Output #4: ***(i) Mapping source communities for children living in Residential Centers, (ii) evaluation of the resources that might be used to compensate for the closing of Residential Centers, and (iii) evaluation of the effectiveness of community-based services***

English version

MINISTERUL MUNCII
ȘI JUSTIȚIEI SOCIALE

Autoritatea Națională pentru
Protecția Drepturilor Copilului și Adopție

Agreement for Provision of Technical Assistance on Development of Plans for the Deinstitutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care (P156981)

OUTPUT #4: *(i) Mapping source communities for children living in Residential Centers, (ii) evaluation of the resources that might be used to compensate for the closing of Residential Centers, and (iii) evaluation of the effectiveness of community-based services*

This report was prepared under the Reimbursable Advisory Services Agreement between the International Bank for Reconstruction and Development and the National Authority for the Protection of Children's Rights and Adoption, concluded on May 12, 2016, for the implementation of the project "Development of the Plan for the Deinstitutionalization of Children in Residential Care and Their Transition to Community-Based Care" - code SIPOCA 2, funded by the European Social Fund under the Operational Program for Administrative Capacity. This report is part of Output 4 under the Agreement.

Acknowledgements

Output #4 under the Reimbursable Advisory Services Agreement on Development of Plans for the Deinstitutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care was developed under the supervision of Mr. Cem Mete, with overall guidance from Ms. Tatiana Proskuryakova.

Data collection and report preparation activities were coordinated by Mr. Emil Teșliuc, Mr. Vlad Grigoraș (team leaders), and Ms. Manuela Sofia Stănculescu. The document received contributions from a team of 69 consultants, comprising 22 professional social workers – members of the Romanian National Association of Social Workers (CNASR), 24 sociologists, and 23 research assistants. The following people contributed to data analysis and report preparation: Simona Anton, Diana Mioara Ardelean, Elena Cătălina Iamandi Cioinaru, Bogdan Corad, Cristina Cornea (Vladu), Adrian Dușa, Marinela Grigore, Lavinia Iagăr, Eugen Lucan, Monica Marin, Mihaela Moțoc, Marcela Neagu, Oana Perju, Emilia Sorescu, Andreea Stănculescu (Trocea), and Mihaela Zanoschi. Monica Lachner translated portions of Output #4 into English. The report was peer reviewed by Aleksandra Posarac (Lead Economist, GSP03) and Yulia Smolyar (Sr. Social Protection Specialist, GSP03). The team also received support from Andrei Zambor, Monica Ion, Corina Grigore, Oana Caraba, and Alexandra Călin.

The World Bank would like to acknowledge the excellent cooperation, guidance and timely feedback provided by the ANPDCA representatives, in particular by Ms. Gabriela Coman (President), Ms. Elena Tudor (Project Manager) and Ms. Simona Oproiu (Responsible with the monitoring of the Outputs 2 and 4). Also, the World Bank would like to express its gratitude to all public employees who got involved in data collection. The World Bank team would like to particularly thank the directors of General Directorates for Social Assistance and Child Protection (DGASPC), the mayors of the 35 source communities, coordinating school principals and the physicians from those communities, for their cooperation.

Also, the World Bank team would like to thank the main child protection NGOs, as well as UNICEF and other institutions which lent their support throughout the data collection process.

Equal opportunities and equity

All project activities were designed and implemented for the equal benefit of boys and girls, men and women. The project team and experts received equal treatment, regardless of gender, ethnic origin, or other characteristics.

Sustainable development

During project implementation, the World Bank team aimed for a wise and effective use of resources to protect the environment and ensure social cohesion. Every citizen and institution should bear in mind that sustainable development is the only way to meet human needs without undermining the integrity of natural systems and the future of humanity as a whole.

CONTENTS

LIST OF FIGURES, MAPS AND TABLES

List of figures

List of maps

List of tables

ACRONYMS

AMP	**Professional foster carer**
ANPDCA	**National Authority for the Protection of Children's Rights and Adoption**
AP	**Apartments**
APL	**Local Public Authorities**
WB	**World Bank**
SEN	**Special educational needs**
CNASR	**Romanian National Association of Social Workers**
CP	**Placement center**
CTF	**Group home**
DGASPC	**General Directorate for Social Assistance and Child Protection**
HCL	**Local Council Decision**
HHC	**Hope and Homes for Children Romania**
ISJ	**County School Inspectorate**
MEN	**Ministry of National Education**
MMJS	**Ministry of Labor and Social Justice**[1]
NGO	**Non-governmental organization**
ROP	**Regional Operational Program**
PNDR	**National Rural Development Program**
PFam	**Family placement**
TD	**Technical design**
SPAS	**Public Social Assistance Service**
FS	**Feasibility study**

[1] Called the Ministry of Labor, Family, Social Protection and the Elderly (MMFPSPV) until January 2017.

Output #4:

Executive Summary

EXECUTIVE SUMMARY

Context and Structure

This diagnostic study was carried out under the Reimbursable Advisory Services Agreement concluded for the *Development of Plans for the Deinstitutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care*, between the World Bank and the National Authority for the Protection of Children's Rights and Adoption (ANPDCA), on May 12, 2016. The Agreement covers the implementation of the ANPDCA project – "Development of the Plan for the Deinstitutionalization of Children in Residential Care and Their Transition to Community-Based Care" – code SIPOCA 2, funded by the European Social Fund under the Operational Program for Administrative Capacity.

Between December 2017 and April 2018, the World Bank team collected and analyzed the data needed to prepare the fourth deliverable under the Agreement (Output #4). This report is a continuation of the first three deliverables, already submitted to the ANPDCA (in February, May and November 2017), as well as an opening for Output #5, which will be developed in the following months and will focus on the plans to develop preventive and support services for children and families at community level.

Output #4 focuses on all four strategic lines of action for the deinstitutionalization of children deprived of parental care provisioned in the "National Strategy for the Protection and Promotion of Children's Rights 2014-2020". Thus, Part 1 presents an update on the closure status of placement centers for children in Romania. Part 2 maps out and analyzes alternative services to residential care, being organized into three sections, as follows: (A) the foster care network (AMP); (B) the network of family placements with relatives and other families or people (PFam); (C) small-sized residential care services, that is group homes (CTFs) and apartments (APs). Part 3 analyzes the case management, more precisely the capacity of the current network of case managers to ensure the timely delivery of good-quality services that meet the needs of children and youth in special care. Part 4 discusses the availability of services for a number of 35 source communities. The report is complemented by 35 stand-alone reports at county level and by an extensive methodological document.

Data

The whole analysis looks at all 35 Romanian counties where there is at least one placement center for children. The data was collected between February and March 2018 by a World Bank team[2]. Output #4 benefited from a workshop with the National Authority for the Protection of Children's Rights and Adoption (ANPDCA), social workers from the Romanian National Association of Social Workers (CNASR), and the General Directorates for Social Assistance and Child Protection (DGASPC), organized by the World Bank at Brașov, from February 5th to February 8th, 2018.

In the field research, 35 interviews with DGASPC directors, 12 interviews with County Council (CJ) presidents (vice-presidents or secretaries), and three interviews with mayors were conducted, from all the counties with at least one placement center for children.

Data collection on professional foster carers has been structured in four distinct stages: (1) making a face-to-face interview with the Head of the AMP Department (or similar) from DGASPC; (2) completing the census of professional foster carers with a limited set of information; (3) the random selection of a sample of 592 AMP that filled out a questionnaire on both the AMP and the children placed at him/her and (4) the selection at each county level of 1-4 case studies. Only AMPs certified by DGASPC were

[2] The research team included professional social workers, members of the NCSAR, sociologists and research assistants. GDSACP specialists, serving as heads of departments, inspectors, counselors, case managers, referents, social assistants and psychologists, also attended data collection.

included in the research, regardless of whether they had children in care at the time of the research or not.

For studying Pfam, in the first stage, a face-to-face interview was conducted with the Head of the Case Management Service or Family-Type Foster Care (or similar) services within the General Directorate for Social Assistance and Child Protection, in connection with county-wide practices. In the second stage, the census of family-type foster care (PFam) was supplemented, containing a small set of information. In the third stage, a sample of 774 PFam was randomly selected, to which a questionnaire was provided in connection both with the foster family, and with the children under their care. The questionnaires were filled out together with the children's case managers, within the General Directorate for Social Assistance and Child Protection, in reliance upon the data existing in their files. In the last stage, 1 to 4 case studies were selected from each county, totaling 57, which were targeted by the social assistants within the World Bank team by on-site visits conducted together with the case managers of the General Directorate for Social Assistance and Child Protection.

Data on small-sized residential care services have been collected in three stages: (i) the first step consisted in the performance of a census of small-scale residential services (AP and CTF) and comprised a limited set of information, applied to each institution, irrespective of whether the institution hosted or not children and youth at the time of the research; (ii) during the second step, a random sample was selected comprising 96 APs and 266 CTFs, to which a desk assessment questionnaire was administered; (iii) in the last step, 1-2 CTFs were selected from each county for case studies, in total 50, which were conducted by the social workers in the World Bank team by means of field visits, together with DGASP case managers. Overall, during the census, 98% of the CTFs and 73% of the APs were functional, out of the total existing services.

For the collection of data on case management implementation at county level, interviews were conducted with DGASPC management representatives and with case managers. In this research, case managers were selected for interviews based on two criteria: (1) the case manager has at least one active case of a child with a special protection measure in place and (2) the case manager is not the service provider. Using these two criteria, 785 case managers were identified, but face-to-face interviews were conducted with only 675 of them.

Closure Status of Placement Centers for Children in Romania

This section discusses the closure of placement centers for children in Romania. We would like to mention that, in our understanding, the deinstitutionalization of children should be child-centered and planned for the best interests of the children and youth living in those institutions. Thus, all deinstitutionalization efforts should take into consideration that no child would be moved out of the place where she/he is unless a better care option is found.

The current situation at national level shows that deinstitutionalization efforts continue to face major challenges in Romania. They come from the large number of placement centers with small chances of being closed down by 2020, the increasing number of children living in centers which are currently not in the process of closure, as well as a series of obstacles identified by DGASPC directors during the closure process. More than half of the centers have small (or zero) chances of being closed down by 2020. The other 40% (or 60 centers) are in the process of closure, either in the initial stage (23 centers) or in a more advanced stage (37 centers). The number of children diminished only in the centers declared to be in the process of closure and it increased in all the other types of centers.

The "hard core" of deinstitutionalization efforts in Romania comprises a number of 87 placement centers for children with relatively small chances of closing down by 2020. More than that, for 56 centers, the DGASPCs say that "closure is not envisaged to take place now or in the future". The share of centers that the DGASPCs do not want to close down is significantly higher among centers without youth aged 18+, but with children under 3, among those with children with disabilities, especially with profound disabilities, as well as among centers with juvenile offenders or with a high share of children with risky behaviors.

The project implemented by the World Bank and the ANPDCA, aimed at the "Development of the Plan for the Deinstitutionalization of Children in Residential Care and Their Transition to Community-Based Care" (code SIPOCA 2), has provided substantial support to the closure of placement centers in Romania. Based on the methodology developed under Output #2 and refined under Output #3, with the e-cuib application, 29 centers have already completed the multidisciplinary evaluation of all children and youth. In addition, another quarter (15 centers) of the centers likely to be closed down either already use the e-cuib application or intend to use it in the future. Overall, the 60 placement centers with high chances of being closed down by 2020 accommodated almost 2,750 children and young people, that is 51% of all children in institutional care, as of February 1st, 2018.

The deinstitutionalization process should continue in a way that takes into account the problems/difficulties identified in this research. The most frequently mentioned problems have to do with land, namely identifying and procuring it, but also with related permits and documentation. Second, the limited institutional capacity of the DGASPCs to implement concurrently several EU-funded projects is highly relevant if we consider that almost half (69 centers) of all placement centers nationwide are concentrated in nine counties. Third, center employees oppose the closure of some centers, mainly because they are offered alternatives that are not considered acceptable. Fourth, problems at community level concern the need to develop preventive and support services for children and families, as well as the need to improve acceptance of special child protection services. There is also a feeling of frustration among the DGASPCs with a relatively small number of centers. During interviews, several DGASPC directors emphasized that: "those who have done nothing until now are more favored" or "performance is punished", since "Romanian counties split into three categories as regards child deinstitutionalization. There are counties which have closed down the CPs and have set up alternative services, counties which have modernized the CPs, and counties which have demonstrated a lack of involvement and strategy for 20 years. The latter are very unlikely to actually do anything now, even with the available funds". In addition, there are also cases of centers where, in the latter programming period, the funds available in the Regional Operational Programme (ROP) have been used for improving the living conditions. For these residential centers, one of the conditions in the financing contract from ROP funds was that the centers should be functional for a number of years.

Other obstacles to the application for EU funds aimed at the closure of placement centers are raised by ROP rules or child protection regulations. ROP-related difficulties concern: (1) the need to finance and rehabilitate buildings, along with new constructions; (2) the cost covered by ROP, namely EUR 395/m2 of new construction, which is too small and requires a substantial financial contribution from the county council; (3) the condition of having a day care center per project is considered unrealistic in terms of sustainability; (4) the conditions for minimizing the risk of creating new services that deepen social or spatial segregation (by expanding or maintaining the current communities of social service beneficiaries). Obstacles related to child protection regulations are: (1) the absence of minimum quality standards for CTFs; (2) the need to update standard costs, which are currently less advantageous for CTFs than for placement centers, especially in the case of children with disabilities.

The Foster Care Network (AMP)

The analysis provides information on: (i) the AMP network; (ii) the profile of children placed on AMP; (iii) the relevance of the AMP network for the closure of children placement centers; (iv) the implementation of standards and case management in AMP, and (v) the effectiveness of AMP services, along with examples of good practice extracted from the case studies.

The current development of the AMP network reflects the history of the AMP network establishment at national level but also the different DGASPC options. In February 2018, AMP services covered almost 8,250 AMPs that cared for more than 13,700 children and were monitored by about 290 case managers. The data on the first active AMPs attestation, identifies the following stages of development of the AMP network, until February-March 2018: (i) between 1998-2001, the capacity was developed at about 20% of the current one; (ii) 2002-2006 when it increased to over 70% of the current capacity; (iii) 2007-2012 with slow growth and (iv) 2012-present, with a stage of expansion to the current capacity. However, some counties have experienced different developments. While counties like Valcea or

Prahova have developed the entire network since 2005, counties such as Constanţa, Dolj, Gorj or Tulcea had less than half of the current network in 2005 and expanded it only after 2011. The average experience as AMP is 11 years (with a minimum of several days and a maximum of 20 years), with inter-county differences given by the network development history at each county level.

The profile of foster carers does not differ significantly between counties. Out of the AMPs, 92% are women aged 21 to 81 (with an average age of 50) and with an average level of training (over 84% of AMPs graduated from vocational school or high school). The youngest AMP networks (46-48 years average age) are in Gorj and Dolj counties, developed largely after 2011, while the highest average age (53 years) networks are in the counties of Alba, Braşov, Covasna and Prahova. AMP education level wise, if the national network includes only about 12% of the AMP who graduated, at most, secondary school, four counties are different, with considerably higher weights, namely: Satu Mare (40% of AMP) , Caraş-Severin and Iasi (with 25% of AMP each) and Timiş (17%).

The size of the AMP network varies substantially between counties. The number of AMPs in the county network varied between a minimum of 75-76 in the counties of Ialomita, Ilfov and Salaj and a maximum of 795 in Iasi. At the same time, the number of children cared for by AMP in February 2018 as a share of the total number of children cared for by these AMP ever (from the first attestation) varies between a minimum of 26% in Arad county and a maximum of 69% in Caras- Severin. In total, the current AMP network has cared for 28,103 children over the past 20 years (between 1998 and 2018). Consequently, children placed in AMP in February 2018 accounted for almost half of all children ever cared for by the current network.

The way the AMP network is used at county level reflects structural influences in the evolution of the special protection system for children in Romania. These are represented on the one hand by the underdevelopment of other types of services, by the poor results regarding the achievement of ICP objectives for family reintegration and adoptions (very low number) and on the other hand, by the large number of children in the special protection system and the large number of entries in the system (especially by maternity abandonment). Thus, although AMP services were been introduced as a temporary care solution in a family environment for children left without parental care (especially for young children), these services have become long-term care solutions, at least in some counties (such as Caras-Severin, Maramures or Neamt).

The territorial distribution and the monitoring of the AMP network at county level differs significantly from one county to another. However, there is a common model of organizational structure- in all counties, DGASPC has a service or a department dedicated to AMP or family-type services (AMP and family placements). In terms of territorial distribution, the network has a high level of territorial concentration, both in the rural and urban areas. Thus, 25 of the cities concentrate 46% of all urban AMPs and 106 of the communes concentrate 43% of all rural AMPs. On average, the AMP/CM ratio is 28 at national level, with variations between 10 (in Alba and Valcea counties) and over 95 (in Suceava). At the same time, in two counties- Constanta and Ilfov- there are no case managers for AMP.

The profile of children placed in AMP includes boys and girls aged 4-14. Approximately 28% of them have one or more of the following special needs: disabilities (20%), SEN (15%) or other special needs (13%). About 30% of AMP-fostered children have at least one sibling placed at the same AMP.

The relevance of the AMP network for the closure of children placement centers is relatively low for the following reasons: (1) the estimated potential capacity is particularly low in six counties, some with many placement centers that should be closed (Harghita, Iasi, Sibiu , Valcea); (2) the profile of children cared for by AMP is very different from that of children in placement centers; (3) only about half of the AMPs are willing to take children aged 15 and above; (4) only 17% of the AMPs express their consent to receive in foster care a child with disabilities, and half of them already have a child with such health problems; (5) the analysis of children care for, throughout time, in the AMP network and that were no longer placed at the same AMP in February 2018 shows that the AMP network is highly

relevant for the adoption process. In addition, the same kind of analysis shows that the AMP service has fed the placement centers, especially in recent years.

The Mandatory Minimum Standards (MMS) to ensure child protection at AMP are partially implemented at county level. According to case managers, almost all children placed in AMP have received an initial or detailed assessment before the protection measure, and almost all children in AMP care have an individual care plan (ICP). However, only about 42% of AMPs, according to DGASPC case managers, and 32% according to AMP statements, received a copy of the initial assessment report. Similarly, only part of AMPs received copies of the ICPs and individual service plans (ISP) for the children they have in foster care. Likewise, nearly one-third of AMPs did not take part in designing the ICPs for the children they foster, and most AMPs receive maximum a quarterly visit (not monthly, according to standards).

The Mandatory Minimum Standards (MMS) to ensure child protection at AMP are poorly known by some case managers. One of the six CMs stated that they did not know Order no.35/2003 regulating these standards. Almost 40% of CMs had problems in identifying the code corresponding to the standard they wanted to mention, although the research team made the Order available to them. Case studies showed that of the 51 AMPs visited, only 30 knew that there was a clear and transparent procedure for situations in which a AMP is incriminated and only 38 would know how to proceed if they were incriminated.

The minimum mandatory standards best met by AMP are MMS 6- ensuring a healthy, safe and incentivizing environment and MMS 1- ensuring services that promote diversity acceptance, that lead to the increased self-esteem of the child and the development of the usefulness feeling, that value and respect the ethnic, cultural and linguistic past of each child, that develop abilities to overcome discriminatory situations, that provide opportunities for developing the child's talent, interest or passions as well as specific support and recovery services for children with disabilities. However, these are also the most difficult standards to meet, along with: (i) maintaining and developing relationships with the family and friends (MMS 9)- difficulties in maintaining/encouraging contact with parents living abroad, with parents/relatives without a stable or known residence, with parents that do not want to keep in touch with the child or with parents in different difficulty situations; (ii) developing independent living skills (MMS 12), because "out of too much love, do not ask the child to do anything"; (iii) meeting the child's educational needs (MMS 11), particularly because of the discrimination in schools both by teachers and colleagues.

The training needs of AMPs are partly known, addressed and centralized in documents or databases. The situation at national level shows that in the 35 counties only 56% of AMPs received additional training in 2017, most of them (32%) receiving 1-8 hours of training. Additionally, the training needs are identified for only 43% of AMPs and only 29% of these needs are recorded in a document/database. However, the Heads of the AMP Services in 23 counties (out of the 35 surveyed) stated that there is a clear picture on the training needs of the AMP network. The training needs identified by them concern: (i) developing parental skills for interacting with adolescents, in particular for behavioral disorders cases, the development of independent life skills and sexuality; (ii) developing skills to work with and integrate children with disabilities. The social workers in the research team, following the field visits, added two topics to the training needs, namely: (iii) managing the relationship between the AMP and the child to reduce the child´s dependence on the carer, and (iv) identifying trauma and working with children with trauma.

The performance of the AMP network in childcare has been assessed as good for all needs and by all evaluators- heads of AMP Services within DGASPC, CMs monitoring the work of AMPs or AMPs themselves. However, as an institutional practice, DGASPCs do not systematically measure the satisfaction level of either children or AMPs. Regarding the costs associated with AMP services, the data provided by DGASPC is weak. Approximately one-third of the Heads of the AMP Services within DGASPC believe that an additional monthly financial support of 250-300 lei per child would be needed,

in order for the service to be attractive for AMPs, and around 300-350 lei per child, so that the child's access to certain services that he needs is not to be denied, postponed or canceled.

The Network of Family Placements with Relatives and Other Families or People (PFam)

The analysis contains information in relation to (i) the family-type foster care network; (ii) the profile of children under family-type foster care; (iii) the relevance of the PFam network upon closing care homes for children; (iii) implementation of standards and case management to PFam; (iv) efficiency of family-type foster care, together with best/worst practices.

In Romania, family-type foster care services are broken down into: (i) foster care provided by relatives up to the fourth degree and (ii) foster care provided by other families or persons, namely relatives, other than up to and including the fourth degree, kin, acquaintances or friends of the family or of the extended family of the child, with which the latter has built an attachment or together with which they enjoyed a family life. The entire network of Pfam is structured as follows: 72% with relatives, 27% with other families or persons, and 1% in mixed foster care (with several children, among which some with relatives and others with other families). Nevertheless, county networks significantly varied between the network existing in the county of Covasna containing 89% PFam to relatives, 11% to other families/persons and no mixed foster care, and the network existing in Teleorman, where 50% of foster care was provided by other families/persons, 48% by relatives and 1% mixed foster care. At any rate, irrespective of the caregiver indicated when the measure was first set up, most of the children live, in fact, in a family, and were given either in the care of a couple, or of a married person.

The current family-type foster care network was set up in three stages. Starting from the date when they received the first children under their care, the current PFam network (carrying for one or several children in February-March 2018) developed at a slow pace between 1994 and 2004, until 7% of its current capacity. The growing pace of the network increased from 2005 until 2014, when it reached almost half of its current capacity. Between 2015 and March 2018, the family-type foster care network virtually doubled and reached the 11,300 foster families with 14,500 children under their care.

The size of the network widely varies across the counties. The number of PFam in the county network ranges between a minimum of 124 and a maximum of 705. Furthermore, in February 2018, the PFam network provided care for approximately 14,500 children. The general model (more than 91%) is 1 to 2 children under the care of the Pfam.

Overall, the family-type foster care network contains almost 16,100 caregiving persons. More than two thirds (66%) of these persons are women. The percentage of women is considerably higher (more than 75%) in foster care provided by a person and in two counties - Alba and Ialomița. Almost half of caregiving persons have graduated no more than a secondary school: 6% are illiterate, 16% have only graduated primary schools, and 29% have graduated secondary schools. At the other end of the spectrum, only 8% of caregivers have graduated an educational institution higher than high-school. The level of education is significantly lower for women, than for men. In general, older county networks and those with more women have an average education level lower than most recent networks and those with fewer women.

The PFam network in the 35 counties is spread in 320 towns and municipalities and 1,930 communes. The network has a high level of territorial concentration, both in the rural environment, and in the urban environment.

Children placed under the care of PFam are to an equal extent boys and girls, of all ages, particularly between 4 and 17 years of age. A percentage of 12% among them have one or several of the following special needs: disabilities (9%), special educational requirements (7%) or other special needs (4%). The percentage of children with special needs is significantly higher among children in the foster care of

other families/persons (17% as compared to 10% among children in the foster care of relatives or in mixed foster care).

Only few counties have a department or office dedicated to family-type foster care. In most counties, the Case Management Department is in charge of monitoring children given in family-type foster care. There is no social assistant or CM for foster families or persons, as it happens in the case of professional foster parents.

In terms of relevance upon closing care homes for children, family-type foster care services bear, most likely, little relevance, in the absence of continued efforts by case managers. Family-type foster care depends on the existence of extended family for the child and on the efforts of case managers to identify relatives or other families/persons willing to take the child in their care. In that respect, the situation of children and youth in care homes is unfavorable. Many of them have arrived in the protection system after having been abandoned after their birth in maternities, while others have been in the system too long.

Different counties employ different practices in the management of family-type foster care. Family-type foster care is accredited as a department of the General Directorate for Social Assistance and Child Protection only in 8 out of the 35 counties under review, according to the heads of Case Management Departments (or for PFam or similar Departments) which we interviewed. In February-March 2018, 14 counties had no written document approved/endorsed by the General Directorate for Social Assistance and Child Protection, containing standards governing the family-type foster care. Furthermore, the social assistant or case manager for the child in PFam should monitor the child's situation by regular visits, at least once a month. Nevertheless, the documentary assessment of family-type foster care services reveals that most foster families/persons are paid visits no more often than once every three months.

As a whole, however, the PFam network saw a positive evolution over time, in particular in terms of the financial and economic conditions and housing conditions of foster families. Given the significant percentage of grandparents, it is understandable that the health condition worsened for 11% of the PFam.

The performance of child care achieved by the family-type foster care network is good, being assessed between 7.6 and 9.8 (on a scale of 1 to 10), in connection with all types of needs and by all appraisers – Heads of CM/PFam (or similar) Department within the General Directorate for Social Assistance and Child Protection, CMs monitoring the children in PFam or the foster families/persons themselves.

The network of small-sized residential care services, that is group homes (CTFs) and apartments (APs)

The RezMic study presents: (i) the network of small-scale public residential services (RezMic); (ii) the clusters of small-scale residential services; (iii) the territorial distribution of small-scale residential services; (iii) the profile of the children placed in RezMic services; (iv) the relevance of the RezMic network for the process related to the closure of placement centers for children; (v) the care-taking environment in the small-scale residential services;(vi) the efficacy of the RezMic services, together with examples of best/bad practices.

The current AP/CTF network was established along three phases. The first phase (between 1990 and 2000) was characterized by a very slow development rate, of up to 10% of the current capacity. During the following seven years (between 2001 and 2007) the network reached the level of up to 77% of the current number of CTFs and up to 84% of the current number of apartments. In the last phase, which started in 2008, the development rate reverted to the rate recorded during the first phase. Nevertheless, the establishment year of the first small-scale residential service is not indicative for the average years of service of the county network. Thus, even if a county developed the first service in the beginning of the '90s, the county in question may have a county network of an average or

relatively low number of operation years if it has established, more recently, several such services. The length of service of the county networks varies, from a maximum of 19 years in Călărași County to a minimum of 7 years in Vâlcea and Bistrița-Năsăud Counties, with an average length of service of 13 years.

The networks of small-scale residential services are significantly different among counties. In 12 counties there were less than 5 CTFs in operation, while in Maramureș there were 27 CTFs, in Mureș 36, while in Harghita 39 CTFs. These three counties alone concentrate 29% of all available CTFs. A similar situation is also recorded for apartments, with 64 apartments in Teleorman, 32 in Mehedinți, 31 in Caraș-Severin and 29 in Botoșani. These 4 counties alone concentrate half of all available APs. Furthermore, more or less territorially or socially-segregated communities of service beneficiaries were established in 18 counties. The largest RezMic clusters are found in Mureș county - 11 CTFs (83 children and youth, in Sâncraiu de Mureș) and in Mehedinți county - 21 apartments (with a total capacity of 48 places, yet hosting only a number of 5 children upon the time of the research, in Drobeta Turnu-Severin).

The residential services (AP, CTF or placement centers) are sometimes used at the full capacity thereof, but there may also be certain situations or timeframes when they operate under or above capacity. The services operating above capacity accounted for 17% of the CTFs and 10% of the APs, while the services with available places accounted for 55% of the CTFs and 31% of the APs. Only approximately one of four CTFs and one of three apartments operated according to their capacity.

The networks of CTFs and apartments present a high degree of territorial concentration. The network of CTFs is concentrated both in the rural area, as well as in the urban area. Half of all children and youth living in the CTFs in the urban area are concentrated in a number of 16 cities/municipalities. Similarly, half of the children and youth placed in the CTFs in the rural area are concentrated in 16 of the communes. The network of apartments is almost fully located in the urban area. There are only two counties which established APs also in the rural area, namely Botoșani and Iași. The network of APs comprises 41 cities and municipalities and 3 communes, from 24 counties. In the urban area, more than two thirds of all children and youth placed in APs are located in 9 cities/municipalities. This territorially concentrated geographic distribution is rather unfavorable to the process concerned with the closure of the placement centers.

The profile of the children placed in small-scale residential services indicates the existence of a larger number of boys than of girls, mostly in the age group 4-17. The children with disabilities account for more than a third of the children and youth placed in the CTFs and for 19% of those placed in apartments. In general, among the children and youth with disabilities, predominant are the children with severe disability rating certificate in the CTFs and those with small and medium disability rating certificate in the apartments. Groups of siblings are found in about three quarters of the CTFs and in about half of the APs. Over one third (35%) of the CTF beneficiaries had one or more siblings in the same CTF.

Most likely, the network of small-scale residential services represents the most relevant alternative for the closure of placement centers. Although not representing family-type alternative services when compared to the placement centers, the apartments and the CTFs provide the children with conditions that are much closer to the family environment. Moreover, the relevance of the RezMic network derives from: (i) the weak capacity of the current networks of alternative services (AMP and PFam) to take over the children and youth from the placement centers scheduled to be closed, (ii) the insufficient number of beneficiaries who leave the system (by reintegration into the family and by adoption), as well as from (iii) the prevailing profile of the children and youth in the placement centers.

Each county prepares/uses its own definition of residential services. Consequently, at territorial level, between counties but also within some of the counties, there is a variety of methods employed to

designate, declare and register the centers, the CTFs and the apartments. The research team identified cases where structures such as a grouping made of the ground floor and the second floor of a building, small houses, wooden shacks, duplex houses, or even apartments in a residential building, were designated and registered as CTFs. The high diversity of practices leads to lack of clarity and to the impossibility of preparing policies that could generate a potentially significant impact.

Most of the apartments and CTFs comply with all modulation requirement proposed under Output #1. Nevertheless, approximately 8% of the CTFs and 15% of the APs are only falling under the category of 'partly modulated'. The 50 CTF case studies revealed that the children living in one third of those CTFs did not have a sufficient personal space except for their bed (shelf, small cabinet, nightstand, desk etc.) and also the fact that, also in one of the three CTFs subject to analysis, the children's spaces were not personalized with photographs, posters or drawings posted on the wall near their bed.

The shortage of staff employed in the RezMic services is significant. The DGASPC representatives claimed that 35% of the CTFs and 33% of the apartments were confronted with a shortage of teaching and care-taking staff. Also, a shortage of specialists was also indicated for almost 40% of the CTFs and also of the APs. Finally, the staff is deemed as a „weakness" in one of every five CTFs and APs respectively.

The quality of childcare in the RezMic services is analyzed along three dimensions: (i) the services and activities available in the AP/CTF for child development, (ii) the interactions between children and the staff and (iii) the implementation of case management.

Many of the CTFs/APs provide different types of services, depending on the specific needs of the beneficiaries, to the extent of the available human, material, financial and institutional resources. The APs/CTFs provide access to suitable educational services for almost all the children. Recovery/rehabilitation services are provided to the children and youth in 44% of the CTFs and 33% of the APs. More than three quarters of the CTFs provide homework support activities, participation in trips and camps - at least for some of the children and organization of birthday parties for each child. The CTF case studies reported that the independent life skills development activities for children and youth who are 14 years old and older, are performed only by some of the CTFs. Also, the Children's Board is only organized in some of the CTFs and not in all of them.

As to the interaction between the children and the staff, the social workers in the research team, by means of direct observation, indicated in their field reports signs of positive interactions in 40 of the 50 CTFs where field visits were conducted. In the other 10 institutions, the observations indicated negative or neutral interactions.

The quality of services provided to the children and youth in the APs/CTFs is not monitored and assessed in an independent manner. The case management in the network of small-scale residential services is provided in 17% of the CTFs and 40% of the APs by the very representatives of the institutions also providing the services.

Case Management

The analysis provides information about: (i) the national network of case managers; (ii) implementation of standards and case management, and (v) evaluation of case management performance.

The national network of 785 case managers shows the highest coverage in the counties of Iași (47 MCs) and Galați (33 MCs) and the lowest in the counties of Bistrița Năsăud (11 MCs) and Sălaj (10 MCs).

In terms of composition, the national network of case managers is predominantly female (92%) and over three quarters of its members are 30 to 49 years old. More than half of case managers have a social work degree and 16% of them have a higher education degree in other fields. In addition, nationwide, almost a quarter of all case managers have a postgraduate degree in social work.

Nonetheless, the census of case managers identified 59 case managers who did not meet the conditions for employment set out in SMO 9 under Order No. 288 of 6 July 2006.

On average, a case manager works with a number of 50 children, which is more than what is stipulated under the compulsory minimum standards (SMO) with regard to the number of active cases. The highest number of cases of children with special protection measures assigned to a case manager is 185 and the lowest is 0, in the case of recently appointed case managers.

The information relevant to PIP/PIS objective/goal achievement requires a better systematization. Some of the case managers (40) do not know the number of indirect MC beneficiaries – parents of children with special protection measures who are currently active cases. Moreover, only one third of the interviewed case managers have a list of parents of children with special protection measures who are active cases.

The difficulties most frequently mentioned by case managers for the implementation of PIP, PIS, PS (service provision) are related to the challenging collaboration with parents, mayoralties and the multidisciplinary team. The difficult collaboration with parents is caused by distance (parents who work abroad), lack of interest, low level of education as well as difficulties in identifying the parents' current address. The difficult collaboration with local authorities derives from the lack of social work professionals at local level, an excessive bureaucratization of their work, the accumulation of social work responsibilities and other mayoralty-specific tasks, and a certain organizational culture "in some mayoralties – they talk to each other and if one of them does not run the social inquiry, the other one won't either". In addition, "usually, the multidisciplinary team is comprised of a single person" and where the multidisciplinary team, however, includes professionals, it is very difficult to cooperate with family physicians and teachers. Other setbacks mentioned are: (i) heavy workload/high caseload; (ii) biological family's poverty, including precarious housing conditions; (iii) lack of transport resources; (iv) lack of services for youth leaving care; (v) difficult collaboration with the beneficiaries (children), placement families and placement center employees; (vi) lack of local services and professionals; (vii) lack of time; and (viii) the difficult collaboration with other institutions. As a conclusion, problems/difficulties were mentioned for reaching PIP/PIS objectives/goals, especially those related to family reintegration.

