

**UNDERSTANDING THE BARRIERS TO IMPLEMENTING  
A NATIONAL SEXUAL EDUCATION  
STRATEGY IN ROMANIA**

by

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A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Master of Public Administration

Spring 2017

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## **ACKNOWLEDGMENTS**

This research project, the first I have conducted by myself and on a topic I am so passionate about, would not have been possible without such a wonderful support system.

I would first like to express gratitude to Dr. Arno Loessner for his mentorship in conceptualizing this research project and for making the Romania study abroad through UD's School of Public Policy both a reality and a success.

Many thanks are due to Babes-Bolyai University in Cluj-Napoca for providing the means for me to carry out this research and creating such a well-organized program. Specifically, Dr. Bogdana Neamtu and Dr. Calin Hintea who worked tirelessly to help secure me interviews and have the most substantive research possible.

A special thank you to Alexandra Opris who came to the interviews with me, translated email correspondences and interviews in real time, helped me explore my way through her city, and made the most delicious tiramisu.

A final thank you to my parents who only sometimes question my constant need to explore new parts of the world, yet always support my passions and hard-headed decisions. This would not have been possible without you both.

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## **LIST OF ACRONYMS**

BBU	Babes Bolyai University
EU	European Union
IRB	Institutional Review Board
MOH	Ministry of Health
NGO	nongovernmental organization
RRHS	Romanian Reproductive Health Survey
SECS	Contraceptive and Sexual Education Society
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## **ABSTRACT**

Romania has some of the highest rates of teenage pregnancies in the European Union and is one of only eight EU member-states without a national sexual health education strategy. This coupled with increasing incidences of sexually transmitted infections and HIV, suggests that Romania needs an effective national program to deal with these issues, including a sexual health education strategy.

In 2014, the Ministry of Health attempted to pass a health law that incorporated a strategy for a national policy on sexual education, but opposition was vocal and present, preventing its passing and implementation. Three years later, in 2017, Romania still has alarmingly high rates of teenage pregnancy with no national strategy mandating sexual education as a means of combatting it.

This paper reports on the results of interviews conducted in Cluj-Napoca, Romania during January 2017 to gain an understanding of the problem, barriers that may exist in the implementation of a sexual health education strategy, and other suggestions from professionals on supplemental strategies that can be adopted.

## **Chapter 1**

### **INTRODUCTION**

The rates of teenage pregnancies in Romania are among the highest in the European Union (The World Bank, 2015a). This, coupled with the increasing incidences of sexually transmitted infections and HIV, demonstrates Romania's need for a national sexual health education strategy. Romania is one of only eight EU member-states without such a strategy (European Parliament, 2013). This study investigates the barriers that exist to the implementation of a much-needed policy to decrease teenage pregnancies.

This first chapter will introduce the following: First, background will be provided to offer an understanding of the historical nature of sexual and reproductive health rights in Romania in conjunction with the rise and fall of communism. Second the research objectives are explored and important definitions are defined. Next, operational definitions are provided to be used throughout the study. Finally, the significance of this study will be discussed.

#### **1.1 Background**

Romania has alarmingly high rates of teenage pregnancies (The World Bank, 2015b). Data available for Romania are inconsistent yet data consistently show that rates of teenage pregnancy are amongst the highest in the European Union (The World

Bank, 2015a). These inconsistencies are due to a lack of emphasis on data collection in Romania. This is obvious within the field of sexual and reproductive health and beyond; this is noted by many professionals as being common in post-communist countries (Public Health Specialist, Personal Communications, January 17, 2017).

The communist regime in Romania cultivated feelings of distrust for the government and other social structures which lingered after the revolution (Pehlivanova, 2009). Data collected and presented by such entities are still not highly regarded or trusted by the Romanian people, and data are not valued in general in society (Public Health Specialist, Personal Communication, January 17, 2017).

Romania had alarmingly strict traditional policies surrounding sexual and reproductive health during the communist era that were used to oppress women and restrict them of their right to choose when they wanted to have children (Rada, 2014). During this time, as a society, Romania highly valued women being virgins until marriage, and it was common-practice for women to not share that they had become sexually active. Combined with new policies limiting access to modern contraceptives many women utilized abortions as a fast and secretive form of family planning (Rada, 2014).

Turcescu and Stan (2005) wrote an article and estimated that Romanian women, on average throughout their sexual lifetime, have five abortions each. This was highly illegal during the communist regime and women and practitioners could face jail-time or large fines if they were caught (Turcescu & Stan, 2005). The communist government crossed what many would consider ethical lines in their

attempt to ensure these laws were not broken by mandating gynecologists in workplaces to inspect women for pregnancy and monitoring them to prevent women from having an abortion (United Nations, 2002).

If women wanted or needed access to an abortion, illegal networks existed in Romania where untrained individuals performed the procedure. These illegal abortions could place the person performing the procedure and the woman at risk of fines or jail time, and contributed to Romania having the highest maternal mortality rate in Europe (Sedgh, Finer, Bankole, Eilers, & Singh, 2002).

Policies that were created to limit Romanian women's sexual and reproductive rights culminated in distrust of data and of Romanian women feeling uncomfortable reporting on their own sexual and reproductive experiences (Rada, 2014). This fear of reporting continued into post-communist Romania and remains an important consideration throughout the duration of this study.

As the number of pregnant teenagers, rates of sexually transmitted infections (STIs) and HIV remain high different stakeholders have begun seeking programmatic solutions. In 2014, the Ministry of Health created and proposed a national health strategy which included a small component on comprehensive sexual health education for the country (Stiripentruviata, 2015). Three years later in 2017, the national strategy has still not been passed mainly due to the sexual health education component.

There are a large proportion of Romanian citizens and NGOs with great influence who vehemently opposes the adoption of any national health strategy which includes topics relating to sexual health education (Stiripentruviata, 2015). This

opposition has been successful in blocking and delaying the implementation of this national health strategy which could positively change the health of Romanian citizens. Talks between all stakeholders invested in this topic have taken place, but have made little-to-no difference in finding a solution that effectively addresses the issue (Public Health Specialist, Personal Communications, January 17, 2017).

## **1.2 Research Objectives**

The primary objective of this research is to understand what barriers exist to implementing a national strategy on sexual health education in Romania, as a means of decreasing its high rates of teenage pregnancy. The sub-objective is to consider alternative recommendations for addressing Romania's high rates of teenage pregnancy. Over the past three years a health policy which included legislation on implementing a sexual education program has sat stagnant in the hands of the Romanian political leaders. In December 2016, Romania Parliamentary elections took place and the Democratic Socialists won an overwhelming majority. Election campaigns were run on nationalist and orthodox values and the new administration includes several members who have been charged with corruption (Gillet, 2016; Gurzu & Paun, 2017). With these recent changes in Romanian political leaders and their emphasis on church-state relations it has become unlikely the policy will be passed.

The hypothesis of this study is that Romania's culture and societal values, namely the political and social power of the Orthodox Church, are the biggest barriers

to implementing a national sexual health education strategy. Adolescents in Romania, much like other countries, continue to consume mass media and are exposed to sex and sexuality through various outlets (Public Health Specialist, Personal Communications, January 17, 2017). Without medically accurate and current information they do not have the knowledge and tools to protect themselves from pregnancy, sexually transmitted infections (STIs), and HIV which is currently on the rise among heterosexual couples in Romania (European Center for Disease Prevention and Control, 2011).

The value of comprehensive sexual health education, which is discussed in Chapter 2, is robust yet Romania remains an outlier EU country without a strategy addressing this (European Parliament, 2013). This research hopes to gain a more meaningful understanding of the different perspectives of stakeholders who both support and oppose the implementation of a sexual education strategy. A study abroad program through the University of Delaware to Cluj-Napoca in January 2017 provided the opportunity to interview 9 professionals with different connections to the research question. The purpose of these interviews was to provide qualitative evidence of the barriers to implementing a national strategy so a comprehensive solution that considers all perspectives could be found.

Following this chapter is an extensive review that explores existing literature to offer context to the research and of research within this sphere of study. It begins with the theoretical and contextual framework used for this study and then considers how communism affected Romania as a country in terms of what provides legitimacy,

migration trends, and the fluctuation of sexual and reproductive health rights. The literature also explores current sexual and reproductive health initiatives, statistics, and how much knowledge citizens have of these. The review concludes by delving into teenage pregnancies in Romania, their several costs, and sexual health education as a means of decreasing these rates.

Following the literature review is a summary of the methodology employed. It discusses how data was collected, who was interviewed and why, and some of the limitations of the study. Next, is an overview of the six major barriers that were found through the interviews conducted in Romania. The findings are accompanied by direct quotations from interviews that provide insight to the entirety of the problem.

Chapter 5 is a discussion on how these barriers all exist on a societal level and what exactly that means for Romania. Included is a comparison between Romania and Netherlands, a country whose society has stark differences to Romania's. Finally, this research concludes with the limitations of the whole study, suggestions for future research if it were to be replicated or continued, and suggestions for implementing what was outlined in the paper.

### **1.3 Definitions**

To fully grasp the extent and scope of this problem, some common terms used throughout this study must first be operationally defined.

### **1.3.1 Adolescents/Teenagers**

In this study “adolescents” and “teenagers” refers to youth between the ages of 15-19 as defined by the World Bank (2015a).

#### **1.3.1.1 Adolescent/Teenage Pregnancy or Fertility**

“Adolescent pregnancy” and “teenage pregnancy” or fertility refers to youth between the ages of 15 and 19 who are pregnant. Adolescent and teenage pregnancy or fertility is an exhaustive definition and refers to those who have miscarriages, abortions, put their child up for adoption, or raise them.

#### **1.3.1.2 Adolescent/Teenage Births**

“Adolescent births” and “teenage births” refers to youth between the ages of 15 and 19 who became pregnant and gave birth to the child. The child may or may not have been put up for adoption. Adolescent and teenage births do not include pregnant teenagers who had a miscarriage or an abortion.

#### **1.3.1.3 Adolescent/Teenage Mothers**

“Adolescent mothers” and “teenage mothers” refers to youth between the ages of 15 and 19 who gave birth and decided to raise the child themselves. Teenage mothers do not include adolescents who gave their child up for adoption, had a miscarriage, or an abortion.

### **1.3.2 Sex Education; Sexual Health Education; Sexual Education**

“Sex education”, “sexual health education”, and “sexual education” in the context of this study all refer to a comprehensive education that includes factual and accurate information on sexually transmitted infections, HIV/AIDs, modern contraceptives, and family planning. If a form of health education is being referenced that does not belong in that category, it will be identified and defined.

### **1.4 Significance of study**

This study provides an analysis of interviews conducted with different stakeholders to offer a comprehensive look at the barriers that exist to implementing a national sexual health education strategy in Romania. The findings of this study will present both sides of an ongoing argument involving the intersection between the traditional and modern values of a country. The two sides have debated this topic before, but studying it in a controlled environment offers the opportunity to observe the barriers to implementing this policy in an exhaustive manner.

This being the first study of its kind focusing primarily on Romania and this conflict could provide insight and resources for those supporting a national strategy. It could help to overcome the barriers and better understand why this issue is experiencing resistance to begin with. While the two sides may not ultimately work together to try to solve this, it could prove to be advantageous for those who want to see a sex education policy passed.

