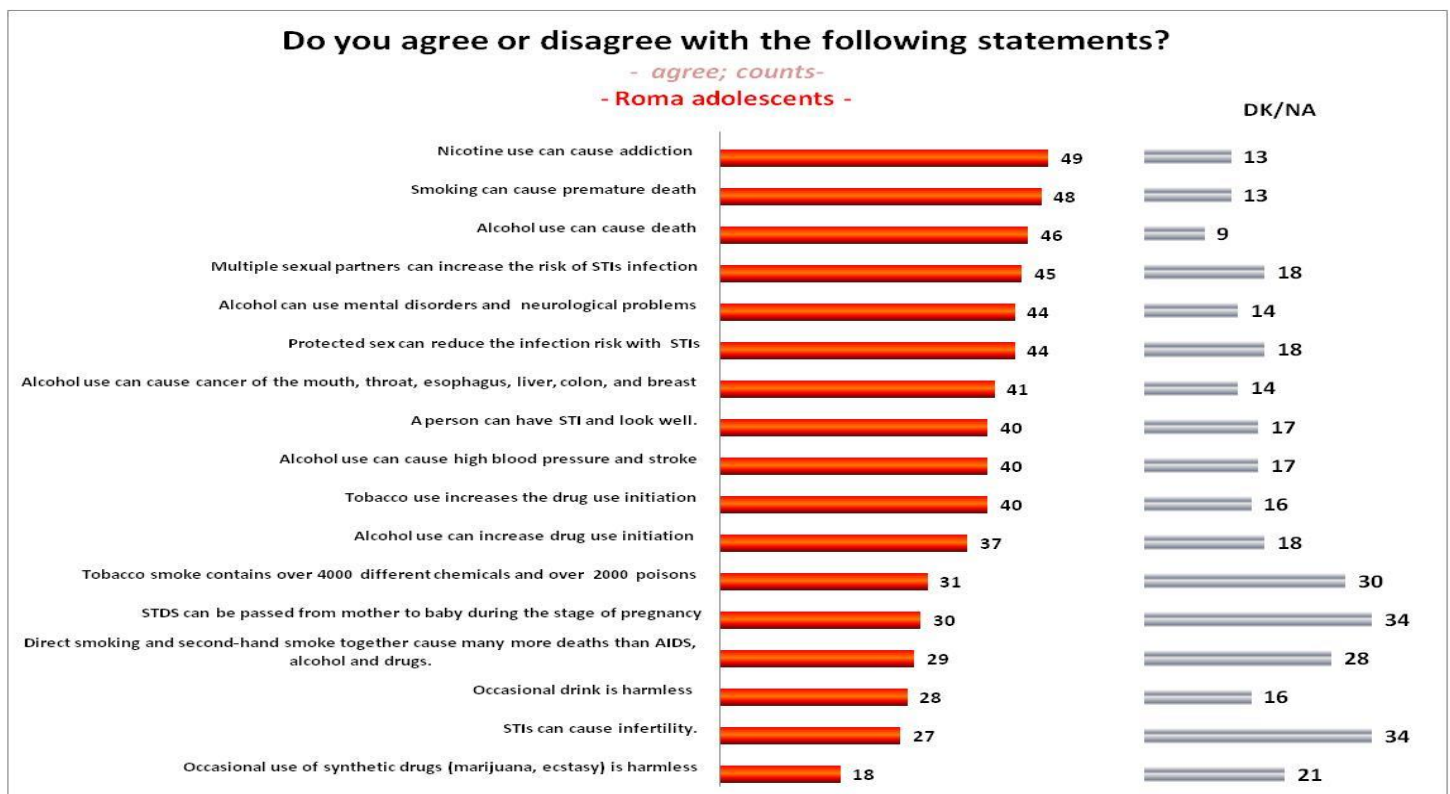
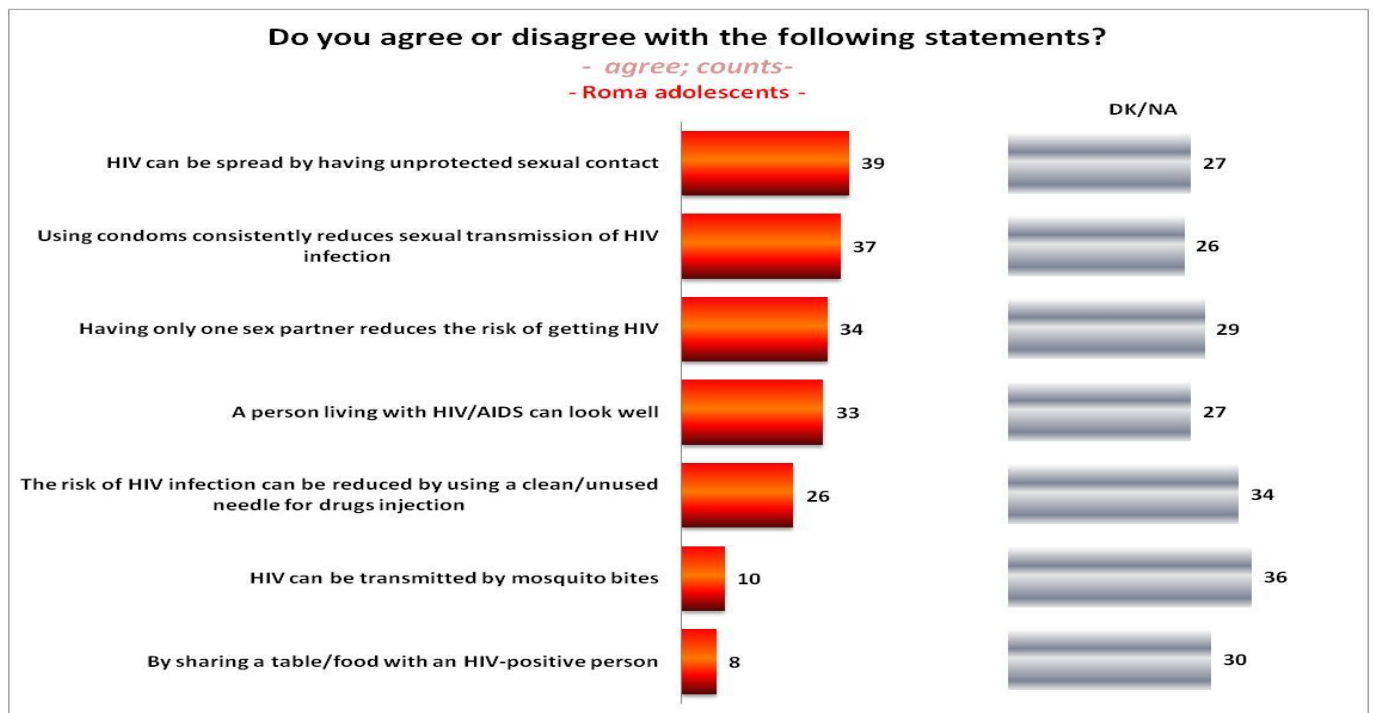