The compulsory minimum standards that MCs fulfill best are SMO 7 concerning monitoring and reevaluation and SMO 4 concerning the detailed/comprehensive evaluation. Apart from these, other standards mentioned as being properly fulfilled were SMO 3 concerning case identification, initial evaluation and takeover and SMO 6 concerning the individual care plan and the service plan.

At the other end of the spectrum, the compulsory minimum standards for case management in the field of child rights protection most difficult to fulfill are Standard 5 regarding the multidisciplinary team and Standard 8 concerning the post-service monitoring and case closure. Both are regarded as falling outside the case manager's control.

The causes/reasons why case managers have had to take/accept other measures/decisions than those that they first identified/planned and that they considered best for the child are related to young people who want to leave public care when they turn 18, children with behavioral disorders, changes in family circumstances (paternity test, biological family members' loss of income), parents' non-involvement hampering the successful reintegration and, hence, having to change the goal from reintegration to adoption.

The lowest rated resources provided by the DGASPC are those related to the sufficient number of case managers for ethnic communities in the county who know the language and culture of those communities and the sufficient number of case managers (meeting conditions for appointment) for children in special care.

On the whole, case managers' superiors and case managers themselves rate case management performance at institutional level as good (scores above 8).

Source Communities for the Child Protection System

The chapter presents: (i) the selection of source communities for the diagnosis of services meant to prevent separation of the child from the family; (ii) the main vulnerable groups of children and young people, and (iii) the effectiveness of child and family prevention and support services available in February-March 2018. By definition[3], "source communities" (be they rural or urban) are areas at the locality or sub-locality level, where from, in comparison with the other localities/areas, a significantly higher number of children reach the public child protection system. Sub-locality areas may refer to a neighborhood, but also to a street, to a group of houses and/or blocks of flats, in urban areas, and to a whole village, to a settlement or to a group of houses in the rural environment

The method of identifying source communities has used a step-by-step approach, as follows:

(1) The first step was the aggregate number of mothers with children in foster care at the level of administrative territorial units. Thus, identified were 994 communes in which mothers of children in foster care centers in the country live. Most of these communities have only 1-2 mothers.
(2) Improving the identification and prioritization of interventions in source communities by using additional criteria. One of these refers to the presence of marginalized areas. Marginalized areas are highly disadvantaged areas where the population has at most lower-secondary education, earns an informal income (especially from agriculture), and lives in precarious housing, even according to rural standards, and generally having little access to basic infrastructure and utilities (overcrowded houses and/or without access to water or electricity).Thus, only 17% of the communes without mothers whose children are in the special protection system include at least one marginalized area, but the likelihood of such an area to exist is much higher for communes where at least 11 mothers (65%) do exist. The 994 communes identified in the first stage are distributed as follows: (i) communes with 5 mothers or more than 5 mothers (52 communes); (ii) communes with 3-4 mothers and with at least one marginalized community (68 communes); (iii) other communes - with either 1-2 mothers or 3-4, but without any marginalized community (874 communes).
(3) Using a participative method to select the 30 source communities provided for in the Agreement.Thus, in the interviews with DGASPC (Directorate General for Social Welfare and Child Protection) directors, a separate chapter on the community selection was introduced. DGASPC directors were asked to choose between the source communities identified in the county, taking into account: (1) the communities where more children, than the other rural communities in the county, are enrolled in the system (in any protection service, and (2) the communities where DGASPC intends to intervene or considers that the development of the community-based support and prevention of separation at the level of the community would be more stringent. In cases where the Director of the DGASPC considered that there are other communes in the county, than those included in the list, having sent a larger number of children and young people to the protection system (regardless of the protection service they are to be found), then, after verifications, this new community could be selected. This was the rule especially for the case of counties with few foster care centers but with numerous alternative services (AMP, foster family).

Based on all this information, in the end, 35 source communities were selected in 32 counties. In addition, in order to map the prevention and alternative services in the 35 selected source communities, we introduced the functional micro-area concept. The functional micro-area contains the selected commune and the accessible area within about 30 minutes distance by means of transport

[3]Stănculescu et al (2016).

or possibly by car. All the collected data on the functional micro-area referred to: (i) the source community - the selected community; (ii) rural micro-area with all neighboring villages accessible within about 30 minutes distance; (iii) the urban micro-area with all neighboring cities or municipalities, including the administrative villages thereof.

The analysis is based on the data collected by the World Bank team in February-March 2018. In each source community, the social workers in the research team collected an extensive set of quantitative and qualitative data from a wide range of relevant representatives at county and community level.In total, in 32 DGASPCs and in the 35 source communities, 233 interviews were carried out involving 276 specialists. In each of the 32 counties where source communities were selected, the team started with an interview with the DGASPC Director on the source community selection. Then, within the DGASPC (i) the list of children in the special protection system (regardless of service) from the selected source community was filled in, in February 2018 and (ii) the DGASPC specialist/ specialists responsible for the selected commune was/were interviewed with regard to: (a) The evaluation of services in the selected source community from the perspective of DGASPC; (b) The list of new services that should be developed in the selected source community, according to the opinion of DGASPC.

In the next stage of fieldwork at community level, in the field visits to each of the 35 selected communities, the research team together with the DGASPC specialists designated for this activity conducted: (a) an interview with the mayor (deputy mayor or secretary of the town hall); (b) an interview with SPAS (Social Welfare Public Service), which also included a list of all mothers who had sent their children to the protection system during the last 5 years and a check of the list of children currently in the system; (c) an interview with the coordinating school principal; (d) an interview with the family doctor (or with the community nurse); (e) an interview with CCS (Community Consultative Structure) representatives or with any other local actor (priest, informal group, police officer, etc.) with initiatives in preventing child separation in the family or child protection; (f) identified social service sheets in the community or in the functional rural micro-area that have only children or adults and children among the beneficiaries.

Source communities and child protection services

In source communities, over half of children and young people in the protection system (569 children and young people) come from only 26 villages in 20 communes. Another 139 children and young people are spread across nearly 50 villages in 7 communes, and for the other 296 children and youngsters, a deeper study of the 8 communities of origin (with a total of 45 villages) is needed to identify the degree of concentration at the village level.

Under the protection system, in February 2018, children and young people from source communities were spread across all types of special protection services. Although source communities were determined starting from children in foster care centers, data analysis shows that children in the system are more numerous in these communities. Only one of the five children who arrive in the system is in a foster care center, while the other four are mostly in a family type service - AMP or PFam.

A percentage of 93% of children and young people in the protection system in source communities had their mothers known and alive. The other 7% had a deceased, unknown or missing mother. Most mothers still live in the source community, but one in three has either moved somewhere in the country (usually in a large city), or has moved abroad, or, rarely, has an unknown address to be found. Thus, out of the 35 selected source communities, there are 10 communes that in February 2018 no longer qualified as source communities (the number of mothers with children in the protection system was already low).

The selected communes are source communities, but at the same time they are part of the county child protection services networks developed by DGASPC. Thus, alongside children and young people in

families, nearly 700 children and young people (mostly from other communities) live in family-type services (AMP and PFam) or small residential services (CTF's).

Groups of children and young people from source communities in difficult situations

At the level of the 35 selected source communities, the following vulnerable groups of children and young people were mentioned by more than half of respondents in all respondent groups, namely over three quarters of school principals and family doctors: i) children in poverty including families with many children, single-parent families); ii) children and young people from marginalized areas; iii) children with parents who moved left abroad; (iv) minor mothers; v) children with disabilities; vi) children with special educational needs (CES); vii) children who have dropped out or left school; viii) children aged between 6 and 15 years, at risk of school dropout; (ix) children and young people who need transport to an educational establishment in another locality; x) children and young people who need support to prepare the documents necessary for disability; xi) children over 1 and under 10 years of age who are not in compliance with development standards.However, the data provided in the interviews are "poor", representing estimates in the absence of solid information.

Effectiveness of the prevention and support services in source communities

Analysis of the prevention and support services for the child and family which existed in the selected source communities is structured according to social services, educational services and medical services, and each of these services are regarded either as centres, or interventions/activities.

Social services centres are very rare in the source communities and in the related rural micro-areas. In total, in the 35 source communities and in the 151 communes in the rural micro-areas (which in total cover 649 villages), during the period February-March 2018 only the following were in operation: i) 3 day centres (one for supporting the integration/reintegration of the child into the family and two for developing the skills for an independent life), ii) 1 centre for counselling abused, neglected and exploited children, and in addition thereto iii) 7 adult institution (two in the source community and five in the rural micro-area). The centres are more numerous in the urban micro-area related to the 35 selected source communities, however, their number is relatively small if we are to take into account that the urban micro-area covers in total 30 cities and municipalities.

The social services as interventions or activities which may be conducted in any kind of institutions/organizations/facilities (including centres) are relatively more numerous; however, they remain accessible to not too many source communities and their functional micro-areas. Out of these services the least represented are the social economy enterprises and assistance services for offenders.

The status of the educational services is better than that of the social services. Pre-school, primary and secondary education institutions are found in almost all source communities. A high school or a technological high school is found in the functional micro-area for 21, respectively 25 source communities. Educational support services or integrated special schooling, as regards primary or secondary education level, are available for children in almost half of the selected source communities. Counselling and guidance services such as sports or club activities are found in more than 30 source communities. Afterschool services are available in more than half of the communes under review, and in almost one third of them one may find A doua șansă (*Second chance*) and services connecting education to the labour market.

The medical units available in the source communities and in the rural functional micro-areas are lower in number than the education institutions, nevertheless greater in number than the social services centres. In these communities, the most frequent (however low in number) are the permanent medical centres and multifunctional centres. Only half of the source communities have access to hospitals and policlinics in the urban micro-area. The rehabilitation centres for addicts, therapeutic community centres, house-care units for children and mobile teams are very rare both in the rural and

in the urban areas. Family planning services, sexual education for teenagers, psychological counselling and speech therapy may be accessed in 19-24 of the source communities. Furthermore, only approximately one third of the communities benefits from access to kinetotherapy, recovery/rehabilitation services, especially in the urban micro-area, and also to parenting services and house-care for children/families with children.

The human resources with SPAS in the source communities confirm the conclusions formulated in previous studies concerning the deficit of skilled personnel. In the 35 source communities, only 24 of them have a SPAS, only 14 have at least one professional social worker and in all of them there isn't at least one person having social assistance duties. For this matter these are the explanations behind the poor development of field activities (only for 56% of the children and teenagers in the protection system did someone from SPAS visit the family in its home (including the extended family) at least once in the last 12 months), of the work conducted with the family in view of reintegrating it (for 40%) or of the support granted by SPAS in view of reintegration (for 29% of the children and teenagers in the special protection system).

From among other specialists at the level of the community, only the family doctor is available in all source communities under review. The specialists in the field of education are also few. A school mediator and/or a school counsellor and/or a support teacher has/have been reported in only 12-15 communities. Although Law No. 272/2004 and Government Decision No. 49/2011 provide the obligation to create Consultative Community Structures (CCS) in the care of the local authorities, they are operational only in half of the source communities. Nevertheless, along CCSs only the religious groups providing support services for children and families in vulnerable situations are somewhat more numerous.

Despite the existence of numerous groups of children and teenagers in difficulty, in the source communities the social services are almost fully lacking. However, in only 7 out of the 35 selected communities neither the local authorities nor other active local players have plans in the future to set up new services or to the develop the existing services. If we are to limit the discussion to local authorities, in 18 of the selected communes the mayors have declared that in the future they are planning to develop the social services within the community.

In brief: Relevance of the study for the process of closing the placement centers for children

- More than half of the centers have small (or zero) chances of being closed down by 2020. The other 40% (or 60 centers) are in the process of closure, either in the initial stage (23 centers) or in a more advanced stage (37 centers). The number of children diminished only in the centers declared to be in the process of closure and it increased in all the other types of centers.

- The number of children diminished only in the centers declared to be in the process of closure and it increased in all the other types of centers.

- The "hard core" of deinstitutionalization efforts in Romania comprises a number of 87 placement centers for children with relatively small chances of closing down by 2020.

- The relevance of the AMP network for the closure of children placement centers is relatively low for the following reasons: (1) the estimated potential capacity is particularly low in six counties, some with many placement centers that should be closed (Harghita, Iasi, Sibiu , Valcea); (2) the profile of children cared for by AMP is very different from that of children in placement centers; (3) only about half of the AMPs are willing to take children aged 15 and above; (4) only 17% of the AMPs express their consent to receive in foster care a child with disabilities, and half of them already have a child with such health problems; (5) the analysis of children care for, throughout time, in the AMP network and that were no longer placed at the same AMP in February 2018 shows that the AMP network is highly relevant for the adoption process. In addition, the same kind of analysis shows that the AMP service

has fed the placement centers, especially in recent years. Yet, provided there are stronger efforts in addressing the development needs identified in the report, the foster care network could play a stronger role in deinstitutionalization. At the present time, the current foster care network has difficulties in absorbing the children in care in placement centers due to lack of sufficient training and support services.

- In terms of relevance upon closing care homes for children, family-type foster care services bear, most likely, little relevance, in the absence of continued efforts by case managers. Family-type foster care depends on the existence of extended family for the child and on the efforts of case managers to identify relatives or other families/persons willing to take the child in their care. In that respect, the situation of children and youth in care homes is unfavorable. Many of them have arrived in the protection system after having been abandoned after their birth in maternities, while others have been in the system too long. Still, deinstitutionalization requires continuous development/ strengthening of family based forms of care. While for many children currently in institutions, family based care may not be an option, for children entering care, institutionalization should be out of question.

- Most likely, the network of small-scale residential services represents the most relevant alternative for the closure of placement centers. Although not representing family-type alternative services when compared to the placement centers, the apartments and the CTFs provide the children with conditions that are much closer to the family environment. Moreover, the relevance of the RezMic network derives from: (i) the weak capacity of the current networks of alternative services (AMP and PFam) to take over the children and youth from the placement centers scheduled to be closed, (ii) the insufficient number of beneficiaries who leave the system (by reintegration into the family and by adoption), as well as from (iii) the prevailing profile of the children and youth in the placement centers.

- In agreement with one of the key principles of deinstitutionalization, according to which family support services need to be available within the community, and the prevention services need to be strengthened, the section relating to source communities reviews the geographic distribution of children facing a risk of being separated from the source communities selected throughout the study. The principle invoked relies on the hypothesis that preventing the enrolment into the system is much more efficient from the perspective of costs than treating the effects of the separation. Nevertheless, the response of the prevention policies substantially depends on the manner in which the separation risk is concentrated or spread at the level of or within the localities.

- The relationship between the source communities and the child protection system is a dual one. On the one hand, source communities enrol the children and teenagers into the system in a relatively larger number than other local communities. Consequently, it is these communities that should be targeted both by the efforts of developing the services for preventing the separation of the child from the family, and by the services working with the families in view of reintegrating the children who are already in the special protection system. On the other hand, DGASPC has set up protection services (AMP, family foster care centres, CTF, AP, foster care centres) in some source communities, in which children from other communities and sometimes even from the community in questionare placed into foster care.

- More than half of the children and teenagers in the protection system (569 children and teenagers) come from only 26 villages in 20 communes. At the same time, out of the 35 selected source communities, there are 10 communes which in February 2018 already no longer qualified to be source communities (the number of mothers having their children in the protection system was already small).

- From the viewpoint of prevention and support services in the source communities, educational services have the best status, as compared to medical units and social services. Pre-school, primary and secondary education institutions are found in almost all source communities. Medical facilities available in source communities and in rural functional micro-areas are fewer than the education institutions, however, they exceed the number of social services centres.

- At the level of SPAS in the source communities there is still a deficit of trained personnel as also presented in the previous studies. In the 35 source communities, only 24 have a Social Welfare Public Service (SPAS), only 14 have at least one professional social worker and in all of them there isn't at least one person having social care duties. Alternatively, the family doctor is present in all source communities, specialists in the field of education are also few, and the CSSs only operate in approximately half of the source communities.

In brief: Recommendations for maximizing the impact of deinstitutionalization efforts

- The impact of the project developed by the World Bank and the ANPDCA could grow significantly in the coming period, provided that a new call for proposals is launched (in the autumn or winter of 2018). At present, for a number of 24 centers, a few more months are still needed to finish the documentation needed to apply for ROP funding. This second call for proposals could make better use of the methodologies developed and refined in the project, along with the institutional capacity built by the DGASPCs through the experience gained by using them. Consequently, a second call for proposals has real chances of getting more applications, with better national coverage and without the concentration of proposals in certain counties.

- The disparities between counties in terms of deinstitutionalization efforts are in part due to different capacity and drive to implement the deinstitutionalization agenda. To reduce regional disparities in implementing the deinstitutionalization process, the following measures/ actions would help: (i) better instruments for evaluating and monitoring the situation of all the children in public care, to be part of the revised regulatory framework; (ii) an MIS that would allow the Child Protection Agency to monitor in real time the situation of the children and of the needed remedial actions; (iii) a national performance monitoring system with modules for Child Protection Agency, County Directorates for Social Assistance and case managers, (iv) a national training system that would be compulsory and adjusted to the needs of the staff and of the children's under their care, (v) better legislation – including new/improved quality standards for social services.

- For developing the network of professional foster carers, there is a need to ensure a standardized implementation of the Mandatory Minimum Standards (MMS) (in present only partially fulfilled), supplementary financial revenues for an increased quality of care offered by the foster carers, assessing and addressing training needs of AMP, but also investments in the development of community level services, in the proximity of AMP, especially day care centers, centers/ services for rehabilitation and school after school services.

- Increased performance of the Pfam networks requires standardized working practices, especially regarding the child's monthly monitoring, training needs of PFam, because none of the counties under review provided training for foster families/persons in the past 5 years, regular measurement of the satisfaction degree of children and of foster families, consistent recording of information on the existence or inexistence of cases of abuse, neglect and exploitation of children in Pfam, drawing up and implementation of a regulation in reliance upon which social services are supplied at home for children in Pfam and increasing the frequency of visits to the domicile of foster families, but also of face-to-face interaction between CMs and children.

- The main development areas in respect of the small-scale public residential services (RezMic) are: (i) a more extensive territorial dispersion of the CTFs and apartments, through the development of the network while avoiding the establishment of service beneficiaries communities; (ii) preparation/use of a common national-level definition for the residential services; (iii) addressing the modulation deficiencies and the staff shortage for a part of CTFs and apartments; (iv) improving the types of services and activities available in the small-scale public residential services (RezMic); (v) independent quality monitoring and assessment for the services provided to children and youth in the APs/CTFs.

- To improve case management performance, DGASPC directors have made a number of recommendations for optimizing the implementation of the following case management standards:

- SMO 1. Improving conditions for method implementation through software development for the registration of all children with special protection measures and/or improving working procedures.

- SMO 5. Improving collaboration with the multidisciplinary team, including through more frequent meetings with CP/AMP teams.

- SMO 6. Raising the targets set for case managers for starting the adoption proceeding.

- SMO 9. Expanding the organizational structure by hiring more case managers and meeting the caseload standard, ensuring a more balanced area coverage or setting a new threshold, closer to the standards ("each MC should work with 50 beneficiaries at most"); filling vacancies; hiring case managers in accordance with SMO; as regards the deinstitutionalization process, the AMP networks could develop, which would lead to a larger team of MCs available for children placed with AMPs.

- SMO 10. Changing the organizational chart by setting up a MC service or reorganizing the MC into a single structure so that a child can have one MC during the entire time spent in special care; clearly separating MC responsibilities from service provision; restructuring the organizational chart based on the recommendations formulated by a Committee of Social Workers and Psychologists responsible for the human resources required for Pfam and AMP (recruitment, evaluation, certification, monitoring).

- SMO 11. Developing initial and continuing training though experience exchanges, various professional training courses, including in the field of supervision, case management, social service quality – "no plans until 2020, only continuing training". Some directors also mention the necessity to train mayoralty employees as well as the need for burnout prevention training ("after a while, they turn into robots, like they are on an automatic mode"). Also motivated by the lack of a training budget, some DGASPC directors suggest experience exchanges to discuss exceptional cases with colleagues from other services.

- SMO 12. Improving MC supervision, especially that "on the ground, you have to make decisions by yourself, you don't know if those decisions are right and your signature can change the course of a child's life".

- The success of the deinstitutionalization process will essentially depend on reducing the number of children entering into foster care centres and, in general, in the special protection system. This target implies developing the prevention and support services in the community. The analysis of the geographic distribution of the separation risk has identified a series of source communities which, on the one hand, cover a large number of children and teenagers in the special protection system, with known mothers who still live in these communities and in which on the other hand, the local authorities, at least in the present, show themselves interested in developing prevention and support services for children and families. Maximizing the impact of the deinstitutionalizing endeavour would equate to prioritizing the interventions required in these source communities, in order to mobilize in the most efficient manner the resources of the child protection system. The study has identified the need for development especially in the field of social services centres, of the trained human personnel at the level of SPAS and of the functionality of the Consultative Community Structures.

BACKGROUND INFORMATION

The National Authority for the Protection of Children's Rights and Adoption (ANPDCA) under the Romanian Ministry of Labor and Social Justice (MMJS)[4] requested assistance from the World Bank in developing an operational plan for the deinstitutionalization of children cared for in traditional placement centers and their transition to the services developed in their home communities.

Reducing the number of children living in unsuitable large child care institutions remains a priority for the Romanian Government in the coming years. The Government has already committed to speed up the deinstitutionalization process and has made this issue a priority under different strategic documents, including the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*, the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, and the *Partnership Agreement*. In line with the European Commission's Social Investment Package and Recommendation on "Investing in Children: Breaking the Cycle of Disadvantage", the ANPDCA established, among other things, the following priorities for 2014-2020: (i) Close down traditional child care institutions and transfer children from those institutions to community-based services, and (ii) Ensure early and preventive interventions for children, which will guarantee children's right to grow up in a family environment and will help them reach their full potential and exercise all their rights.

Communism left Romania with a disastrous child protection system. Between 1945 and 1989, the State set up a network of large institutions and poor families were encouraged to put their children (especially those with disabilities) into public care. Traditional child care patterns, like placing the child in difficulty with a member of his or her extended family, were undermined. In the context of aggressive pro-birth policies, combined with the economic crisis of the 1980s, the outcome was devastating. In 1989, more than 100,000 children were living in such institutions, in appalling conditions. Moreover, even when material conditions were reasonable, institutionalization had a strong negative impact on children's health, development and psychological state because of depersonalization, rigid routines and social isolation.[5]

Over the past 15 years, the Government has made significant progress in reducing the number of institutionalized children, also by developing alternative family-based services, but progress has stagnated since 2010. The number of children in residential care (in public and private placement centers, including group homes) declined from a record high of 57,181, reported in December 2000, to approximately 15,478, as of September 30, 2016. Nonetheless, in 2011, for the first time in 15 years, the number of institutionalized children escalated[6], as a consequence of a larger poor population and the limited budget available for family-based services. However, in the past few years, the rate has started to drop again. Moreover, the total number of children in special care in Romania[7] benefiting from a special protection measure diminished significantly, from approximately 98,000 children in 1997 to approximately 52,774, as of September 30, 2016. However, there was also a decline in the total child population, which means that the rates of children in special care actually stagnated (1,776 per 100,000 children in 2000 and 1,641 per 100,000 children in 2011), illustrating the limited ability of the system to reduce the number of children entering care. Compared with other countries in Central and Eastern Europe and the Community of Independent States (CEE/CIS), Romania has an average rate[8] of children placed into public care. Nevertheless, in absolute figures, the child protection system of

[4] Called the Ministry of Labor, Family, Social Protection and the Elderly (MMFPSPV) until January 2017.
[5] Johnson et al. (2006), Browne (2009), Tobis (2000), National Scientific Council on the Developing Child (2014).
[6] MMFPS, DGPC (2011: 1). The number of institutionalized children (placed in residential care) was 23,240 in 2011, compared with 23,103 in 2010.
[7] In Romania, the special care system comprises a set of measures, benefits and services developed for raising and caring for children who are temporarily or permanently separated from their parents and cannot be left in their care.
[8] Romania has between 1,600 and 1,700 children in public care, per 100,000 children, in the total population aged 0 to 17, compared to an average of 1,850 per 100,000 children aged 0 to 17 reported in the CEE/CIS region and in the countries from Eastern Europe and Central Asia (Transmonee database, 2015, Table 6.1.22).

Romania remains one of the largest, having to look after approximately 60,000 children (with 52,000 in special care).[9]

The closure of child care institutions has been a slow process and the share of children placed in (traditional or modular) institutions has not changed since 2011. According to the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*:[10] "Child care institutions were restructured as efforts were made to provide family-based alternatives to residential child care and to prevent child abandonment. On the one hand, large-sized traditional institutions (100 to 400 places) were reorganized in an attempt to make them smaller, to modulate them, and to offer more space to each child, in a setting as close to family environment as possible. The decrease in the number of children due to deinstitutionalization – especially through children's reintegration into their biological or extended families or their placement with a family or a person – made institutional 'humanization' possible. Still, not all placement centers had this kind of makeover; due to lack of funding and experience, after 2007 the whole process ran at a slow pace, in stages, as dictated by available funds or priorities set under county strategies. In 2011, 52% of children in residential care were living in traditional and modular institutions."[11] At the end of 2014, 50% of children in residential care were still living in institutions (placement centers).

The child deinstitutionalization reform implemented so far in Romania offers five key lessons which decision-makers have to consider for this new wave of reforms (see also Box 2). The key lessons learned show that: (i) Institutional closure and new service development need to be planned based on the specific needs identified for each child and his or her family, and by consulting them; (ii) The closure of placement centers should be combined with the development and strengthening of services meant to prevent children's separation from their families, at community level; (iii) The monitoring and evaluation of the child's post-closure circumstances and the quality of the newly created alternative services need to improve considerably; (iv) NGOs are valuable child protection partners and, for that reason, deinstitutionalization should be mostly built on public-private partnerships; (v) It would be useful to roll out information and awareness-raising campaigns for the general public and local decision-makers in order to improve community acceptance and integration of these children, especially of those with special needs.

As of March 31st, 2015, most of these children were still living in placement centers, be they traditional or modular.[12] According to the official statistics of the ANPDCA, there were 81 traditional placement centers, with a total of 3,866 children and young people. Additionally, there were other 83 modular placement centers, with 3,492 children. Although the need to close down those centers had been unanimously accepted, the costs of that process were extremely high and available funds were clearly insufficient. Consequently, at the start of the SIPOCA 2 project, priorities had to be set so as to decide which centers would be closed down first, based on a thorough analysis of their circumstances and the quality of the services they were providing to children.

Therefore, within the project, Output #2 (May 2017) proposed an evidence-based typology of traditional and modular centers and a prioritization methodology with a set of list options for prioritizing the closure of placement centers for children in Romania. The typology of traditional and modular centers has not yet been recognized as such in a consistent manner nationwide. The prioritization methodology was based on a multi-criteria evaluation meant to rank all placement centers in Romania (both traditional and modular ones) according to the quality of care delivered to

[9] The other approximately 8,000 children benefit from guardianship, day care, special supervision, counseling, prevention and different other services which don't require removal from family and placement into family-based services or residential care.
[10] ANPDCA (2014: 30)
[11] According to HHC (2012), an "old-type", "traditional" or "classic" institution is a placement centre accommodating over 12 children or young people, with more than four children in a bedroom and with shared sanitary facilities for the residents living on the same floor. A "refurbished", "restructured" or "modular" institution is a placement centre accommodating over 12 children or young people, organized into units, which typically consist of one bedroom, one living room, and one bathroom. By comparison, a group home (CTF) is a residential facility based on a family model, with a living room, a kitchen, and bathrooms.
[12] March 13, 2015 was the reference date set when the project was developed, back in 2015.

children.[13] Thus, the prioritization methodology identified the centers where children's health and developmental needs were unlikely to be covered.[14] For this, the multi-criteria evaluation looked at: (1) the quality of child care in every placement center, in terms of (a) the number of affected children,[15] (b) environment of care,[16] and (c) quality of care[17]; (2) children's views about the quality of life in the placement centers where they were living;[18] and (3) the options of the DGASPC regarding which centers needed to be closed down and in which order.[19] Hence, since it is impossible to find a one-size-fits-all solution for prioritizing the closure of placement centers, a set of "good" process planning practices was proposed.

The closure of placement centers is a process[20] which needs to be carefully and thoroughly planned in order to establish:

(i) The needs of children currently living in those centers;

(ii) Alternatives to the care currently delivered in those centers, which could be considered after centers are closed down;

(iii) Services that could be delivered, considering the resources available and those needed;

(iv) Areas and levels of investment that will be needed;

(v) Staff training needs and new types of employees to be hired;

(vi) Preventive measures to be taken or strengthened for reducing the number of children who enter special care.

[13] For example, based on the multi-criteria evaluation, Output #2 has clearly showed that, although modular centers are somewhat better than traditional ones as concerns the environment of care, there are no differences in the quality of care. Hence, modular and traditional centers deliver the same quality of care (not very good) to their beneficiaries.
[14] Mulheir and Browne (2007: 55).
[15] (a) Number of affected children: the bigger the center, the greater the need to close it down in order to give all the children who live there the chance to grow up in an environment as close to a family setting as possible.
[16] (b) Environment of care: insufficient and/or low-quality human and material resources in a center can affect the health and development of children living there. As a result, the poorer the resources available in a center, the greater the need to close it down. Structural variables associated with the environment of care have been categorized into four sub-dimensions: distance and isolation, institutional infrastructure, health and safety issues, and carers (López Boo et al, 2016: 53)
[17] (c) Quality of care: children's health and development can also be negatively impacted by abusive interaction and neglect or other forms of violence from center employees or other children. As a result, the poorer the quality of care in a center, the greater the need to close it down. Relevant process variables have been categorized into three sub-dimensions: child development services and activities, interaction between children and carers, and implementation of quality standards and case management. (López Boo et al, 2016: 53)
[18] Information from focus groups.
[19] Information from interaction with the DGASPC, mainly during interviews.
[20] According to the recommendation of the European Expert Group on the Transition from Institutional to Community-based Care formulated in the "Common European Guidelines on the Transition from Institutional to Community-based Care" and in the "Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care" (EEG, 2012).

To that end, Output #2 (May 2017) included a "Guide on Developing Individual Closure Plans for Placement Centers in Romania". That way, every traditional or modular center can be closed down based on a methodology and a plan which consider all the aforementioned elements (with special attention to children's needs) and look at the extent to which the available human, financial and material resources are adequate for that institution.

Moreover, Output #3 (November 2017) showed the manner in which the preliminary methodology for developing individual closure plans for placement centers (presented in the Guide) was refined for the multidisciplinary evaluation of children. At the same time, it provided valuable information about alternative care measures for children living in placement centers, based on a multidisciplinary (medical, psychological, social and educational) assessment of their needs[21] and on their preferences for and choices of alternative care options, as expressed by the very children during focus groups.

The success of deinstitutionalization will essentially depend on the decrease in the number of children entering placement centers. It is particularly necessary to draw up a methodology for identifying children at risk of being separated from their families.

Reducing the number of children in special care will require preventive services developed in the community. Research shows that there are places (especially source communities) without early intervention and guidance services, which is one of the reasons why children may end up in special care.[22] According to official statistics, almost 1.4% of all Romanian children aged 0 to 17 are at risk of being separated from their families. Nevertheless, a UNICEF study has estimated that the rate is higher – almost 2% of children aged 0 to 17 – if we also count 'invisible' children.[23]

[21] The multidisciplinary evaluation of a representative sample of 1,712 children and young people from placement centers, with data entered into the E-cuib application.
[22] Stănculescu et al. (coord.) (2016)
[23] Stănculescu and Marin (2012). 'Invisible' children are those who "are disappearing from view within their families, communities and societies and to governments, donors, civil society, the media and even other children", according to UNICEF (2006) *The State of the World's Children 2006: Excluded and Invisible*, www.unicef.org

INTRODUCTION

This diagnostic study was carried out under the Reimbursable Advisory Services Agreement concluded for the Development of Plans for the Deinstitutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care, between the World Bank and the National Authority for the Protection of Children's Rights and Adoption (ANPDCA), on May 12, 2016. The Agreement covers the implementation of the ANPDCA project – "Development of the Plan for the Deinstitutionalization of Children in Residential Care and Their Transition to Community-Based Care" – code SIPOCA 2, funded by the European Social Fund under the Operational Program for Administrative Capacity.

Between December 2017 and April 2018, the World Bank team collected and analyzed the data needed to prepare the fourth deliverable under the Agreement (Output #4). This report is a continuation of the first three deliverables, already submitted to the ANPDCA (in February, May and November 2017), as well as an opening for Output #5, which will be developed in the following months and will focus on the plans to develop preventive and support services for children and families at community level.

Output #4 benefited from a workshop with the National Authority for the Protection of Children's Rights and Adoption (ANPDCA), social workers from the Romanian National Association of Social Workers (CNASR), and the General Directorates for Social Assistance and Child Protection (DGASPC), organized by the World Bank at Brașov, from February 5th to February 8th, 2018.

Report structure

In line with the vision of the ANPDCA, translated into the "National Strategy for the Protection and Promotion of Children's Rights 2014-2020",[24] under this Agreement, the World Bank provides technical assistance on four strategic lines of action for the deinstitutionalization of children deprived of parental care, as follows:

(i) Closure of placement centers[25]

(ii) Development of alternative services to residential care[26]

(iii) Improvement of case management, to ensure good-quality and adequate protective services

(iv) Development of preventive and support services in the community.

Output #4 focuses on all four key themes. Thus, Part 1 presents an update on the closure status of placement centers for children in Romania. Part 2 maps out and analyzes service alternatives to residential care, being organized into three sections, as follows: (A) the foster care network (AMP); (B) the network of family placements with relatives and other families or people (PFam); (C) small-sized residential care services, that is group homes (CTFs) and apartments (APs). Part 3 analyzes the case management, more precisely the capacity of the current network of case managers to ensure the timely delivery of good-quality services that meet the needs of children and youth in special care. Part 4 discusses the availability of services for a number of 35 source communities. The report is complemented by a number of 35 stand-alone reports at county level and by an extensive methodological document.

[24] GD no. 1113/2014
[25] This theme is also tackled under Output #1 (February 2017) and Output #2 (May 2017).
[26] See also Output #3 (November 2017).