## **Chapter 2**

### **LITERATURE REVIEW**

This section analyzes preexisting literature concerning Romanian culture, politics, and health to provide context to the barriers of implementing a national sexual health education strategy. First, the chapter begins the theoretical and conceptual framework used to guide this research. This is followed by a review of communism's collapse in Romania and how that affected church-induced nationalism, urban migration, and sexual and reproductive rights. Next, the chapter provides a detailed look at Romania's current health standings, statistics, and conditions including an in-depth analysis of knowledge surrounding sexual and reproductive health.

The literature review continues with an investigation into the social, economic, and opportunity costs of teenage mothers to different societies. Finally, this chapter concludes with an analysis of sexual education then more specifically at sexual education in Romania.

#### **2.1 Theoretical Framework**

This section will present the use of the social-ecological theory and model in analyzing the barriers that exist to implementing a national strategy for sexual health education.

Social Ecology Theory is widely used in the field of health promotion. It was developed in response to growing chronic health conditions that were embedded in larger societal factors extending beyond the individual's health and well-being (Wandersman, Valois, Ochs, de la Cruz, Adkins, & Goodman, 1996). The theory recognizes that behavior is often determined by the environment one engages in and the resources and interventions available to them (Brindis, Sattley, & Mamo, 2005). Social Ecological Theory maintains interventions must occur on several levels both behaviorally and environmentally for any prevention measures to be effective (Bronfenbrenner, 1979).

Social-ecological theories and models commonly originate from Urie Bronfenbrenner's Ecological Systems Theory (Raingruber, 2014). Ecological Systems Theory focuses on how what takes place in an individual's macro sphere has direct effects on the individual's micro sphere (Bronfenbrenner, 1979). The theory delves into mesosystems or institutional factors, exosystems or community influences, and macrosystems which are defined as cultural influences (Bronfenbrenner, 1979). All three work in conjunction to build the environment which in turn influences the individual based on how the two interact (Oetzel, Ting-Toomey, & Rinderle, 2006).

Most of the policies created within this framework are done on a mesosystems level so the individual benefiting from the policy change does not have to actively sustain a new behavior or action; it is built into their environment (Raingruber, 2014). For example, Romania implementing a national sex education policy would positively affect youth throughout the country, and because it would be a national policy and

required of schools the whole country would benefit without having to exude extra effort in their day-to-day lives.

The Social-Ecological Model closely considers the complex interactions between societal, community, relationship, and individual factors (Centers for Disease Control and Prevention, 2015). Figure 1. is an example of a social ecological model. This model has four levels which encompass the individual and represents what makes up that individual's environment. The social ecological model stresses the importance of working across multiple levels to successfully impact the individual's environment (Centers for Disease Control and Prevention, 2015). This becomes essential when looking for the most effective means of changing a behavior.

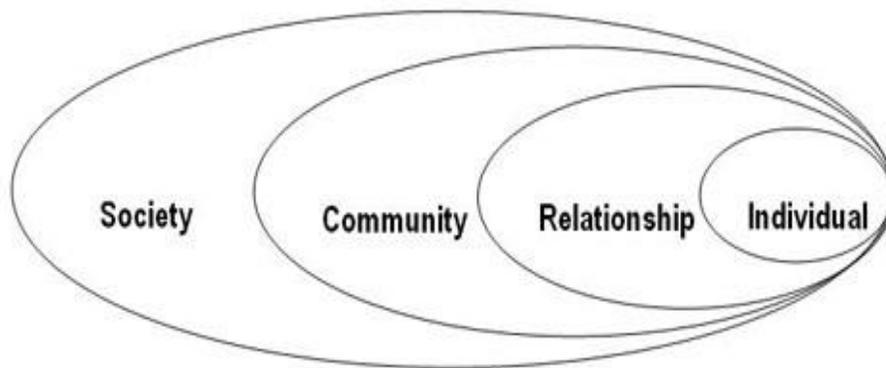


Figure 1. Social Ecological Model

### **2.1.1 Social-Ecological Theory in Context**

Looking at this theory in the context of the research questions informed the layout of this study. In its purest form this study focuses on teenage pregnancies as a major problem in Romania and an equally important issue being the lack of national sex education as a preventative measure.

Arguably the most critical aspect of Social Ecological Theory is the need to examine both the barriers and support of a proposed prevention policy (Raingruber, 2014). Both barriers and support could take the form of organizational and community resources and societal norms affecting where they are allocated (Raingruber, 2014).

The previous administration of the Romanian government created a health bill that included a national strategy for sexual health education, however several barriers prevented its implementation and although support existed, it was not effective in helping to push the law through (Former Ministry of Health Worker, Personal Communication, January 25, 2017). Using this theory and model, the barriers to implementing this policy can be gauged and analyzed in an encompassing model.

Looking at the Social-Ecological Theory through that lens informed who was asked to participate in interviews for this research. Rather than focusing on the people who wrote the law and were attempting to pass it, the interviews in this study attempted to gain insight from individuals who fall on the societal, community, and relationship level of this problem. This would then provide qualitative data to be analyzed in understanding the overlap between the barriers and supports.

Keeping to the Social Ecological Theory, when looking for alternatives to decrease rates of teenage pregnancies, all but the individual levels were consulted in interviews. The study hoped to reach a wide range of people who had interacted with the problem of teenage pregnancies through formal and informal situations on societal, community, and the relationship level.

Ultimately, national public policy shapes a country's environment. Based on this theory, changing an individual's environment can in turn help change their health behaviors. It is for that reason understanding modern-day Romania and what contributed and continues to contribute to the environment young women live in is so imperative.

## **2.2 Communism and its Collapse**

Communism in Romania mirrored communism in most other Soviet countries. Information from the rest of world was limited, policies were generally conservative, and everyone was expected to collectively work for the good of the state. Nationalism reigned supreme, nongovernmental organizations were outlawed, and women's sexual reproductive rights were expanded and then strictly retracted (Hord, David, Donnay, & Wolf, 1991). This communist mentality and way of ruling had lasting consequences that are still affecting present-day Romanian society.

### **2.2.1 Church Induced Nationalism**

For centuries, there has been a link between religion and ethnicity in Romania. Religious and ethnic exclusion was a commonality between the 13<sup>th</sup> and 16<sup>th</sup> century with Romanian, Hungarian, and German inhabitants located throughout the north-western region of Romania (Flora, Sizilagy, & Roudometof, 2005). This led to extreme polarization in the country along ethnic lines with the main legitimizing factor that strengthened national identity and aspirations being religion.

Following the First World War Romania inherited parts of Hungary which brought together two ethnically and religiously different groups of people. The Eastern Orthodox Church capitalized on this inter-war period and deemed itself the “dominant church in the state” and, in turn, legitimized the Romanian nation-state itself. (Flora et al, 2005).

The relationship between the Orthodox Church and the Romania State continued throughout the communist era despite the variance of beliefs between the two entities (Flora et al., 2005). Communism as a political ideology inherently rejects religion. While in power, the Communist Party destroyed religious places of worship, used anti-religious propaganda, and executed religious leaders all over the world (Froese, 2004). The Communist Party instead favored “scientific atheism” a philosophy and world view that largely mimicked religion, complete with a moral code and atheistic rituals (Froese, 2004).

With these ideological differences, the relationship between the Eastern Orthodox Church of Romania and the Romanian Communist party was unique (Flora

et. al, 2005). The Orthodox Church was privy to privileges from the communist regime because it had an important role to play in offering historical legitimacy to the regime (Gillet, 1997). The Orthodox Church took public and often extreme stances on controversial communist arguments to further legitimize the communist party. The arguments they made went far beyond what the communist party was allowed to say publically. What they preached most, unity between Nation, State, and Church (Flora et. al, 2005).

To maintain secure control of Romania, the communist regime wanted homogeneity in all aspects of social life. With the passage of Decree number 358 in 1948 minority churches were confiscated and redistributed to the Eastern Orthodox Church (State Secretariat for Religious Affairs, 2015). Almost 40 years later the communist revolution began on December 16, 1989 with a clash between religious minorities and local authorities. From there expressions of resistance grew and soon the entire country backed the call for revolution (Flora et. al, 2005).

The end of communism in Romania did not bring with it the end of nationalism and the Orthodox Church's relationship with the state (Flora et. al, 2005). After 40 years under communism, freedom and democracy did not have the same meanings as they held before 1948. Religious values were one of the few remaining values the people of Romania still believed in and put trust into (Flora et. al, 2005). Thus, the new government was sure to emphasize the importance of the Orthodox Church. Many of the same leaders of the communist party took power after the

revolution and used their affiliation with the Church as a means of legitimizing their power (Flora et. al, 2005).

The Church's position in Romanian politics, and as a major source of nationalism, has remained strong in the 30 years since the revolution. Public discussions have been held over the role the Church should be playing with many believing it is the Church's duty to take stances on important situations where the future of Romania is at stake (Flora et. al, 2005).

In 2005, to better secure their chances of joining the European Union, Romania wrote a freedom of religions law explicitly stating all religions were welcomed in Romanian society (State Secretariat for Religious Affairs, 2015). Still today approximately 86 percent of Romanians consider themselves loyal to the Eastern Orthodox Church and the reach of its influence remains obvious (State Secretariat for Religious Affairs, 2015). Recognizing the role the Orthodox church plays in the politics and governing of Romania is imperative to understanding the struggle health professionals endure in their fight to implement a national sexual health education strategy.

### **2.2.2 Urban Migration**

During the communist regime, there was an influx of Romanians who migrated from rural to urban areas. This stimulated a gap that has continued to grow over the past thirty years between the wealth, health, and prosperity of those living in rural verses urban regions in Romania (Rada, 2014).

Today, major Romanian cities resemble other European cities throughout the continent. However, the rural areas are destitute, many homes do not have indoor plumbing, and the quality of education is poor compared to their urban counterparts (Public Health Specialist, Personal Communications, January 17, 2017). This urban migration has largely affected the health of citizens living in the rural areas. Many doctors migrated to the large cities leaving rural regions without necessary resources for inhabitants to prosper (Feraru, 2013).

This migration has continued as young doctors distrust the Romanian government and choose to practice medicine in places with a more established health system (Feraru, 2013). This has created a significant gap in the quality and access to health services between rural and urban regions in Romania. With large amounts of health education disseminated through doctors, it has also resulted in a disproportionate number of citizens who do not have access to sexual health information and contraceptives (Rada, 2014).

This reality has culminated in a disparity between the sexual health education rural and urban adolescents are receiving, which Cornelia Rada (2014) found in turn, may affect when these adolescents are initiating sexual intercourse for the first time and their use of contraception.

In a study of 1,215 randomly selected Romanian women, Rada (2014) found a higher percentage of rural residents initiated first intercourse at 15 or younger compared to urban residents. Even though adolescents are having sexual relations at younger ages in rural areas, Rada (2014) found significantly more urban residents used

protection at first intercourse. Rada (2014) also found a higher percentage of urban residents were 25 years or older at first intercourse.