Fig. 6.4*.



* Note: The first figures in the chart above represent cumulative counts of “strongly agree” and “agree” scale items

Fig. 6.5.

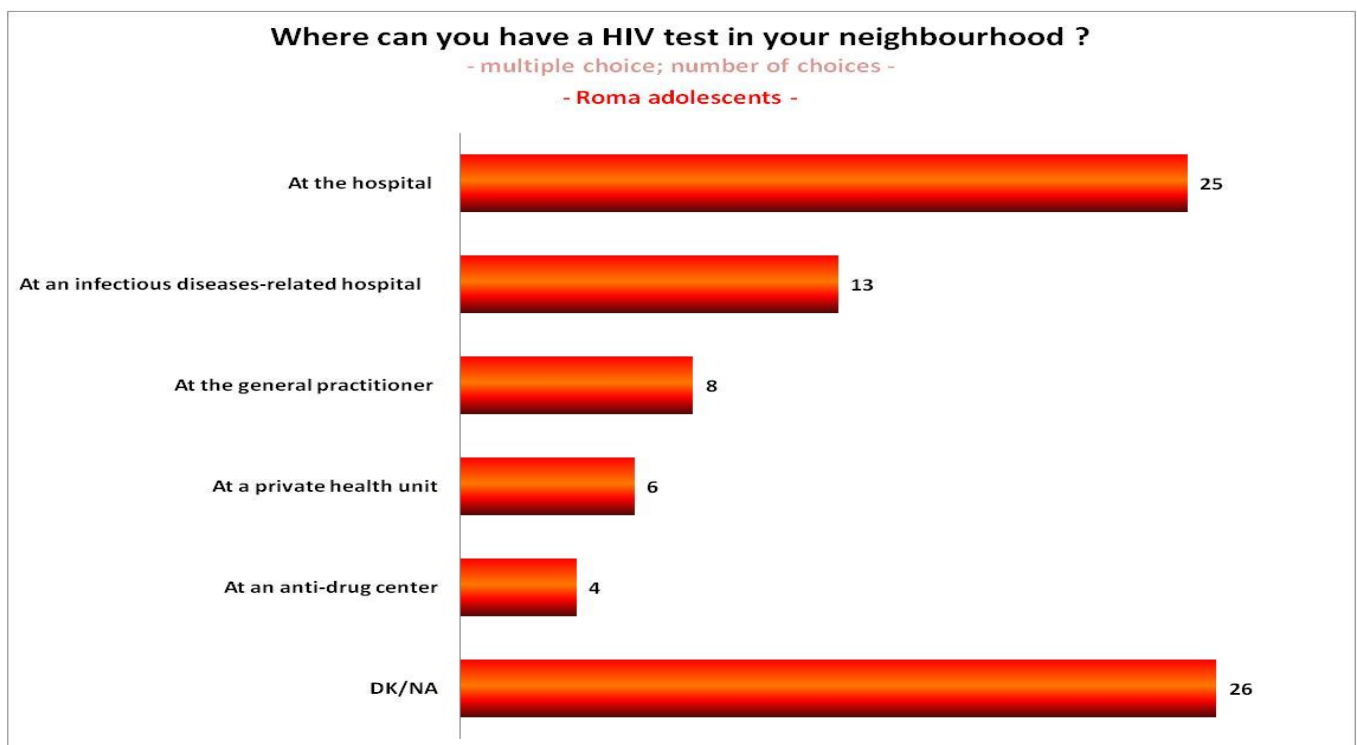


Fig. 6.6.