Table 1: Children and youth in the special protection system, by types of protection services, in February-March 2018

Children and youth in …	Number	Percentage
Residential services	10188	27
Placement centers	5353	14
Group homes	3494	9
Apartments	1341	3
Family-type services	28179	73
Professional foster carers	13725	36
Placement families	14487	38
Family placements with relatives	10580	28
Family placements with other families/persons	3745	10
Mixed family placements	162	0.4
Total	38400	100

Source: World Bank, Census of placement centers, of small size residential services, of professional foster carers and of placement families (February-March 2018).

The whole analysis looks at all 35 Romanian counties where there is at least one placement center for children (see Annex 1. Table 1).

Our key messages

This document discusses the closure of placement centers for children in Romania. We would like to mention that, in our understanding, the closure of placement centers for children is aimed at improving the conditions of children and young people living there, not at the actual shutdown of those institutions. Thus, no institution should be closed down before better care solutions have been identified for each child and young person at that center.

The children and youth who are currently in residential care make a very diverse group and (re)integration is not a possible option for some of them. Those children should continue to be looked after either in foster or family care or in small-sized residential facilities, like group homes or apartments.

Hence, the deinstitutionalization of children should be child-centered and planned for the best interests of the children and youth living in those institutions. Therefore, the closure of a placement center implies setting up, developing and strengthening new services, so as to provide the most adequate form of alternative care, in a family setting, along with different preventive and support services in the communities.

Child deinstitutionalization principles

The below set of principles[27] has guided all the methodologies, analyses, instruments and recommendations under Output #4.

Residential care should be used only as a last resort	**Residential care should be used only as a a last resort and provided only temporarily either in placement centers or in small-sized facilities (groups homes or apartments) before finding a permanent family care solution as quickly as possible.** **One has to bear in mind that any newly created residential facility comes with a need for permanent residents.**
Children are the main beneficiaries of deinstitutionalization processes	Therefore, the institutional closure process should, first and foremost, be centered on children and their families.
Children need to participate in and be consulted throughout the entire process, and their views have to be heard	All the conditions need to be provided so as to involve children in decisions that concern them, in accordance with their age and maturity. Children with disabilities, too, need to be encouraged to express their views, their ability to evolve has to be valued, and focus should be maintained on their developmental potential while showing trust in that potential.
It is preferable for children to grow up in their biological families	Whenever possible, children should be reintegrated into their biological families, be cared for within their extended families, or be adopted.
Children and family need to be taken as a whole	Children's needs and circumstances cannot be separated from those of the family. Hence, the assessment of circumstances and the planning of interventions or new services need to look at family and child as a whole.
Family support services need to be available in the community and preventive services need to be strengthened	Children and their parents may need support and specialized services to prevent family separation and disruption, as well as to ensure the child's sustainable reintegration. Family support services need to be available in the community and adapted to the individual needs of each child and family.
Deinstitutionalization should start with the multidisciplinary evaluation of each child's needs	No child will be moved out of an institution before s/he and his or her family have been through a multidisciplinary evaluation process. Based on those evaluations, a conclusive report will be prepared, setting out the service plan, and measures will be planned and taken to ensure that the child is moved out as adequately as possible from a physical and psychoemotional perspective.
New services need to be planned based on the needs identified for each child, not on administrative priorities	Where and how new services are developed and everything related to their planning need to match the needs of the children benefiting from those services, which should prevail over any other considerations.
Under the institutional closure program, no child will be transferred to a larger institution	The practice of moving "bad children" to centers that are not closed down and transferring "good children" to the new services, as it sometimes happens, will not be accepted.
Quality standards need to be followed	Quality standards have been developed for most services; they should be followed during planning and implementation phases.
In planning each action, priority should be given to	Children are extremely sensitive to change. Consequently, during the institutional closure process, any move should be a positive experience and final,

[27] The UN Convention on the Rights of the Child, ratified by Romania under Law No. 18/1990, and the UN Convention on the Rights of Persons with Disabilities, ratified under Law No. 221/2010, provide the general framework of principles and values for deinstitutionalization. All these principles have been incorporated into the "National Strategy for the Protection and Promotion of Children's Rights 2014-2020" and into laws, including compulsory standards and regulations for all interventions in this area.

the child's stability and changes should be minimized	as much as possible. This means that all children will be moved for the long term, in a well-prepared and planned manner, to alternative family-based services or small-sized residential facilities (CTFs, apartments).
Outcomes should be realistically planned	New services, planned interventions and their expected outcomes should be realistic and consider all options (including, moving into specialized institutions for adults, where applicable).
Respect for the child's best interests and the improvement of children's living conditions should be demonstrable	Improvement needs to be noticeable, quantifiable and sustainable. Temporary and partial solutions are not enough. For each child, the outcome should be what that child needs in order to reach his or her full potential, not a slight improvement of the current situation.
Children need to be protected from harm or abuse	Reintegration into the biological family or placement with relatives should not happen at all costs. Children will not be exposed to any risk or abuse. For instance, if one of the reasons for child placement was family abuse or neglect, the child will not be reintegrated into the family unless a rigorous assessment proves that things have changed and the child is no longer at risk, paired with a strict post-integration monitoring plan.
Children need to maintain contact with their families	Children who cannot be reintegrated into their biological families or cared for within their extended families should be allowed to maintain contact with family members. Thus, an alternative form of placement should be sought without moving the child too far away and visits should be facilitated when they are in the child's interest.

Children will be reunited with their siblings, whenever possible	**Groups of siblings will not be separated as a result of the institutional closure process. Where it is possible and in the interest of each child, groups of siblings will stay together or be reunited.**
Special attention should be paid to youth leaving care	This involves careful step-by-step planning and adequate support (qualification, job, housing, etc.), counseling and monitoring services until social integration is complete. Planning will be done with every young person about to leave care.
Post-deinstitutionalization monitoring and evaluation are vital	Post-deinstitutionalization monitoring and evaluation are needed for each child and family and for all newly created services.
Center buildings should no longer be used for residential child care	Options for the future use of those buildings should under no circumstances include group-based residential care. Wherever possible, consideration may be given to the possibility of splitting those buildings into fully independent apartments for people leaving care (and not only), with accessible housing options.
Deinstitutionalization requires a multidisciplinary approach	Integrated interventions are needed in all aspects of family life (sometimes implemented by several bodies): housing conditions, family and social relations, physical and mental health, and finances/ability to make a living.
Deinstitutionalization is not a stand-alone process	Deep changes are needed in attitudes towards children, family life and child abandonment. The deinstitutionalization process should be rolled out along with attempts to change attitudes, social and cultural norms regarding family life and child abandonment. It is highly important to promote acceptance of parental responsibilities and ensure the general and specialized support that parents need.
NGOs can be extremely valuable partners throughout the entire deinstitutionalization process	Civil society organizations can always bring the innovation, flexibility, quality and celerity required in the deinstitutionalization process. More than that, NGOs have the ability and capacity to reach local communities, to quickly adapt responses to the needs identified and build capacity, where needed.

	For all these reasons, consideration should be given to ways to involve private service providers in the long term and build public-private partnerships. Creating an open market for provision of services based on contracting/outsourcing procedures could ensure a prompt and flexible response to the needs and the sustainability of actions taken by the civil society and the private sector to provide good-quality services. The role of NGOs should not be limited to direct provision of services. NGOs should act as partners for the DGASPC in the efforts to close down placement centers and, more broadly, to deinstitutionalize children. Their participation can create added value in all process phases, from preparation, planning and application for funding to implementation and, in particular, as part of the monitoring and evaluation process.

***Sources*: Mulheir and Browne (2007), UN (2010), EEG (2012), ANPDCA (2014).**

Output #4:

Part 1

CLOSURE STATUS OF PLACEMENT CENTERS FOR CHILDREN

PART 1. CLOSURE STATUS OF PLACEMENT CENTERS FOR CHILDREN IN ROMANIA

Part 1 of Output #4 provides an update on the closure status of placement centers for children in Romania. In January 2017, Romania had 159 placement centers for children, located in 37 counties.[28] In February 2018, the number of placement centers went down to 147, in 35 counties (see Annex 1. Table 1). Hence, 12 placement centers for children, accommodating 290 children and youth at the time of the initial evaluation (October 31st, 2016), were dissolved over the past year.

Nonetheless, the total number of children and youth living in placement centers declined very little between the time of the initial evaluation (October 31st, 2016) and that of the current evaluation (February 1st, 2018), by less than 140 children (accounting for less than 3% of the total).[29]

1.1. Data

The analysis we present here is based on the data collected by the World Bank team in February-March 2018. Data were collected by a team of sociologists, through face-to-face interviews, using the guides in the methodological report. Overall, 35 interviews were conducted with DGASPC directors, 12 interviews with County Council (CJ) presidents (vice-presidents or secretaries), and four interviews with mayors, from all the counties with at least one placement center for children.

[28] Additionally, eight centers were reported in the city of Bucharest. See more data in Output #1 and Output #2.

[29] The number of children and youth living in placement centers in Romania (not counting those from the city of Bucharest) declined from 5,491, as of October 31st, 2016, to 5,353, as of February 1st, 2018 (see Table 1). We have to mention that, at the time of the initial evaluation, approximately 6,300 children and youth had a protection measure to be implemented in placement centers (not counting those from the city of Bucharest), but about 900 of them were missing from those centers as they were away for school or treatment or runaways or in other circumstances. In addition, around 100 children were living in those centers without a protection measure or with a protection measure for other services (for example, AMP). So, 5,491 children and youth were actually living in those centers, with or without protection measures to be implemented there. As of February 1st, 2018, the situation was similar, meaning that there were children with special protection measures to be implemented in centers but who were missing from those institutions, just as there were children with protection measures for other services who were living in those centers. Nevertheless, in this report, we refer strictly to the children and youth who were actually living in placement centers as of February 1st, 2018.

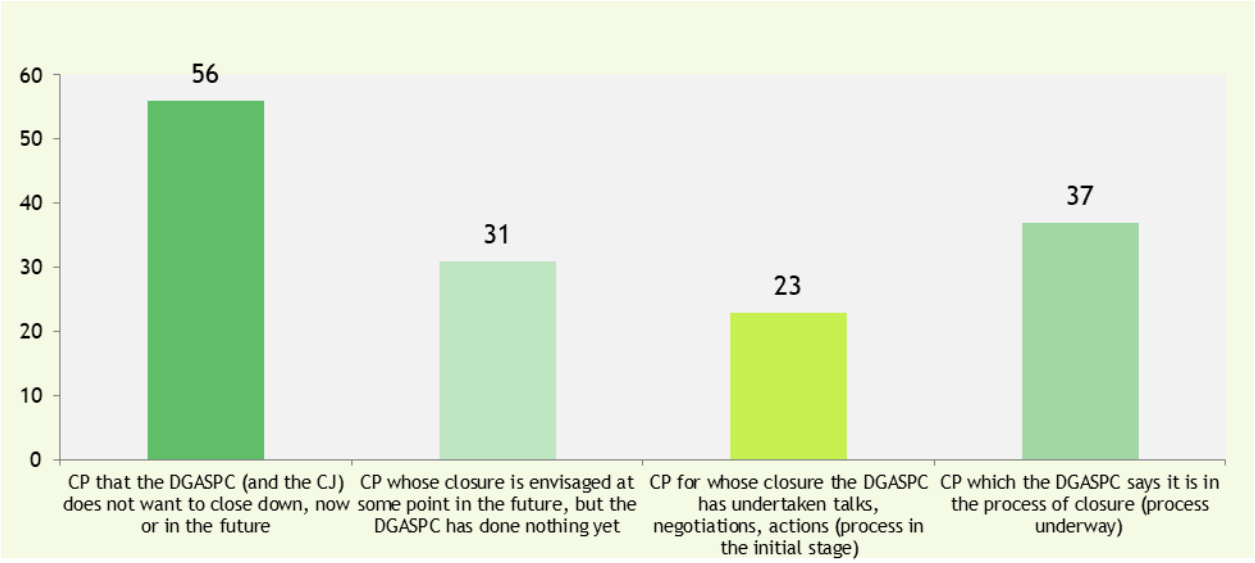
1.2. General overview

Of the 12 dissolved placement centers (see Annex 1. Table 2), half were closed down with support from NGOs (SERA and HHC) and the other were shut down based on an administrative procedure. The six centers closed down with NGO support accommodated 137 children and young people, who were reintegrated into their families, transferred to foster care or moved into CTFs. The other six centers closed down by the DGASPCs with their own resources (or by the CJs) accommodated 153 children, who were mainly transferred to school residences (with cancellation of their protection measures) or to other placement centers.

Out of the 147 placement centers operational in February 2018, almost 60% have small (or zero) chances of being closed down by 2020. The other almost 40% (or 60 centers) are in the process of being closed down, either in the initial stage (23 centers) or in a more advanced stage (37 centers).

Figure 1 shows the situation at national level, while Annex 1. Table 3 presents the county-level situation.

Figure 1: Distribution of placement centers in Romania, according to closure status, as of February 2018 (number of centers)



Source: World Bank, Interviews with DGASPC directors and CJ presidents (N=147 centers).

It would be useful to mention that, in some counties, decision-makers' answers were seriously affected by social desirability bias.[30] Consequently, categories in the middle, concerning the centers that the DGASPC wants to close down at some point in the future and the centers who are in the initial stage of the closure process, in particular, should be treated with caution.

We should also mention the consensus between DGASPC directors and CJ representatives, except for two counties. In other words, CJ representatives seem to support entirely the positions/views expressed by DGASPC directors. Although all CJ representatives state that they fully agree with the process of child deinstitutionalization, they immediately mention some centers which should not be closed down (which normally coincide with those indicated by DGASPC directors).

[30] The tendency of DGASPC directors and, more rarely, CJ representatives to answer in a way that puts the DGASPC in a good light ("the County has to look good"). (Paulhus, 1991)

As previously mentioned, in the period November 2016 – January 2018, the number of children and youth in institutional care declined only marginally. In fact, Table 2 shows that the number of children diminished only in the centers declared to be in the process of closure and it increased in all the other types of centers.

Table 2: Changes in the number of children and youth living in placement centers in Romania, between October 31st, 2016 and February 1st, 2018, according to closure status

		No of children and youth living in CPs			
	No CPs	October 31st, 2016	February 1st, 2018	% change	% in 2018
Dissolved CPs	12	290	0	0	0
CP that the DGASPC (and the CJ) does not want to close down now or in the future	56	1,401	1,508	108	28
CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	31	1,002	1,088	109	20
CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage)	23	1,102	1,132	103	21
CP which the DGASPC says it is in the process of closure (process underway)	37	1,696	1,625	96	30
Total CPs nationwide, Bucharest excluded	159	5,491	5,353	97	100

***Source*: World Bank, Interviews with DGASPC directors.**

1.3. Placement centers with relatively high chances of being closed down

A number of 60 placement centers, accommodating almost 2,750 children and young people, that is 51% of all children in institutional care, as of February 1st, 2018, have relatively high chances of being closed down by 2020 (Table 2). The list of these centers is included in Annex 1.Table 4.

About half (29 centers) of these centers have already completed the multidisciplinary evaluation of all children and youth, based on the methodology developed under Output #2 and refined under Output #3, using the e-cuib application. Following the training of DGASPC specialists on how to use the new methodology for the multidisciplinary evaluation of children, another quarter (15 centers) of the centers likely to be closed down either already use the e-cuib application or intend to use it in the future. Finally, the other 16 centers will be closed down without using the e-cuib application or the methodologies developed in this project. Most of them are using or will use the methodologies of the NGOs with which they cooperate, especially HHC[31] or SERA Romania.

The features of the e-cuib application, the activities aimed at institutional capacity building and the constant support provided to the DGASPCs that have started to develop individual closure plans for one or several placement centers have also led to 20 centers already having individual closure plans all done and to 24 other centers in the process of completing them or stating their intention to use the e-cuib application to that end.

[31] For instance, Dărăbuș et al (2017).

Table 3: Activities performed and funding sources considered by placement centers with chances of being closed down, as of February 2018 (number of centers)

		CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage)	CP which the DGASPC says it is in the process of closure (process underway)	Total
Total N		**23**	**37**	**60**
Have you conducted the multidisciplinary evaluation of all CP children in e-cuib (using the methodology from the Guide)?	No and it will not be conducted in e-cuib	7	9	16
	No, but we intend to do it when CP closure starts	11	0	11
	Yes, underway	4	0	4
	Yes, all done	1	28	29
Have you prepared the individual closure plan for the CP in e-cuib?	No and it will not be prepared in e-cuib	7	9	16
	No, but we intend to do it when CP closure starts	12	0	12
	Yes, underway	3	9	12
	Yes, all done	1	19	20
Funding source planned to be used for CP closure	ROP (current call)	0	15	15
	ROP/OP HC (future calls in 2018)	12	12	24
	CJ, own resources	5	3	8
	NGOs or other sources	6	7	13

***Source*: World Bank, Interviews with DGASPC directors and CJ presidents. For the e-cuib application, see World Bank (2017d).**

Regarding funding sources, DGASPC directors say they will apply for ROP funding under the current call only for a quarter of these centers (15). For the other 24 centers, a few more months are still needed (until June or September, according to different estimates) to prepare all the documentation required for the application. Consequently, even with cautious interpretation, data show that a new call for proposals (in the autumn or winter of 2018) could really help the deinstitutionalization process. This second call for proposals could get more applications for funding than the current call, considering that the refined methodology is already available, the e-cuib is operational, and the DGASPCs have already gained experience on how to use them. Moreover, the effect would be even greater if the second call is announced well in advance, so that the DGASPCs don't stop/slow down the actions they have already started but step up.

Although 29 centers have conducted the evaluation of children in e-cuib, only 20 have completed the individual closure plan. Even fewer have sent them to and received the approval of the ANPDCA. Finally, DGASPC directors say they will finish all the documents needed to apply for ROP funding under the current call only for 15 centers. Table 4 shows the main problems/difficulties that explain why the number of centers closing down has halved throughout the process (from 29 to 15) and why there are

(15) centers for which the DGASPCs have already undertaken talks/actions but have not started the multidisciplinary evaluation of children.

Table 4: Main problems/difficulties in the closure of placement centers for children (number of centers)

	CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage)	CP which the DGASPC says it is in the process of closure (process underway)	Total
Total N	**23**	**37**	**60**
No problems/difficulties	0	5	5
Yes, there are problems/difficulties regarding: (*Multiple answer*)	23	32	55
- Land/buildings	9	16	25
- The limited capacity of the DGASPC to implement concurrently several EU-funded projects	3	11	14
- Resistance to closure from CP staff	2	12	14
- Insufficient alternative services	5	7	12
- CJ support	3	4	7
- Insufficiently developed services in the community	15	14	29
- The mentality of mayoralties as they refuse to accept child protection services (CTFs) in their communities	4	13	17
- Other	17	16	33

Source: World Bank, Interviews with DGASPC directors.

Problems most frequently concern land, namely identifying and procuring it, but also related permits and documentation.

Second, the limited institutional capacity of the DGASPCs to implement concurrently several EU-funded projects is highly relevant if we consider that almost half (69 centers) of all placement centers nationwide are concentrated in nine counties.[32] Actually, 21 of the 37 centers declared by the DGASPC to be in the process of closure come from only five counties,[33] which would thus have to manage EU-funded projects for three to six centers. Such an endeavor is realistic only for organizations with strong institutional capacities.

Third, center employees oppose the closure of some centers, mainly because they are offered alternatives that are not considered acceptable. For instance, in one county, the jobs offered by the DGASPC required a 19-km commute. These problems concentrate in three counties: Constanța, Neamț, and Vâlcea.

Fourth, there are problems at community level, highlighting the need to develop preventive and support services for children and families, as well as the need to roll out information and education campaigns to improve acceptance of special child protection services. In the absence of these measures, even if placement centers close down, children cannot be effectively transferred to

[32] The counties with more than five placement centers, as of February 2018, were (in alphabetical order): Argeș, Brașov, Constanța, Iași, Neamț, Prahova, Sibiu, Tulcea, and Vâlcea.
[33] These are: Brașov, Constanța, Iași, Neamț, and Vâlcea.

community-based care. Moreover, besides reintegration that will be difficult to achieve, the inflow of children into the system will not be reduced, let alone stopped.

Other problems concern: insufficient alternative services (and insufficient funds for their proper development), educational and medical service dysfunctions, poor capacity of the current network of case managers to monitor and evaluate available services, the fact that the centers have not been included on the list of 50 centers eligible for ROP funding, or the complexity of the methodology for the multidisciplinary evaluation of children (brought up in the counties with many centers).

1.4. Placement centers with small to zero chances of being closed down

In Romania, 87 placement centers for children have relatively small chances of being closed down by 2020. In the case of 31 centers, the DGASPCs want to close them down in the future, but they haven't done anything yet, and for 56 centers, the DGASPCs (typically, supported by the CJs) say that "closure is not envisaged to take place now or in the future". As of February 1st, 2018, almost 2,600 children and youth were living in those centers, meaning 49% of all institutionalized children (Table 2). The list of these centers is included in Annex 1.Table 5.

Most centers with small chances of being closed down are (Table 5):

- Institutions where modernization investments have been made (mainly, from MMJS and ROP funds, with the obligation to keep the service running);

- Centers with an already small capacity (according to DGASPC directors); and

- Centers which are not on the list of 50 placement centers eligible for ROP funding, from counties with many institutions, where the DGASPCs are already preparing several EU-funded projects (each) for closing down a number of centers.

Table 5: Main reasons given by DGASPC directors for not having done anything/not wanting to close down these centers (number of centers)

	CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	CP that the DGASPC (and the CJ) does not want to close down now or in the future	Total
Total N	**31**	**56**	**87**
The DGASPC is already preparing several EU-funded projects for the centers that should be closed down first, in counties with many institutions	10 (a)	11	21
Centers where investments have been made either with ROP or MMJS funds, bound by contract clause to keep the service running until 2019/2020, or with other funds (CJ, international NGOs), all having "good conditions" according to DGASPC directors	9 (b)	25 (c)	34
Centers with an already small capacity, in the opinion of DGASPC directors, for which a "natural closure process" is envisaged	5 (d)	23 (e)	28
Centers with highly specialized services (for children and youth with profound disabilities, juvenile offenders, or with behavioral disorders) or located in areas that ensure children's access to certain services (special school, high school, etc.)	9	15	24
The CJ does not agree to increase the funds allocated to the DGASPC (since moving children to the CTFs implies higher costs, at least in the short term)	6	4	10
Centers from Ilfov County, which are not eligible for ROP funding	4	0	4
Other reason	0	9	9

Source: World Bank, Interviews with DGASPC directors.

Notes: Multiple answer question, with maximum three answers. (a) For these centers, problems related to the land/buildings needed for closure are also mentioned. (b) Seven centers are bound by contract clause to keep the service running/maintain the scope of activity. (c) Seventeen centers are bound by contract clause to keep the service running/maintain the scope of activity. (d) The number of children and youth living in those centers as of February 1st, 2018 varied between 18 and 35 children. (e) The number of children and youth living in those centers as of February 1st, 2018 varied between 6 and 39 children.

The centers that the DGASPCs do not want to close down account for 55% of modular centers nationwide, compared with 15% of traditional centers.[34] Also, this share is significantly higher among centers without youth aged 18+, but with children under 3, among those with children with

[34] By definition, a modular center meets all of the following six criteria: organized into units (criterion 1), adequate size (criteria 2 and 3, meaning a maximum of 16 beds per unit and of 5 beds per dormitory), indoor play area (criterion 4), food preparation infrastructure allowing children to eat at least some of the meals inside the unit (criterion 5), and proper sanitary facilities (criterion 6, meaning that each unit has at leat one bathroom with at least one toilet and a sink). In all the other cases, if only some criteria are met, the centers are defined as 'traditional' or between traditional and modular, namely improved traditional or semi-modular center. (World Bank, 2017c, Output #2)

disabilities, especially with profound disabilities,[35] as well as among centers with juvenile offenders or with a high share of children with risky behaviors[36] (especially, centers for boys).[37]

1.5. Main obstacles to the closure of placement centers for children and youth

The overrepresentation of the centers from certain counties[38] on the list of 50 placement centers eligible for ROP funding poses two problems.

- The first problem concerns the institutional capacity of those DGASPCs to prepare and implement concurrently several EU-funded projects. In most of these counties, authorities state that they have limited institutional capacities and experience to make closure plans for all the centers on the list, especially when combined with a lack of/difficulty to find land/buildings as needed. This reduces the number of potential applications for funding which will be submitted under the current ROP call.

- The second problem regards the feeling of frustration among the DGASPCs with a relatively small number of centers. During interviews, several DGASPC directors emphasized that: "those who have done nothing until now are more favored" or "performance is punished", since "Romanian counties split into three categories as regards child deinstitutionalization. There are counties which have closed down the CPs and have set up alternative services, counties which have modernized the CPs, and counties which have demonstrated a lack of involvement and strategy for 20 years. The latter are very unlikely to actually do anything now, even with the available funds".

As already highlighted, a second call for proposals (in the autumn or winter of 2018) would really help the deinstitutionalization process. Table 6 below shows that, under a second call, applications for funding would most probably come from the list of 50 eligible centers and the reserve list (of 20 centers). Noticeably, these potential projects would be more spread out across the country, without marked clustering in some counties. Overall, the 23 institutions on the lists of 50+20 centers for which the DGASPC directors say they would apply for funds under future ROP/OP HC calls are located in 13 counties (see also Annex 1.Table 4).

Moreover, to ensure a higher number of applications for funds in the second call for proposals, the list could be open to all DGASPCs with a genuine desire to close down placement centers and with strong CJ support. Such a strategy would also reduce the level of frustration in the counties where the DGASPCs have made great efforts so far and have managed to close down most placement centers for children.

[35] These were institutions designated as residential care centers for children with disabilities and former special school dormitories taken over by the DGASPC from the Ministry of National Education (MEN), with over 70% of beneficiaries being children with disabilities, of whom more than 50% with profound disabilities. (World Bank, 2017c, Output #2)
[36] Underage parents, beatings or other acts of violence involving other children, gang membership or deviant peer group affiliation, runaways from the center, trouble with the police, begging, prostitution, victims of trafficking and exploitation.
[37] Centers where boys account for 80-100% of the beneficiaries.
[38] There are nine counties which each have three to seven centers on the list. These centers are: Brașov, Buzău, Constanța, Galați, Iași, Neamț, Prahova, Tulcea, and Vâlcea. In total, 40 centers on the list of 50 come from these counties.

Table 6: Distribution of placement centers for children in Romania, according to eligibility for ROP funding, closure status and the funding sources that DGASPC directors say they intend to use for closing down the centers, as of February 2018

	List of 50 centers eligible for ROP funding	Reserve list of 20 centers	Other placement centers	Total
Number of centers				
Dissolved CPs	4	0	8	12
CP which the DGASPC says it is in the process of closure (process underway), with funding from:	33	0	4	37
- Current ROP call (application deadline March 2018)	15		0	15
- Future ROP/OP HC calls	12		0	12
- CJ, own resources	2		1	3
- NGOs and other sources	4		3	7
CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage), of which:	9	10	4	23
- Future ROP/OP HC calls	5	6	1	12
- CJ, own resources	1	4	0	5
- NGOs and other sources	3	0	3	6
CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	1	4	26	31
CP that the DGASPC (and the CJ) does not want to close down now or in the future	3	6	47	56
Total	**50**	**20**	**89**	**159**

Number of children and youth living in the centers				
CP which the DGASPC says it is in the process of closure (process underway), with funding from:	1,532	0	93	1,625
- Current ROP call (application deadline March 2018)	786		0	786
- Future ROP/OP HC calls	523		0	523
- CJ, own resources	25		0	25
- NGOs and other sources	198		93	291
CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage), of which:	559	379	194	1,132
- Future ROP/OP HC calls	244	206	20	470
- CJ, own resources	41	173	0	214
- NGOs and other sources	274	0	174	448
CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	34	138	916	1,088
CP that the DGASPC (and the CJ) does not want to close down now or in the future	122	139	1,247	1,508
Total	**2,247**	**656**	**2,450**	**5,353**

Source: World Bank, Interviews with DGASPC directors.

Also, Table 6 shows that, if all DGASPCs managed to submit applications under the current ROP call for the closure of 15 centers as planned, then almost 800 children and young people would benefit from better living conditions. In addition, if a second call were held, the number of children and young people from the centers for whose closure the DGASPCs say they would apply for funds under future ROP/OP HC calls would increase by almost 1,000 children.

To these are added the 291 children and young people living in the centers that are in the process of closure with support from NGOs and almost 450 other children and youth from the centers for which the DGASPCs have already started talks with one or several NGOs. In addition, a number of 239 children and young people live in centers that are in the initial or advanced stage of closure, with own or CJ resources.

Overall, in the best case scenario, more than 2,750 children and young people could benefit from the deinstitutionalization process supported from all funding sources. In other words, the lives of 52% of the children and youth currently living in centers would change for the better: 15% would benefit from ROP funds under the current call, 19% would benefit from the second ROP call, 5% have benefited from the funds already invested by NGOs and other 8% from the funding negotiated (or under negotiation) by NGOs with the DGASPCs for the future, and 5% from DGASPC funds from own or CJ resources.

Obstacles to the application for EU funds aimed at the closure of placement centers are raised by ROP rules or child protection regulations.

Regarding ROP funding rules, DGASPC directors and CJ representatives mentioned the following:

- The need to finance and rehabilitate buildings, not only new constructions;

- The cost covered by ROP, namely EUR 395/m2 of new construction, was repeatedly valuated as insufficient or too small, requiring a substantial financial contribution from the CJ;

- The condition of having a day care center per project is considered unrealistic in terms of sustainability. Anyhow, the vast majority of the DGASPCs involved don't even try and don't find it useful to enter into a partnership with the local authorities, which are often described as the "enemy" that sends children into care;

- The conditions for minimizing the risk of creating new services that deepen social or spatial segregation (by expanding or maintaining the current communities of social service beneficiaries), namely the condition to build a maximum of two CTFs on a plot of land and that the land should not be in the close proximity of residential facilities for children or adults. These conditions require the DGASPCs to change their practice of setting up new services on the same land (which they own) or in the same buildings with other services, which creates larger communities of beneficiaries that are ever more socially isolated from the local communities in which they are located. DGASPC directors support this practice with arguments like "tradition", cost efficiency and a streamlined process by removing all the steps needed to identify and procure new land that is well-integrated into the community. Still, this practice conflicts with the spirit of deinstitutionalization and transition from institutional to community-based care. Moving children from large buildings into small facilities located in the immediate vicinity of large buildings is not deinstitutionalization. This is something that many DGASPC directors and CJ representatives still need to grasp and accept.

As regards child protection regulations, many DGASPC directors point out the fact that "the new CTFs risk being just like the centers, only smaller", considering:

- The absence of minimum quality standards for CTFs which, they say, creates licensing problems and, most of all, a design which incorporates institutional practices associated with the old pattern of care (from placement centers) for it does not support children and youth from CTFs to acquire

independent living skills. For instance, according to current regulations, in a CTF with youth over 18, the residents are not allowed to manage the home on their own, but they need help from staff just like in the CTFs with children. Or, the children are not allowed to do the daily shopping and their involvement in the preparation of meals is restricted (at least in some counties).

- Standard costs which have not been updated since 2015 and are less advantageous for CTFs than for placement centers, especially in the case of children with disabilities. “These are not just words, it’s the reality”, says a DGASPC director, and the CJ president adds that the county budget cannot bear the real cost of caring for a child in a CTF, which is much higher than in the case of a center. “And if a CTF with a capacity of ten children only has eight children, then the costs go up even more, by 10-15% per child”. This is how many directors explain why institutional closure could get a boost if standard costing changed in favor of CTFs and alternative services, especially if the law on contracting out social services were passed and clarified.

Finally, almost all DGASPC directors brought up the need to develop and strengthen alternative services, especially professional foster care, as well as the critical need to roll out information and education campaigns in local communities and to develop services that prevent children’s separation from their families and offer support to children and families in the community. These themes are dealt with in Part 2 and Part 4 of this report.

Part 2 (A)

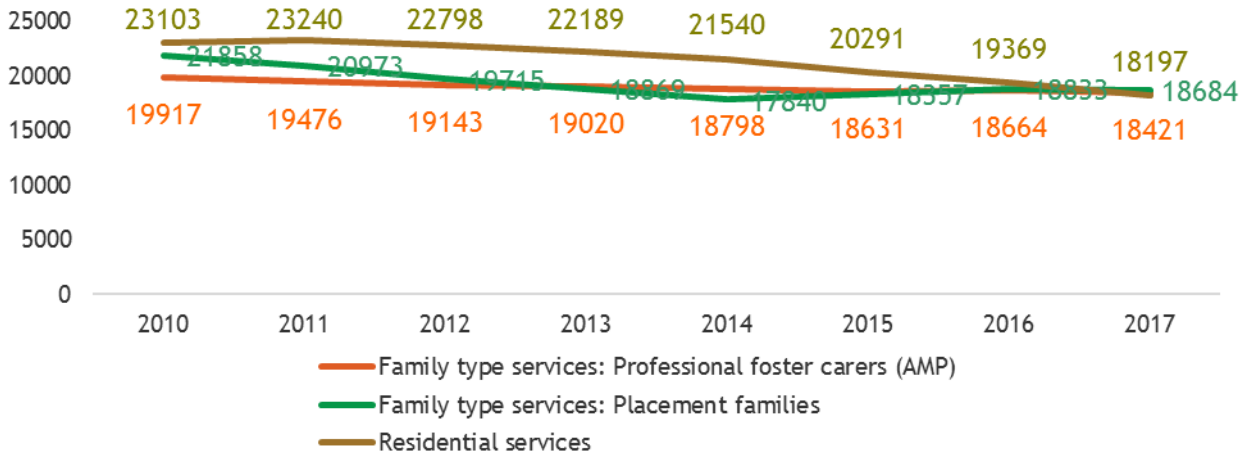
ALTERNATIVE SERVICES TO PLACEMENT CENTER CARE:

Professional foster care

PART 2A. PROFESSIONAL FOSTER CARE (AMP)

The total number of children and young people in the special care system has constantly decreased, from about 65,000 in 2010 down to about 55,000 in 2017. The decrease was recorded for all types of special care services, but the most for children and young people in residential care (Figure 2). In terms of structure, during this period one third of the children in public care were distributed to foster carers (AMP), one third to family placements (relatives or other families/persons) and one third in residential settings.

Figure 2: Evolution of the number of children and young people in the special care system, by types of care, between 12.31.2010-12.31.2017



Source: www.copii.ro, ANPDCA (2010-2017).

At national level, the number of children in foster care (AMP) decreased from almost 20,000 in 2010 to about 18,421 on 12.31.2017. Consequently, for the same period, the number of foster carers was reduced from 13,300 to 11,680.