### **2.2.3 Sexual and Reproductive Health's Rise and Fall**

Throughout the rise and fall of communism, the Orthodox Church remained steady in its power and influence, whereas the state of sexual and reproductive health rights changed dramatically. Life in Romania was depressed both socially and economically following the Second World War which resulted in a sharp increase in infant mortality (Hord et al, 1991). To offset this increase and keep its population rising the government outlawed abortions and modern contraceptives in 1945. By 1957, abortions were once again legal under specific circumstances in an attempt by the government to advance women's health after so many suffered under the restrictive law of 1945 (Government of Romania, 1957).

The combination of the legalization of abortions and the lack of modern contraceptives available to Romanians under communist rule, left Romanian women with few options for family planning (United Nations, 2002). Most women used rhythm and coitus interruptus and abortion as means of fertility control. By 1966 the birth rate had decreased significantly and annual population rate fell below 1 percent. The president decided to implement one of the most restrictive population policies Romania, and most of the continent had seen (David and Baban, 1996; David and MacIntyre, 1981).

The Council of State passed decree 770 which severely limited women's access to abortions making them legal in only limited circumstances (Ceausescu, 1966). It banned the importation of contraceptives and incentivized having children by offering allowances to large families (Ceausescu, 1966; Hord et. al, 1991). When Romanian women had no choice but to give birth to an unplanned child, many chose to leave them at an orphanage giving the responsibility of that child to the state. During this time, there was an increase in children in orphanages and estimates suggest that 98 percent of these children were abandoned at birth and not true orphans, by its definition (Hord et. al, 1991).

This oppressive trend continued, when after one year of decreased abortions and increased births, the trends stopped reflecting the change the government wanted to see. An underground illegal abortion network had been created offering women an unsafe option for fertility control. Women and those performing the illegal abortions, 90 percent of whom were not medically trained to do so, could be sentenced to time in prison and large fines if they were caught (Hord et. al, 1991).

Throughout this period, between 1965, when the decree was enacted, to the mid-80's, an unprecedented increase in maternal mortality occurred in Romania. According to the Guttmacher Institute, the rate doubled making it the highest Europe had ever seen (Sedgh, Finer, Bankole, Eilers, & Singh, 2002). Nearing the end of the 80s, there were an estimated 159 maternal deaths per 1,000 women in Romania, with 87 percent of the deaths attributed to illegal and unsafe abortions (Hord et. al, 1991).

Investigations were also initiated into cases of miscarriages amongst citizens, a practice that still occurs today in the United States. Possibly the most invasive of them all, gynecologists regularly came to do check-ups on women at their place of work to see if any women were pregnant and if they were, monitor the pregnancy to ensure they had their child and did not get an abortion (United Nations, 2002).

During these years, sexual health education barely existed and health education taught in schools referred to basic anatomy and female hygiene (Rada, 2014). After the revolution of 1989, the restrictive policies were lifted. However, it was not until November 1996 that Law No. 140 was passed which legalized abortions performed with the consent of the mother, in a medical setting, and only during the first 14 weeks of pregnancy (Population Policy Data Bank, 2002). Abortions performed after the first 14 weeks of pregnancy could result in jail time for the person performing the abortion. The Ministry of Health (MOH) was efficient in removing the barriers to family planning services but the barriers deeply rooted in traditional Romanian society have proven more difficult to rid (Hord et. al, 1991).

The communist regime brought with it a suppression of information. Those in the medical field did not have access to the most recent data, literature, and training when the government shut down the national medical documentation center in 1975 (Hord et. al, 1991). In 1981, the communist regime even halted trainings for specialized nurses and doctors, including gynecologists. After the revolution, it took time for medical providers to familiarize themselves with new trainings and trends in the medical field experiencing a serious setback in that most literature available was in

French or English, not Romanian (Hord et al, 1991). When abortions were finally legalized and the government was ready to invest in family planning, MOH estimates that of the 1,200 gynecologists in Romania, approximately 40% were going to retire soon (Hord et al, 1991).

Fortunately, many international development organizations rose to the occasion and invested funds, resources, and personnel to help Romania decrease its maternal mortality rate and transition into the modern era of sexual and reproductive health (Rada, 2014; Melnic, 2004). The US Agency for International Development (USAID) funded a ten-year family planning program, which educated the public, in both urban and rural areas, on sexual and reproductive health (Melnic, 2004).

USAID is responsible for training a significant number of family planning specialists throughout the country (Melnic, 2004). United Nations Population Fund (UNFPA) and USAID also made a major donation of free contraceptives to Romania to increase usage. Even with more than 3,000 doctors trained in family planning around the country and the availability of free modern contraceptives, in 2004 people living in low-income and rural communities in Romania were still relying on abortion as their primary means of regulating pregnancies (Melnic, 2004). In Romania, abortions are partially funded by the state but still require payments from the patients. Abortions cost the patient money whereas modern contraceptives and family planning may cost less if nothing. Thus, Romanian women relying on abortions for family planning still do not fully trust modern contraceptive and family planning tactics, a suspicion carried over from the communist (Melnic, 2004).

These major international organizations worked tirelessly to decrease unwanted pregnancies and maternal mortality rates and increase sexual health education. During this time, a new family planning organization was created called Societatea de Educatie Contraceptiva si Sexuala din Romania, which is translated to The Contraceptive and Sexual Education Society (SECS) in Romania whose role was to work in conjunction with the international agencies in the field of sexual and reproductive health (Hord et al., 1991).

In a conference held in August 1990 to launch Romania's family planning program, it was determined that such efforts would only be successful if local and regional governments assumed responsibility and helped disseminate the important resources and tools to make such a program sustainable (Hord et. al, 1991). Romania's accession to the European Union in 2007 ended the USAID and family planning funding; the important trainings and free contraceptives ceased with it (Melnic, Personal Communication, January 23, 2017).

As an EU member state, Romania became eligible for funding through the European Regional Development Fund (ERDF), the Cohesion Fund, and the European Social Fund (ESF). For the 2007 through 2013 funding period, the country received 19.7 billion Euros from these sources (European Commission, 2013). However, due to the inefficient administrative capacity in the Romanian government and without pressure to allocate the funds to specific projects, such as family planning, Romania has had difficulties spending the money provided to them (European Commission, 2013). Since joining the EU, Romania's use of their funding has increased, but there

has been no movement from political leaders to put that money towards sexual and reproductive health.

Without encouragement and resources from international agencies, most family planning efforts were not sustained. The SECS has continued providing information on sexual education in schools, but has not done much work on the topic since Romania joined the EU. Their most recent project focuses on breast cancer. Trainings either slowed or stopped altogether for family planning in Romania and the country was left to its own devices with a new standing as a member of the European Union. This status as an EU member decreased wider international attention paid to the country, and as it began to eliminate sexual and reproductive health measures, few noticed (Sexual and Reproductive Health Specialist, Personal Communications, January 24, 2017).

### **2.3 Sexual and Reproductive Health Initiatives**

Today in 2017, Romania still leads most EU member states in their alarming sexual health statistics. In 1990, Romania's maternal mortality rate was 124 deaths per 1,000 live births; the highest Europe had ever seen and highly correlated to the country's illegal and medically dangerous abortions (The World Bank, 2015d). By 2015, in line with the legalization of abortions, the rate of maternal mortality in Romania decreased to 31 deaths per 1,000 live births. While impressive, Romania's maternal mortality rate is still almost two times higher than the second highest rate in the European Union (The World Bank, 2015a).

HIV is also a serious concern in Romania at present with 65 percent of diagnoses contracted through heterosexual contact (European Centre for Disease Prevention and Control, 2011). Due to erratic and unpredictable national sexual and reproductive health programs, this rate is significant compared to countries where prevention and education programs are regularly accessible (Rada, Hudita, Manolescu, Prejbeanu, & Zugravu, 2010; European Center for Disease Prevention and Control, 2011).

Many organizations and centers created to focus on matters of sexual and reproductive rights in Romania have become less active. In 1992, the National Center for Family Planning and Sex Education was created but in the 25 years since its creation, there have been no laws relating to sex education passed by the Romanian government (Center for Reproductive Law and Policy, 2000). A National Strategy for Sexual and Reproductive Health in Romania 2012-2015 was also conceptualized but it has been neither funded, nor adopted by government officials (Rada, 2014). Romania received European structural funds for 2014-2020, and a coalition of NGOs reached out to the Minister of Health requesting those funds be allocated towards sexual and reproductive health initiatives, but this has not yet occurred (Rada, 2014).

Unlike other organizations, the Society for Contraceptive and Sexual Education has continued to work on behalf on sexual and reproductive rights focusing on the importance of sexual education and sharing information (SECS, 2016). Their newly renovated website offers information on sexual and reproductive health, usually from other sources, and houses several articles from major organizations on the

importance and value of sex education (SECS, 2016). In April of 2016 they even helped host a round table discussion with different stakeholders to review the optional subjects that should be offered in sexual education in Romania. While their work is admirable and useful, with other people not valuing the importance of such information, it is difficult for them to be effective (SECS, 2016).

#### **2.4 Sexual and Reproductive Health Statistics**

Romania leads most European countries in both highest rates of adolescent fertility and number of adolescents between the ages of 15-19 who gave birth. Romania's data on abortions are incomplete due to underreporting, thus the number presented in Table 1 below, is likely lower than the actual rate of abortions among adolescent females. Research conducted by the Guttmacher Institute found Romania, out of 23 other countries, had the highest rates of young adolescent pregnancy (10-14 years old) and they were likely underestimates due, again, to incomplete data (Sedgh et al, 2002).

Table.1- Rate of Adolescent Pregnancies per 1,000 females 15-19

<b>Country</b>	<b>Pregnancies</b>	<b>Abortions</b>	<b>Births</b>
<b>ROMANIA*</b>	<b>61</b>	<b>17</b>	<b>35</b>
Estonia	43	19	19
Belarus*	39	12	22
Hungary	38	16	18
Iceland	30	15	11
France	25	15	7
Portugal	25	8	13
Finland	23	13	8
Denmark	21	14	5
Croatia*	17	3	12
Slovenia	14	7	5

\*- Countries with incomplete official abortion statistics

*Source: (Guttmacher Institute, 2015)*

Due to the large influence of the Orthodox Church on Romanian culture, abstinence has been a long-practiced approach to family planning. After the revolution of 1989, as Romania shed its communist influence and monitoring of mass media, traditional norms weakened, the country modernized, education quality increased, and the initial age of sexual activity, marriage, and maternity began evolving (Rada, 2014).

The Ministry of Health created The Romania Reproductive Health Survey (RRHS) to better grasp reproductive health in Romanian society. RRHS was conducted on three different occasions, in 1993, 1999, and 2004 and includes representative samples of the Romanian population (Romanian Ministry of Health, 2005).

For unknown reasons the survey has not continued since 2004. Between the 1999 and 2004 survey the sexual behavior of adolescents and young adults changed dramatically. In that 11-year span, women who had sexual experiences before marriage doubled in percentage (Romanian Ministry of Health, 2005; Romanian Ministry of Health, 1999). In 2004, a study was conducted on the ‘Demography and Lifestyle of Romanian Women’ and sampled 1,982 Romanian women aged 18-84. The most interesting finding was a decrease in age of sexual initiation for women born after 1975 (Oanes, 2007).

Teenagers in Romania are engaging in sexual intercourse at younger ages than ever before, but they are not necessarily being safe about it. Rada (2014), found in her study that only 23.7 percent of sexually active survey participants used contraceptives at first intercourse. Rada also found older participants were less likely to use contraceptives than younger participants. This can be attributed to the increase in technology and modern adolescents’ ability to access information outside of what the government shares.