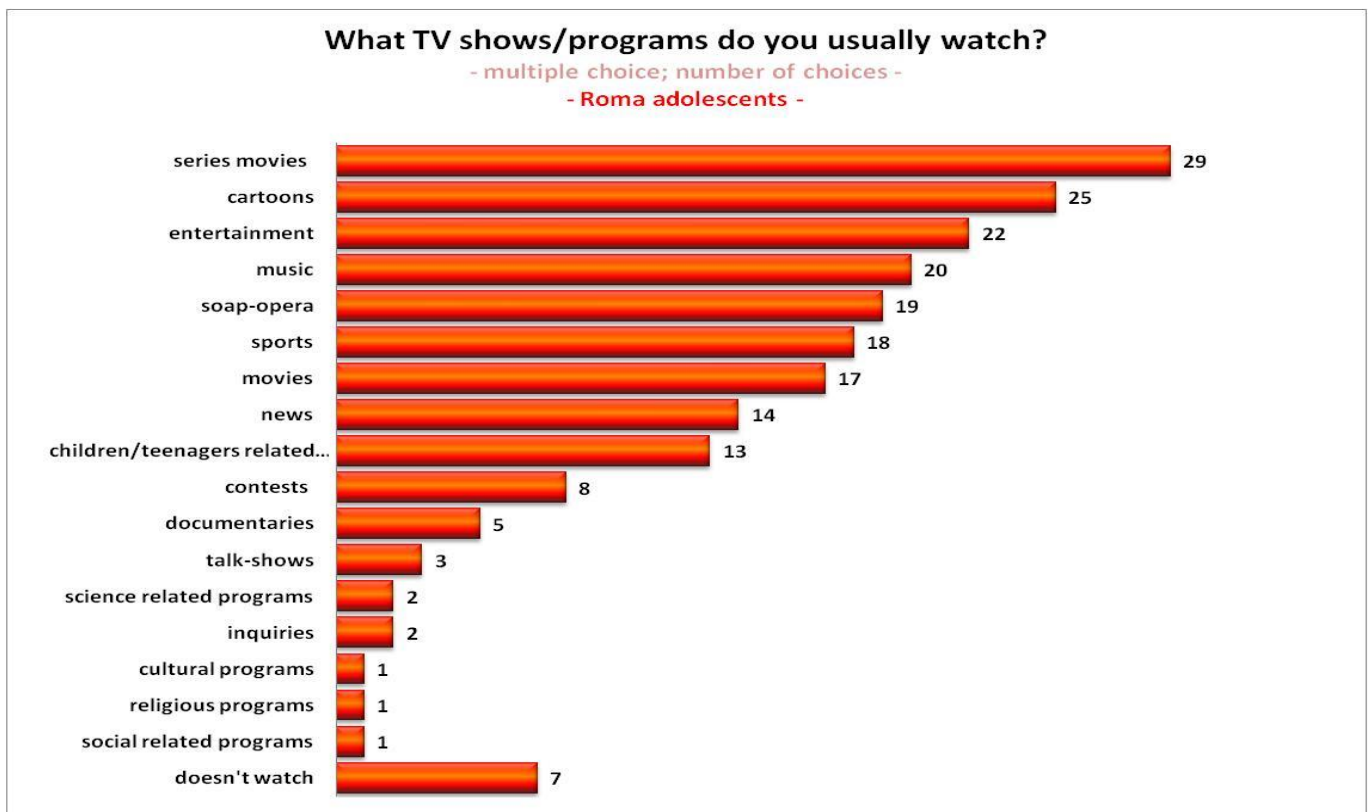


Fig. 6.7.

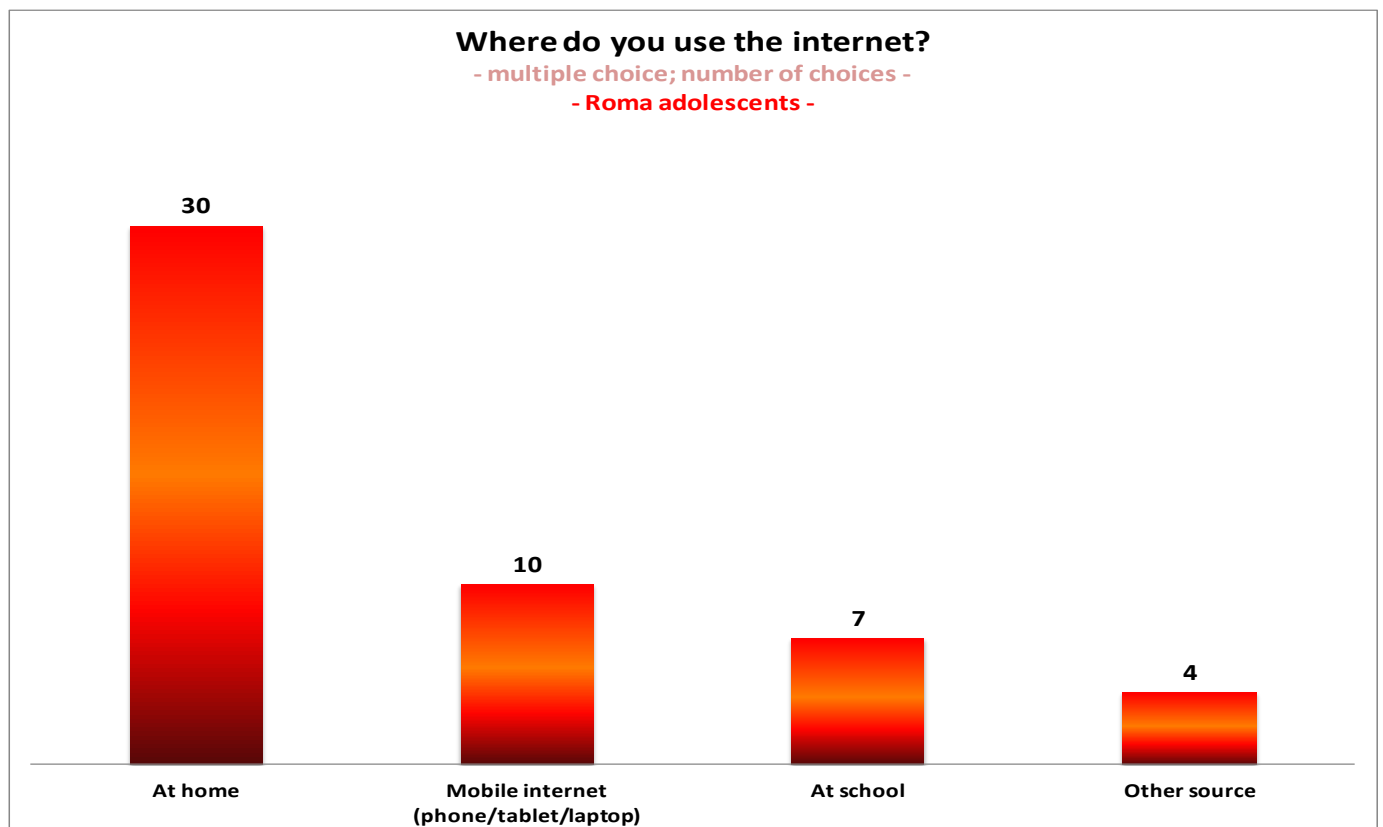


Fig. 6.8.