The same trend was also noticed in the 35 counties where, on February 2018, placement centers were running. In some of these counties, the number of children in foster care (AMP) increased (Dolj, Gorj, Iasi and Mehedinti), while in others the number was significantly reduced (down to half – two thirds of the total number at the end of 2010), namely in: Brasov, Calarasi, Hunedoara, Salaj and Sibiu.

Part 2 (A) of Deliverable #4 presents an analysis of professional foster care services (AMP) in the 35 counties that have placement centers. In February 2018, these family-type DGASPC services included about 8,250 AMPs, looking after more than 13,700 children, who were monitored by about 290 case managers (see Annex 2A, Table 2).

2A.1. Data

The analysis we present hereunder is based on the data gathered by the World Bank team between February - March 2018 (Annex 2A. Table 1). The first step in all 35 counties analyzed was to conduct a face-to-face interview with the head of the AMP Service (or similar) from DGASPC, on AMP-related practices in that county. As a second step, a full census of professional foster carers (AMPs) was carried out, with a limited set of information. As a third step, a sample of 592 AMPs was randomly selected; a survey was administered for them, with questions on the AMP but also on the children placed with them.[39] The surveys were filled out together with the DGASPC case managers, based on the data in the files. In the first step, 1-4 case studies were selected for every county, 51 in total, which were carried out by the social workers in the World Bank team through site visits conducted together with the DGASPC case managers.[40] The methodological report includes the research instruments.

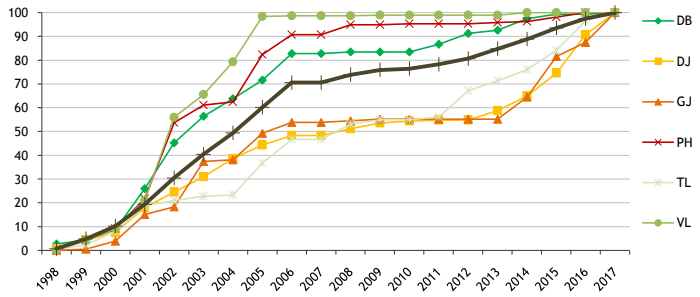
Data was gathered by a team comprised of: 22 professional social workers, CNASR members (National College of Social Workers), 24 sociologists and 23 research assistants. At the same time, 327 DGASPC specialists took part in the data gathering, occupying positions such as heads of service, inspectors, counselors, case managers, referents, social workers and psychologists.

2A.2. The foster care (AMP) network

The data from the professional foster carers census conducted between February-March 2018 only consider AMPs with a DGASPC certification, irrespective of them having children to look after when the research was conducted or not.[41]

History of the AMP network: At national level, the current AMP network was developed in three stages. According to the data from the first certification of AMPs active in February-March 2018, between 1998 and 2001 the AMP network was developed at a capacity of about 20% of the current one. Between 2002-2006 the AMP network significantly increased to over 70% of the current one. After 2007, its development was slowed down until 2012, when a new development was launched, up to the current size.

Figure 3: Year of first certification for AMPs active in February-March 2018



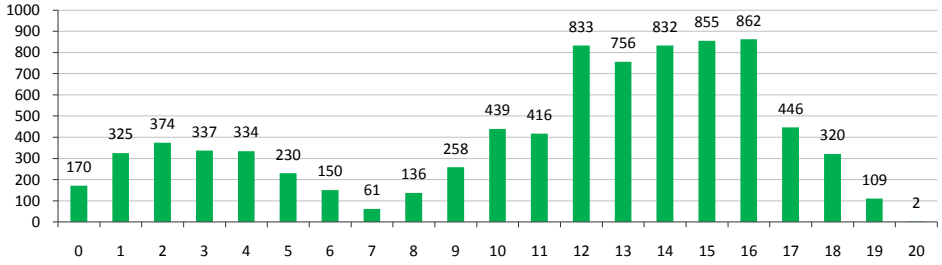
[39] 10-20 AMPs were selected in every county, based on statistical steps. For the survey analysis, the data is weighted.
[40] The case studies were randomly selected, from the AMPs in the sample.
[41] All in all, 68 AMPs did not have children to care for, 10 of which recently certificated, who had never received a child in their care before.

Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

DGASPCs had different options in terms of developing the AMP network (Figure 3). While some counties, like Valcea or Prahova, developed the entire network as of 2005, others, like Constanta, Dolj, Gorj or Tulcea had, in 2005, less than half of their current network, which they expanded after 2011.

Consequently, early developed networks have AMPs with significantly more seniority than those recently developed. Thus, if in Valcea, Dambovita or Prahova the average number of seniority years for an AMP is of 13-14 years, in networks such as Constanta, Dolj, Gorj or Tulcea the average seniority as an AMP is of about 8 years.

Figure 4: AMPs' distribution, based on seniority
(from the first certification as an AMP till February 2018) (number of AMPs)



Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

All in all, in the 35 counties analyzed the average seniority for an AMP is of 11 years (ranging from a few days minimum to a maximum of 20 years).[42] About 2% of the entire network is represented by AMPs who were first certified in 2017, 19% have a 1-5 years seniority, 18% of AMPs have 6-11 years seniority, half of the network has between 12-16 years seniority and 11% have between 17 and 20 years seniority as an AMP (Figure 4).

Composition of the AMP network: The foster carers' (AMPs) profile does not significantly differ from one county to another. 92% of AMPs are women,[43] aged between 21 and 81 years old (average age is 50) and with a medium level of education (over 84% of them graduated from vocational school or high school).[44]

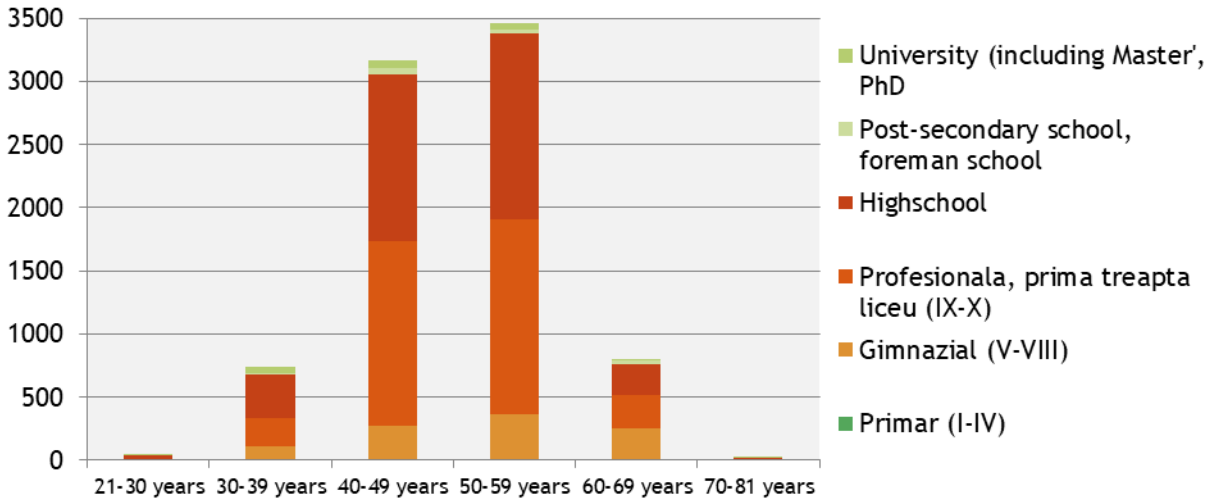
The youngest AMP networks (with an average age of 46-48 years) are in Gorj and Dolj and were largely developed after 2011, whereas county networks with the highest average age are in Alba, Brasov, Covasna and Prahova.

If in the national network only about 12% of AMPs don't have more than lower secondary education, four counties stand out and show significantly higher percentages: Satu Mare (40% of AMPs), Caras-Severin and Iasi (25% of AMPs, each) and Timis (17%).

Annex 2A. Tables 3, 4 și 5 show the distribution of AMP networks by gender, age groups and education level.

[42] Standard deviation of 5 years.
[43] In Tulcea, Valcea, Gorj and Buzau over 99% of AMPs are women.
[44] In the 35 counties, 0.2% of all AMPs have primary education at the most, 12% lower secondary education, 42% vocational school or step 1 of high school, 42% high school education, 2% post-secondary education or foreman school and 2% higher education (including post-graduate education).

Figure 5: Foster carers' distribution by age groups and level of education (number of AMPs)



Source: World Bank, AMP census (February - March 2018).

Size of the AMP network: As already mentioned, in February-March 2018, in the 35 selected counties there were almost 8,250 active AMPs (see Annex 2A. Table 2). In terms of size, there were major differences from one county to another. The number of AMPs in the county network ranged from a minimum of 75-76 in Ialomita, Ilfov and Salaj, to a maximum of 795 in Iasi.[45]

Table 7: AMP distribution, based on the number of children in their care (% of total AMPs)

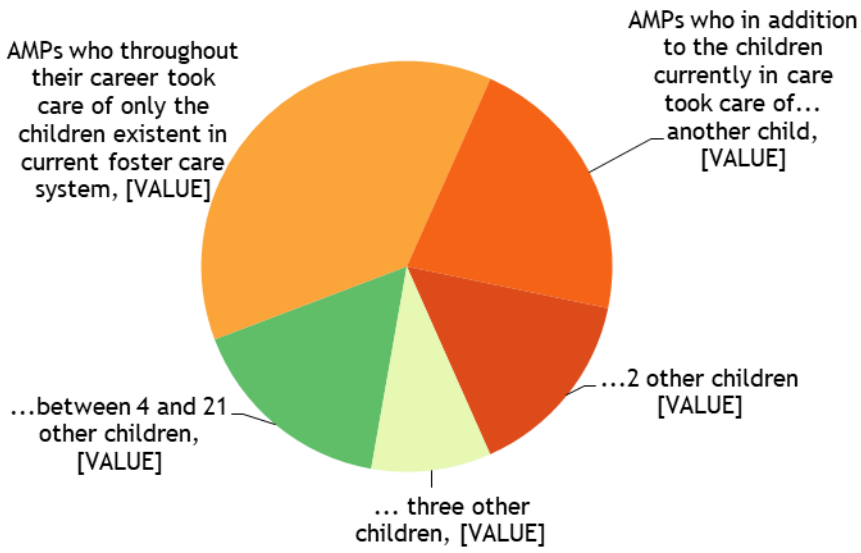
	Total number of children cared for since their first certification until February 2018:							
Number of children cared for in February 2018:	**0**	**1**	**2**	**3**	**4**	**5-10**	**11-22**	**Total**
0	0.1	0.1	0.2	0.1	0.0	0.1	0.0	0.8
1	0.0	14.3	8.8	5.6	3.4	6.1	0.4	38.6
2	0.0	0.0	20.9	11.6	8.4	13.2	0.7	54.8
3	0.0	0.0	0.0	2.0	0.9	2.1	0.1	5.1
4-6 kids	0.0	0.0	0.0	0.0	0.1	0.5	0.0	0.7
Total	**0**	**14**	**30**	**19**	**13**	**22**	**1**	**100**

Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

In February 2018, the AMP network was caring for 13,725 children. Table 7 shows that over 92% of AMPs were taking care of 1-2 children and that, throughout their career, more than three quarters of the AMPs have taken care of 1-4 children (including those currently in their care). Consequently, as seen in Figure 6, about three quarters of AMPs have taken care only of kids still in their care (37%), or another one (22%) or two (15%) apart from these.

[45] Five counties have under 100 AMPs, whereas six have between 300-500 AMPs. Timis county has 555 AMPs.

Figure 6: AMPs' distribution based on the number of children in their care in February 2018 and those cared for in the past, since their first certification as an AMP (number of AMPs)



Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

All in all, the current AMP network has cared for 28,103 children in the past 20 years (between 1998 and 2018). So, the children in foster care in February 2018 represented about half of all children ever put in the current foster care network.

But there are major differences between counties, as can be noted from Annex 2A. Table 6. Thus, the number of children in foster care in February 2018, out of all children ever looked after by these AMPs (from their first certification) ranges from a minimum of 26% in Arad to a maximum of 69% in Caras-Severin. This is a combined effect of the AMP network history - older networks have had time to care for more children than those recently developed - and the specific manner in which the DGASPC is managing the AMP network in every county.

How the AMP network is used at county level: Professional foster care services were introduced as a temporary solution of family-type caring for children deprived of parental care, especially for small children. Because of the high number of children in the special care system, the high number of entries (especially by abandoning them in the maternity), of the fact that the other services were underdeveloped and the very small number of family reintegrations and adoptions, foster care services became long term care solutions, at least in some counties, as can be seen in Annex 2A. Table 7.

In other words, some DGASPCs keep, in average, only for 2-3 years a child in the care of the same AMP (for instance Arad), unlike others that leave the child in the care of the same AMP for almost 9 years, in average (such as Caras-Severin, Maramures or Neamt). The data on the average period spent by a child with the same AMP, in every county, is found in Annex 2A. Table 8.

Table 8: Relation between the use of the AMP network and average time spent by a child with the same AMP

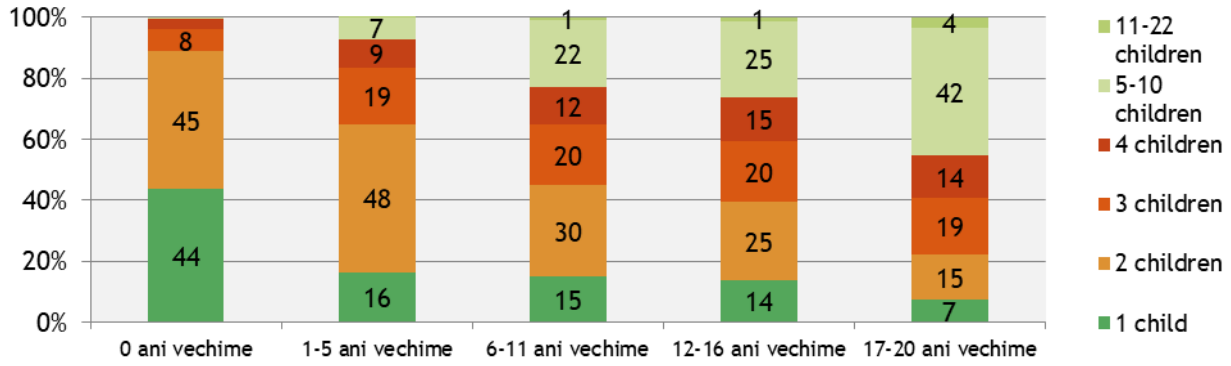
	% AMP	Average seniority as AMP	% children cared for by the AMP in February 2018	% children ever cared for by these AMPs (1998-2018) (*)	Average number of years spent by a child with the same AMP
AMP that throughout their career have taken care only of the children that were still with them in February 2018	37	9	38	18	9
AMPs that apart from the children in their care in February 2018 have also taken care of .... more 1 child	22	12	21	17	6
... more 2 children	15	12	15	16	4
... more 3 children	9	13	10	13	3
....between 4 and 12 other children	16	14	16	36	2
Total	**100**	**11**	**100**	**100**	**6**
N	**8.247**		**13.725**	**28.103**	

Source: World Bank, AMP census (February - March 2018)

Note: (*) children cared for by the AMP in February 2018 are included.

There is a statistically significant correlation[46] between the number of seniority years as an AMP and the total number of children cared for. This correlation is extremely high in some counties,[47] but it looses its statistical significance in counties in which foster carers take care for too many years of the same 1-2 children (for instance, Caras-Severin or Maramures).

Figure 7: AMPs' distribution depending on their seniority and number of children ever cared for, since their first certification (between 1998-2018)(%)



Source: World Bank, AMP census (February - March 2018) (N=8,234 AMP) Foster carers (AMPs) recently certified in 2017, that have not received a child in their care yet, are not included.

Anyways, in the 35 counties, it can be noticed that the share of AMPs that have taken care of a single child in their entire career decreases from 44% of AMPs with less than one year seniority to 7% of those with 17-20 years seniority. Similarly, the share of AMPs that have taken care of only two children is of

[46] Pearson coefficient of 0.289 (p=.000).
[47] For instance, Pearson coefficient of 0.583 (p=.000) in Arad county.

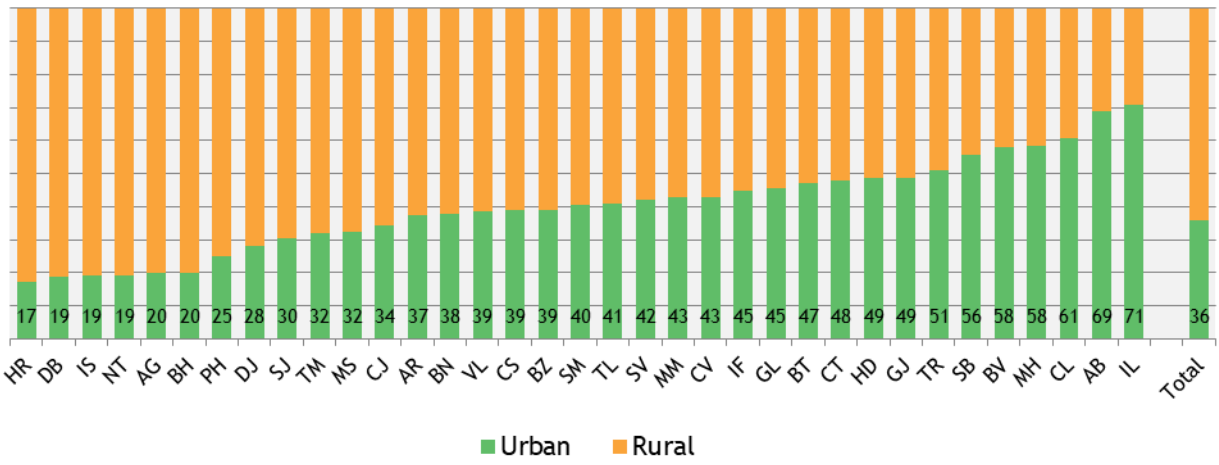
45% of AMPs with less than one year seniority compared to 15% of those with 17-20 years seniority. However, the share of AMPs that have taken care of 5-10 children in total increases from 1% of those with less than 1 year seniority to 42% of those with 17-20 years seniority. However, it should be mentioned that although 61% of the AMP network has between 12-20 years seniority (Figure 7), only 36% of AMPs have taken care of 4 or more children since their first certification until February 2018 (Table 8).

How the AMP network is monitored at county level: DGASPC has, in all counties, a service or office dedicated for foster care or family-type services (foster care and family placement). The 8,247 AMPs are monitored and supported by 290 case managers (CMs), that is roughly 28 AMPs per CM. But the number of CMs for AMPs differs significantly from one county to another. In two counties - Constanta and Ilfov - there are no case managers for AMP. In the other counties, the number of CMs for AMPs ranges between 2 (in Arad, Hunedoara and Tulcea) to 30 (Valcea). Thus, the AMP/CM ratio varies from 10 (in Alba and Valcea) to over 95 (in Suceava). The county-level data is available in Annex 2A. Table 9.

Case studies have shown that only three quarters of AMPs have had in their career just one case manager, whereas the others have changed between 2 and 10 case managers.

Territorial distribution of the AMP network: 36% of the AMP network analyzed is in the urban area, whereas 64% in the rural area. County discrepancies are striking (Figure 8). The AMP share in the urban area ranges from 17% in Harghita to 71% in Ialomita.

Figure 8: AMP distribution by county and residential area (%)



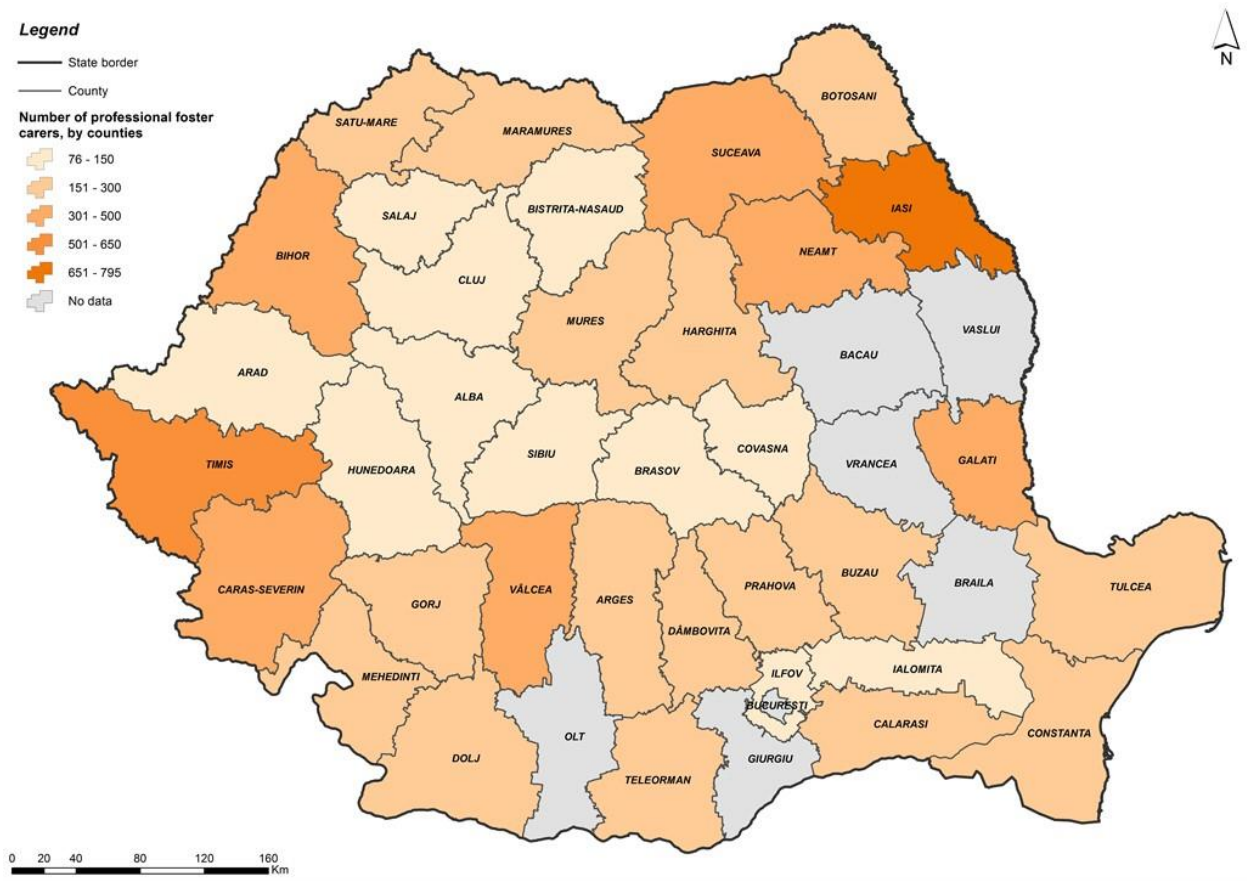
Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

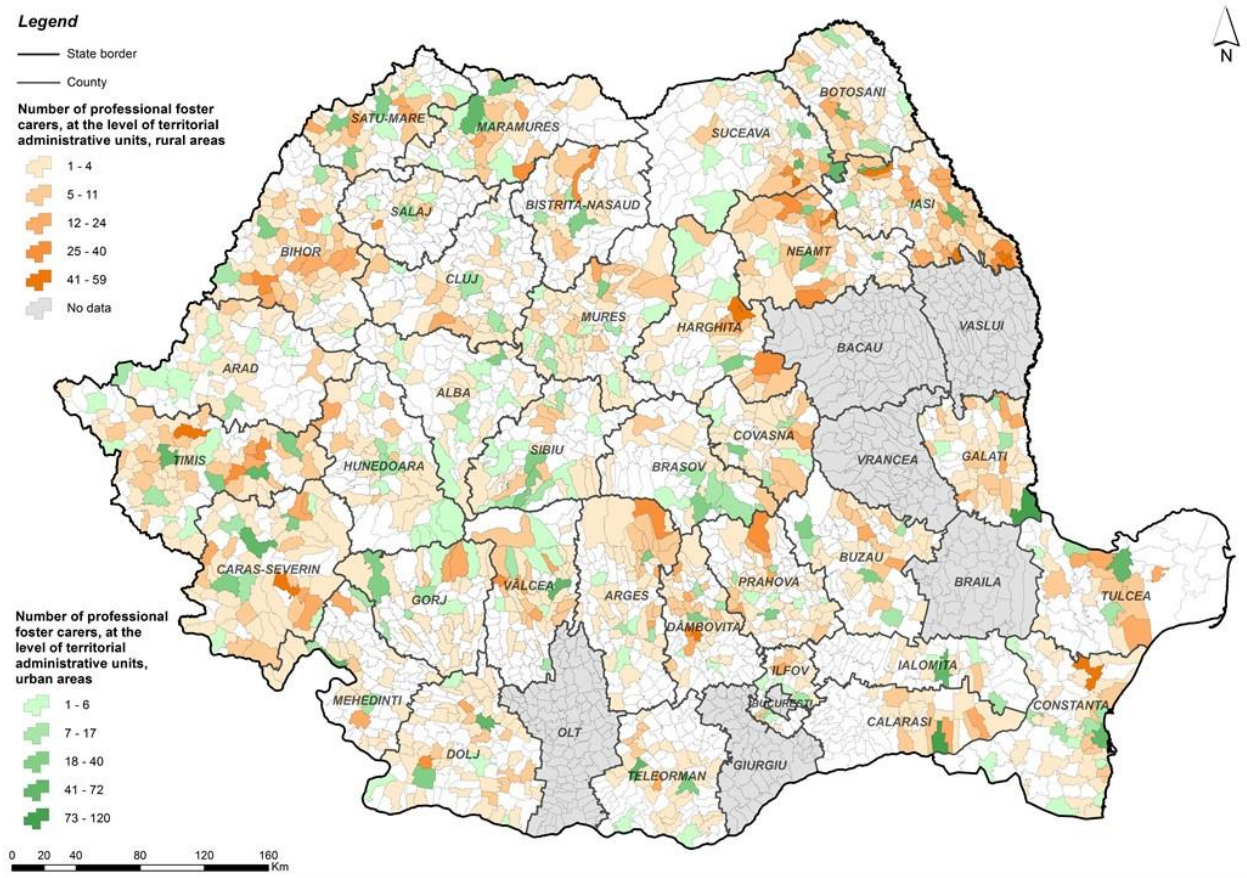
The AMP network in the 35 counties covers 233 towns and 1,129 communes. The network has a high territorial concentration, both in the rural and in the urban area. Thus, 25 towns[48] concentrate 46% of all urban area AMPs and 47% of all children in foster care in the urban area. Similarly, 106 communes[49] concentrate 43% of all rural area AMPs and 45% of all children in foster care in the rural area. The list of these localities is available in Annex 2A. Table 10.

Maps 2 and 3 show the AMP services in the 35 counties.

[48] Towns with more than 50 children placed with AMPs (between 51 and 215 children). They are located in 19 counties.
[49] Communes with more than 20 children placed with AMPs (between 20 and 108). 20 of these communes are in Iasi county.

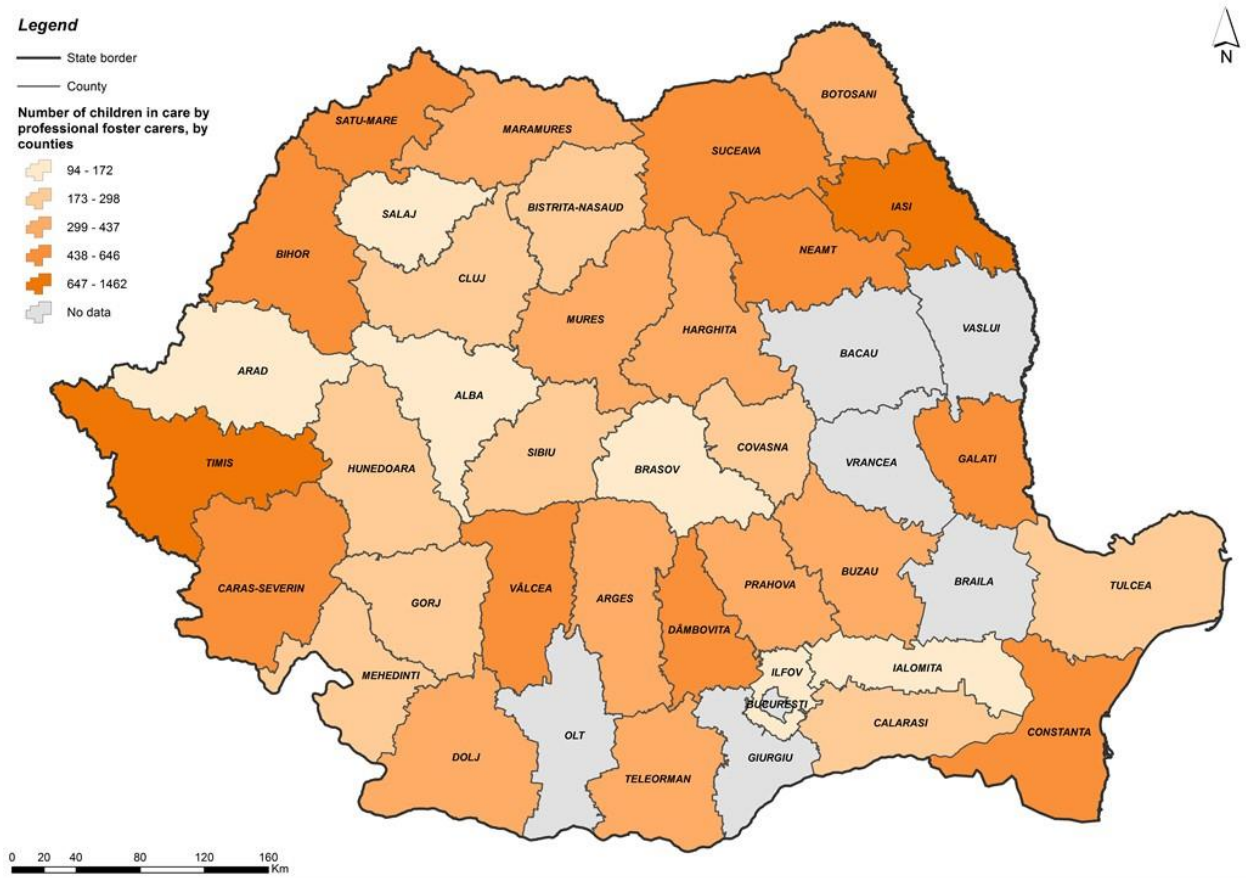
Map 1: Map of AMP services for the 35 counties analyzed (number of AMPs)

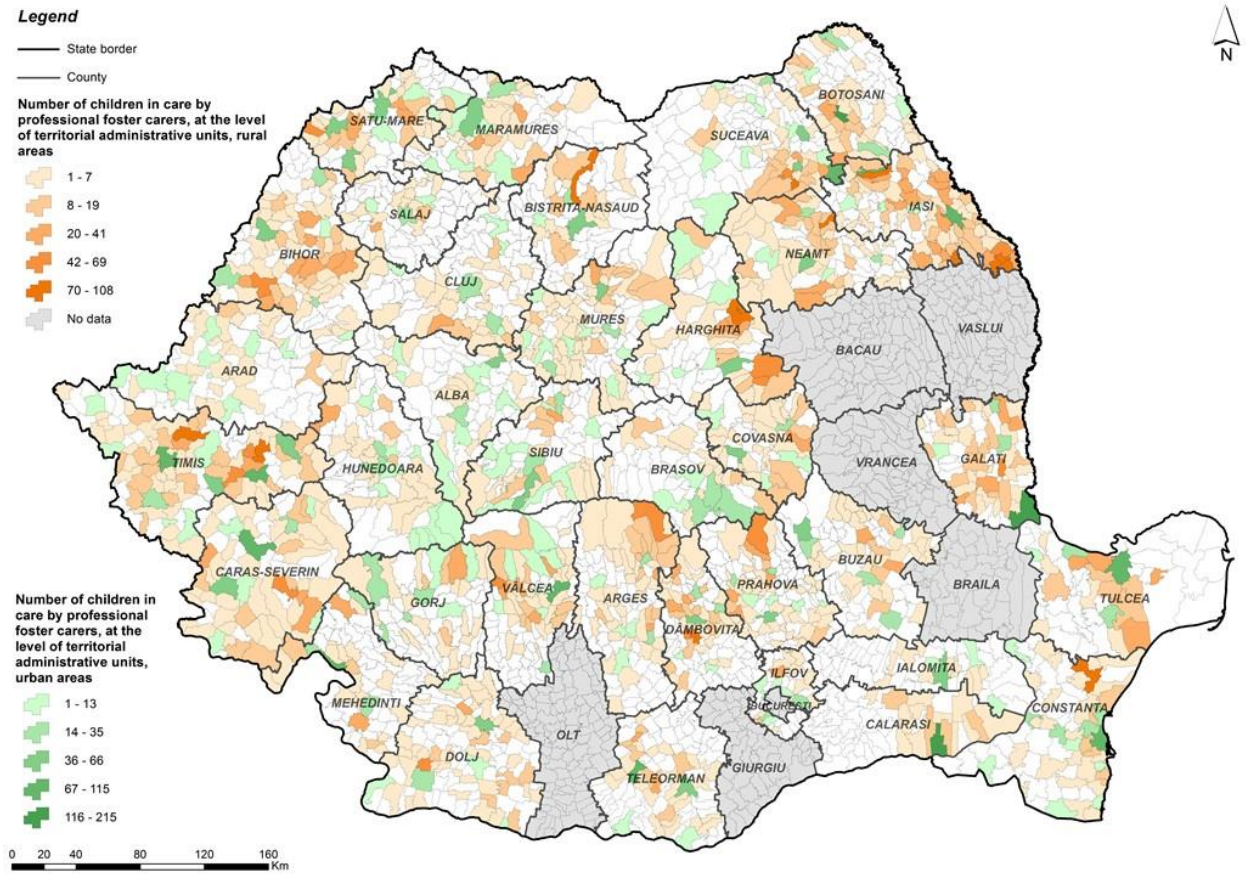




Source: World Bank, AMP census (February - March 2018) (N=8,247 AMP)

Map 2: Map of children placed with AMPs in the 35 counties analyzed (number of children)





Source: World Bank, AMP census (February - March 2018) (N=13,725 children with AMPs)

2A.3. Profile of children in foster care

Most of the children in foster care are boys and girls aged 4-14. About 28% of them have one or several of the following special needs: disabilities (20%), SEN (15%) or other special needs (13%). About 30% of children in the AMPs' care have at least another sibling placed with the same AMP (see Annex 2A. Table 11).