#### **2.4.1 Knowledge of Sexual and Reproductive Health**

As the reach of the internet increases so does access to information, both accurate and inaccurate. In communist-Romania traditional and conservative beliefs were upheld and hygiene was the primary topic of any health education offered in schools. Modern Romania looks quite different. Cornelia Rada's (2014) study surveyed 1,215 residents between the ages of 18-74, and provides evidence of how much Romania has changed.

The study considers environment (urban vs. rural), gender, age group, and level of education of participants and utilizes the Pearson chi-square test and LCA statistical analyses (Rada 2014). Of the sexually active participants 6.7% had first intercourse between 14 and 15 years old, 30.1% between 16 and 17 years old, and 34.8% between 18 and 19 years old. Table 2 shows the breakdown by gender, educational level, and age groups.

Table 2. Distribution of subjects by age at first intercourse

<b>Age Groups at First Intercourse</b>	<b>Male</b>	<b>Female</b>	<b>Low Education Level</b>	<b>Medium Education level</b>	<b>High Education Level</b>	<b>Ages 18-35</b>	<b>Ages 36-74</b>
<b>&lt;15</b>	75.0	25.0	33.0	38.6	28.4	67.0	33.0
<b>16-17</b>	57.9	42.1	33.0	42.1	24.9	63.7	36.3
<b>18-19</b>	47.7	52.3	28.8	36.7	34.5	43.6	56.4
<b>20-24</b>	38.8	61.4	20.3	42.8	36.9	23.4	76.6
<b>&gt;25</b>	40.9	59.1	18.2	29.5	52.3	22.7	77.3
<b>Total</b>	50.3	49.7	27.9	39.7	32.4	45.8	54.3

Source: (Rada, 2014)

This information is significant because 44% of respondents first received any information on sex when they were older than 15 which usually correlated with first spontaneous ejaculation for men and first menstrual cycle for women (Rada, 2014). For those who received “a lot” of information from their parents, most claimed menstruation and ejaculation respectively, as well as preventing pregnancies were the primary focus of the conversation. This can be interpreted to mean even when having these conversations with their parents, they were likely not explicitly covering comprehensive sexual education in the manner that is necessary to help prevent teenage pregnancies, STIs, and HIV/AIDs (Rada, 2014).

Of the respondents who learned about sex, less than 10 percent learned about it from reputable and medically accurate sources such as schools, doctors, or health staff. The majority received their information from friends or acquaintances and the mass

media or internet, all of which can be inaccurate sources. From those who received information, only 2.1% claimed they received “a lot” and those respondents were disproportionately from urban areas. Those living in urban areas were more likely to use protection when having sex and were two times more likely to have some form of sexual education in schools than their rural counterparts (Rada, 2014).

## **2.5 Teenage Pregnancies in Romania**

Teenage pregnancies are a major problem in Romania. They are especially prevalent in women of a low-socioeconomic status, lower levels of education, women who come from broken families, and rural areas. The World Health Organization (WHO) (2007) prepared a report that claimed there is an association between teenage mothers, high rates of poverty and low rates of educational attainment. Compared to countries around the world with more family planning resources and mandatory sexual health education programs who have lower rates of teenage pregnancies, a correlation can be found between Romania’s high rates and their inefficient policies.

Having some of the highest rates of teenage pregnancies in Europe carries with it effects that go beyond potential harm to mother and child, trickling into the entire society at large. Romania, as a country, is paying the social, economic and opportunity costs as it takes no preventative measures to reduce its rates of adolescent pregnancies. Rather, the Romanian government focuses its time and efforts on providing social services to mother and child that costs the country and its citizens large amounts of

money (Child Protective Service Worker, Personal Communications, January 25, 2017).

### **2.5.1 Social Costs**

The social costs associated with a high prevalence of pregnant teenagers in a society are substantial. Adolescent pregnancy affects the health of the mother and child which in-turn affects the society at large. Adolescent mothers are less likely to finish their schooling and generally, those who do not graduate high school are more likely to live shorter and less healthy lives (Brace, Hall, & Hunt, 2008).

This is problematic because a less educated society has serious ramifications on the growth and development of a region. Compared to their peers who choose to wait to have children, adolescent mothers are also more likely to live in poverty and rely on welfare for resources to provide for themselves and child (Hoffman, 2006). A study conducted by the WHO (2007) also found a correlation between social deprivation and teenage pregnancy in developed countries.

The health of the mother can be severely affected by giving birth at a young age which is significant because maternal mortality is an indicator often used to measure the overall health of a society (Sajedinejad, Majdzadeh, Vedadhir, Tabatabaei, Mohammad, 2015). Compared to women who choose to delay childbearing, pregnant teenagers have higher incidences of maternal illness and are more likely to miscarry, experience a stillbirth, and neonatal death (Luker, 1996).

There are also health risks posed to children who are born to adolescent mothers. Children of teen mothers are commonly born at low birth rates which can have lasting effects on a child. These children are also more likely to experience poor health and have developmental problems throughout their lives. Due to the often-unstable household children of teenage mothers grow up in, they are at a higher risk for living in poverty, being abused, and/or neglected (Hoffman & Maynard, 2008; Martin, Joyce, Hamilton, Ventura, Osterman, Kirmeyer, Mathews, & Wilson, 2011; NCPTUP, 2010). While not a health risk, studies have shown the children of adolescent mothers are more likely to be involved in the criminal justice system; more youth and adults committing crime negatively affects the whole society (NCPTUP, 2011).

### **2.5.2 Economic Costs**

Economic costs to both the mother and larger society are substantial because teenage mothers and their children make up a large proportion of welfare recipients (Personal Communications, Social Worker, January 23, 2017). Whether it is public assistance, health care for mother and child, or other forms of government aid, these resources come at a cost to Romanian tax payers (NCPTUP, 2011). With a greater likelihood of teenage mothers not completing their education, there is a loss of potential tax revenue these teenage mothers could be contributing (NCPTUP, 2011).

While no research has been conducted in Romania to quantify exactly how much it costs the country to provide these services, in 2008 an in-depth study was

conducted by Kids Count in the US which looked at state and federal costs of teenage mothers (Brace, Hall & Hunt, 2008). To offer context according to the World Bank the US, as of 2015 had a rate of 21 per 1,000 adolescent fertilities, Romania a much smaller country, has a rate of 35 per 1,000 (The World Bank, 2015b, The World Bank, 2015c).

With that in mind, in the US specifically the state of Georgia, each teen 17 years or younger that gives birth to a child costs the state \$3,562 annually (Brace et al, 2008). This number considers the costs of a child's participation in the state's public health system, foster care, child protective services, criminal justice system, and public assistance programs for parents. The number calculated in the study also accounted for the societal costs associated with teenage pregnancies.

### **2.5.3 Opportunity Costs**

Opportunity costs, while more hypothetical in nature, are a serious consideration when reviewing the effects of adolescent mothers on a society. Adolescents who are dropping out of school, not finishing their education, and raising children lose out on opportunities that could positively affect their lives. Without a high school education, teenage mothers are likely to have a lower salary than their female counterparts who finished secondary education (World Health Organization, 2007). Teenage mothers are also more likely to raise their child in a single-parent home, which increases chances of physical abuse and neglect. High rates of teenage mothers also result in less women contributing to the country's workforce which may

have peripheral effects on a country's GDP and unemployment rate (World Health Organization, 2007).

## **2.6 Sexual Health Education**

Literature from all over the world, and research that has been done specifically in Romania, have found comprehensive sexual education to be a more effective means of decreasing rates of teenage pregnancies, STI's, and HIV compared to abstinence-based education (Rada, 2014). Many researchers believe the earlier sexual health education is introduced, the greater positive effects it will have on adolescent's sexual behaviors. The importance of teaching adolescents this information has a long history in international politics. In 1994 at the International Conference on Population and Development for the United Nations, governments were urged to provide adolescents with education on sexual and reproductive health, sexuality, gender relations, and other relevant topics (Haberland & Rogow, 2015).

A complete understanding of the link between sexual health education and sexual behaviors would be a major achievement in overcoming the barriers to implementing a national strategy, especially in Romania. A major concern of those who do not support sexual health education in Romania, and the rest of the world, is that teaching adolescents about this topic will result in sexual activity starting at a younger age and more sexual partners (Planned Parenthood, 2013).

Many studies have been conducted to measure the effectiveness of abstinence based education programs within these parameters and how adolescents who receive

no formal education fair in their sexual behavior compared to those receiving abstinence-based and comprehensive sex education (Hall & Hall, 2011; Kohler, Manhart, & Lafferty, 2007).

Of these studies, most findings highlighted the ineffectiveness of programs that are not evidence-based and comprehensive. Hall and Hall (2011) compared abstinence-based and comprehensive sex education by clustering different policies throughout the fifty states in the US and finding if they were statistically significant in lowering the state's rates of teenage pregnancies, births, and abortions. They found teaching abstinence in the US does not result in abstinent behavior among teens (Hall & Hall, 2011).

Similarly, Kirby (2007) authored a report that found significant evidence that abstinence-only education programs have no impact on the sexual behaviors of teenagers. Underhill, Montgomer, & Operario, (2007) came to the same conclusion with the results from their "meta-study" examining 13 abstinence-only programs reaching approximately 16,000 students. Once again looking at programs in the United States, they concluded the decrease in the rate of teenage pregnancy un 2007 was likely attributed to increased use of contraception rather than a decrease in sexual activity (Underhill et al., 2007). The state of Pennsylvania, Texas, and others have conducted research on the effectiveness of abstinence-only education programs implemented in their state and all found the programs to be "ineffective in reducing sexual onset" and having "no significant changes" in students waiting to have sex until marriage (Smith, Dariotis, & Potter, 2003; Goodson et al., 2004).

Measuring the impact of sex education programs have primarily shown positive impact or no impact on adolescents' sexual behavior. Contrary to those against its' implementation there was no significant evidence showing it increased sexual activity or STD (Kohler et al., 2007). Braeken and Cardinal (2008), attributed an increase in information to help make informed sexual decisions to comprehensive sex education and claimed it can increase the quality of life for adolescents.

A study that measured the impact of 83 sexual health education programs measured the significance of these programs on risky sexual behaviors and STD and pregnancy rates (Kirby, Laris, & Rolleri, 2007). Of the programs studied, each differed in their measurements of the programs impact on the behaviors studied.

Fifty-two programs measured the initiation of sex and 42 percent found it played a significant role in delaying the initiation of sex (Kirby et al., 2007). Thirty-four studies measured for sexual health education's impact on the number of sexual partners finding a decrease in the number in 35 percent of programs. Approximately half of the 54 studies measuring condom use saw an increase in usage and some studies looked at sexual activity and condom use to determine sexual risk taking finding half of the 28 programs reduced sexual risk-taking significantly (Kirby et al., 2007).

Out of all the studies conducted looking at sexual behaviors and STDs no more than three programs for any indicator found a negative impact of the sexual health and HIV programs (Kirby et al., 2006). Pregnancy rates were also studied; out of 13 studies 3 found major positive impacts, 9 had insignificant impacts, and one study

found a negative impact. Other research has found adolescents who receive sexual education are at a lower risk of pregnancy (Kholer, Manhart, & Lafferty, 2007).