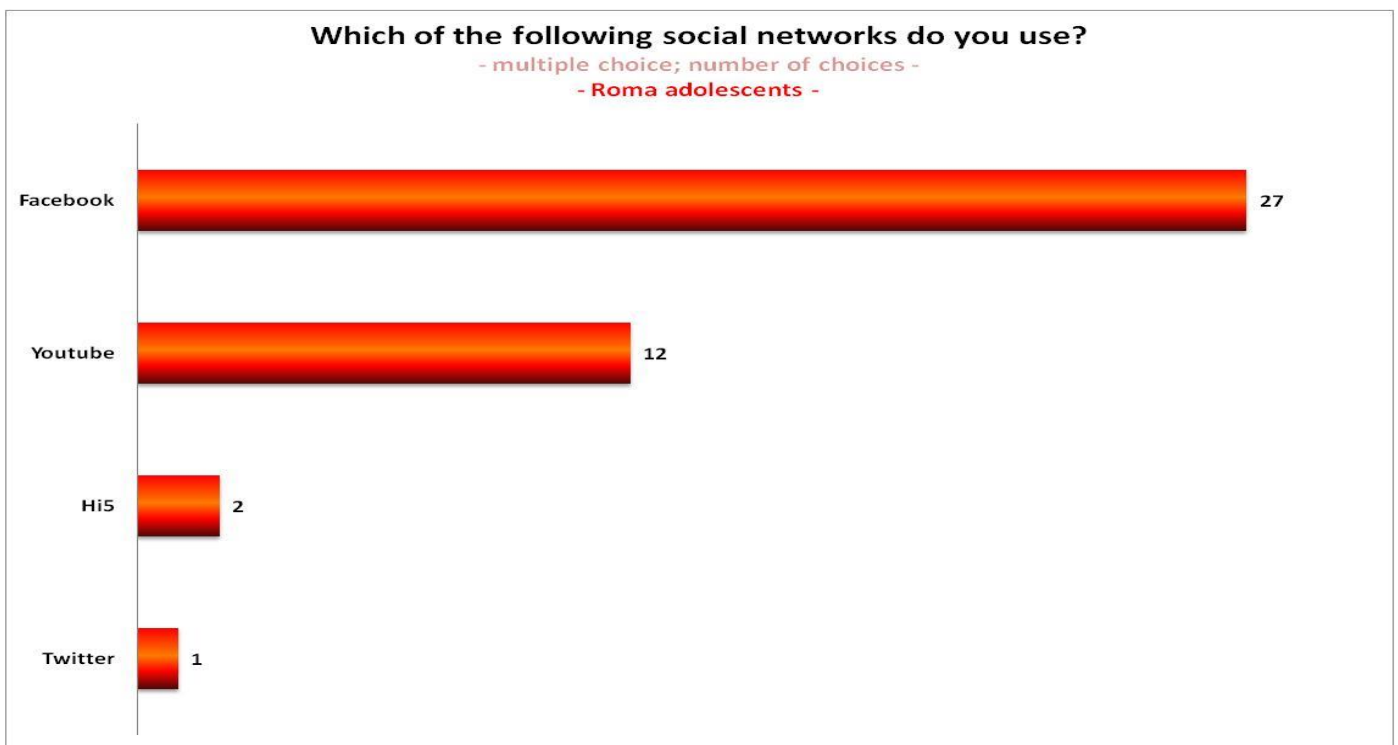


Fig. 6.9a.