Table 9: Distribution of children in the AMPs' care in February 2018, by gender and age (% of total)

	Boys	Girls	Total
0-3	9	9	18
4-10	18	16	34
11-14	14	12	27
15-17	8	8	16
18+	2	2	5
Total	52	48	100

Source: World Bank, AMP census (February - March 2018) (N=13,725 children with AMPs)

2A.4. Relevance of the AMP network for the process of closing down placement centers

The demands related to number of children n care expressed by AMP in the certification request,[50] show that the current AMP Network has a potential capacity of 2,100 children more than those currently in foster care. And yet, the relevance of the AMP network for closing down placement centers is relatively low given the following reasons:

(1) The estimated potential capacity is extremely low (0-20 additional children) in six counties, of which some with many placement centers that should be closed down (Harghita, Iasi, Sibiu, Valcea).[51]

(2) The profile of children in foster care is extremely different from that of children in placement centers. Whereas the AMP network is profiled on looking after young children, with no special needs and no groups of siblings, most children in placement centers (for which closure is desired, as part of the de-institutionalization process) are over 11 years old, a third actually 16 or more, more than half of them have a disability certificate or are constantly monitored for a serious chronic disease and 41% have siblings in the same center.[52]

(3) Only about half of AMPs, including those that potentially could receive more children in their care, are willing to receive in foster care children aged 15 and more.

(4) Only 17% of AMPs agree with receiving a child with disabilities, and out of these, half are already taking care of a child with health problems.

(5) An analysis of the children that the AMP network has taken care of over the years, that were no longer at the same AMP in February 2018, shows that 70% have left the public care system: 40% through adoption, 22% through family reintegration and 8% through socio-professional integration, after turning 18. Actually, one of ten AMPs has adopted or is currently in process of adopting a child

[50] The AMP certificate is issued for a 3-year period and has compulsory requirements in terms of number, age and particularities of children that can be placed (deficiencies, language, ethnicity, religion).
[51] In the other counties, the available capacity is of more than 21 children, with maximums of about 100 children in Dolj and Maramures, respectively 250 children in Suceava and Timis.
[52] Data from Deliverable #3 of SIPOCA 2 project (World Bank, 2017d).

they had in their care. So we could say that the AMP network is highly relevant for the adoption process.

Table 10: Children who left foster care in the last 12 months, depending on the exit method (%)

		Procent
Total		**100**
Exits from the protective system	Reintegration back into the family or with relatives within the 4th degree of consanguinity	**22**
	Adoption	**40**
	Socio-professional integration	**8**
Transfer into another protective service	Transfer to the same AMP in family placement	**2**
	Transfer into family placement	**9**
	Transfer into a residential service for children	**17**
	Transfer into a residential service for adults	**1**

Source: World Bank, QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

Note: This information was requested in the interviewes with the Heads of the AMP Departments, the estimates were different, the percentages being as follows: 12%, 36%, 15%, 11%, 9%, 16% și 1%.

The other 30% of children were transferred to other services. Many of them (17%) were transferred to a placement center. So, the AMP service actually fed (more and more in the past years) placement centers. 8% were transferred to other AMPs, whereas the other children left for family placements, for an adult institution or were in several other situations.

Less than 6% of all AMPs have ever refused to receive a child in placement, most of these cases because the child's age.

2A.5. Implementing standards and case manage-ment at the AMP

This section is structured in line with Order no 35/2003[53] on Compulsory Minimum Standards (CMS) to ensure child protection at the AMP.

It is expected for the AMP service to acknowledge and answer the children's individual needs taking into account religion, ethnicity, language, culture, disabilities and sexuality.[54] In this respect, most counties have only Romanian Orthodox ethnics as AMPs. Only 14 counties have AMPs of different ethnicity and religion, meaning that they have the capacity to meet the specific needs of children from minority groups/communities.[55]

Table 11: AMP distribution based on ethnicity and religion (% total)

	Orthodox	Catholic	Another religion	Not stated	Total
Romanian	83.6	1.1	5.2	0.2	90
Hungarian	0.0	3.9	3.6	0.0	7
Roma	1.4	0.0	0.1	0.0	1

[53] Available on http://www.monitoruljuridic.ro/act/ordin-nr-35-din-15-mai-2003-privind-aprobarea-standardelor-minime-obligatorii-pentru-asigurarea-protectiei-copilului-la-asistentul-maternal-profesionist-si-a-ghidului-metodologic-de-implementare-a-acestor-standarde-43957.html

[54] => **CMS 1:** Every child is entitled to foster care services, if need be; the service shall accept diversity and promote equality.

[55] These counties are: AB, AR, BH, BN, BV, CS, CJ, CV, HR, IF, MS, SM, SJ and SB.

Another ethnicity	0.0	0.0	0.1	0.0	0
Not stated	0.6	0.0	0.0	0.4	1
Total	**86**	**5**	**9**	**1**	**100**

Source: World Bank, QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

According to case managers, almost all children in foster care were subject to an initial or detailed evaluation[56] before taking the protection measure. But only 42% of AMPs, according to the DGASPC case managers, or 32% of them, according to the AMPs, have received a copy of that report.

At the same time, almost all children in foster care have an Individual Care Plan (ICP). In line with the standards,[57] when drafting the ICP it is compulsory for all stakeholders to participate: the child's social worker or case manager, foster carer (AMP), the child (depending on his/her age and maturity), biological family. Data from the desk-research survey of the AMP services reveal that:

- 29% of AMPs were not involved in drafting the ICP for the children in their care;
- 18% of AMPs were involved in drafting the ICP, according to the case managers, but there is no document signed by them as proof of this;
- 52% of AMPs were actively involved in drafting the ICP and there are documents proving this;
- for 1% of AMPs, it is not known whether they participated or not in drafting the ICP.

Only in some counties does the DGASPC also draft Individual Services Plans (ISP) that accompany the ICPs. That is why only the children placed with 60% of AMPs also have ISPs accompanying the ICPs. Out of these AMPs, 17% were not actively involved in drafting the ISPs, 14% participated in this, without this being documented in any way, 24% participated and signed a document in proof of this.[58]

Anyways, case studies have revealed that only 38% of AMPs have received a copy of the ICP for the children in their care. At the same time, only 17% of AMPs received a copy of the ISP. And yet, case managers estimate that 93% of AMPs know the ICPs/ISPs drafted for the children they look after. On the other hand, one out of five AMPs assessed their knowledge of the ICIP/ISPs of the children in their care with the grade 5, on a 1 to 10 scale.

As part of the foster care services, the child benefits from the care provided by a professional foster carer (AMP) and a social worker or case manager[59], who monitors the the AMP's activities in the child's best interest. A child is placed with an AMP following a matching process that entails organizing several meetings, except for emergency placements.[60] The matching process considers both the child's and the AMP's opinions.

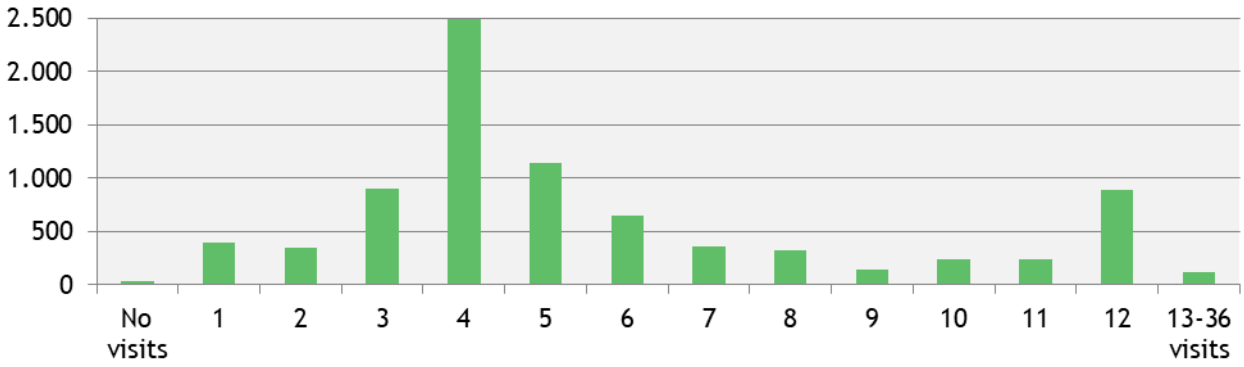
The interview with the heads of the AMP Service (or similar) within the DGASPC reveals that in all counties AMPs got the certificate and were re-certified every 3 years. The evaluation criteria used for

[56] => **CMS 2:** The child's needs assessment is conducted before taking the foster care measure, is disseminated to all stakeholders and constantly reviewed.
[57] => **CMS 3:** The child placed with an AMP shall have an ICP and all activities in this plan shall be implemented. The ICP comprises short and long-term objectives and activities, which are set after assessing the child's needs.
[58] As for the remaining 5% of AMPs it is not known whether they participated or not in drafting the ISPs for the children in their care.
[59] => **CMS 5:** The child placed with an AMP has a social worker that ensures that the provisions on child protection and care are complied with and who promotes the child's wellbeing and development.
[60] => **CMS 4:** The child is placed with an AMP only after a careful process of matching the two, so that the child's needs and preferences are met.

the certification and re-certification of AMPs are those set in GD 679/2003[61] or Order no 35/2003. The AMP certification criteria has been assessed as being sufficient, receiving 8.4 on a scale from 1 to 10. Anyways, 83% of the heads of Services feel that it is necessary for two criteria to be introduced when certifying the AMPs: (a) at least 10 or 12 grades as a minimum level of education; and (b) an age limit of 45-50 years old.

By the standards, the social worker or the case manager should monitor the child's status through regular visits, conducted at least once a month. The desk-research of AMP services shows that most AMPs receive a visit every three months, at the most (Figure 9). The visits are documented in the visit or monitoring reports, included in the child's file, in most cases. In less than 1% of these visits case managers report they were faced with situations in which the child was imminently endangered by the AMP, the latter's family, neighbors or community. Field evaluations conducted for the case studies revealed similar results.

Figure 9: Number of field visits at AMPs' paid by CMs during the past 12 months



Source: World Bank, QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

[61] GD 679/2003 on conditions for acquiring the certificate, certification procedures and the status of the professional foster carer.

Focusing on standards and administrative tasks could endanger the service quality

For the purpose of a social assistance activity from any social service being carried out at professional standards, for the child's best interest, that service should be licensed and, in this way, the Social Inspection asks for the compulsory minimum standards to be met. In this case, we are talking about the AMP Service in a given county, where the Social Inspection, in view of providing the license, asked for three visits paid monthly to the foster carer's residence, namely two for the child and one for monitoring the professional foster carer.

For monitoring a number of children and foster carers in line with the legal provisions in force, and if there were enough staff, in line with the standards, namely a case manager for the AMP and another one for the child, these requirements could probably be met, provided there is also the logistics and administrative capacity (means of transportation, enough financial resources, etc.)

But in the field we've come across cases in which the social worker is both case manager for the child and for the professional foster carer, with over 100 cases that have to be monthly monitored. How would it be possible for him/her to monitor this high number of cases, paying three monthly visits and prepare the associated documentation, as well as other types of activities necessary in line with the case management steps? Under these circumstances, the social worker specialists, although they tried to comply with the standards by visiting more than once a month the child's residence, the reporting and the proof of their qualitative involvement, of the time spent with the child and family could not be captured in the documentation produced.

Moreover, there were registration numbers for the visits paid, without the social workers having had the time to write the visit report which should follow quite a dense template, but fails to catch the progress or a clear picture of the child at that point.

It is required to have balance and a good analysis of whether these standards were met, which would lead to qualitative results felt, on one hand, by the child in foster care and by the professional foster carer and, on the other hand, by the social worker who also needs support and specialized supervision.

(Case study AMP, Field report social worker Marinela Grigore)

The data arising from the desk research shows that, in the urban area, children in foster care usually live in households comprising an average of 4 people, namely 2 adults and 1-2 kids in foster care. In the rural area, the household size is of 5 people, 2-3 adults and 1-2 children in foster care. Irrespective of the area, only about 30% of AMP families have also their own children to look after.

Table 12: AMP distribution, based on household composition and number of rooms (% of total AMPs)

	Total number of people in the household, of which:	Adults	AMP's own children	Children in foster care	Number of rooms
	% AMP in URBAN (N=2,945 AMP)				
0	0	0	72	2	0
1	0	14	21	49	0
2	6	66	5	43	22
3	31	15	2	4	39
4	32	3	1	2	24
5	18	2	0	0	8
6-10	13	0	0	0	6
Total	100	100	100	100	100
	% AMP in RURAL (N=5,302 AMP)				
0	0	0	70	0	0
1	0	9	18	26	0
2	2	56	9	56	3
3	16	24	2	7	29
4	30	9	0	9	33
5	22	1	0	0	18
6-10	29	0	0	1	17
Total	100	100	100	100	100

Source: World Bank, QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

The AMP's house[62] needs to be clean, have enough space as to ensure the privacy of all its inhabitants, separate beds for each child and appropriate annexes for hygiene, and ensure a safe environment in terms of health and wellbeing. If in the urban area the usual house of an AMP is a 2-4 room apartment, in the urban area AMPs inhabit 3-5 room houses. Thus, in both residential areas the average is of 1,2 people per room (with a minimum of 0.33 - that is, three rooms per person - and a maximum of 3 people per room). About 80% of them did some house works before bringing in the child, especially refurbishments, painting and sanitation works, changing the doors, building an inside bathroom, a new room or annexes, installing a heating station or replacing the furniture.

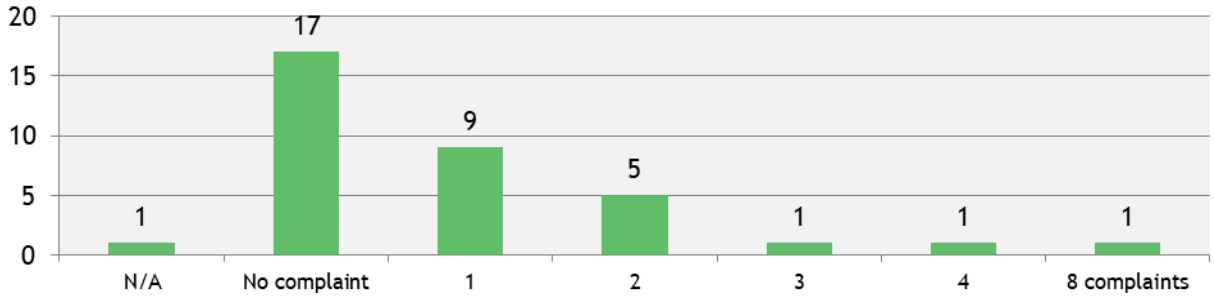
The study cases reveal that almost all AMPs visited live in houses owned by the family, which they can afford to heat properly every day, with a number of rooms that meets the necessities, with a separate kitchen equipped with everything necessary to cook, with enough bedrooms, properly furnished (beds have linen, blankets, pillows). All in all, the World Bank experts and the DGASPC case managers conducting the field visits scored from 9.5 - 9.9 (on a 1 to 10 scale) all the aspects related to space, cleanness, smell, hygiene products, children's hygiene, their clothes and footwear and the overall environment (warm, friendly, colorful, happy, personalized). So the acre environment provided by the AMP network seems to be a very good one, although some heads of AMP Services draw the attention on

[62] => **CMS 6:** The foster carer shall ensure a healthy and safe environment, that stimulates the child.

the need to support AMPs to improve the conditions, expand or adjust their house, especially in the case of children with disabilities.

34 complaints/petitions/allegations against AMPs (irrespective of the source)[63]have been filed during in the past 12 months, including cases /suspicions of abuse, neglect or child exploitation involving AMP's family, relatives, neighbors or members of the community.

Figure 10: Number of petitions/complaints/allegations against AMPs recorded in the part 12 months (number per county)



Source: World Bank, Interview with the heads of AMP Services within DGASPC on AMP-related county practices (February-March 2018) (N=35).

The total number of complaints/petitions/allegations against the AMP network increases to 552 for the 1998-2018 timeframe, that is from the first certification until February 2018. In 12 counties no cases of this kind have ever been recorded (Annex 2A. Table 12), whereas others report about 90 complaints/petitions/allegations for the entire period (Caras-Severin, Iasi). The most recurrent accusations related to unfair treatment between children, complaints in respect to house sanitation, accidents endangering the children, complaints from neighbors or schools about the children's inappropriate behavior, and various types of child abuse. Following the DGASPC investigations, most allegations were not confirmed.

Out of the 35 counties analyzed, 30 DGASPCs state they have a clear and transparent procedure for those cases in which complaints are filed against an AMP. The procedure is known and understood by the AMP network at a 8.5 level on a scale from 1 to 10, according to the heads of the AMP Service from DGASPC. However, the case studies revealed that only 30 out of the 51 AMPs visited were aware of this procedure and only 38 would know what to do if allegations were brought against them.

The AMP services, just like all other protection services, apart from a healthy, safe and stimulating environment (CMS 6 and CMS 7) should ensure children in public care suitable medical care, tailored to their specific physical, emotional and social development needs (CMS 10), the education services best suited to encourage children reach their top potential (CMS 11), support to maintain and develop links with the family and friends (CMS 9), but also to develop independent living skills (CMS 12).

In order to assess the extent in which the AMP network complied with all the standards in Order no 35/2003, the interviewed case managers (CMs) were asked about the two standards best met and the two standards most difficult to meet by every foster carer included in the sample. As a first comment, one out of six CMs declared not to know Order no 35/2003. As a second comment, about 40% of CMs had a hard time in identifying the appropriate code for the standard they intended to mention, although the research team provided them the Order. In the end, CMs gave information on 78% of AMPs, as can be seen in Table 13.

[63] => **CMS 7:** The child in foster care is protected from any type of abuse, neglect, exploitation or deprivation.

Table 13: Compulsory Minimum Standards (CMS) best met and most difficult to meet by the AMP network (%)

	Best met by the AMP		Most difficult to meet by the AMP	
	First option	Second option	First option	Second option
CMS 1	16	9	5	3
CMS 2	2	3	0	1
CMS 3	2	2	2	0
CMS 4	2	1	3	1
CMS 5	5	2	1	1
CMS 6	33	28	11	3
CMS 7	3	9	0	1
CMS 8	2	2	3	0
CMS 9	3	4	6	3
CMS 10	7	7	1	1
CMS 11	3	7	5	3
CMS 12	1	1	4	6
Total AMPs about whom the CMs provided answers	**78**	**74**	**42**	**23**
Total AMPs about whom the CMs did not provide answers	**22**	**26**	**58**	**77**
Total AMP	100	100	100	100
N	8.247	8.247	8.247	8.247

Source: World Bank, QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

Note: CMO in virtue of Order no 35 from May 15th, 2003.

The compulsory minimum standards best met by AMPs are CMS 6 - on ensuring a healthy, safe and stimulating environment, and CMS 1 - ensure services that promote acceptance of diversity, that lead to an increased self esteem in children and to developing the feeling of usefulness, that value and respects the child's ethnic, cultural and language past, that develop skills allowing them to overcome discriminatory situations, that offer opportunities for talent, interest or passion development, as well as specific support and recovery services for children with disabilities. Case studies confirmed these opinions. Apart from the extremely positive assessment of the physical environment created for children by AMPs, the research team gave an average score of 9.7 on a scale from 1 to 10 for endowments existing for recreational-education activities and noticed signs of positive interaction between children and the AMP/AMP's family in 45 cases (out of the 51), with no observations on signs of negative or indifferent interactions.

The same standards (CMS 6 and CMS 1) are also some of the most difficult to meet, together with:

- Maintaining and developing links with the family and friends (CMS 9) - usually it's about difficulties in keeping or encouraging links with parents left abroad, parents/relatives with no stable or unknown domicile, parents who do not want to be in contact with the child or parents in various difficult situations. For instance: `Father is unknown and the mother has psychological problems and changes quite often her domicile" or "Alcoholic father and schizophrenic mother, who runs off quite often with various lovers" or "The mother started the reintegration steps in 2015 and was constantly in touch with her daughter. In 2016 and 2017 she spent 1-2 weeks with her daughter in August. At the trial, the girl said she does not want to live with her mother, and from that point on, her mum never again sought her and refuses to see her."

”I asked the kids if they know their parents names. One of them, a boy with a very large smile, instantly answered ”my mum’s name is Maria and my dad’s Liniuta”... I was about to skip to the next question, thinking that I’ve come across another unusual name. But I refrained from doing this, because the two kids started to contradict each other. The older girl was trying to convince the boy that their dad’s name was not Liniuta. Liniuta is actually the horizontal line put in their birth certificate instead of the father’s name. I was struck by the dramatism of this situation and surprised by the ardent conviction with which the child had said that his dad’s name was Liniuta. I changed the subject at that point, to get out of this ...meeting his brother who was with another foster family. He was very happy to show me his brother’s photo. I was happy that his brother had a name, that he had met him; and yet, my mind was still on Liniuta...on the child in front of me and on dozens of children who do not know their fathers and for whom the line in their birth certificate hides so much pain and hope, because no specialist has ever taken the time to talk to the child...” (Case study AMP, Iasi County, Field report social worker Mihaela Zanoschi)

- Develop independent living skills (CMS 12), because ”out of too much love, they don’t ask the children to do anything”.

- Satisfying the child’s education needs (CMS 11), usually because of discriminations in school both from teachers and from colleagues.

DGASPC should train AMPs as to give them the necessary skills and knowledge.[64] Out of the studied counties, only a part have ensured in 2017 additional training for AMP (see Annex 2A. Table 13). According to the heads of AMP Services, 12 counties have not organized this kind of trainings.[65] But the data gathered on every AMP reveals that in only 9 counties none of the AMPs have received additional training in 2017. At the other end, 9 counties provided training for the entire AMP network.[66] In the other counties, the share of AMPs that attended trainings ranges from 8% to 95%.[67]

All in all, out of the 35 counties only 56% of AMPs received additional training in 2017,[68] most of whom (32%) benefited from 1-8 training hours. Moreover, training needs have been identified only for 43% of AMPs and only 29% of these needs are recorded in a document or a database. For the other AMPs, training needs are known only by the CM who is monitoring them. However, heads of the AMP Service in 23 counties (out of the 35 analyzed) claim there is a clear record of the training needs of the AMP network. In all these counties, the AMPs’ training needs mostly refer to:

(1) develop parental skills for working with teenagers, usually topics such as behavioral disorders, developing independent living skills and sexuality

(2) develop skills for working with and integrating children with disabilities.

Following the field visits, social workers part of the research team added two more topics to the training needs, that seem to be quite wide-spread among AMPs, without actually giving them the due attention, which are:

(3) Manage the AMP-child relation, to reduce the child’s dependence on the carer. Several case studies have revealed that some AMPs encourage children to call them ”mum” and ”dad”, not only because this is a sign of the child accepting them as parents, but also to minimize or weaken the biological family’s role in the child’s life. Consequently, during the talks held with children it was quite difficult to constantly make the distinction between the ”mum/dad” from here (AMP) and those from home. Or, as a head of AMP service put it: ”In general, AMPs don’t really get their profession. The children become theirs; they don’t understand that being an AMP is a job.”

[64] According to CMS 15 the social worker or case manager is responsible to monitor the AMP’s activity and to identify their training needs. 15.2. Training foster carers is part of the training program for the SPPC/OPA staff and includes opportunities for common trainings with social workers and staff in residential centers.
[65] These counties are: AG, BT, CT, DB, IF, MM, MH, PH, SM, TR, TL, VL. But in AG, BT and TR part of the AMPs did receive additional training in 2017.
[66] Counties that trained the entire network are AR, BH, BN, CS, CV, IL, NT, SB, SV.
[67] The AG and HD counties trained only 8-10% of AMPs, whereas AB, TM and SJ trained over 90%.
[68] On 2% of the AMPs there is no information on 2017 trainings.

(4) Identify trauma and work with a traumatized child.

Apart from training, the DGASPC also offers county AMP networks:

- Psychological counseling, in 34 out of the 35 counties
- Individual or group psychotherapy sessions, in 12 counties
- AMP support groups, in 20 counties.

Table 14 below shows the support received by AMPs from the AMP Service within the DGASPC, according to the AMPs' statements. As can be seen, the most recurrent type of support, and also the most necessary, refers to providing information on the children, counseling and information on the available services.

Table 14: Support received by the AMP at the AMP Service/Office, in the past 12 months (number of AMPs)

	Support received in the past 12 months	Support deemed by the AMP to be the most necessary
Total AMPs participating in the case studies, of which:	**51**	**51**
a. Information on children	36	22
b. Information on services (location, how to access them)	28	15
C. Mediation with the medical services (specialized, dentist, mental health services, recovery services, etc.)	23	15
d. Mediation with the educational services (school network, clubs, etc.)	20	8
e. Counseling and support for parents/carers	29	16
f. Temporary care (*respite care)*	2	8
g. AMP support groups, formal/informal AMP associations	21	17
h. Trainings	29	20
i. Psychological counseling	30	6
j. Individual or group psychotherapy	5	4
k. Support in keeping the link between the child/children and the natural/extended family	20	8
m. I haven't received any support *(the AMP salary is not considered)*	1	-

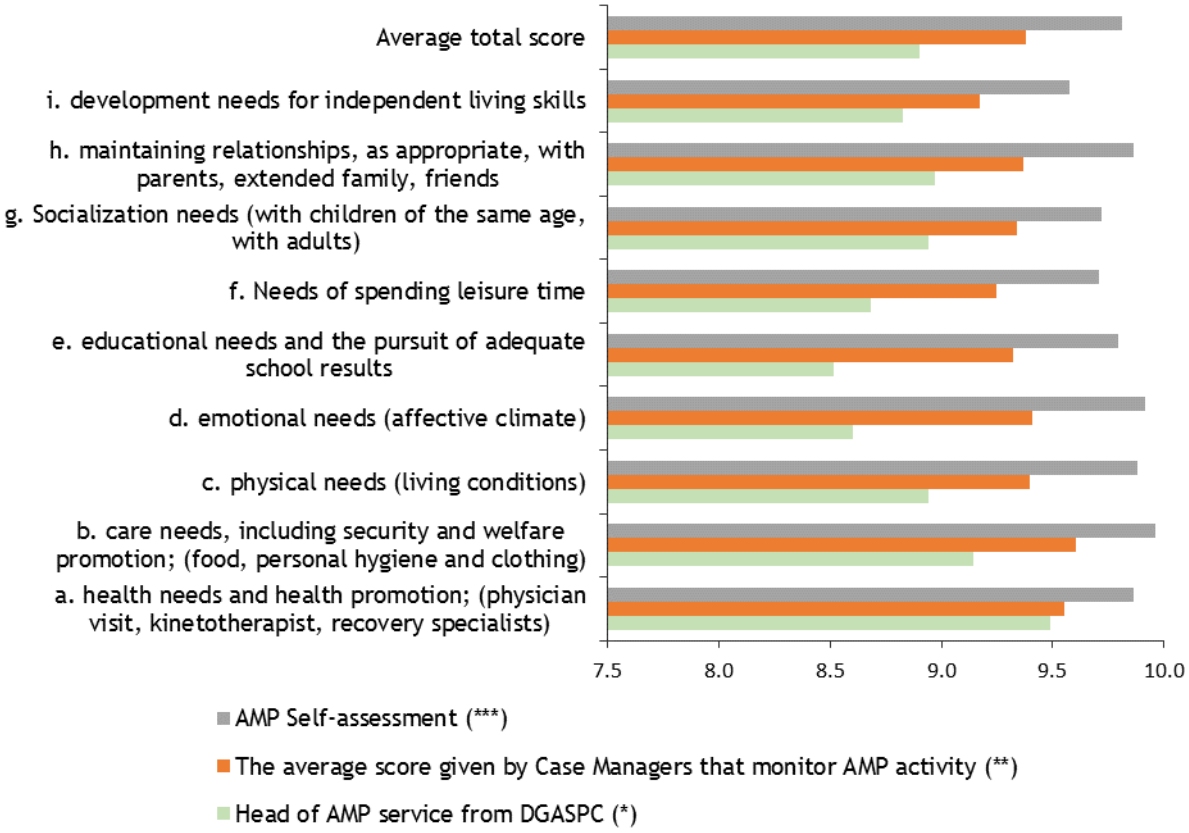
Source: World Bank, CS AMP Case studies for AMPs (February-March 2018)

All in all, during the case studies AMPs appreciated the support received from the AMP Service as being "vital; without it we wouldn't have managed" or "useful, but we could have managed without it too" (almost equally). At the same time, about half of them appreciated as vital the support received from other DGASPC specialists, such as psychologist, doctor, kinetotherapist, speech therapist, etc. In some counties the DGASPC is also organizing camps and trips for children, reimbursing medical bills and providing other services, especially for children in emergency placement.

2A.6. Effectiveness of the AMP services

The performance of the AMP network in taking care of children is good, being evaluated at 8.5 up to 10 (on a 1 to 10 scale), in respect to all types of needs and by all evaluators - heads of AMP Service within the DGASPC, CMs monitoring the AMPs' activity and the AMPs themselves.

Figure 11: Evaluation of actions and activities carried out by AMP to meet the child's needs , by types of needs



Source: World Bank, (*) Interview with the heads of AMP Services within DGASPC on AMP-related county practices (February-March 2018) (N=35). (**), QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted. (***) CS AMP Case studies for AMPs (February-March 2018) (N = 2018)

Note: Averages calculated based on valid answers. Child's needs, in line with Order no 286/2006 from 07/06/2006, approving the Methodological Norms on developing the Services Plan and the Methodological Norms on developing the Individual Care Plan, published in the Official Gazette Part I, no 656 from 07/28/2006.

DGASPCs do not measure systematically the satisfaction of children and AMPs. Best case scenario, they randomly administer surveys for a small sample (for instance, in Dolj, for 20 children and 20 AMPs), or use the forms filled out in the field by the CM (in Alba or Arad), or use the reports filled out for AJPIS (County Agency for Payments and Social Inspection). However, social workers part of the research team that conducted the case studies made evaluations similar to those in Figure 11, following the discussions with the AMPs and the children in their care. The general conclusion was that in almost all cases "children are well taken care of, sociable, open and active in the family environment".

As for the costs associated to the AMP services, DGASPC has provided poor data. First of all, only a small part of the heads of AMP Service gave an estimate of the total monthly cost per child in foster care, as can be seen in Table 15. Secondly, the estimates received range between a minimum to a five-times higher maximum, both for children without disabilities and for those with disabilities.

Thirdly, the average monthly cost per child is almost double the minimum cost standard for this service, set in Decision no 978/2015.[69]

Table 15: Total monthly cost per child placed with an AMP

		Child without disabilities	Child with disabilities
Direct expenditures	No of counties that answered	19	18
	Average (lei)	2,281	2,886
	Minimum (lei)	1,517	1,896
	Maximum (lei)	3,500	4,500
Indirect expenditures	No of counties that answered	10	10
	Average (lei)	1,345	1,513
	Minimum (lei)	100	150
	Maximum (lei)	6,000	6,500
Total expenditures	No of counties that answered	10	10
	Average (lei)	3,728	4,479
	Minimum (lei)	2,100	2,450
	Maximum (lei)	9,500	11,000

Source: World Bank, Interview with the heads of AMP Services within DGASPC on AMP-related county practices (February-March 2018) (N=35).

And yet, about one third[70] of heads of AMP Service within DGASPC feel that an additional monthly financial support of 250-300 lei per child would be necessary, to make the service more attractive for AMPs, and of 300-350 lei per child, so that the child is not denied, postponed or canceled access to services they need. This is also the opinion of about one third of[71] CMs, but their estimates are higher, to about 500-700 lei per month per child. Half of the foster carers interviewed say they would need an additional 800-900 lei per month per child, generally for medical and recovery services and for expenses incurred with school and extracurricular activities.

> ”Children (in foster care) participate in extracurricular music activities (organ and saxophone) and extra tutoring (foreign languages and maths). there are signs of clear emotional interactions, and the AMP can be seen as a best practice example. At home we noticed that there were several pictures of the two children, taken during important events for them (celebrations, award festivities, trips to Germany to the AMP’s biological children). The AMP states that it would be impossible to offer the children extracurricular activities without the support of her bilogical children.” (Case study AMP, Brasov County, Field report social worker Florentina Andrei)

In any case, in view of increasing the quality of foster care all stakeholders agree that, apart from money, more and better training of AMPs is also needed and developing community services, in the AMP’s vicinity, especially daycare centers, recovery services and school after school.

[69] http://www.mmuncii.ro/j33/images/Documente/Legislatie/Assistenta-sociala-2018/HG_978_-2015_la_18012018.pdf
[70] Out of the 35 counties, 9 answered and 15 agreed that an additional financial support is not necessary.
[71] 7% of CMs did not answer and 61% did not feel that additional financial support is needed.

Best practices

M, from Miracle

I am in Buzau and we are heading towards a foster family from the rural area that are looking after 2 children: a 4-year old girl and a 9-year old boy. The house in which the foster carer lives, together with her family, is clean and welcoming. The lady welcomes us with a smile on her face, together with her husband. In the room we enter, M, a 4-year old girl, looks at use in a relaxed way, is very sociable and immediately interacts with us. She shows us her toys, approaches the case manager, while talking about friendship, kindergarten, colleagues.

The center of everyone's attention, from time to time she climbs into the foster carer's arms, pirouettes, turns back to the case manager, gets into bed, explores, communicates, talks, looks at us carefully, fills out all the space with her being and, eventually, asks the case manager for a little lipstick, to put on some make-up like "a young lady". Somehow aware of being the center of attention, she makes me say in my head "how natural and relaxed is this child, how bright her eyes are", and how good she feels in this foster family.

M comes from a disadvantaged family, who ended up at the AMP for poverty-related reasons, with no apparent medical issues. In the social evaluation in her file I read later on: M was born on 08.15.2013 in the Rm. Sarat Maternity, father unknown, domiciled in Rm. Sarat. After giving birth, her mother abandoned her in the Newborn Ward of the Rm. Sarat Municipal Hospital, later motivating that she did not have the financial or material means to raise and look after the child, because she already has three other.

From the discussions, I was surprised to learn that M had not had any special medical issues until May 2015. I can't believe that a child so alive and healthy was actually sick. "As of May 2015, the following behavioral signs are recorded: low appetite, low interest for surrounding objects, she rocks herself to sleep, she would bang her head against the floor, sometimes was aggressive with the others and according to the psychological assessment, she was not developed according to her age, had signs of auto and hetero-aggressiveness, hyperkinetic syndrome, light psychomotric retardation. In May 2015 she was admitted for medical investigations to Prof. Dr. Alexandru Obregia Hospital in Bucharest, with a recommendation to periodically go to the neuro-pshychiatrist in Buzau The child received the treatment given by the latter - Encephabol, Timonil, Cerebrolizin (for about 1 year). Periodic encephalograms were done, as the specialist doctor recommended."