Of the highest importance is that sexual health education does not increase rates of sexual activity, initiation, or number of sexual partners (Braeken & Cardinal, 2008). Abstinence-based education, contrary to the narrative supporters tell, has little to no impact on decreasing rates of sexual activity, initiation, or number of sexual partners. While sexual activity may not always significantly impact different sexual behaviors, it provides adolescents with the knowledge and skills to make informed decisions about their sexual health (Braeken & Cardinal, 2008).

### **2.6.1 Sexual Health Education in Romania**

Sexual health education does exist in Romania; however, it is not required in schools. In 2014, the Ministry of Health attempted to pass a national strategy requiring it in schools but religious organizations signed a public letter to the Minister of Health for parents to be consulted on matters of sexual education and the importance of delaying sexual intercourse until marriage (Stiripentruviata, 2015). Since the new administration took power in 2016, no further attempts have been made to pass such legislation.

Until a national strategy is passed, the job of disseminating sexual education falls to nongovernmental organizations (NGO) and school teachers. NGOs have taken the lead in emphasizing the importance of sexual education but local school boards must approve the lecture, the content itself varies based on the organization teaching

the information, and the information only reaches where the NGO can (Center for Reproductive Law, 2000).

The information provided from the NGOs is dependent upon the values and beliefs of the organization. A religious NGO may teach about the importance of delaying sexual intercourse never mentioning ways to protect oneself, whereas a more progressive organization may focus on a more comprehensive education. This means adolescents are receiving different information. There are also different regions throughout Romania that receive no sexual education of any kind if they are more rural (Center for Reproductive Law, 2000).

In some cases, teachers play a role in educating youth on sexual health. Most commonly it is a biology teacher who has not been trained to teach sexual education and has chosen to teach it on top of all the other courses expected of her/him (Health Educator, Personal Communications, January 17, 2017). Recently, a law in Romania passed the senate to imprison teachers who teach classes on sexual education without the consent of parents. Prison time could last between 2 -months and three years (Serghescu, 2016).

Threatening teachers with jail time for disseminating information that can improve adolescents' lives and decrease their risk of STIs, HIV, and teenage pregnancy is a serious precedent the new Romanian government is setting. Therefore, while sexual health education may exist in different forms in Romania, it is not accessible to everyone and not taught in a consistent manner throughout the country. A national and uniform strategy is needed.

## **Chapter 3**

### **METHODOLOGY**

This chapter presents the methodology employed to answer the research questions. The foundations of this study's methodology are grounded in qualitative interviews with professionals that were conducted January 17-25, 2017 in Cluj-Napoca, Romania. This research study received exemption from the University of Delaware's Institutional Review Board on Human Subjects.

#### **3.1 Research Approach**

This study solely utilizes qualitative research methods. The research attempts to understand the problem of adolescent pregnancies from multiple angles with some myriad professionals. By employing qualitative research methods there was flexibility in how interviews were carried out (Babbie, 2010). The qualitative approach does not require a structured format and interviews can take multiple paths generating unanticipated information (Babbie, 2010).

Qualitative methods were also preferred in this study because although the literature review offered insight to the major barriers of implementing a national strategy, there were several uncertainties about the findings when interviews commenced in Romania. This method offered a flexibility that allowed the analysis to

be redirected even after interviews had been conducted (Babbie, 2010). Due to the inconsistency of raw data in Romania, it was decided to only apply qualitative methods.

### **3.2 Data Collection**

This data collection was carried out as part of a study-abroad program through the University of Delaware. Partnering with Babes-Bolyia University (BBU) in Cluj-Napoca, Romania a PhD student and faculty member set up interviews based on a list created on who could provide the most versatile and well-rounded professional-perspectives on this topic. When asking for interviews, the PhD student and faculty gave an overview of the research being conducted and the conversations took place in Romanian.

There were three instances where interviewees were unable to meet face-to-face so email correspondence was utilized instead. Based on the integrity of Babes-Bolyai's contacts, it was trusted that emails and questions were received and completed by the intended interviewee.

Two interviews took place completely in Romanian with a PhD student translating between each question and response; three interviews were conducted via email in Romanian and then translated by a PhD student; three interviews were recorded by hand and three were recorded on a recording device. After being transcribed the recording was destroyed. Those interviewed were asked if their

responses could be used for publication and all preferred to be referred to in papers by their generic job title to maintain confidentiality.

Each interviewee was asked the same four questions at the beginning of the interview to gain an understanding of their perspective of the problem. The first four questions were:

1. *What is your assessment of Romania's rate of teenage pregnancies?*
2. *In your opinion, is the current situation a problem for Romanian society?*
3. *Is it a problem of any ethnic, economical, or geographic subset?*
4. *What do you (your organization) think would be the most effective way to address this situation?*

This provided responses that could be coded and understood allowing for the organization and sorting to outline and incorporate what would otherwise be nine completely different and non-overlapping interviews (Thorne, 2016).

Due to the variety of professionals who were interviewed and their wide-ranging expertise, the initial four questions were followed by questions tailored specifically to the professional being interviewed. This allowed the interview to be unstructured and unfold depending on the perspective of the professional.

### **3.3 Interviewees**

In-person interviews were conducted in Romania with major stakeholders who are invested in decreasing Romania's high rates of teenage pregnancies. This is a multifaceted problem in Romanian society and while interviews did not occur with all

preferred professionals, those who agreed to them offered different perspectives and insight on the problem and how to address it. Each interviewee was chosen based on their professionalism and integrity perceived by the distinguished Babes-Bolyai University in Cluj-Napoca. A more detailed look at who was interviewed and why can be found on Table 3.

Table 3. Interviewees, date, language, location, reason

<b>Interviewee</b>	<b>Date</b>	<b>Language</b>	<b>Location</b>	<b>Reason</b>
<b>Public Health Specialist</b>	01/17/2017	English	In-person	Offered perspective on intersection between public health and the Romanian government
<b>Health Educator</b>	01/17/2017	English	In-Person	Only certified health educator in the country.
<b>Health Inspectorate 1</b>	01/21/2017	Romanian	Email	Works as medic in schools across Romania.
<b>Health Inspectorate 2</b>	01/22/2017	Romanian	Email	Works as medic in schools across Romania.
<b>Biology Teacher</b>	01/23/2017	Romanian	Email	Has voluntarily taught sexual health education classes.
<b>Reproductive Health Specialist</b>	01/24/2017	English	In-Person	Worked on USAID/UNFPA projects, has worked in sexual and reproductive health since communist regime.
<b>Social Worker/Parent</b>	01/25/2017	Romanian	In-Person	Offered perspective of social worker who works with teenage mothers and that of a mother.
<b>Pro-Life Clinic</b>	01/25/2017	English	In-Person	Works with pregnant teens and holds beliefs similar to the church.
<b>Former Ministry of Health Worker</b>	01/25/2017	English	In-Person	Worked in old administration of MOH.
<b>Child Protective Service Worker</b>	01/25/2017	Romanian	In-Person	Works with both teenage mothers and children of teenage mothers.

### **3.4 Limitations**

The primary limitations that affected the methodological component of this study were a lack of time and data. Due to the data being collected while on an organized study-abroad trip, and interviews taking place with working professionals, time limited the expanse of the research. Interviews were only conducted on normal business days and one of those days was filled with obligational meetings with Romanian officials. The limitations of this methodology all fall under the category of being short on time, but also include age restrictions and the taboo nature of the research topic.

#### **3.4.1 Time**

As per the organization of the study-abroad trip, Dr. Bogdana Neamtu, a professor at BBU in the School of Public Administration was to serve as the liaison, setting up meetings for all the University of Delaware students based on a predetermined list of necessary interviewees. This specific study, categorically, did not fit in the School of Public Administration and was paired with the School of Public Health and a PhD student within the school was assigned to assist on the study. Dr. Neamtu gave the responsibility of setting up interviews to the PhD student who did not begin calling for until the program began. It was unknown by anyone other than Dr. Neamtu and the PhD student that the responsibility of setting up interviews had changed. The delay may have cost the study some people willing to be interviewed.

On 1/19/17 the Romanian government announced it was going to celebrate a national holiday the following Monday and Tuesday. Public organizations would be closed both days, with most of the country shut down just Tuesday. Babes-Bolyai, the partner university, did not anticipate this and neither did most of the country. Interviews had been set up for that Monday and Tuesday but after the holiday was announced all but one were cancelled as many people decided to use those days to travel. This led to two of the email correspondences taking place rather than face-to-face interviews.

#### **3.4.2 Age Restrictions**

Another major limitation was the restriction to speaking to minors without parental consent and a more thorough review by the University of Delaware's Institutional Review Board (IRB). Both the PhD candidate and the professor's from BBU did not believe there was appropriate time to carry out this portion of the study due to the need of a signed parent permission slip. Having to explain the extent of the study so parents would agree to let their children participate would also be difficult with the contentiousness of the topic in Romania. To include minors in the research would also require a more intensive IRB application that may not have been approved in time for the start of the research.

### **3.4.3 Taboo Nature of Topic**

The topic of sex, sexual education, and sexual education in schools has been a controversial topic in Romania for years. The church, with its political influence and loyalty from 86 percent of Romanian citizens has aggressively and publically fought to keep sexual health education out of schools; believing in abstinence and the importance of this conversation taking place in the home (Turcescu & Stan, 2005).

The last administration to have power in Romania was actively working towards implementing a national strategy for sexual health education, but the newest administration which took power in December 2016 has halted all efforts. With the status of such legislation unknown, people were less inclined to accept the invitation to be interviewed. Approximately five different people from reputable organizations refused to be a part of the study, claiming they did not want to discuss the topic. If there was more time to conduct in-person interviews and the PhD candidate had discovered people's concern with speaking to us earlier, a larger net might have been cast to offset those who were not comfortable being interviewed.

## **Chapter 4**

### **FINDINGS**

The findings described below are products of the substantive interviews that took place in Romania between January 17, 2017 and January 25, 2017. The interviews, when summarized and synthesized presented six major barriers, to most of which are located on the societal level of the social-ecological model. These barriers, both directly and indirectly, are preventing the implementation of a national strategy for sexual health education. Since this study used qualitative research methods, each interview was different and not everyone contributed to each of the six findings.

First the lack of visibility of teenage pregnancies is discussed as a barrier to Romanian citizens being aware a problem even exists. The chapter then looks at how Romanian society cultivates a lack of purpose in young women which is a common determinant of teenage pregnancy. Next the organization of those opposed to the implementation of a national strategy is discussed followed by why a lack of political engagement contributes to the problem. This chapter ends with findings on why a data deficit and the absence of a health education field are major barriers.

#### **4.1 Problem Not Visible**

One of the most important findings that informed those which follow is while teenage pregnancy is a glaring problem to public health workers both domestic and

abroad, it is not a recognized one by the general Romanian public. All interviews included the questions:

1. *What is your assessment of Romania's rate of teenage pregnancies?*
2. *In your opinion, is the current situation a problem for Romanian society?*
3. *Is it a problem of any ethnic, economical, or geographic subset?*
4. *What do you (your organization) think would be the most effective way to address this situation?*

Responses from interviewees were unanimous in which the professionals were highly concerned with Romania's rates yet admitted the public does not see it as a problem. The Public Health Specialist explained it was "Because they do not know about it" (Personal Communication, January 17, 2017). This has serious implications because if Romanians are not concerned with their high rates of teenage pregnancies they have no incentive to make the societal changes necessary to affect the rates.