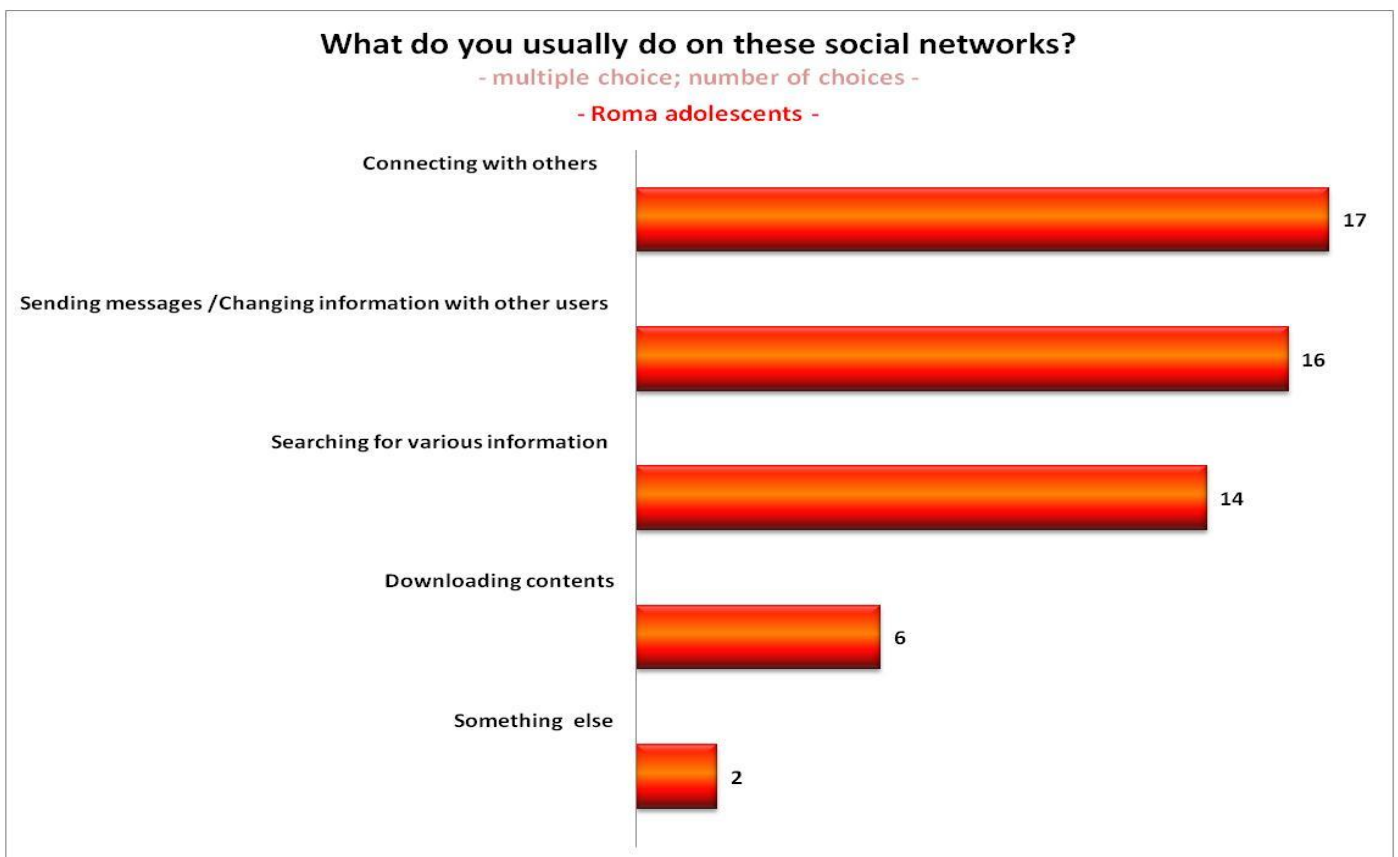