Later on she started to develop her vocabulary, she stopped being aggressive and became interested in activities, in games. As of the 2016-2017 school year, M has been going to the local kindergarten, she fit in, she takes part in the activities, gets along well with the other children. "The foster carer was constantly in involved in raising, looking after and educating the child, followed the doctors' recommendations and those of toher specialists, actively collaborated with them and got involved in the child's individual development", says the case manager. I don't think that if this child had been in residential care she would have had the same chance!

This is one of the best experiences I've had as an evaluator/social worker: to have in front of you this wonderful child, playful and full of energy, and to learn that in the past she showed signs of hospitalism, that she has the NPI diagnostic or shows low interest in the surrounding objects. And for none of these things to be obvious; to just learn them from the case manager, while talking or by reading the file.

There are the miracles you read of in the Bible, but there are also the living miracles, experienced, that surprise you. Here, in Buzau, in a beautiful family, I saw the 4-year old M. M's destiny is not a prophet's miracle; the miracle was made by a foster carer!

(Case study AMP, Buzau County, Field report social worker Eugen Lucan)

Part 2 (B)

ALTERNATIVE SERVICES TO CARE HOMES:

Family-type foster care

PART 2B. NETWORK OF FAMILY-TYPE FOSTER CARE WITH RELATIVES AND OTHER FAMILIES / PERSONS

In Romania, foster care type services are broken down into:

- Foster care with relatives up to the fourth degree and

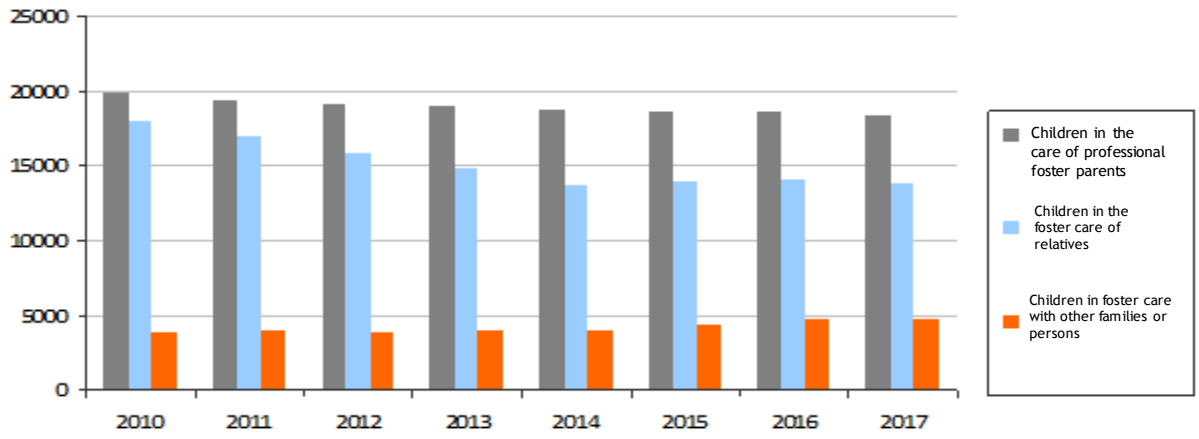
- Foster care with other families or persons, namely relatives, other than up to the fourth degree, kin, acquaintances or friends of the family or of the extended family of the child, with which the latter has built an attachment or together with which they enjoyed a family life.

In the official statistics, foster care is registered at child level, and there is no information on the persons taking care of the children or the households in which they live. This data is all the more relevant as many foster families take care not only of one child, but of between 2 and 12 children. This is why this chapter provides an analysis of foster care, in addition to the analysis of children benefiting from care supplied by such services.

The total number of children in foster families decreased between 2010 and 2017, as it also happened in the case of children placed in residential care or with foster parents (please also see Part 2A). Nevertheless, regarded as weight in the total number of children in the special protection system, foster care continued to account for approximately one third. Among all types of protection services, there is a service which, unlike all the others, witnessed a surge. This is the service of foster care with other families/persons, as indicated in Figure 12. However, in the total number of foster care, the weight of care provided by other families/persons merely increased from 18%, in 2010, to 26%, in 2017.

Figure12: Evolution in the number of children and youth benefiting from special protection measure in family type services, broken down per types of services, between 31 December 2010 and 31 December 2017

Figure 1: Evolution in the number of children and youth benefiting from special protection measure in family type services, broken down per types of services, between 31 December 2010 and 31 December 2017



Source: www.copii.ro, National Authority for the Protection of the Rights of the Child and Adoption (NAPRCA) (2010-2017).

At national level, the number of children placed in foster families with relatives up to the fourth degree has decreased from more than 15,100 in 2010 to approximately 11,200 on 31 December 2017.

In contrast, the number of children in foster care with other families/persons has increased from approximately 3,300 to approximately 3,900 (see Annex 2B. Table 2).

A similar evolution was also recorded at the level of the 35 counties where, in February 2018, there were in operation care homes for children. Among such counties, however, in some of them the number of children in foster care with relatives has increased (Dolj, Ilfov, Suceava and Tulcea), while in others, the number dramatically dropped, for instance, in Galați, up to one third of the number existing at the end of 2010. At the same time, although the number of children in foster care with other families/persons increased in general, it also saw considerable drops in counties such as Harghita or Timiș.

Table 16: Distribution of family-type foster care (PFam), children under care and caregivers, broken down per types of PFam

	Family-type foster care		Children in PFam		Caretakers	
	Number	Percentage	Number	Percentage	Number	Percentage
Total, out of which:	11,300	100	14,487	100	16,079	100
- with relatives up to the fourth degree	8,133	72	10,580	73	11,435	71
- with other families or persons	3,099	27	3,745	26	4,553	28
- Mixed	68	1	162	1	91	1

Source: World Bank, PFam Census (February-March 2018).

This Part 2 (B) of Output #4 contains an analysis of family foster services in the 35 counties where there are in operation care homes for children. In February 2018, these General Directorate for Social Assistance and Child Protection services of the family-type contained a total of 11,300 placements (with families or persons) who provided care for approximately 14,500 children whose wellbeing was monitored by more than 340 case managers. Among these placements, 72% were with relatives, 27% with other families or persons, and 1% were placements with several children, some of which with relatives and some of which with other families.

2B.1. Data

The analysis detailed in the sections below relies on data collected by the World Bank team in February-March 2018 (Annex 2B. Table 1). In each of the 35 counties under review, in the first stage, a face-to-face interview was conducted with the Head of the Case Management Service or Family-Type Placement (or similar) services within General Directorate for Social Assistance and Child Protection, in connection with county-wide practices. In the second stage, the census of family placements (PFam) was supplemented, containing a small set of information. In the third stage, a sample of 774 PFam was randomly selected, to which a questionnaire was provided in connection both with the foster family, and with the children under their care.[72] The questionnaires were filled out together with the children's case managers, within the General Directorate for Social Assistance and Child Protection, in reliance upon the data existing in their files. In the last stage, 1 to 4 case studies were selected from each county, totaling 57, which were targeted by the social assistants within the World Bank team by on-site visits conducted together with the case managers of the General Directorate for Social Assistance and Child Protection.[73]

Data was collected by a team comprised of: 22 professional social assistants, members of CNASR, 24 sociologists and 23 research assistants. Furthermore, the collection of data was attended by 327

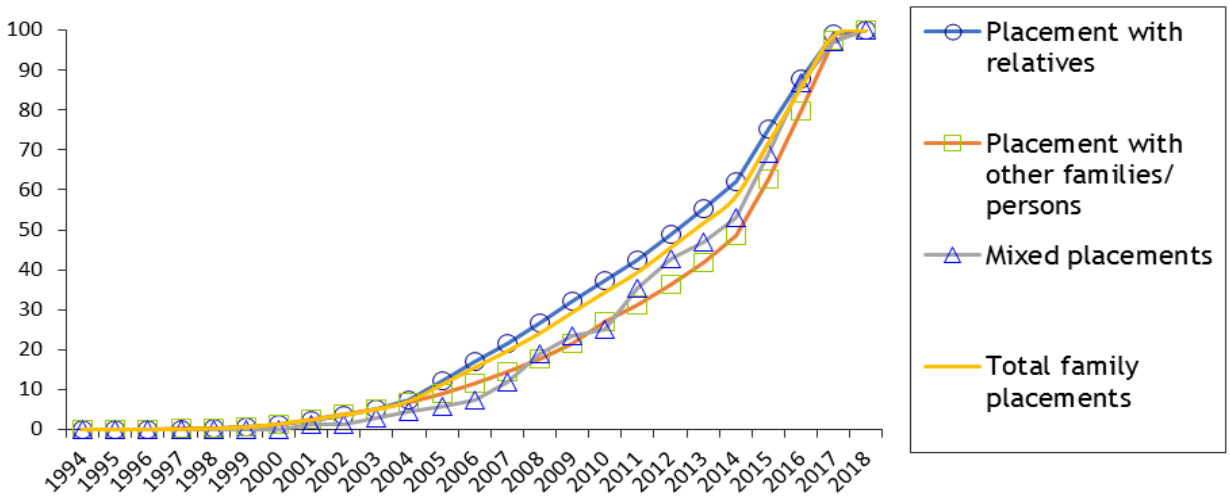
[72] In each county, 10-20 placements with relatives and 5-7 placements with other families or persons were selected, in reliance upon statistic pitch. For questionnaire analysis, data has been weighted.
[73] Case studies were randomly selected from among the PFam selected in the sample.

specialists with the General Directorate for Social Assistance and Child Protection, holding positions such as head of department, inspectors, counsellors, case managers, clerks, social assistants and psychologists.

2B.2. Family-type foster care network

The history of the PFam network: At the level of the 35 counties under review, the current network of family-type foster care was set up in three stages. Starting from the date when they received the first children under their care, the current PFam network (carrying for one or several children in February-March 2018) developed at a slow pace between 1994 and 2004, until 7% of its current capacity.[74] The growing pace of the network increased from 2005 until 2014, when it reached almost half of its current capacity. Between 2015 and March 2018, the family-type foster care network virtually doubled and reached the 11,300 foster families with 14,500 children under their care.

Figure 13: Year when family-type foster care active in February-March 2018 received the first children under their care, broken down per types of PFam



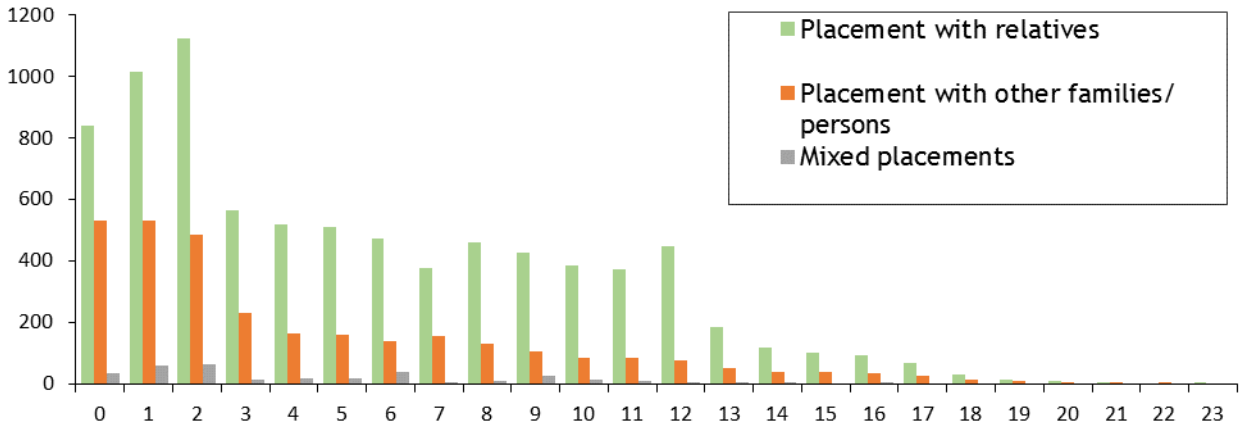
Source: World Bank, PFam Census (February-March 2018) (N=11,300 PFam).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

Annex 2B. Table 3 illustrates that the county networks of family-type foster care have gone through the same development stages. There are, however, differences between the networks which were set up earlier - in the counties of Galați, Iași, Maramureș, Neamț, Sălaj, Teleorman and Vâlcea - and the networks set up more recently, in particular in Dolj, Ilfov and Tulcea. Accordingly, the average period spent by a child under family-type foster care is twice as long (around 6 years) in the counties where networks were set up earlier, than in those developed after 2015 (where the average period is approximately three years).

Figure 14: Distribution of family-type foster care depending on their length of service as PFam (from the time when they received the first child under their care until February 2018), broken down per types of PFam (number)

[74] The first mixed foster care center (with several children, some of which under foster care with relatives and others with other families/persons) was set up in 2001.



Source: World Bank, PFam Census (February-March 2018) (N=11,300 PFam).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

In total, at the level of the 35 counties under review, the length of service as foster family is of:

- 5.5 years, for relatives up to the fourth degree (minimum a few days and maximum 23 years),
- 4.4 years, for other families or persons (maxim 22 years), respectively
- 4.5 years, for mixed foster care (maximum 16 years).75

The structure of the PFam network, per types: the General Directorates for Social Assistance and Child Protection have taken different preference in developing certain types of family-type foster care centers (Annex 2B. Table 4). As already indicated, in the 35 counties under review, out of the entire PFam network: 72% were with relatives, 27% were with other families or persons, and 1% were mixed foster care centers (with several children, some of which with relatives and some with other families). Nevertheless, county networks widely varied from the network in the county of Covasna[76], which comprised 89% PFam with relatives, 11% with other families/persons and no mixed foster care center and the network in the county of Teleorman[77], where 50% of the placements were with other families/persons, 48% with relatives and 1% were mixed. Mixed foster care centers are but a few (maximum 5) in 26 counties among the 35; the other 9 counties have not used this type of PFam.[78]

Groups of PFam and PFam with professional foster parent (PFP): the analysis conducted at household level in foster care families and foster parents revealed that there are both households where several PFam co-exists, and households of foster parents also providing care for children under family-type foster care. Thus,

- approximately 1% of PFam live in the same households as other foster care families.79 In general, PFam groups also include children under the foster care of relatives.

[75] Corresponding standard deviations are of approximately 4.5 years for all types of PFam.
[76] A similar structure per types of PFam also existed in the county of Gorj.
[77] The counties of Bihor, Galați and Sibiu had a similar structure.
[78] Counties which, until February-March 2018 had not used mixed family-type foster care consisted of: AR, BH, BN, CS, CJ, CV, IL, TL and VL.
[79] The maximum percentage of PFam living in households containing several foster care families was in February-March 2018 of 3.2%, in the county of Dâmbovița.

- other 1% of PFam forming part of households of professional foster parents.[80] Almost all placements forming part of PFam groups with professional foster parents are placements with other families or persons. Most often, they emanate from retired foster parents who have applied for placement with other families/persons, in order to keep the child.

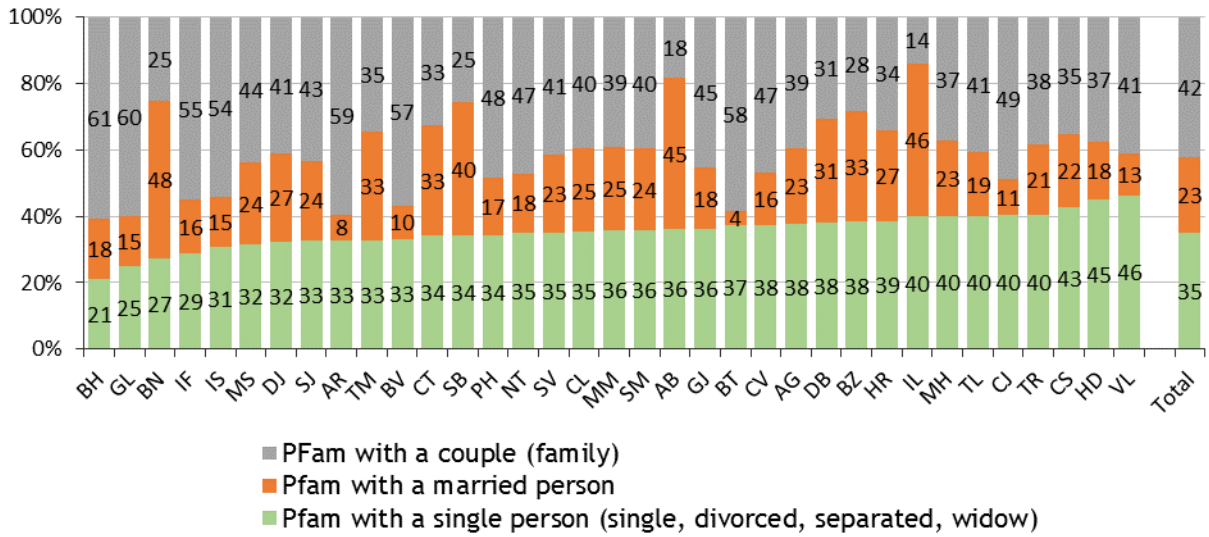
Groups of PFam and PFam with professional foster parents may be found in 29 out of the 35 counties under review, as illustrated in Annex 2B. Table 5.[81]

Composition of the PFam network: According to applicable regulations in force, upon enforcing the protection measure consisting of family-type foster care, the caregiver of the child shall be identified, who may be a person or a family. Among all family-type foster care units in the 35 counties, in 57% of the cases the caregiver is identified as a person and in 43% as a family. Practices vary, however, across the counties. Thus, the percentage of foster care with a person varies between 35% (in the county of Bihor) and a maximum of 86% (in Ialomița) (Annex 2B. Table 6).

At any rate, irrespective of the caregiver identified upon enforcing this measure, most children live, in actuality, in a family, as they are given in the care either of a couple, or of a married person. Placements to other families or persons contain a significantly higher percentage of PFam where the children live, in effect, in a family, when compared to placements to relatives up to the fourth degree - 72% versus 63% (Annex 2B. Table 6).

Figure 15 reveals that in all counties, in more than half of foster care families, children live in a family (with a maximum of 79% in the county of Bihor) (Annex 2B. Table 7).

Figure15: Distribution of family-type foster care depending on the caregiver of the child/children under special protection measures (%)



Source: World Bank, PFam Census (February-March 2018) (N=11,300 PFam)

The distribution of children among these types of family-type foster care is similar to the one in the figure above.

As a generalized practice, when placement is concluded with a person (married or not), the caregiver of the children/child is a woman (Annex 2B. Table 6). For this reason, women account for 89% of placements to singles (not married, divorced, separated or widow) and 87% of placements to married persons.

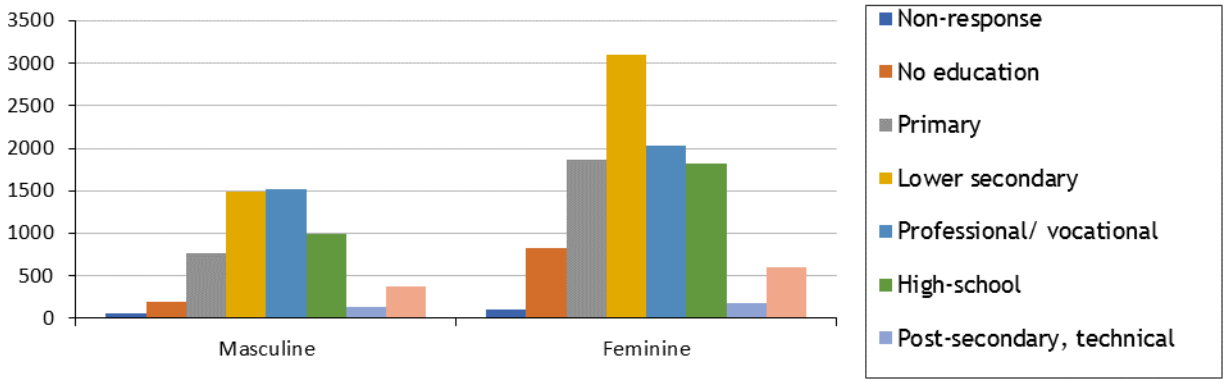
[80] The maximum percentage of family-type foster care in households containing groups of PFam and professional foster parents was in February-March 2018 of 4.3%, in the county of Teleorman.
[81] The counties where, in February-March 2018, there were no such groups were as follows: AG, BN, CV, GL, GJ and PH.

Overall, the network of family-type foster care contains approximately 16,100 caregivers. More than two thirds (66%) of them are women. The percentage of women is considerably higher (more than 75%) in placements to a person and in two counties - Alba and Ialomița (please see Annex 2B. Tables 8 and 9).

The average age of caregivers in the family-type foster care network is 55 years,[82] with a minimum of 17 years and a maximum of 90 years. While persons younger than 40 years of age account for 10% of the total number, persons older than 60 years of age are four times as many. Relatively younger are caregivers in the placements to other families/persons (as average, 52 years, as compared to 57 years for placements to relatives), those in groups of PFam with professional foster parents (as average, 53 years) and in the four counties - Bihor, Ilfov, Satu Mare and Arad (51-53 years) (please see Annex 2B. Tables 10 and 11).

Almost half of the caregivers have graduated no more than a high-school: 6% are illiterate, 16% have only graduated primary schools, and 29% have graduated secondary schools. At the other end of the spectrum, only 8% of caregivers have graduated an educational institution higher than high-school.[83] The level of education is significantly lower for women, than for men.[84]

Figure 16: Distribution of caregivers per gender and level of education (number)



Source: World Bank, PFam Census (February-March 2018) (N=16,079 persons in PFam).

Additionally, the level of education is substantially higher in the network of placement with other families/persons as compared to placement to relatives. The percentage of persons who graduated no more than a secondary school is 26% in the network of placement with other families/persons than 61% in the network of placement with relatives. The highest level of education is held by caregivers in groups of PFam with professional foster parents, where the percentage of persons who graduated no more than secondary school is only 11% (Annex 2B. Table 12).

Furthermore, the differences between county networks are considerable. As a general rule, older county networks and those containing more women have an average level of education lower than more recent networks or those containing fewer women. The network of family-type foster care in the county of Covasna contains 77% of caregivers who graduated more than a secondary school, 22% who graduated a vocational school or high-school and 1% with higher education. On the contrary, in the county network in Vâlcea, the corresponding percentages are 34%, 54%, and 5% respectively.[85] Annex 2B. Table 13 illustrates the distribution of caregivers per levels of education and per counties.

In terms of ethnicity, as expected, in the PFam network, the Romanian or Roma ethnicities and the Orthodox religion prevail.

[82] Standard deviation of 12 years.
[83] Furthermore, 22% of caregivers have graduated a vocational school, and 17% have graduated high-school. For approximately 1% of caregivers, there is no education information available.
[84] The percentage of persons who graduated no more than a secondary school is 55% for women, as compared to 45% for men.
[85] There is no education information available for 7% of the caregivers in the county of VL.

Table 17: Distribution of PFam depending on ethnicity and religion (% total)

	Orthodox	Catholic	Other religion	Not disclosed	Total
Romanian	72	1	3	1	77
Hungarian	0	2	1	1	4
Roma	11	0	3	1	15
Other ethnicity	2	0	1	1	4
Not disclosed	0	0	0	0	1
Total	**85**	**4**	**8**	**3**	**100**

Source: World Bank, QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted.

Size of the PFam network: As already indicated, in February-March 2018, in the 35 selected counties, there were 11,300 foster care families active (see Annex 2B. Table 2). The differences between the counties were considerable, in terms of network size. The number of PFam in the county network ranged between a minimum of 124 and a maximum of 705; two counties had small networks below 150 PFam, in particular Harghita and Teleorman, while other two counties had developed networks in excess of 600 PFam (Constanța and Iași).[86]

In February 2018, the PFam network provided care for approximately 14,500 children. Table 18 reveals that more than 91% of PFam provided care for 1 to 2 children.

Table 18: Distribution of family-type foster care depending on the number of children in their care and on the type of PFam (% total PFam)

	1 child	2 children	3 children	4-12 children	Total
Foster care with relatives up to the fourth degree	55.7	12.4	2.7	1.1	72
Foster care with other families or persons	23.3	3.3	0.5	0.3	27
Mixed foster care	0.0	0.5	0.1	0.0	1
PFam with a single (not married, divorced, separated, widow) - woman	24.6	4.8	1.3	0.4	31
PFam with a single (not married, divorced, separated, widower)- man	3.1	0.5	0.1	0.0	4
PFam with a married person or part of a civil union	17.7	4.0	0.7	0.4	23
PFam with a couple (family)	33.6	6.8	1.2	0.7	42
Total	**79**	**16**	**3**	**2**	**100**

Source: World Bank, PFam Census (February-March 2018) (N=11,300 PFam).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

Mention is to be made that foster care families with 6-12 children were only 18 in the 35 counties. Among them, 7 were PFam with relatives and 11 consisted of foster care with other persons or families. In fact, in certain counties, the General Directorate for Social Assistance and Child Protection uses foster care with other persons as a way to place children under the care of NGOs/foundations providing residential-type services (CTF or apartments), that do not hold a license. Therefore, at least in some instances, foster care with other persons is merely a solutions for difficulties encountered in the service subcontracting process by the General Directorate for Social Assistance and Child Protection to private bodies.

[86] The network contains 11 counties with 151-250 PFam, other 11 counties with 251-350 PFam and 9 counties with 351-450 foster care families.

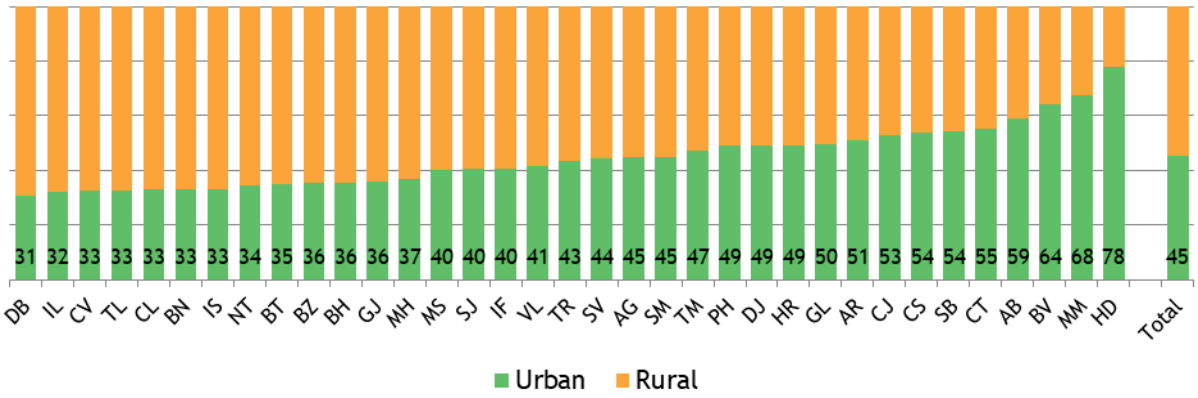
Monitoring methods for the PFam network at county level: Only few counties have a department or office dedicated to family-type foster care. In most counties, the Case Management Department is in charge of monitoring children given in family-type foster care. There is no social assistant or CM for foster families or persons, as it happens in the case of professional foster parents.

The children living in the more than 11.300 PFam are monitored by 341 case managers (CM). The number of case managers for children in PFam considerably varies from one county to the next, between 2 CMs and 29 CMs (in the counties of Mureș, and Vâlcea respectively). [87] The ratio of children in PFam per CM is 42, in average, but also widely varies, between 12 and 283 (in Ialomița, and Mureș respectively). The data at the level of each county is available in Annex 2B. Table 14.

Case studies on PFam have revealed that less than one third of the foster care families have worked with only one case manager since they received the child. The other foster care families have changed between 2 CMs and 10 CMs over the time. Even in the past 12 months, 40% of PFam in our case studies had changed between 2 CMs and 5 CMs (Annex 2B. Figure 1).

Territorial distribution of PFam network: Out of the entire PFam network under review, 45% is located in the urban environment and 55% in the rural environment. Discrepancies across counties are significant (Figure 17). The percentage of family-type foster care in the urban environment ranges between 31% in the county of Dâmbovița and 78% in the county of Hunedoara.

Figure 17: Distribution of family-type foster care per county and residence environment (%)



Source: World Bank, PFam Census (February-March 2018) (N=11,300 PFam).

In the rural environment, there are significantly more placements with relatives up to the fourth degree, which, upon setting up the protection measure, have indicated as caregivers either a family, or a (married) man and they occurred between 2015 and 2018. On the contrary, in the urban environment, there are significantly more arrangements occurred very early (1994-2004), in particular placements with other families/persons which indicated a single woman as the caregiver. (please see Annex 2B. Table 15)

It is to be mentioned that, in certain counties, there are children in family-type foster care living, in fact, abroad, either with foster parents, or with the biological family, for which payment of foster care allowance was suspended, but are still registered as active PFam. On the other hand, approximately 1% of all PFam live in a county other than the one in which they were set up.

The professional foster parent network in the 35 counties is spread in 320 towns and municipalities and in 1,930 communes. The network is highly concentrated as territory, both in the rural environment, and in the urban one. Thus, 26 of the towns[88] host 44% of all family-type foster care in the urban

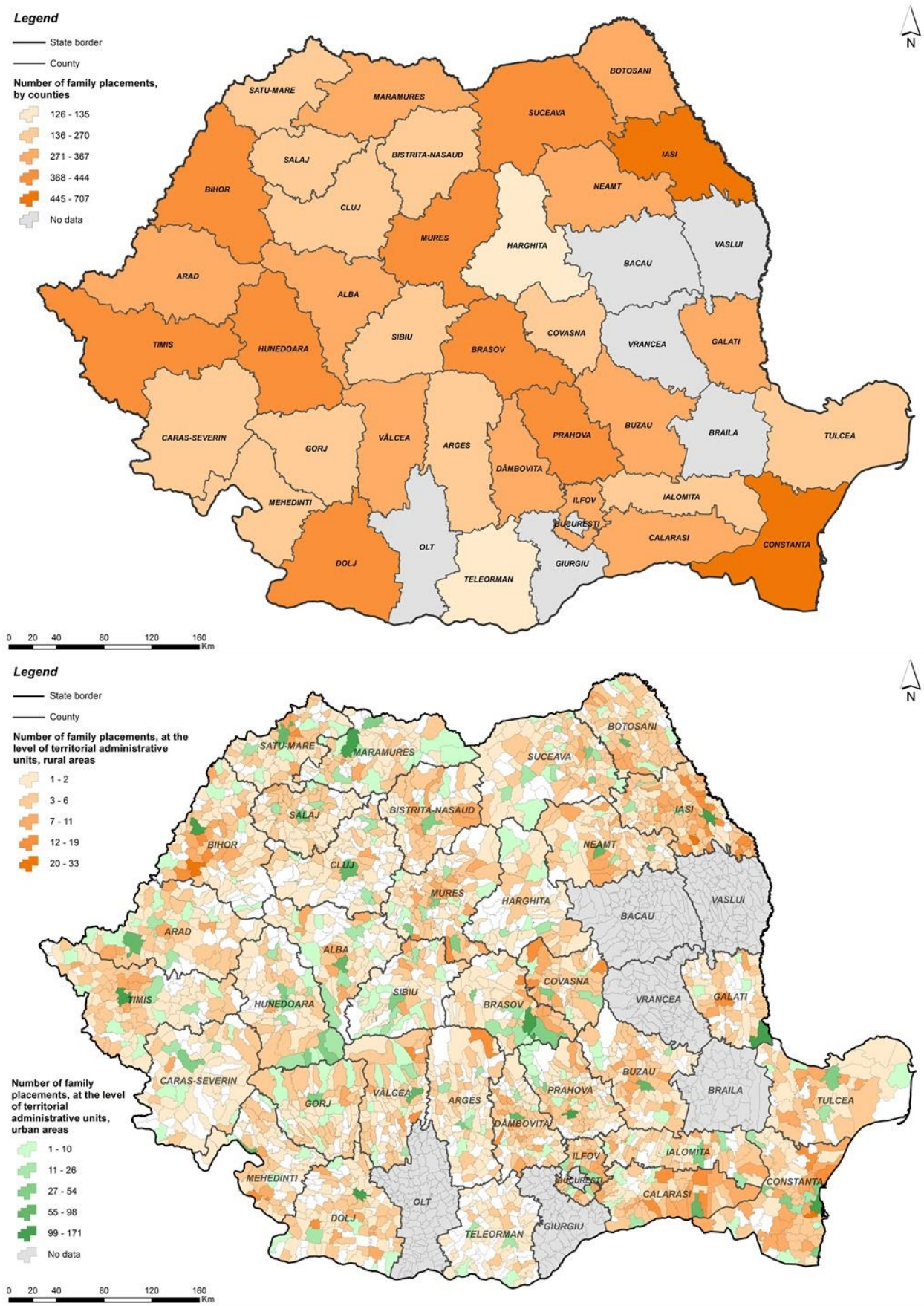
[87] The County of MM provided no information of CM for children in PFam.
[88] Towns in which there are 60 children or more placed with PFam (between 60 and 212 children). They are located in 24 counties.

environment and 44% of all children in PFam in the urban environment. Similarly, 170 of the communes[89] gather 26% of all family-type foster care in the rural environment and 29% of all children in PFam in the rural environment. The lists of such localities are available in Annex 2B. Table 16.

Maps 4 and 5 illustrate the family-type foster care services at the level of the 35 counties. County maps may be found in the 35 reports at county level.