The lack of visibility of teenage pregnancy and its impact on the implementation of a national strategy can be broken down into three categories: education, media's portrayal, and the options that exist for teenagers who become pregnant.

Many of the interviewees, specifically the Public Health Specialist, Pro-Life Clinician, and Health Educator found educational attainment to be a factor influencing the visibility of the problem. All interviewees admitted teenage pregnancy

disproportionately affects people of low socioeconomic status and often those from broken families.

Per the Pro-Life Clinician, these adolescents are likely to give birth when they become pregnant because it is more normalized in poorer communities (Personal Communication, January 25, 2017). The Public Health Specialist described the importance of educational attainment by explaining those with lower levels are more likely from rural areas and less likely to be observed by people in the major cities. The Health Educator offered a similar observation claiming those with greater education, who may someday be working in a position that influences national policies, will not have interacted often if ever with pregnant teenagers who do not leave their rural hometowns (Personal Communication, January 17, 2017).

The Public Health Specialist also spoke extensively on the role of the media in keeping the scope of the problem out of the public's attention. He emphasized the sectionalism that defines media in Romania and how that affects what is covered by journalists (Personal Communication, January 25, 2017).

Visibility of teenage pregnancies in Romania is lacking because there are many options for how teenagers choose to address the situation. The Social Worker expressed that although she has worked with many pregnant teenagers throughout her career, she could not offer a normal course of action most pregnant teens take (Personal Communication, January 25, 2017).

Health Inspectorate 1 described seeing pregnant teenagers in the school system, some would try to hide their pregnancy if they could while others chose to

leave school immediately. The Pro-Life Clinician whose organization offers free pregnancy tests claimed, “Quite a lot of them [fetuses] are aborted” (Personal Communication, January 25, 2017). While some choose to receive counseling, and give birth it is more common, especially in a city as big as Cluj for teenagers to get an abortion. The Clinician explained “After it [the abortion] happens the problem disappears” (Personal Communication, January 25, 2017).

This may explain the lack of general concern regarding this topic and the lack of awareness beyond public health professionals and those working directly with these young women.

#### **4.2 Lack of Purpose**

A major barrier to decreasing the rates of pregnant teenagers through a national strategy was identified by the interviewees who interact with pregnant teenagers daily. The Social Worker explained teenagers want to “becom[e] something” more than what they think is available to them, the Pro-Life Clinician described it as “a lack of hope among both young men and women” and the Child Protective Worker called the teenagers “helpless” (Personal Communications, January 25, 2017). The concept of Romanian teenagers, often low income, feeling as though their life lacks purpose was a common theme in the interviews.

The Pro-Life Clinician talked in detail about this idea, questioning aloud if some cohorts of Romanian adolescents “ever dreamed of going higher” (Personal Communications, January 25, 2017). Explaining that when this idea manifests itself in

these poor youth, that there is nothing to work towards in life they consider motherhood an admirable alternative.

She further explained that she was surprised to see women who objectively have the resources to raise a child choose not to while those who are relatively poor and cannot afford the responsibility come to the clinic looking for counseling. When they come the clinic highly encourages the mother to have the child and offers support and classes to help prepare her.

The Social Worker described the negative externalities associated with this dangerous mentality. She explained that these adolescents who lack a purpose and do not have the means to support a child are a major recipient of social welfare offered by the state. Unable to quantify the expense, she described it and it was translated as “huge” (Personal Communication, January 25, 2017). The Child Protective Worker supported this with accounts of many teenagers and their children in the government’s system using resources that were meant for them, but all reactive rather than policies that could help prevent it in the first place.

### **4.3 Organized Opposition**

The impressive organization of those opposed to the implementation of a national strategy for sexual and reproductive health was a common discussion point for most of the interviews that were conducted. The Public Health Specialist and Reproductive Health Specialist, the two interviewees who have been working in the health field the longest, were the most passionate about the topic and had the most to

say. When the interviews were analyzed, the biggest theme was the opposition is organized in their resources and the people who fight on their behalf.

The Reproductive Health Specialist explained the greatest weapon the opposition has is their organization and their resources. She explained that she and her colleagues thought the facts alone of the high rates of teenage pregnancies and proven effectiveness of sexual education were enough to implement a policy so they sat complacent waiting for the public to agree while the church organized (Reproductive Health Specialist, Personal Communication, January 24, 2017).

The Church feared the passage of a sexual education strategy and started “anti” campaigns. The Public Health Specialist explained the Church has so many resources due to the large sums of money they receive from the state and the fact that 86 percent of the Romanian population is associated with the Church (Personal Communication, January 17, 2017). They also have a great revenue from donations. With all this money, the church has their own television and radio channels which they have used in the past to combat the implementation of sexual education policies (Public Health Specialist, Personal Communication, January 17, 2017).

The Public Health Specialist explained that in modern society with a higher socioeconomic status and standard of living, the number of people attending church has begun to decrease (Personal Communication, January 17, 2017). This worries the church due to fears that their morals might not hold the same values in society as they used to. In response, they organized and created satellite NGOs that promote their values through an alternative format. The Public Health Specialist was equally

impressed and unsettled they had the ability to adapt and continue promoting their ideals so effortlessly (Personal Communication, January 17, 2017).

A perfect example of this is the clinic the Pro-Life Clinician works for. Her organization teaches what she calls “sexual education” to hundreds of students throughout the country (Personal Communication, January 25, 2017). When asked what topics are covered she explained STD and pregnancy prevention, abstinence, morals, values, and the sanctity of marriage. When pushed about what exactly is covered when she teaches STD and pregnancy prevention she described a presentation that focused on why birth control and condoms are ineffective, adolescents’ sexual urges are just a product of their environment, and delaying sexual initiation is most effective (Pro-Life Clinician, Personal Communication, January 25, 2017).

The people whose values align with the churches were described as instrumental by the Reproductive Health Specialist when acting as barriers to the implementation of policies. She explained that while the Ministry of Health was attempting to pass their health law in 2014 town halls and meetings were conducted to measure the public’s perception of it. She explained the opposition was well organized and sent groups to each town hall to express contempt for the new bill and vocalize their dissatisfaction with it (Reproductive Health Specialist, Personal Communication, January 24, 2017).

Health Inspectorate 1 also mentioned the most vocal group when the bill was trying to be passed was the Church (Personal Communication, January 21, 2017). Those who supported it were not organized and were not working hard enough for it to

pass because they thought reason and facts were on their side. Conservative NGOs wrote letters showing their outrage in the government for even proposing such a policy (Health Inspectorate 1, Personal Communication, January 21, 2017).

This outrage, especially when expressed by the church, holds clout in Romania the Public Health Specialist explained. He discussed how “the Orthodox church in Romania is very active politically” and then went on to say the church was invaluable for securing votes for the party now in power and thus receives a great number of resources from the state (Personal Communication, January 17, 2017).

#### **4.4 Lack of Political Engagement**

Another theme that emerged from the interviews is there exists a lack of trust for the government from the public, which discourages people from engaging politically and thinking their involvement could affect change. The Reproductive Health Specialist was an activist for women’s health rights leading up to and during the revolution and had a great deal of concern for the lack of political engagement from Romanians (Personal Communication, January 24, 2017). She called those who were in favor of a national sexual education strategy lazy thinking that having the facts on their side would be enough. She also explained “[sexual education] became a hot issue, and people are afraid to [put pressure on their government]” (Reproductive Health Specialist, Personal Communications, January 24, 2017).

The Public Health Specialist touched more on this when he described a country where there is “political pressure to keep things the way they are. Schools don’t care”

(Personal Communication, January 17, 2017) When asked if getting school administrators to make a plea for the importance of a comprehensive national sexual education strategy would be beneficial he responded, “School principals are politically appointed [...] so basically they just follow the direction of the party that is in power” (Public Health Specialist, Personal Communication, January 17, 2017).

He did not even have confidence in the power of political engagement in this situation. He went on to further comment on the alarming resemblance between modern day Romania and communist-Romania (Personal Communication, January 17, 2017). The Reproductive Health Specialist made a similar comment when she claimed “women’s rights and civil rights can be lost in a matter of a few years” as someone who has seen the rise and fall of women’s rights in Romania she fears Romania today is similar to the Romania she grew up in (Personal Communication, January 24, 2017).

#### **4.5 Lack of Data**

A lack of accurate and shared data is another serious barrier that presented itself through the interviews. A former Ministry of Health worker who helped draft legislation for previous health policies claimed even while working for the main health department in Romania, data was neither accurate nor recent (Personal Communication, January 25, 2017). She explained it often left workers with several questions about how to conduct their research. The Public Health Specialist explained this in his interview by offering “we have a problem in all former Soviet countries

with data collection. We do not have any respectful data; we do not collect it, we do not rely on it, we do not use it” (Personal Communications, January 17, 2017).

The Reproductive Health Specialist explained most health clinics are supposed to send their data to the government but oftentimes they do not. The Pro-Life Clinician supported this. When asked about the clinic’s data she claimed that while they technically have a lot of data on hand about adolescent pregnancies, doing anything with the data “seems unproductive so [we] haven’t spent time on it” (Personal Communication, January 25, 2017). The clinician seemed slightly surprised by the question and eventually answered that nothing is done with the research because they do not have the room in their budget.

Pessimistic about Romania’s government, the Reproductive Health Specialist stated she believed even when data are collected those who are creating laws and deciding policies “simply don’t look at the numbers” (Personal Communications, January 24, 2017). The Public Health Specialist made a similar claim saying even if the data were available it would not be used to produce anything of substance to help Romanians.

#### **4.6 No Health Education Field**

Interviews for this study offered a better understanding of what sexual health education currently resembles in Romania and why a field specifically dedicated to health education is crucial to the implementation of a national strategy. At present the field of health education does not exist in Romania. There is one known health

educator who received her Master's degree in France and may be the only to return to apply her knowledge to Romania; unfortunately, the country does not recognize her degree (Health Educator, Personal Communications, January 17, 2017).

She explained Romania is suffering significantly without a field that focuses completely on educating people on health. Currently sexual health education is either taught by NGOs or teachers. Some NGOs, such as the one the Pro-Life Clinician is affiliated with, teach health education in a way that educates adolescents more on the morals of the organization than comprehensive information that prepares them to make their own decision on their sexual life.

The Reproductive Health Specialist explained not as many NGOs exist today that focus on comprehensive sexual education. When international organizations were providing resources on family planning and sexual health more NGOs taught sexual education, but without their presence it is not emphasized as much anymore (Reproductive Health Specialist, Personal Communications, January 24, 2017).

If NGOs are not providing sexual education, the information usually comes from biology teachers taking the time to teach an optional course on top of their already filled course load as described by the Biology Teacher who has offered this optional course to her students for the past ten years (Personal Communications, January 23, 2017). The actual curriculum depends completely on the teacher and what they choose to cover. The Biology Teacher interviewed explained that she spends about eight hours of the semester long class discussing sexual health education in comprehensive and explicit terms. The school does not provide resources to help teach

the topic and all students must have parental permission or else there may be serious repercussions for the teacher (Biology Teacher, Personal Communications, January 23, 2017).