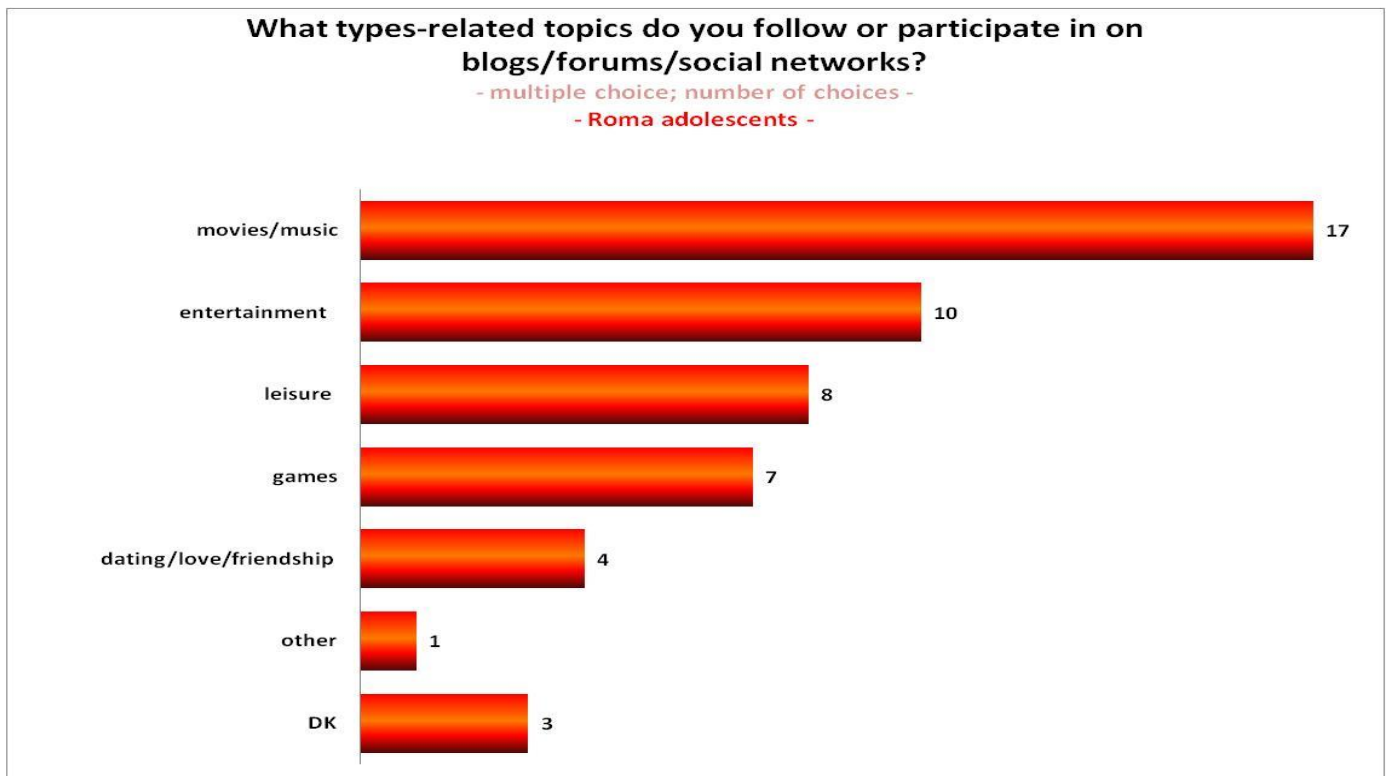