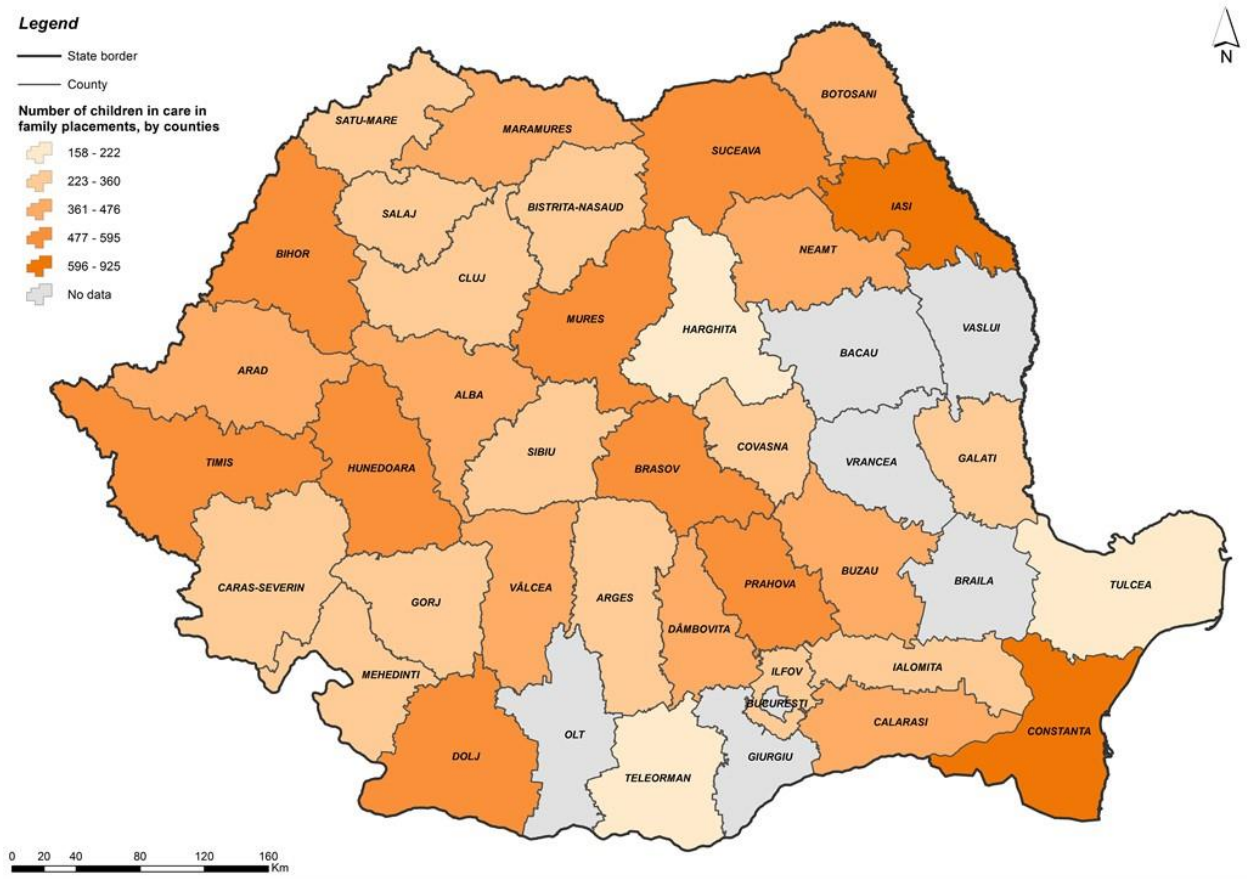
[89] Communes in which there are 10 children or more placed with professional foster parents (between 10 and 45). These communes are located in 32 counties. Among them, 20 communes are in the county of Iași, 16 in Constanța, 11 in Bihor and 10 in Mureș.

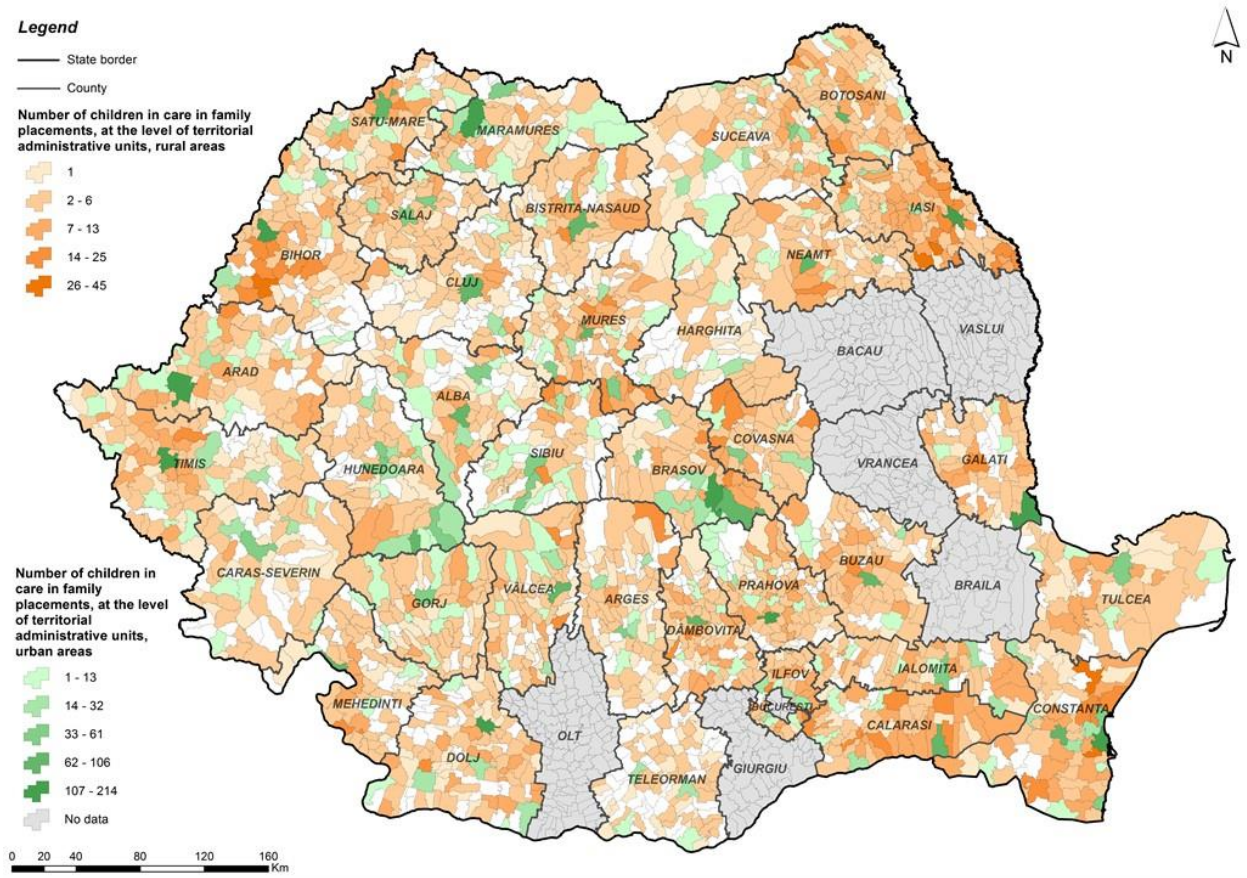
Map 3: Map of family-type foster care services for the 35 counties under review (number of PFam)



Source: World Bank, Census of professional foster parents (February-March 2018) (N=11,300 PFam).

Map 4: Map of children under family-type foster care in the 35 counties under review (number of children)





Source: World Bank, Census of professional foster carers (Febr-March 2018) (N=14,487 children in PFam).

2B.3. Profile of children in family-type foster care

Children placed in PFam are to an equal extent boys and girls, of all ages, particularly between 4 and 17 years of age. A percentage of 12% among them have one or several of the following special needs: disabilities (9%), CES (7%) or other special needs (4%). The percentage of children with special needs is significantly higher among children in the foster care of other families/persons (17% as compared to 10% among children in the foster care of relatives or in mixed foster care).

Approximately one third (35%) of the children in PFam have at least one sibling under the care of the same center (please see and Annex 2B. Table 17). This percentage reaches 65% among children under mixed foster care, 39% among children in the foster care of relatives up to the fourth degree and only 20% of children under the foster care of other families or persons.

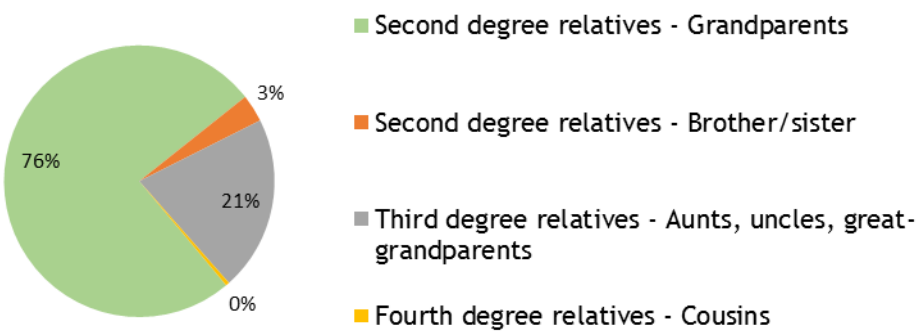
Table 19: Distribution of children benefiting from foster care in PFam in February 2018, broken down per gender and age (% total)

	Boys	Girls	Total
0-3 years	2	3	5
4-10 years	14	14	28
11-14 years	15	14	29
15-17 years	13	12	26
18+ years	6	6	12
Total	50	50	100

Source: World Bank, Census of professional foster parents (February-March 2018) (N=14,487 children in PFam).

Irrespective of the type of family-type foster care, more than 73% of the children are provided with care by relatives up to the fourth degree, below 1% by other relatives (a sister of their grandmother, a cousin of their father, an uncle of their mother, etc.) and 26% were in the care of persons to which they were not related. Most often, the grandparents (grandmother, grandfather) and aunts (more seldom uncles) are the relatives up to the fourth degree who take the children under their care.

Figure 18: Distribution of children benefiting from care in PFam in February 2018 depending on the kinship to the caregiver (%)



Source: World Bank, Census of professional foster parents (February-March 2018) (N=10,665 children to which care is provided by relatives up to the fourth degree in PFam with relatives and in mixed PFam).

2B.4. Relevance of the professional foster parent network in the process of closing the care homes for children

Family-type foster care depend on the existence of extended family for the child and on the efforts of case managers to identify relatives or other families/persons willing to take the child in their care. In that respect, the situation of children and youth in care homes is unfavorable. Many of them have arrived in the protection system after having been abandoned after their birth in maternities. Others have been in the system too long. In total, for less than one third (31%) of the children living in care homes, a family has been identified for (re)integration purposes. Therefore, family-type foster care services bear, most likely, little relevance for the closing of care homes for children, in the absence of continued efforts by case managers.

The data on children who have lived in family-type foster care in the past 12 months has not been recorded and subject to a consistent analysis by most General Directorates for Social Assistance and Child Protection. In 10 counties, the heads of the Case Management Department (or of the PFam or similar Department) who were interviewed could not provide any estimate in that respect. Nevertheless, in 32 counties, information was delivered in connection with the children who left the family-type foster care in the past 12 months. In the overall, 1,815 children and youth were reported to have left family-type foster care. The vast majority (88%) have left the protection system, and 12% were transferred to other services. Table 20 illustrates that most exits were upon the children turning 18 years of age (by socio-professional integration). At the same time, most transfers from family-type foster care were to care homes for children.

Table 20: Children who left family-type foster care in the past 12 months, depending on the exit method

Among all children who were in family-type foster care in your county in the past 12 months, not counting those still in PFam at present (February 2018), how may children ...?		**Number**	**%**
Total		**1815**	**100**
Left the protection system	Reintegrated in their family or with relatives up to the fourth degree	388	21
	Adoption	169	9
	Socio-professional integration	1035	57
Transfer to another service	Transfer to a professional foster parent	63	3
	Transfer to a residential-type service for children	150	8
	Transfer to a residential-type service for adults	10	1

Source: World Bank, Interviews with the Heads of Case Management Department or PFam (or similar) Department within the General Directorate for Social Assistance and Child Protection (February-March 2018) (N=32). No estimates were provided by the counties of Constanța, Harghita and Sălaj.

Only one of ten children and youth (9%) have left the system by adoption. On the other hand, less than 2% of current foster families have adopted or are in the process of adopting a child they had in their care. Almost all of these cases are placements with other families or persons (6% of all PFam with other families or persons), which comes to support the assertions of specialists within the meaning that there are counties in which this type of foster care is used as a way to circumvent difficulties or barriers relating to the adoption process.

Only one in five children and youth (21%) have left the system by reintegration in their families. As deriving from the interviews with case managers, family reintegration is difficult to achieve for several reasons.

- 67% of family-type foster care have been requested by the children's relatives/families, in particular from the need for a legal guardian for children whose parents are deceased, imprisoned or have left abroad

- only 57% of family-type foster care have been set up with the parents' consent,90 therefore, in many cases, the relationship between caregivers and parents (mother or father) of the children is not a good one and they do not allow visits.

- Almost 20% of foster arrangements have been set up because the parents (mama or father) cannot take care of the child or because they suffer from various illness impairing their parental capabilities, or because they have no home or economic means to take care of the child. In such cases:

> "Mothers build other families, find other concubines, make other children and they are ok with the grandparents taking care of the children, while grandparents are content with the foster care allowance." (Case Manager, county of Neamț)
>
> "Since the foster care allowance was increased, families prefer this alternative instead of reintegration" (Case Manager, county of Bistrița Năsăud)
>
> "Grandparents do not have a good relationship with the parents and do not allow them to see their children" (Case Manager, county of Suceava)

- a small part of family-type foster care are maintained active, especially for 18+ years youth, because in the absence thereof, the youth would no longer afford the necessary means to continue their education.

Transfer from PFam to other services is most often brought about by the death or poor health of caregiving grandparents, "behavioral disorders" associated to adolescence and health conditions of the children (in particular, of children with disabilities).

> "A child living under the foster care of grandparents arrived in a care home because the mother refused to take responsibility for the child, did not wish to reintegrate them, and the grandmother gave up (the family-type foster care arrangement), as the child was older than 15." (Case Manager, county of Iași)
>
> "A girl under family-type foster care with her former professional foster parent, everything seemed all right. But, when adolescence-related issues occurred, the lady no longer wanted to keep her. So, she had to be transferred to a residential-type OPA, this was the only alternative." (Case Manager, county of Alba)

2B.5. Implementation of standards and case management to professional foster parents

Family-type foster care is accredited as a department of the General Directorate for Social Assistance and Child Protection only in 8 out of the 35 counties under review, according to the heads of Case Management Departments (or for PFam or similar Departments) which we interviewed. In February-March 2018, 14 counties had no written document approved/endorsed by the General Directorate for Social Assistance and Child Protection, containing standards governing the family-type foster care. Out of the other 21 counties that declared that they have such a document in place, only 14 could provide it to the research team. At any rate, 34 counties declared that they developed, at the level of their

[90] Holding a maximum of 62% of foster care provided by relatives, 44% of PFam with other families/persons and a minimum of 35% of mixed foster care.

county, procedures and guidelines for the family-type foster care service. Case studies indicated that at the question relating to operating documents and instruments conducted with a certain periodicity, only 34 out of the 57 foster families envisaged could provide an affirmative answer, clarifying that they referred to: certificates for the child from school, from the doctor, reports (or notebook) of expenses, signing visit reports, monitoring reports and the statement to maintain the foster care measure.

Different counties employ different practices in the management of family-type foster care. Agreements between foster families and the General Directorate for Social Assistance and Child Protection are not concluded in 8 counties or are concluded at child level (for each child) in 18 counties or are concluded at the level of PFam (foster family for all children under their care) in other 8 counties.[91] Among all family-type foster care, only 58% have an agreement in place with the General Directorate for Social Assistance and Child Protection concerning the care provided to the child/children (40% have no agreement in place and 2% did not provide a reply), among which 48% agreements at child level and 10% agreements at the level of PFam.

According to case managers, almost all children placed under family-type foster care arrangements have benefited from initial or detailed assessment, before the protection measure was set up.[92] However, only approximately 26% of the PFam, according to the case managers within the General Directorate for Social Assistance and Child Protection, more specifically 16%, according to the statements of foster families, received a copy of that report.

Furthermore, almost all (97%) children under the care of PFam have a customized protection plan (CPP). Nevertheless, the data in the documentary assessment poll for PFam families reveals that the participation of foster families is rather low, irrespective of the type of foster care arrangement.

Only in 18 of the counties under review, does the General Directorate for Social Assistance and Child Protection also draw up customized services plans (CSP) to accompany the CPPs. For this reason, for less than half (48%) of the children in PFam have CSPs been drawn up together with CPPs. The active participation in setting up CSPs is very low for all kinds of family-type foster care.

At any rate, case studies have revealed that only 21% of PFam have received a copy of the CPP for the children in their foster care. Similarly, only 6% of PFam have received a copy of the CSP. However, case managers believe that 85% of the foster families (irrespective of their type) are aware of the CPP/CSPs for the children under their foster care. On the other hand, foster families have assessed their own knowledge about the CPPs/CSPs of children in their care with an average scoring of 6, on a scale from 1 to 10.[93]

Table 21: Participation of foster families/persons in setting up the CPP and CSP for the children in their care, broken down per types of PFam (%)

	Foster care provided by relatives	Foster care provided by other families/ persons	Mixed foster care	Total
There are no CPPs	3	3		3
PFam who have not taken part in setting up the CPP for the children in their care	33	37	50	35
PFam who have taken part in setting up the CPP, according to case managers, but there is no document signed by them to attest to it	24	20	19	23

[91] One county did not provide a reply to this question.
[92] Only 1% of the children in PFam have not undergone any assessment, and for 3% this is unknown.
[93] Standard deviation of 4. A percentage of 11% of PFam in the case studies have replied "I don't know".

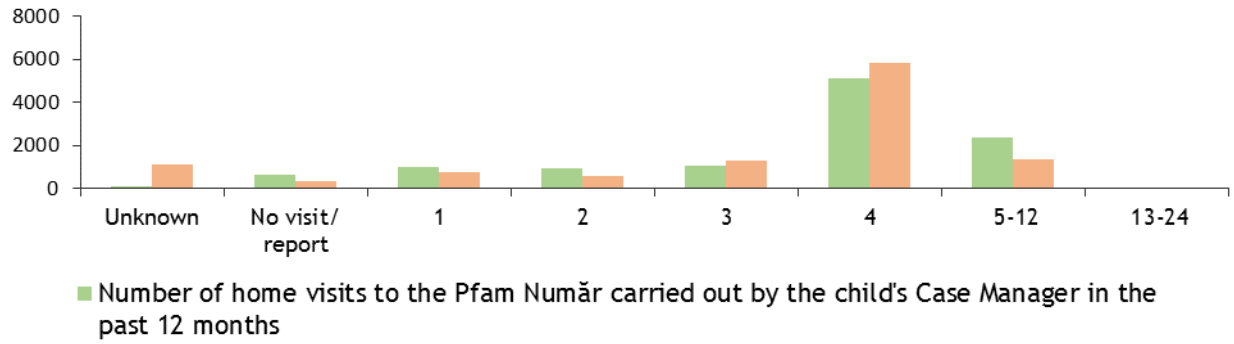
PFam who took an active part in setting up the CPP and there are also documents attesting to it	40	40	31	40
There are no CSPs	53	51	65	52
PFam who have not taken part in setting up the CSP for the children in their care	22	24	25	23
PFam who have taken part in setting up the CSP, according to case managers, but there is no document signed by them to attest to it	12	13	0	12
PFam who took an active part in setting up the CSP and there are also documents attesting to it	13	12	10	12

Source: World Bank, QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted.

Irrespective of the type of family-type foster care, case managers claim that both the implementation of CPP, and monitoring the implementation of CPP are in charge of the General Directorate for Social Assistance and Child Protection. Cooperation with local SPASs is limited to 23% of PFam, for CPP implementation, and only 15% of PFam, for monitoring such implementation.

The social assistant or case manager for the child in PFam should monitor the child's status by regular visits, at least with a monthly frequency. Documentary assessment of family-type foster care services reveals that most foster families/persons are paid at most one visit every three months (Figure 19). Visits are recorded in visit or monitoring reports, which may be found in the child's file, in most cases. In approximately 3% of these visits, case managers report that they were faced with impending jeopardy from the foster family, the neighbors or the community where it lives. On-site assessment in case studies have revealed comparable results.

Figure 19: Number of on-site visits at the domicile of the foster parent conducted by the CM in the past 12 months



Source: World Bank, QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted.

Emphasis is to be placed on the fact that, even though CMs have visited 93% of the foster families at least once, in the past 12 months, they have not had a face-to-face talk/played/interacted with the child or youth in their care even once, by ensuring that the meeting was confidential (not allowing other family members to be present) in 45% of PFam. They have interacted with the child once or twice per year in 30% of PFam or 3 to 12 times in the past 12 months in 25% of PFam. This means that on-site visits at the domicile of foster families are rare, and face-to-face interactions between the CMs and the children are even rarer. The rules imposed by county guidelines/procedures (Table 22) are breached in almost all counties.

Table 22: County rules on the interaction between the CM and the child under family-type foster care

How often is the CM obliged to talk with the child in PFam (depending on their age and maturity level) about how they feel in the foster family, about how they are treated, about the observance of their rights, any intra-family conflicts or conflicts with their biological family?		Number of counties
	- There is no obligation for the CM to talk with the child	1
	- Once every 4 months	2
	- Once every 3 months	30
	- Once every 1.5 months	1
	- Once every month	1

Source: World Bank, Interviews with the Heads of the Case Management Department or of the Department for PFam (or similar) within the General Directorate for Social Assistance and Child Protection (February-March 2018) (N=35).

In respect of these interviews, case managers frequently bring up cumbersome communication and cooperation with the foster families/persons, in particular when compared to professional foster parents. In particular, cooperation is poor because of the little time for interaction able to build a trusting relationship. For instance, the most recent visit in the past 12 months by case managers to foster families in the sample lasted for approximately 30 minutes.[94] The little time, as the CMs claim, is an effect of the "large number of cases", of long distances between the offices of the General Directorate for Social Assistance and Child Protection and the domiciles of many PFam and of inappropriate transportation resources.

> "Cooperation with foster families is different from that with professional foster parents, they look at us like we are unwanted guests; they are working, children are at school, we do not find them at home. We need forms, documents, we cannot find them. There are no legal means to coerce them." (Case Manager, county of Bihor)

> "Our time on site is very short to be able to interact with the foster family – the beneficiary. We are 5 case managers in one car, each having 4-5 cases. At the time of our visits, children are at school." (Case Manager, county of Prahova)

> "At the time of our visit, PFam (the husband) had a swollen foot, bluish-red, it had broken it. I would have expected the case manager to send him to a specialist. He had worked for 23 years with the Romanian Railways Company, he could have benefited from a partial illness pension. The case managers only focus on children, on the forms, on what they need in terms of the General Directorate for Social Assistance and Child Protection, and ignore anything else related to the family, play no prevention role. Cooperation with SPAS is also missing." (Case study, On-site report of the social assistant with the World Bank team)

> "At the time of our visit, the child "had just left for school", although we agreed with the social assistant to choose the time of our visit in such a way as to be able to talk to the child, too. From the very beginning, we faced resilience both from the head of the care home, and from the social assistant in conducting the interview with the family. Whereas, later, the head of the care home changed his mind and approved visits both in CTF, and with family-type foster care, the social assistant told us that she knew nothing about any visits to the family, that she had not been informed... We rescheduled the meeting for the day of..., but I was told as soon as I entered the office that we had to hurry up, not to go past 4:00 p.m., because she has other things to do." (Case study, On-site report of the social assistant with the World Bank team)

[94] The average duration of a visit ranges between 5 minute and 240 minutes. Standard deviation of 15 minutes. For approximately half of the PFam, a visit lasted between 15 and 30 minutes.

Composition of households with PFam and their lodgings: The composition of households containing foster families does not differ depending on the type of foster care, but widely vary between the rural and the urban environments. The documentary assessment data reveals that, in the urban environment, children in family-type foster care usually live in households consisting of 3 persons, as average, of which 2 adults and 1 foster child. In the rural environment, the average size of households is of approximately 4 persons, of which 2 adults and 2 children (biological and foster). Only one of five PFam in the urban environment and one in four PFam in the rural environment also have biological children in their care.

There are no standards for the lodgings of foster families. From one county to the next and from one case to the next, the housing conditions requested for granting family-type foster care may vary. Whereas, in the urban environment, the typical lodgings for PFam is a 2-3 room apartment in a block of flats, in the rural environment, professional foster parents live in houses with 2 or more rooms. Thus, in both residential environments, there is approximately 1.40 persons per lodging room (with a minimum of 0.3 – namely three rooms per person - and a maximum of 7 persons per room).

Only 54% of foster families, in particular PFam with relatives in the rural environment, have made various improvements to their house before receiving the child in their care, in particular renovation, whitewashing and sanitation, changed joinery, doors, building an indoor bathroom, a new room or annex, purchasing household appliances, heating plant or new furniture. One third (32%) did not make any improvements to their house, either for lack of financial resources or manpower (in particular in the case of grandparents), or because their lodging conditions were already good (in general, this is the case of foster care with other families or persons). There is no information in that regard for 14% of the PFam.

Table 23: Distribution of family-type foster care depending on the members of the household and the number of rooms, per residential environments (% total PFam)

	Total number of persons in the household, of which:	Adults	Biological children of the foster family	Foster children	Number of rooms in the lodging
	% PFam in the URBAN environment (N=5,104 PFam)				
0	0	0	80	14	0
1	1	24	13	70	9
2	21	49	4	13	39
3	40	20	2	2	31
4	20	4	0	0	13
5	7	1	0	0	5
6-11	10	1	0	0	1
Total	**100**	**100**	**100**	**100**	**100**
	% PFam in the RURAL environment (N=6,196 PFam)				
0	0	0	75	10	0
1	0	18	14	66	2
2	13	54	8	16	32
3	38	19	2	4	32
4	19	6	1	1	18
5	15	1	0	1	9

6-16	15	2	0	1	6
Total	**100**	**100**	**100**	**100**	**100**

Source: World Bank, QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted.

Note: PFam with zero children in there care are foster families who provide care to youth 18+ years of age.

Case studies reveal that approximately three quarters of the foster families to which visits were paid own their lodgings, they afford to suitably heat it every day, it contains a number of rooms able to satisfy the requirements of the household, have a separate kitchen equipped with all appliances required for cooking, sufficient bedrooms, with beds completed with everything required (bedspreads, blankets, pillows). The other approximately 20-25% of the foster families that were visited have lodgings with relatively poor conditions, without utilities, poorly equipped and furnished, which face difficulties in suitably heating their lodgings. In total, the World Bank experts and case managers of the General Directorate for Social Assistance and Child Protection who conducted on-site visits have granted average scores of 7.5-9 (on a scale of 1 to 10) for every aspect relating to the condition of the premises, cleanliness, odors, hygiene items, children's level of hygiene, condition of the children's clothing and footwear and overall assessment of the physical environment in which the children live (warm, friendly, colorful, joyful, customized). Therefore, the standard of care provided by the professional foster parent network seems to be satisfactory.

> "They have a shelter that it improvised to some extent, in a former pig farm of the town. There is no running water or sewerage. The toilet is outdoor. They hope to receive, in the spring, a youth house from the town hall." (Case Manager with the General Directorate for Social Assistance and Child Protection, county of Hunedoara)

> "The apartment is modest, crowded with many items and trinkets, with an obsolete air. It is visibly cleaned regularly, but the furniture and everything else is old and worn out. The temperature is extremely low in the whole apartment. Nevertheless, both the grandmother, and the grandchild seemed comfortable." (Case study, county of Botoșani)

> "A simple country house, with a room for sleeping, meals and where the child does his homework and plays. The equipment in the house is the bare minimum, but everything is orderly and neat." (Case study, county of Dolj)

> "There is mold in the child's room. In fact, the child's room is an extension of the bedroom, a passing room from the bedroom to the bathroom and consists in two bunk beds where the child and the daughter of the foster family sleep." (Case study, county of Prahova)

> "I entered the only room of the foster family through a hallway, to the right there was a dish cabinet and a hotplate, and to the left there was simply a toilet and a basin. A curtain was there for intimacy. The only room of the foster family, measuring approximately 25-30 sqm, contained three beds – one bed for the child, one for the grandmother and one for the ill uncle. There was electricity, but in the entrance hall there was no functional bulb.
>
> The lodging was clean, as much as possible, but equipped with old, worn-out items, some of them torn (the bedspread). There was no table. There were no personal items of the child. There was a towel hung on a string running through the room. ... The entire block of flats was disagreeable, with a stale odor, a lot of dirt – garbage all around the blocks of flats. Heat was supplied by an electrical heater and there is only cold water in the shared bathroom on the floor. There is mold and dampness in the lodging, and the grandmother

told me that through the ceiling (there is no roof) water leaks whenever it rains, which they gather in pots and bowls." (Case study, county of Satu Mare)

Abuse, neglect and exploitation of children in PFam: A total number of 23 complaints/petitions/accusations were submitted against the foster families (irrespective of their source), including cases of/suspected abuse, neglect or exploitation of the child, involving the members of PFam, their relatives, neighbors or members of the community, in the past 12 months. They were reported in 10 counties out of the 35 under review, 1 to 4 complaints/petitions per county.[95] Most frequently, the accusations concerned neglect and abuse against the child in the foster family. Following the investigations conducted by the General Directorate for Social Assistance and Child Protection, most of the accusations could not be confirmed.

Out of the 35 counties under review, 24 General Directorates for Social Assistance and Child Protection have declared that they have a clear and transparent procedure in place for cases where accusations are raised against a foster family. This procedure is known and understood by the professional foster parent network at a level of 7.3, on a scale from 1 to 10, according to the Heads of the Case Management (or PFam or similar) Department within the General Directorate for Social Assistance and Child Protection.

The county practices and methodologies for cooperation with foster families significantly vary between counties in many respects. Nevertheless, in general, in the standard forms of monitoring, visit, reassessment, etc. reports, the General Directorates for Social Assistance and Child Protection do not request CMs to check and to record on a regular basis information on whether the following cases occur or not: (i) potential cases of sexual abuse or "indecent" proposals, physical or emotional abuse, from the members of the family, their relatives, neighbors or members of the community, (ii) any intervention/interventions by the Policy in the foster family, (iii) any changes in the criminal records of the persons living with the minor child, (iv) any case/cases of contagious diseases in the family or in the community or (v) data regarding the psychological reassessment of the members of PFam. They seem to be rare occurrences, in less than 3-4% of PFam, as deriving from the documentary assessment data of PFam. Still, in 57 case studies in PFam, the research team identified 6 foster families where the Police had to intervene, and 2 of them resulted in changes in the criminal records of a family member.

It is assumed that the case managers conduct such verifications during their visits on site: "They perform an assessment in reliance upon their knowledge of the family and its situation" (Head of Case Management Department). However, they merely record in the reports a simple checking of the alternatives "yes" or "no" opposite a field such as "High-quality care and appropriate protection is provided to the child against abuse/neglect", with no other details, or provide information in another field, such as "Other information". Or, as regards changes in the criminal records or psychological assessment, it is possible that no information whatsoever is requested. For instance, in certain counties, the psychological assessment of the foster family is conducted only before setting up the protection measure, and never repeated. In other counties, psychological assessment "is conducted only if necessary", and in others every year, as part of the reassessment of the measure. Similarly, the criminal records are requested twice a year in certain counties, and only when the measure is set up, in other counties.

In other words, in general, the information referred to above is not part of the institutional memory, is not clearly recorded in the file of the child or of the foster family. Its existence at the level of the General Directorate for Social Assistance and Child Protection depends on the skills, interests and efforts of the CM. This is a sensitive issue of particular substance in developing a system responsible for children wellbeing. Insofar as CM so rarely talks with the children, and clear and regular

[95] Heads of the Case Management Department in 2 counties provided no reply.

information, useful to identify risks of neglect, abuse and exploitation is not available, we can consider that the system fails to provide appropriate protection for children deprived of parental care.

Services provided to children: Only in 16 counties out of the 35 de counties under review there is a regulation in reliance upon which social services are provided at home for children under PFam. This regulation is not, however, known to foster families in 3 of these counties and little known in the other 13 counties (an average score of 6.5, on a scale of 1 to 10, granted by the Heads of the Case Management or PFam Department for PFam's familiarity with this regulation).

Nevertheless, in almost all counties,[96] the foster family is held accountable if one of the social services included in the CPP/CSP is not provided to the child. Thus, PFam needs to provide the child with a healthy, safe and stimulating environment, adequate healthcare, appropriate educational services, support to maintain and build his relationships with the family and friends, but also to develop skills for an independent life. Mention is to be made that, as regards disabled children under family-type foster care requiring recovery services, therapy, special school, etc., the General Directorates for Social Assistance and Child Protection declare that they have the ability to provide all (or a large part) of such services. Thus, in all counties, the responsibility for bearing the costs of social services to be provided to children in PFam, in observance of CPP/CSP, is borne between the foster family and the General Directorate for Social Assistance and Child Protection. And, in that regard, case managers deem that 95% of foster families use the foster care allowance to ensure the wellbeing of the child/children.[97]

In the case studies, in addition to satisfactory assessments of the physical environment provided to children by PFam, the research team granted an average score of 8, on a scale of 1 to 10, for the appliances existing for leisure-educational activities and noticed positive interaction between the children and the foster family in 42 of the cases (out of 57), while signs of negative interaction or indifference were only recorded in a single case.

The services pointed out as being more difficult to provide by the foster families relate to the goals specified in CPP in connection with education and maintaining relationships with family and friends, according to case managers. The goals relating to education are difficult to achieve, mainly because foster families/persons themselves have a low level of education, "do not put much price on education", "cannot help the child in that respect". Maintaining and building relationships with family and friends is difficult because parents are abroad, imprisoned, drunkards, do not wish to keep in touch with the child, have conflicting relationships with the caregivers or face other various burdens.

In less than 5% of the family-type foster care arrangements, there were noticed cases of refuse to allow the child's access to certain social services, for financial reasons. The percentage thereof is merely 2% of PFam in connection with healthcare or recovery services. On the other hand, other barriers in providing the necessary services to children pertain to the unavailability of services/specialists in the communities where children live in foster families, in particular in the rural environment.

Support provided to PFam: None of the counties under review provided training for foster families/persons in the past 5 years (2012-2017). The data collected for each PFam reveals that less than 3% of such persons benefited from training, since the measure was first set up (since they received the child in their care). These PFam are from different counties and received training as part of various projects.

In addition to training, the General Directorate for Social Assistance and Child Protection also provides the county professional foster parent networks with the following:

[96] Except for three counties - Buzău, Ialomița and Vâlcea, while the county of Constanța delivered no reply.
[97] Case managers were asked to assess for each PFam selected in the sample the extent to which it uses the foster care allowance in order to ensure the wellbeing of the child, on a scale of 1 to 10. For 79% of PFam, case managers granted a score of 10. Other 11% of PFam were scored with 9 and 5% with 8.

- Psychological counselling, in 31 out of the 35 counties - in total, in 2017, 30% of PFam benefited from psychological counselling (once or several times)

- Individual or group psycho-therapy sessions, in 4 counties

- Support groups for PFam, in 9 counties.

Table 24 below illustrates the support received by foster families/persons from the General Directorate for Social Assistance and Child Protection, as per the PFam's statements. It may be noticed that the most frequent type of support, and also the most required, relates to the provision of information about the child, counselling and information on the services available. Furthermore, certain foster families/persons might consider necessary to receive more support in relation to educational services.