Both the dual biology-sexual health education teacher and the Pro-Life Clinician who teaches “sexual education” admitted that they received no formal training to provide this information to the students. The Biology Teacher explained that to her it seemed like an extension of biology and made sense for her to teach it, while the Pro-Life Clinician said she read up on the topic before teaching it. This is the exact concern the Health Educator expressed while being interviewed.

The Health Educator explained the extensive training she went through in her Master’s program and how that is the level of training anyone disseminating this information should be held to (Personal Communication, January 17, 2017). The Public Health Specialist echoed this sentiment in his concern with the lack of properly trained teachers for this topic. He also mentioned that if the schools and parents were more interested in students receiving this information it would be much different (Personal Communication, January 17, 2017).

## **Chapter 5**

### **DISCUSSION**

The findings from the qualitative interviews support the hypothesis that the societal and cultural norms and values of Romania help create the greatest barriers to implementation of a national sexual education strategy. The hypothesis singled out the influence of the Orthodox Church as the biggest barrier, and while that is still true, the need for a health education field emerged as an equally important barrier. Without it, Romania will not have the resources to implement such a policy.

Overcoming certain barriers without overcoming the Orthodox Church's influence could also result in successful implementation. For example, if there was greater awareness of the problem, data increased, and a health education field was created, the new Romanian society would likely pass a sexual education policy.

This chapter discusses the findings in context with the literature that surrounds this topic. It begins with an in-depth look at the theoretical framework in conjunction to the findings and what information it yields. Next, a brief comparison between Romania, a country with high rates of teenage pregnancies, no national strategy, and where the Church plays a significant role and the Netherlands, where the opposite is true is conducted. Following that is a brief discussion of the Roma population, a poor community whose society is strikingly different than the major Romanian one. Finally,

this chapter will discuss several broad recommendations are presented which offer alternative ways to decrease teenage pregnancies without the implementation of a national strategy and suggestions that may initiate its adoption.

### **5.1 The Church's Fight for Relevancy**

The interviews conducted for this study with respect to the literature as well, presented a fight that is currently taking place in Romania for the control to shape society. The Orthodox Church has had a significant influence on Romanian society for over a century (Turcescu & Stan, 2005). It has been the most permanent fixture in Romanian history that has always provided concrete morals and values even as the country itself has had its values and morals change with the rise and fall of communism (Turcescu & Stan, 2005).

The Social Ecological Theory emphasizes a society's role in influencing the community, relationships, and individuals that make it up. The Orthodox Church has always served this role while also holding political power at the same time, making the Church a force to be reckoned with. As this power is threatened by the constant flow of information in the modern era, the church is struggling to find ways to influence the behaviors of individuals in the Social Ecological Model. As participation and engagement with the Church continues decreasing, the church will have to decide if they should try to influence just the community, relationship, and individual level, or if it is worth it to continue fighting for influence on the entire society.

Romania has modernized since the revolution resulting in fewer people engaged with the church and more access to alternative values, morals, and beliefs. The Pro-Life Clinician, whose organization's values and morals align with the Orthodox Church's almost perfectly attributed the rise in teenage pregnancies to the changing of Romanian society. She explained people are not following traditional religious teachings and are having sex before marriage at higher rates and are more comfortable getting divorces which is something the church does not support (Pro-Life Clinician, Personal Communications, January 25, 2017).

The Public Health Specialist described it as conservatives pushing back against the rise of technologies and changing morals. He explained their blockage of the implementation of a national strategy on sexual education is their way of trying to grab onto whatever they can to keep certain aspects like the traditional society they believe in (Public Health Specialist, Personal Communications, January 17, 2017).

The Pro-Life Clinician further supported this by offering her disapproval that adolescents think sex is about pleasure, which researchers have found is a significant factor driving people to have sex (Garcia, Reiber, Massey, & Merriwether, 2012; Personal Communication, January 25, 2017). Whereas, the Church and this Pro-Life Clinician believe sex should purely be about procreation.

This can create a fundamental problem in Romanian society. As the Pro-Life Clinician teaches her "sexual health" where hundreds of students are not learning how to protect themselves when engaging sexually and are told sex is about marriage not pleasure, they are then going home and accessing the internet and mass media which is

telling them sex is everywhere and everyone is doing it (Personal Communications, January 25, 2017). This creates a disjointed society where information is coming from different sources and the adolescents who need it most are not receiving it adequately.

Ultimately, the Orthodox Church and others who believe in the traditional Romania, cannot stop the spread of information that is so accessible in the modern world. Every interviewee, when asked, gave the internet as adolescent's main source of information on sex. These youths already are educating themselves on sexual matters, and they are likely not always using reputable sources (Public Health Specialist, Personal Communication, January 17, 2017).

The society modern teenagers are growing up in is extremely different from that in which their parents grew up. Traditional times and practices are not likely to make a full return. It is a change that is bigger than Romania and is affecting the entire world at large. Traditionalists are going to have to find a way to adapt to changing times else they will become irrelevant to upcoming generations.

### **5.1.1 A look at Secular Netherlands**

To better understand how the Church may be influencing Romania, the Netherlands is studied as a country where the Church holds little societal influence.

It is important to note when looking at the Netherlands as a case study for Romania, that the two countries share few similarities in their historical context. In Romania, the Church has been used as a means of legitimizing nationalism, political leaders, and programs for decades. Its role in society has been much greater in

Romania than the Netherlands. For this analysis, this section will consider how limiting the influence of the Church, such as the Netherlands has done, can positively impact the health and well-being of the Romanian society.

Unlike Romania, where the church is currently struggling to maintain its influence on society, in the Netherlands the fall of the religious regime took place back in the 1960s. Today, most citizens in the Netherlands are considered ‘secular non-religious’ and do not place high value on religion and religious institutes (Storm, 2009). Since the 60s there has been a decline in traditional Christian beliefs as well as church membership rates (De Graaf & Te Grotenhuis, 2008). All of this has led to the absence of religion from the public sphere, and importance placed on religion in an individual’s private realm (Achterberg, Houtman, Aupers, Koster, Mascini, & van der Waal, 2009).

As the church’s influence on the Netherlands decreased, acceptance of family planning increased dramatically and the societal values of sexuality and the family changed (Ketting & Visser, 1994). Netherlands’ society reflects these changes as they have one of the lowest abortion rates in the world and have been successful in preventing teenage pregnancies through strategies that have been less successful in religious Romania (Ketting & Visser, 1994).

Limiting and eventually ridding the Netherlands’ of religious traditional influences on the functioning of society has positively impacted the country as a whole. Decisions are made based on fact and what is best for citizens rather than trying to balance national decisions with religious teachings, values, and morals.

Breaking free from religion in politics has afforded the Netherlands with the ability to lead the world in impressive and progressive policies.

For example, sex education has been mandatory since 1993 in the Netherlands under a national health promotion program (Planned Parenthood, 2013). Teachers within schools provide information on the topic and are trained during their “pre-service” training with additional training provided by the Netherlands Institute for Health Promotion and Disease Prevention (HEBS, 2001). When teaching the subject, topics that must be included are: “pregnancy, STIs, sexual orientation and homophobia, value clarification, respect for differences in attitudes, and skills for healthy sexuality” (Greene, Rasekh, & Amen, 2001: 48).

Sex education begins in preschool in the Netherlands and the country has just 14 pregnant teenagers per 1,000, compared to Romania’s 61 pregnant teenagers per 1,000 (Berne & Huberman, 1999; Sedgh et. al, 2015). The Netherlands also uses media campaigns nationally to promote healthy sexual behavior and has found they have been successful in influencing young men and women (Berne & Huberman, 1999).

In Romania, the Church’s conservative influence has resulted in a public outcry for sexual health education to focus on the morals and values of the Church emphasizing abstinence and the importance of marriage. Had the Church not fought so vehemently against the 2014 bill, it likely would have passed (Reproductive Health Specialist, Personal Communication, January 24, 2017). Without the influence of the Church, the Netherlands successfully provides autonomy through comprehensive sex

education for students to have the tools and skills to safely engage in sexual activity and make safe sexual choices (Valk, 2001).

Where religious Romanians have attempted to instill fear in the repercussions of comprehensive sexual education, the Netherlands have proven most of their arguments wrong. The Netherlands have extremely low fertility rates and high rates of contraceptive usage, especially at first intercourse (Ketting & Visser, 1994).

Organizations such as Planned Parenthood (2013) reference the Netherlands as a prime example of countries who have successfully reduced teenage pregnancy and highlight sexual education as the main contributor to the lower rates. Other research has also attributed low rates of teenage pregnancy to low barriers to reproductive health services, open-discussions on sexuality taking place in public spheres, and educational campaigns beyond sex education (Ketting & Visser, 1994).

Romania can certainly look to the Netherlands as an example of the benefits of decreasing the Church's influence in society and they can also look to the Netherlands to realize how citizens can be successful in making changes on a larger scale. Ketting and Visser (1994), explained unplanned pregnancy was deemed a societal issue by the people of the Netherlands, who decided it was a problem law-makers needed to address immediately.

Citizens, making their concerns about the problem known, were the catalysts that lead to legal changes and a more concerted effort of solving the problem made by decision-makers (Ketting & Visser, 1994). If Romanian citizens were to imitate the Netherland's show of political engagement they could be successful in holding the

government accountable for the influence and close relationships the church has with political leaders. They could also hold the power of emphasizing the seriousness of teenage pregnancy in Romania and vie for policy adoptions and program implementations.

## **5.2 Roma Population**

It is important to discuss, in conjunction with this research, the Roma population; what American's commonly refer to as gypsies. The Roma population originated in India and has lived in Europe for over a thousand years (McKee & Jajioff, 2000). For hundreds of years, located on Romanian territory, the Roma people were treated similar to slaves, they lived on the out-skirts of cities and towns and were not included in social developments, thus having no impact on greater society (Achim, 2004). Achim (2004) explains that when the Roma were emancipated from the harsh conditions created by the Romanian government, they were only done so by legal terms, with the country not addressing serious social and economic realities in their communities.

As one of the largest minority ethnic groups in Europe, the Roma population is largely discriminated against, oppressed, and stigmatized in society (Lee, Keyes, Bitfoi, Mihova, Pex, Yoon, & Masfety, 2014). The Roma population makes up approximately 3.6-4.3 percent of Romania and of that population around 79.4 percent of men and women do not have a profession (Achim, 2004). The Roma standard of living is below the norm for Romanian cities and rural regions, and the traditions

within the communities are not widely accepted beyond them. For example, one of the most contested traditions is child marriages which inherently lead to a gender-gap of access to education between girls and boys in the Roma community (UNICEF, 2010).

Understanding that the Roma population is oppressed within the Romanian context and that their traditions differ from the larger society's helps to explain why most citizens, when hearing about Romania's high rates of teenage pregnancies, attribute them solely to the Roma population (Reproductive Health Specialist, Personal Communication, January 24, 2017). Throughout this study several informal interviews were conducted with random Romanian citizens in the city of Cluj. They were asked only one question: "*What is your perception of teenage pregnancies in Romania?*" Many did not initially know how to respond, but almost all eventually explained while they did not know anything about it, it probably existed in the Roma communities.