Fig. 6.9b



Annex A

- Ministry of Interior: National Antidrug Agency, National Agency against Trafficking in Human Beings, General Police Inspectorate
- Ministry of Education
- Ministry of Labour, Family, Social Protection and Elderly- Child Protection Department; Departments for Persons with Disabilities
- Ministry of Justice: Probation Department
- Ministry of Health: Department of Public Health; National HIV / AIDS Center, National Institute for Infectious Diseases
- Ministry of Youth and Sports
- National Roma Agency
- National Institute of Statistics
- Institute of Education Sciences
- School Inspectorates of Braşov, Giurgiu, Timis
- General Departments for Social Assistance and Child Protection: Brasov, Constanta, Cluj, Iasi, Timis and 6th district in Bucharest
- Public Health Departments: Brasov, Timis, Giurgiu
- Constanta Mayoralty - Child Protection Service
- Craiova Mayoralty - Department of Social Assistance
- Giurgiu Municipality - Department of Social Assistance
- Center for Drug Use Prevention: Timis, Iasi, Bucharest
- Family Planning Office - Braşov
- ALIAT Bucharest
- Alternative Sociale - NGO
- Romanian Association Against AIDS
- Save the Children, Dolj Branch
- Education 2000+
- Parade Foundation
- World Vision Constanta

Annex B

List – Observed services

1. Center for mother and children Iași
2. Day care center for children with disabilities Catharsis –Brașov
3. Center for reproductive health education - Brașov
4. Social services center Bucium/ Iași
5. Services for child protection Cluj Napoca
6. Day care center for children with disabilities ASCHF Giurgiu
7. Services for protection of victims of trafficking in human beings – Reaching Out Pitești
8. Day care center for street children – Parada
9. Family type of unit ”Constantin” for adolescents with disabilities
10. Family type of unit ”Casa Dunării”
11. Services for PLHIV, HIV/SIDA, World Vision Constanța

Annex C

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