Of the nine interviews conducted with professionals on the topic only two mentioned the Roma population, with both saying it is a serious problem in their communities but is equally problematic in the greater Romanian society. This is especially interesting because all interviewees were specifically asked "*Is it a problem of any ethnic, economical, or geographic subset?*". While average citizens quickly assumed teenage pregnancies were only prevalent in Roma communities, professionals who see the problem often knew this to not be true.

Average Romanian citizens' natural inclination to assume the Roma populations are the only ones contributing to this issue highlights a major problem in the lack of awareness of teenage pregnancy in Romania.

### **5.3 Recommendations**

Several of the interviews with stakeholders included a discussion on alternative solutions for decreasing Romania's high rates of teenage pregnancies and helping to propel forward and pass a national strategy. They included altered suggestions of programs that had been done in the past such as public and explicit campaigns aimed at concerned parents and adolescents, a means of offering sexual health education to a different cohort than students, creating and broadening the entire health field to alleviate stress from under-resourced organizations, and valuing the impressive amounts of data so many organizations collect.

#### **5.3.1 PSA Campaign**

One of the major findings discussed in Chapter 4 was the lack of awareness of the high rates of teenage pregnancies in Romania. Interviewees discussed Romanians not recognizing it as a problem could be a major reason citizens haven't pushed for a national strategy. The Public Health Specialist suggested, and many of the following interviews agreed, there would be value in launching public campaigns to raise awareness (Personal Communication, January 17, 2017).

These could take the form of campaigns aimed at parents informing them of the serious statistics plaguing their children's generation emphasizing why safe sex is the most efficient preventative measure. This would likely encourage a conversation within the family or increase a parent's interest in having their child exposed to sexual health education.

A social media campaign could also be adopted to empower youth and transmit why they deserve sexual health education in their schools to help prevent diseases and pregnancies. The Reproductive Health Specialist thought this would be a particularly useful campaign in Romania because it can be low cost and any number of family planning NGO's can take it on (Personal Communication, January 24, 2017)..

Creating a campaign that focuses solely on the empowerment of women in Romania could be useful in increasing the purpose low-income adolescents see for themselves. A major finding from the qualitative interviews was many adolescents who choose to give birth after getting pregnant are of low income, had a lower educational attainment, and felt a lack of purpose in their lives. Interviewees thought an approach that incorporated the empowerment of women could be useful in reaching adolescents who get pregnant because they feel a lack of purpose in their lives and research conducted in the US supports this.

Edin and Kefalas (2005), conducted a qualitative study in the Philadelphia area of low-income mothers. They sought to understand low-income women's values and morals when it comes to marriage and childbearing. Unlike traditional society, Edin and Kefalas (2005) found marriage and childbearing are not viewed as synonymous

among low-income women. Low-income women often place high value on children and are willing to give birth without economic and social stability in their lives which often takes the shape of teenage pregnancies (Edin & Kefalas, 2005). Similar to teenage mothers in Romania, low-income mothers in the US see having a child as providing purpose, even more fulfilling than marriage. Those interviewed in the study claimed they would rather have a child while poor and out of wedlock than wait and hope to find a suitable partner to have a child with (Edin & Kefalas, 2005).

Participants in their study, many of whom became mothers as teenagers, acknowledged adolescent pregnancy is extremely difficult and “not the best way to do things.” Therefore, campaigns empowering women and showing there is no shame in having children at older ages and other ways exist to find success in life could go far in helping these young women find a purpose (Edin & Kefalas, 2005; 65).

Creating a campaign where teenage mothers share their stories and experiences of having a child at a young age could influence both adolescents and parents to realize the gravity of this issue within Romanian society. The Social Worker and Pro-Life Clinician who both work with teenage mothers often thought this could be beneficial to show the realities of teenage pregnancies, but also acknowledged it may be difficult to find teenage mothers who feel comfortable being the face of such a campaign (Personal Communications, January 25, 2017). However, both agreed it would be worth the effort to find a few because the campaign has the potential to have a large impact.

The national government could also benefit from using similar campaigns to distribute information regarding any health strategy they choose to implement. The Pro-Life Clinician and Former Ministry of Health Worker both explained the government is not efficient in how they disseminate information on different policies which results in some people not paying attention to new policies and others to immediately fear what they are aiming to achieve (Personal Communications, January 25, 2017). Transparency on the national level would keep the public informed and educated on different policies the government is working on.

### **5.3.2 Parent Sex Ed Course**

A recommendation which could potentially have the support of both those in support of and against sexual health education implementation would be offering a sexual health education program to parents and guardians. The Social Worker initially recommended this alternative when expressing her own realities of being a parent and not knowing how to teach her children about sex. She then explained most schools have meetings throughout the year in which parents are expected to attend; those meetings instead could be turned into an opportunity for a health educator to discuss the importance of safe sexual relations and specifically how to disseminate the information productively from parent to child (Social Worker, Personal Communications, January 25, 2017).

This would allow the conversation of sex and sexual health to begin in the home and within the family, which is something the Church and the Pro-Life Clinician

highly value. While initially parents may not have incentives for attending the class, if the public campaigns recommended above were created they may help parents realize the benefits of learning this information and sharing it with their children.

The Health Educator explained during her training she learned the importance of engaging parents when trying to change health behaviors. She claimed most youths do not start making their own decisions about their lives until they are about 16 years old, so “parents must be the targets” (Personal Communications, January 17, 2017).

Social workers working with teenage mothers have also found many are looking for skills and classes to learn to become better parents. This could provide the perfect opportunity to educate parents who will then educate their children (Social Worker, Personal Communications, January 25, 2017).

### **5.3.3 More Data**

Another recommendation that would require compliance from NGOs, abortion clinics, pro-life clinics, social workers, and school medical inspectorates is a comprehensive database focused on sexual and reproductive health. The Social Worker, Child Protective Worker, Former Ministry of Health Worker, and Pro-Life Clinician all claimed their organizations had raw data but none were actually able to show me how to retrieve it or had it analyzed (Personal Communications, January 25, 2017).

Finding data in Romania surrounding this topic is extremely difficult and every stakeholder interviewed, except one, expressed concern over the lack of easily

accessible data on this issue. A Reproductive Health Survey conducted large studies which generated great data on sexual and reproductive health in Romania.

Unfortunately, they only offered the surveys in 1993, 1999, and 2004, and only the 1993 and 1999 data are available as raw numbers (Romanian Ministry of Health, 2005). No explanation for why these studies stopped being conducted was found, but the timing does match up with when international organizations stopped giving Romania resources for sexual and reproductive health.

Combining basic data on the number of pregnant teenagers, number of abortions by age groups, teenagers bringing their pregnancy to term, as well as several other indicators could help create a pool of data that can be used to better understand the complexities of this problem and inform future programs and policies.

#### **5.3.4 Health Educator Field**

A final recommendation and possibly the most important is to grow a cadre of health education professionals in Romania. The Public Health Specialist and Health Educator both claimed, and the Biology Teacher's interview supported, that the resources in Romania at present are not robust enough to support a sexual health education strategy (Personal Communication, January 17-23, 2017).

Currently a health education field does not exist within Romania, and students who are interested in the topic must leave the country to gain a substantive education in the field (Health Educator, Personal Communications, January 17, 2017). While this will new field will take years to cultivate in Romania, the need for health educators

will continue to grow alongside. Rather than pull resources from teachers and NGOs who have a plethora of other tasks to focus on, having a singular field whose one job is to disseminate health information would be invaluable.

The Health Educator also explained while working towards her degree she was taught a specific way sexual health education should be taught. It should be taught by both a man and a woman so both perspectives are heard, they should not be associated with the school so students feel comfortable fully participating, and the educators must make it engaging and creative so students digest the information and can easily recall it (Health Educator, Personal Communications, January 17, 2017).

## **Chapter 6**

### **CONCLUSION**

This study has examined the barriers that exist to implementing a national strategy for sexual health education in Romania as a means of decreasing rates of teenage pregnancies. While several barriers exist, they all exist on the societal level of the Social-Ecological Model, meaning to overcome the barriers changes must be made on the national level. At present, the new Romanian government does not seem to consider breaking down these barriers to be imperative to the well-being of its citizens. For changes to be made and teenage pregnancy rates to decrease, Romanians are going to have to recognize their right to comprehensive sexual education and demand it be provided by their government.

This final chapter first recognizes the limitations of the research conducted. Next, it discusses suggestions for future research and studies. Finally, it ends with an implementation strategy and what is necessary for change to occur.

#### **6.1 Limitations**

A major limitation in this study was few interviews were conducted with people who are opposed to a national strategy. Many organizations and individuals refused to be interviewed when they learned the research was on sexual education.

The literature on the opposition's perspective was plentiful, but actual interviews, anecdotes, and narratives would have been much more appreciated.

Time restraints also limited the study to in-person interviews with professionals in Cluj and the surrounding area. Email correspondences only took place due to extreme circumstances and were discouraged as time was to be spent meeting and interacting with people directly. This problem disproportionately affects people from rural areas. Not having the time to interview stakeholders from the poverty-stricken regions which see this problem often was a major limitation.

## **6.2 Suggestions for Future Research**

There is considerable room for future research on this topic. Speaking to minors and teenage mothers would provide a key narrative that could be instrumental to understanding the full scope of the problem. It would have been useful to identify whether students perceive teenage pregnancies to be a problem and how they think it might be addressed.

Also, research on how modern adolescents receive information regarding sexual and reproductive health and how accurate their information is would be important to know. This requires interviewing adolescents, which entails a more rigorous IRB review but would offer information researchers cannot gain from only speaking to adult professionals. Hearing the adolescent narrative is the key to better understanding this problem fully. Talking with the adolescents could also provide

answers on how to better target the recommendations mentioned in Chapter 5 to their generation.

Future research should also engage with teenage mothers to learn if they ever received sexual health education, why they chose to have their child, what resources from the government they use, and how they handle living in modern society with a child would be useful narratives to better understand how the problem manifests itself and the effects it has.

### **6.3 Implementation Strategy**

These different recommendations bring with them the question of who will be charged with their implementation. When asking this question, considering the theoretical framework and how policies on the society level have the greatest influence, the obvious answer is the government.

If the government chose to take on these initiatives they would be sure to reach the Roma populations, those in the rural areas, and of lower socioeconomic status who are all at higher risk for teenage pregnancies. However, with the present state of the Romanian government it is unlikely they will adopt these recommendations, especially because of the topic they surround.

Moving forward it will depend on NGOs, activists, and professionals in the field to take on this responsibility. If these entities can engage and enrage the public, help them see it is their right to comprehensive education on sexual and reproductive rights and something they deserve in this modern age movements can be made. In the

past two months since this study was conducted, Romanian youths proved the Reproductive Health Specialist wrong and created large demonstrations throughout the country to protest a new law that would make it legal for governmental officials to be corrupt. It showed they were engaged citizens and their protests eventually led to the retraction of the law.

If Romanian youths were to become as outraged that the government was actively working to limit their access to pertinent information regarding their safety in sexual relations, it could be enough pressure for them to adopt some of the recommendations provided above.

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Appendix

IRB EXEMPTION LETTER