Table 24: Support received by PFam from the General Directorate for Social Assistance and Child Protection, in the past 12 months (number of PFam)

	Support received in the past 12 months	Support considered by PFam most necessary
Total family-type foster parents who took part in the case studies, out of which:	**57**	**47**
a. Information about the children	21	8
b. Information about the services (location, access methods)	27	15
c. Mediating the relationship with healthcare services (specialized, dentistry, mental health services, recovery services, etc.)	19	13
d. Mediating the relationship with educational services (school network, clubs, etc.)	20	18
e. Counselling and support for parents/caregivers	28	15
f. Respite care for the child/children	1	3
g. Support groups of family-type foster parents, formal/informal associations of family-type foster parents	1	6
h. Training and education courses	1	7
i. Psychological counselling	22	15
j. Individual psycho-therapy or group psycho-therapy	1	3
k. Support for maintaining the connection between the child/children and their biological/extended family	20	7
l. Discounts	2	4
m. I received no support whatsoever (*the monthly cash benefit for the child's upbringing not included*)	2	16

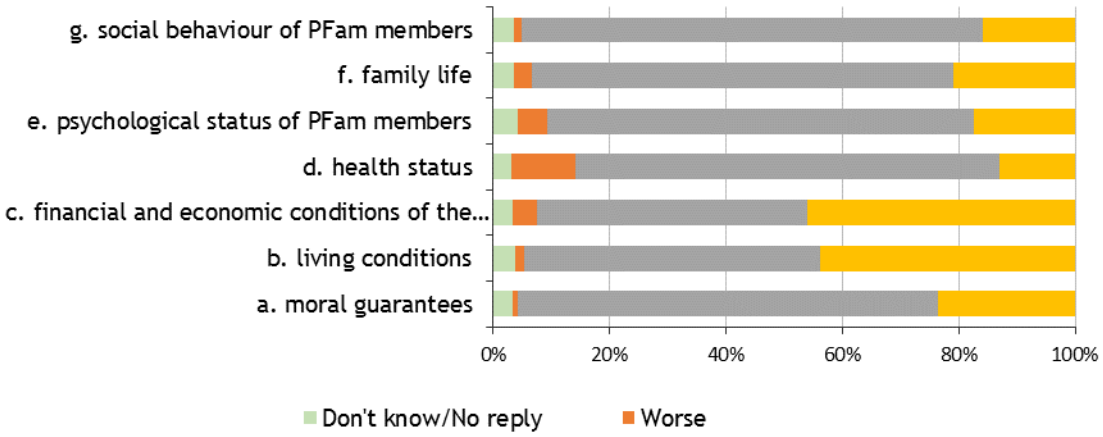
Source: World Bank, SC PFam Case studies for PFam (February-March 2018).

Overall, in the case studies, foster families have considered the support received from the General Directorate for Social Assistance and Child Protection as "vital, we could not manage without it" or "useful, but we would manage without it", in almost equal ratios.

2B.5. Efficiency of family-type foster care

The PFam network saw a positive evolution over time, in particular in terms of the financial and economic conditions and housing conditions of foster families. Given the significant percentage of grandparents, it is understandable that the health condition worsened for 11% of the PFam.

Figure 20: Situation of foster care in February 2018 as compared to the time when the foster care measure was set up (when the first child was received)



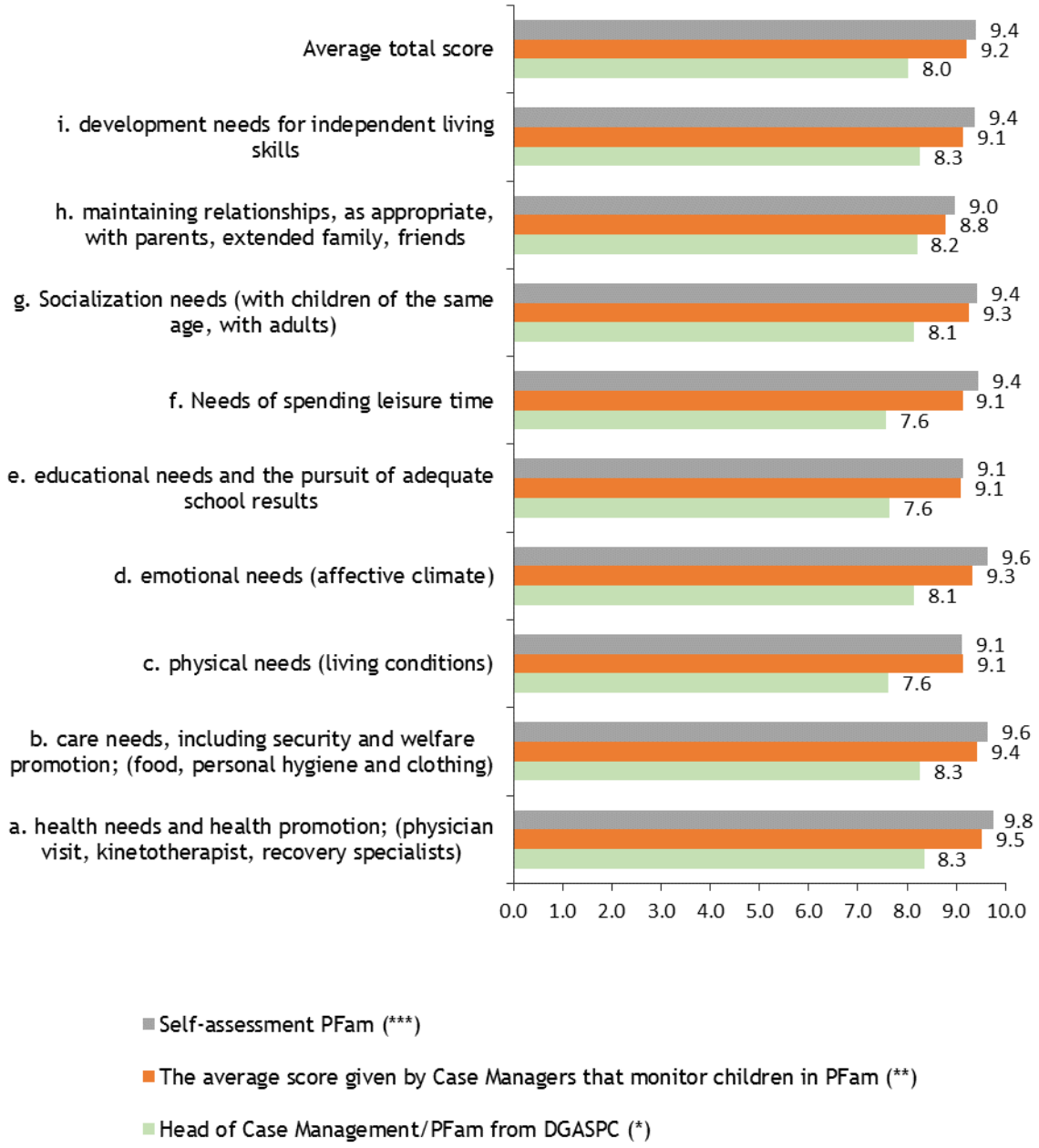
Source: World Bank, QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted.

The performance of child care achieved by the family-type foster care network is good, being assessed between 7.6 and 9.8 (on a scale of 1 to 10), in connection with all types of needs and by all appraisers – Heads of CM/PFam (or similar) Department within the General Directorate for Social Assistance and Child Protection, CM monitoring the children in PFam or the foster families/persons themselves (Figure 21).

The General Directorates for Social Assistance and Child Protection neglect to regularly measure the level of satisfaction of children and of foster families. Only 5 counties have declared that they measure satisfaction in any way, but even in these cases references were to a questionnaire not applicable to children and not applied on a regular basis. However, the social assistants in the research team who conducted the case studies performed assessments similar to those in Figure 21, further to their talks with foster families and with the children in their care. The general conclusion reached was that, in almost all cases, "children are well taken care of, benefit from affection, feel good bine, even when they live in relatively poorer conditions, even if their life is no stranger to want and accent is not placed on education".

The risk for a caregiving family/person to give up the family-type foster arrangement is no more assessed by the General Directorate for Social Assistance and Child Protection. As deriving from the statements of the case managers, in February-March 2018, only approximately 2-3% of family-type foster care arrangements faced such a risk. On the contrary, out of the 57 case studies, 8 declared that they have decided or are thinking to put an end to the foster arrangement. One of the main reasons brought forth was the fact that, because of the foster care allowance, the caregivers may not receive unemployment benefits, which comes with medical insurance. Especially when there are medical issues, the fact that the foster care allowance is not also accompanied by medical insurance could jeopardize the wellbeing of children under family-type foster care.

Figure 21: Assessment of actions and activities conducted by PFam in order to satisfy the children's needs, broken down per types of needs



Source: World Bank, (*) Interviews with the Heads of the CM/PFam (or similar) Department within the General Directorate for Social Assistance and Child Protection on county-wide practices in connection with PFam (February-March 2018) (N=35). (**) QQ PFam Documentary assessment questionnaire for PFam (February-March 2018) (N=11,300 PFam). The data has been weighted. (***) SC PFam Case studies for PFam (February-March 2018) (N=57).

Note: Average scoring calculated depending on valid replies. The child's needs, in accordance with Order no. 286/2006 of 06 July 2006, approving the Methodological Guidelines for drawing up the Service Plan and the Methodological Guidelines for drawing up the Customized Protection Plan, published in Official Gazette of Romania, Part I no. 656 of 28 July 2006.

As for the costs relating to PFam services, direct expenses are declared to be equal to the value of the foster care allowance, while estimates for indirect expenses range between RON 70 and RON 5,000 per child per month.

Approximately 45%[98] of the Heads of CM/PFam Department within the General Directorate for Social Assistance and Child Protection consider that additional monthly financial support is required. As for the value of such financial support, however, opinions widely vary, between RON 100-200 per month per child to RON 1000-2000. The same opinion is also acquiesced to by 20-25%[99] of the CMs, and by most foster families. Nevertheless, in their case, estimates on the value of the required support vary to a too large extent. In most cases, additional support is requested with a view to covering current expenses - food, clothing, hygiene and lodgings.

At any rate, in order to improve the standard of care for professional foster parents, all actors involved agree that, apart from the money, there is a dire need to develop services in the community, close to PFam, in particular daycare centers, recovery centers/services and afterschool facilities.

[98] Out of the 35 counties, 5 delivered no replies and 14 claimed that additional financial support is not necessary.
[99] Among CMs, 6% delivered no replies and 69% did not consider that additional financial support is required.

Best and worst practices

At the stables

The on-site visit paid to PFAM at 1 Fabricii St., "At the stables" was the visit that emphasized the inability of the system and of the State to take care of the children. The "Stables" commissioned as social housing in 2001, now shelter more than 200 children and their families, who live in unimaginable conditions. The foster family - the girl's grandmother - lives in a room that is simultaneously bedroom, kitchen, place for homework and bathroom … with a toilet out in the field and a dirty water pump from where they take their drinking water. There is no toilet/bathroom fitted indoors - they wash in a basin or go to a neighbor to wash themselves. Their toilet is the "field" around the stables or the "water closets" of other neighbors. Furthermore, there are no toiletries (soap, shampoo). They have an aunt where the child is washed now and then.

The grandmother is in charge of the granddaughter's raising and care, but the financial resources for household needs are insufficient, and access to information, support pensions from the local authorities is scarce/ insufficient. The grandmother's concerns for raising her granddaughter relate to the risks of the environment in which they live (there are minor mothers, children who do not attend school, adults and children who use drugs, pre-school children, there are rapes, aggressive stray dogs).

The safety and protection of the girl reflect, in the grandmother's belief, in the need to live in another part of the town, but although she repeatedly insisted, did not receive an audience with the Mayor of the town... The grandmother is considering, for reasons pertaining to her health, to give up the foster care and the girl to be reintegrated in her family, who lives "several stables away" - the girl's mother and father, together with 6 other siblings, between 11 years and 3 months of age.

In reality, the girl spends a lot of time with her younger siblings and with her family. We talked with her in an area of the Daycare Center within the School... The girl was waiting for her younger siblings for two more hours, to ride home together on the bus and did not seem to mind that she starved until 2:00 p.m. for them. She never read any books, was never on any trips, summer camps, to any other town, but says that she is happy. She gave a score of 10 for the relationship with her family, the reason being that "it's my family". She wishes that her aunt "sweeps the street", although, from talking to her, I believe she could do more. She has no role models (her mother is not a role model for her, she disapproves that she also has other relationships, aside from her father). Her world is comprised of her grandmother and little siblings, she does not dare look "beyond the stables". She would like to do better in school, but finds reading difficult (she repeated a grade) and her grandmother cannot help with her homework.

(Case study PFam, county of Neamț, On-site report by social assistant Mihaela Zanoschi)

The „mother" from the family placement

The car stops right next to the last house on the street. It is in a part of a village from Oltenia that has opulent houses and, here and there, a poor one, like the one we have to visit. The wide open door hangs on an old wooden fence.

In the yard we encounter a skinny dog too busy fighting a piece of dry flatbread baked on the hob in order to pay more attention to us.

A woman seeming to have the age of 60 invites us smiling in a two-room house, that doesn't have a porch. The kitchen has a separate entrance and is rather an improvised annex of the house. The blue gaze on the beautiful face of the little boy who greets us and watches us with curiosity, waiting, strongly contrasts the poverty and simplicity around.

Both of them know the social worker who is accompanying me, but this does not seem to reassure them. Both of us are smiling a lot, one of us sits on the bed, next to the child, the other on an old chair, we explain and try to relax the atmosphere.

In the room there is a bed covered with a blue blanket, next to an old dressing table with a large mirror. There are some cars and robots on it. Next comes a table along the wall on which there is an old TV. The clear side of the table serves as a desk for doing homework and as a dining table. At the foot of the bed there is a stove with a hob, and in front of it, by the door to the other room, an armchair covered with a blanket.

On the floor are overlapping carpets and mats that strive to leave no space uncovered. It's clean, tidy, a bit cool. The fire is not yet made in the stove. The woman remains standing in the frame of the open door, I do not know whether it is out of respect or due to anxiety, but she rejects any invitation to take a seat on the stool near the table.

We talk a lot, I ask, reformulate, she answers, she relates. She tears up when she remembers how she took him in: "When she died, he hadn't seen her for more than a year. I went to pick him up from an old Romanian woman, a neighbor who had taken care of him since his mother left for Spain. I still remember how the old woman was stood, supported by her cane, and how she wept after him. The boy thought I was his mother and he kept asking why I had aged, why I had white hair, why I had teeth like that (she has a couple of teeth covered in golden metal). He did not know his mother anymore."

For two years, the child believed that his maternal grandmother's sister was his mother, and it was hard for her to tell him that his mother had died. His father told him, father who makes sure to denigrate his deceased mother at every meeting with the child at DGASPC (where he does not find any pretext of not coming, as he usually does).

I'm trying to access the question about the stressors she had in the past twelve months as a person that has a child in family placement:

- „What worried you? What would you have needed? Did it happen not to have any money for fire wood, food, something for the child?

The child intervened:

- Maybe she needed something more, I haven't."

He is happy with what he has and is very aware of the fact that the old woman leaves herself aside for him.

The child's uncles and aunts help buy the fire wood: "In August each one gives me: one 20 euros, one 30, as much as they can. I save the money and they are enough for me to buy wood. They buy clothes for him, and they give me some of theirs. They always call us."

There are a few things upsetting her: she has no medical insurance, has no well or water pump in the yard and her washing machine broke ("It's the old kind, three water buckets go into it, but it stopped working.")

We talk to the boy, who tells us that he is very pleased with everything that "mother" offers him. His face lights up at every answer he gives us. He tells us that he was sad to hear that his birth mother had died, but not very sad, as he does not remember her and he already has a "mother". He's upset with his father for talking badly about his mother, and he does not think he's interested in him. He would not want to be with anyone other than his "mother."

After we leave, the neighbor across the street, whom we found at the gate of a large, two-storied

house, and who has been patiently waiting for us to leave, curiously asks:

- Did they come to take him away from you?

We can't hear the answer. I am thinking where would it be better for this child? Where would he be just as loved?

(Case study PFam, Dolj county, Field report social worker Emilia Sorescu)

Part 2 (C)

ALTERNATIVE SERVICES TO CARE HOMES

Small-Sized Residential-Type Facilities

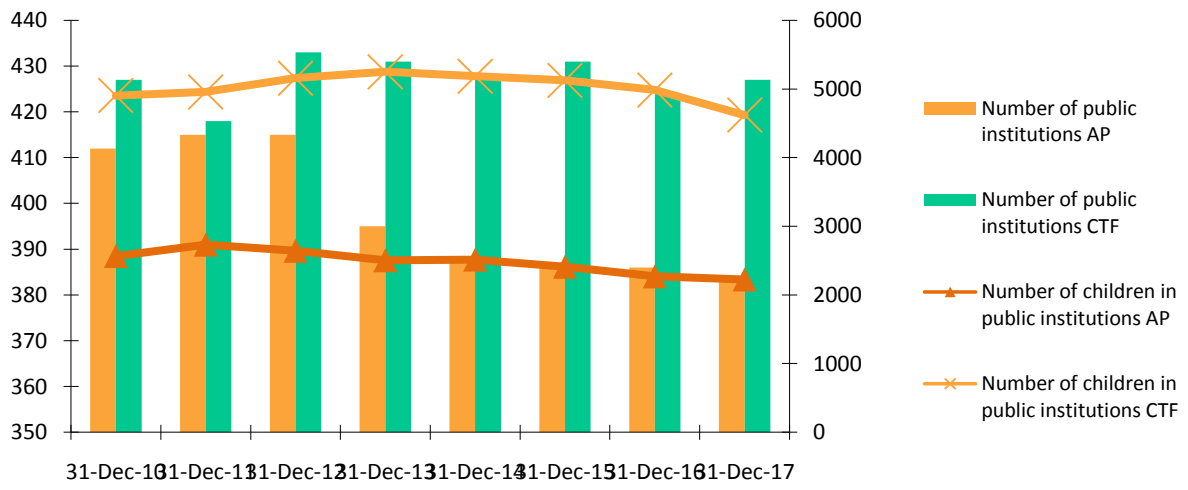
PART 2C. SMALL-SIZED RESIDENTIAL-TYPE FACILITIES: FAMILY-TYPE HOMES AND APARTMENTS

In Romania, small-sized residential-type facilities include:

- apartments (APs) and
- family-type homes (CTFs)

According to official statistics, between 2010 and 2017, both the number of institutions, and the number of institutionalized children living in small-sized residential-type facilities have decreased, as illustrated in Figure 22 and Annex 2C. Table 1.

Figure 22: Evolution in the number of children and youth in small-sized residential-type facilities, broken down per types, between 31 December 2010 and 31 December 2017



Source: www.copii.ro, National Authority for the Protection of the Rights of the Child and Adoption (NAPRCA) (2010-2017).

This Part 2 (C) of Output #4 contains an analysis of public small-sized residential-type facilities existing in the 35 counties where there are care homes for children. In February 2018, these General Directorate for Social Assistance and Child Protection services included 311 apartments (APs) and 347 CTFs, hosting a total of 4,835 children and youth (please see Annex 2C. Table 2).

		Number of public institutions		Number de children in public institutions	
At ...	**level ...**	**AP**	**CTF**	**AP**	**CTF**
31-Dec-17	National	383	427	2225	4619

Feb-Mar-18	35 counties where there are care homes	311	347	1341	3494
	The 35 counties under review % at national level	81	81	60	76

2C.1. Data

The analysis detailed herein below relies on the data collected by the World Bank team in February-March 2018 (Annex 2C. Table 3). In each of the 35 counties under review, in the first stage, a census was conducted in relation to small-sized residential-type facilities (AP and CTF), containing a small set of information. In the second stage, a sample of 96 AP and 266 CTFs was randomly selected, to which a documentary assessment questionnaire was applied.[100] The questionnaires were filled out together with the representatives (heads, social assistants, counsellors) of AP/CTF/ care homes or of the service compounds to which they are attached. In the last stage, 1-2 CTFs were selected for case studies in each county, totaling 50, case studies which were conducted by the social assistants of the World Bank team by on-site visits, together with the case managers of the General Directorate for Social Assistance and Child Protection.[101] The methodological report sets forth the research instruments used.

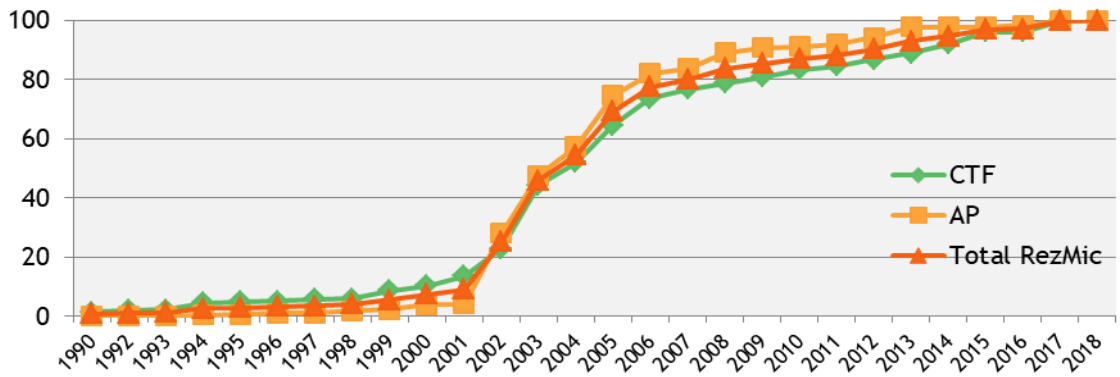
Data was collected by a team comprised of: 22 professional social assistants, members of CNASR, 24 sociologists and 23 research assistants. Furthermore, the collection of data was attended by 327 specialists with the General Directorate for Social Assistance and Child Protection, holding positions such as head of CM or Residential Departments within the General Directorate for Social Assistance and Child Protection, heads of care homes/compounds, inspectors, counsellors, case managers, clerks, social assistants and psychologists.

2C.2. Network of small-sized residential-type facilities

The data deriving from the census of small-sized residential-type facilities (RezMic) conducted in February-March 2018 took into account all apartments (APs) and family-type homes (CTFs) within the General Directorate for Social Assistance and Child Protection, irrespective of whether they hosted children and youth at the time of the research or not. Thus, out of all existing services, 98% of the CTFs and 73% of the APs were in operation (please see Annex 2C. Table 2).

History of the RezMic network: In the 35 counties under review, the current AP/CTF network was created in three stages. In the first stage, between 1990 and 2000, it developed at a very slow pace, when the network grew merely up to a capacity below 10% of its current size. In the following seven years (2001-2007), the network was substantially extended, up to 77% of its current number of CTFs and 84% of apartments. Starting from 2008, the development pace reverted to that of the first stage. Some APs/CTFs were even closed (in general, because their operation was too costly).

Figure 23: Year of first certification for small-sized residential-type **Facilities**

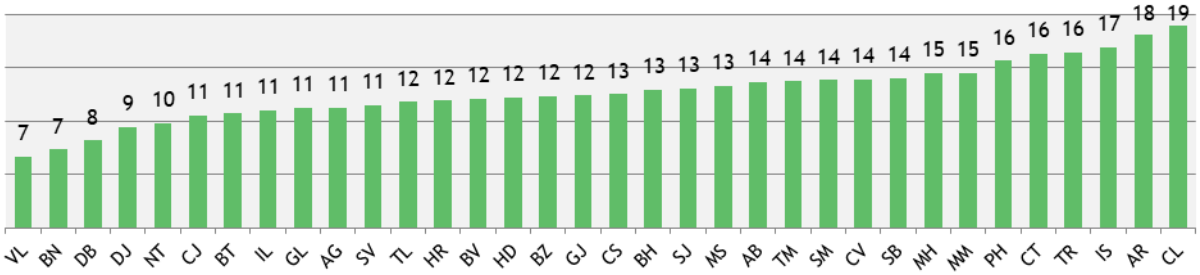


[100] In each county, 5 AP and 10-20 CTFs were selected, in reliance upon a statistical pitch. If, in a certain county, the number of AP/CTF was smaller than the threshold, them all AP/CTFs in that county were included in the sample. For questionnaire analysis, the data has been weighted.
[101] Case studies were randomly selected from among AP/CTFs selected in the sample.

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Only 12 out of the 35 counties set up small-sized residential-type facilities during this stage.[102] The other counties set up the first such facility no earlier than after 2001. At any rate, irrespective of the year when the first facility was created, depending on the pace at which they developed over time, county networks widely vary in terms of their average service life. Even if a county has developed the first facility at the beginning of 1990s, its county-wide network may have an average or even relatively short service life, if it set up several such facilities more recently. Therefore, the age of county network ranges between a maximum of 19 years in the county of Călărași and a minimum of 7 years in Vâlcea and Bistrița-Năsăud, with an average service life of 13 years.[103]

Figure 24: Distribution of county networks of small-sized residential-type facilities (AP/CTF), depending on the average number of years for which they operated until February 2018

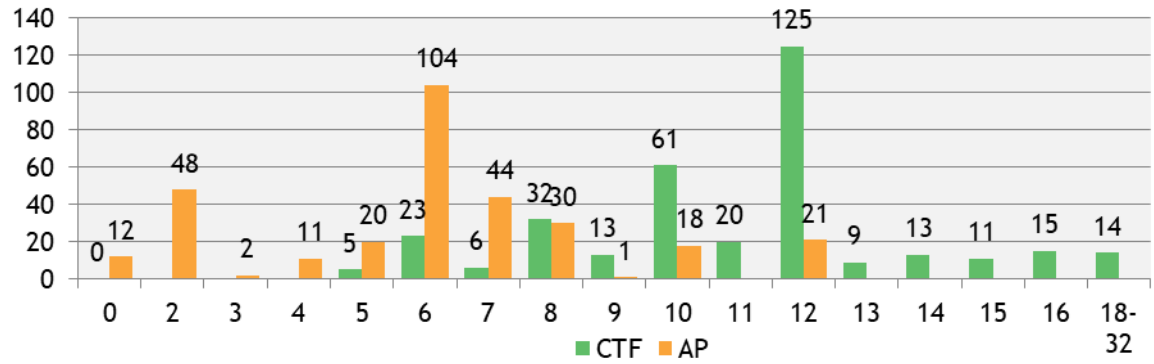


Source: World Bank, Census of small-sized residential-type facilities (February-March 2018) (N=311 APs and 347 CTFs).

Size of the RezMic network: Annex 2C. Table 2 reveals that CTFs may be found in 33 counties out of the 35 under review,[104] while APs operate in 24 counties. In February-March 2018, there were considerable differences as regards the size of county networks. In 12 counties, there were less than 5 CTFs in operation, while in Maramureș, there were 27 CTFs, in Mureș 36, and in Harghita there were 39 CTFs. These three counties alone gather 29% of all CTFs available.

The situation is similar in the case of apartments. In addition to the 11 counties where there are no APs, other 6 counties only had 1-3 APs, while in Teleorman there are 64, in Mehedinți 32, in Caraș-Severin 31, and in Botoșani 29. In fact, these 4 counties alone cumulate half of all APs available.

Figure 25: Distribution of small-sized residential-type facilities depending on their capacity, as declared by the General Directorate for Social Assistance and Child Protection (number)



[102] The 12 counties were: AR, IS, AB, TR, CL, SJ, DB, BH, MM, SV, BZ and CT.
[103] Standard deviation of 7 years.
[104] The two counties where there are no CTFs are Ilfov and Mehedinți.

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018) (N=311 APs and 347 CTFs).

According to the capacity declared by the General Directorate for Social Assistance and Child Protection, most CTFs may hold 10-12 places (Figure 25). There are, however, (23%) CTFs with a capacity of 5-9 places, but also (18%) CTFs with 13 up to 32 places. In theory, in February-March 2018, the number of available places in CTFs was 3,922.

As regards apartments, their capacity may vary between 0 and 12 places. Most of them, however, have a capacity of 6 places (Figure 25). The total number of available places in APs was 1,859.

Manner in which the RezMic network is used: Residential-type facilities (AP, CTF or care homes) are sometimes used at full capacity, however, there are also cases or periods when they operate above or below their designated capacity. The data of February-March 2018 (Table 25) reveals that the percentage of overcrowded facilities was 17% of CTFs and 10% of APs, while the percentage of facilities with vacancies was 55% of CTFs and 31% of APs. Only approximately one in four CTFs and one in three apartments operated at full capacity. The total number of available places in the RezMic network amounted to approximately 1,100 places in apartments and CTFs.

Table 25: Manner in which the small-sized residential-type facility network is used, broken down per types, in February-March 2018

		Institutions		Number of filled places	Capacity (number of places)	Number of vacancies
		Number	%			
CTF	Out of operation	6	2	0	46	46
	In operation and overcrowded	58	17	750	649	NC
	In operation 100% filled	93	27	979	979	0
	In operation with vacancies	190	55	1765	2248	483
	Total	347	100	3494	3922	529
AP	Out of operation	84	27	0	387	387
	In operation and overcrowded	30	10	269	229	NC
	In operation 100% filled	102	33	599	599	0
	In operation with vacancies	95	31	470	644	174
	Total	**311**	**100**	**1338**	**1859**	**561**

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Note: Number of filled places = the number of beneficiaries subject to a special protection measure at the time of our research in that residential-type facility (children and youth actually present were counted, plus those who were temporarily at school, treatment or absent for various other reasons). Number of vacancies = Capacity - Number of filled places. NC = not applicable, negative values. Please also see Annex 2C. Tables 6 and 7.

The vast majority of small-sized residential-type facilities are mixed, containing places both for girls, and for boys. There are, however, 11 counties in which some or all of the services are dedicated exclusively to girls - 4% of CTFs and 3% of APs – or exclusively to boys - 7% of CTFs and 4% of APs.[105]

[105] These counties are: AR, AG, BH, BV, CJ, DB, HR, MH, MS, VL and CL.

2C.3. Groups of small-sized residential-type facilities

In addition to the concentration of RezMic facilities in certain counties (Annex 2C. Table 2), 18 General Directorates for Social Assistance and Child Protection have also developed small-sized residential-type facilities in the close proximity of other services. Thus, communities of service beneficiaries were created with more or less territorial or social segregation. 35% of CTFs and 10% of APs are located in such groups, either together with services such as care homes, daycare centers, multi-purpose centers, special schools, institutions for adults etc., or with other APs/CTFs.

Table 26: Distribution of small-sized residential-type facilities individually or in communities of social service beneficiaries

	CTF		AP	
	Number	%	Number	%
Total	**347**	**100**	**311**	**100**
Individual AP/CTF	241	69	279	90
AP/CTF in groups of care homes or services other than AP/CTF	18	5	0	0
AP/CTF in groups of AP/CTF, potentially together with other services	88	25	32	10

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Note: A group of services involves close proximity - in the same courtyard, in the same building or next building. By definition, a group contains 3 or more CTFs. In respect of apartments, a group means that they occupy whole floors or entrances in a block of flats. If the AP are mixed with apartments owned by households of the general population, they are not construed as a group, irrespective of the number of APs.

The largest groups of RezMic are located in the county of Mureș - 11 CTFs[106] (83 children and youth, in Sâncraiu de Mureș) and in the county of Mehedinți - 21 apartments (with an overall capacity of 48 places, where only 5 children were living at the time of our research, in Drobeta Turnu-Severin).

2C.4. Territorial distribution of small-sized residential-type facilities

A percentage of 69% of the CTFs network is located in the urban environment and 31% in the rural environment. Whereas, in 14 counties, the entire CTF network is located in the urban environment, in the county of Călărași the corresponding percentage is a merely 15%, while in Iași 25%.[107] The CTF network covers 33 counties, being spread in 73 towns and municipalities, but also in 63 communes. The network is characterized by a high degree of territorial concentration, both in the rural environment, and in the urban one. A number of 16 towns/municipalities[108] gather half of all children and youth living in CTFs, in the urban environment. Similarly, 16 of the communes[109] host half of the children and youth living in a CTF. The list of these localities is given in Annex 2C. Table 4.

The network of apartments is almost entirely located in the urban environment. There are only two counties which set up AP in the rural environment, too, in particular Botoșani and Iași. The AP network contains 41 towns and municipalities and 3 communes, in 24 counties. In the urban environment, more than two thirds of all children and youth living in AP may be found in 9 towns/municipalities (please see Annex 2C. Table 5).

[106] At the time of this research, one CTF was not in operation.
[107] The other counties have corresponding percentages of 42-93%.
[108] The towns with more than 50 children living in CTFs (between 52 and 98 children and youth). They are located in 13 counties.
[109] The communes where there are 20 children or more living in CTFs (between 20 and 103). These communes are located in 11 counties.

Table 27: Network of small-sized residential-type facilities, broken down per types and residential environments

		Number of CTF	Number of children and youth in CTF	Number of localities (Administrative and Territorial Units) containing CTFs	Number of AP	Number of children and youth in AP	Number of localities (Administrative and Territorial Units) containing AP
Urban	Number	239	2397	73	306	1314	41
Rural	Number	108	1097	63	5	27	3
Total	Number	347	3494	136	311	1341	44
Urban	%	69	69		98	98	
Rural	%	31	31		2	2	
Total	%	100	100		100	100	

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

2C.5. Profile of children living in small-sized residential-type facilities

The beneficiaries of small-sized residential-type services are more boys than girls, mostly between 4-17 years of age. Disabled children account to more than one third of the children and youth living in CTFs and 19% of those living in apartments. As a general practice, among the children and youth with disabilities, children with severe disability certificate are preponderantly in CTFs and those with mild or medium disability in apartments.[110] Moreover, approximately half of both CTFs and APs do not host disabled children. At the other end of the spectrum, one quarter of CTFs and one in ten apartments host exclusively disabled children.

Table 28: Characteristics of children and youth living in small-sized residential-type facilities

		CTF		AP	
		Number	%	Number	%
	Total	3494	100	1338	100
Gender	male	1932	55	706	53

[110] Disabled children and youth in CTFs are distributed as follows: 50% with severe disability certificate, 15% with high degree of disability and 35% with mild or low degree of disability. Conversely, the corresponding percentages for disabled children and youth in AP are: 22%, 17%, 61%. Source: World Bank, QQ RezMic Documentary assessment questionnaire for RezMic (February-March 2018) (N=266 CTFs and 96 APs). The data has been weighted.

	female	1562	45	632	47
Age	0-3 years	27	1	11	1
	4-17 years	3029	87	1035	77
	18+ years	438	13	292	22
Health condition	Disabled children	1184	34	251	19

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

In February-March 2018, bedridden children and youth were 4% of those living in CTFs and 2% of those living in APs. On the other hand, merely 11% of CTFs and 4% of APs hosted between 1 and 18 bedridden children and youth.

Children and youth with special educational requirements account for 29% of the beneficiaries living in CTFs and 13% of those living in apartments. At the time of this research, the children and youth with special educational requirements could be found in 57% of the CTFs and 42% of the APs.

Children and youth with legal issues or risky behavioral types accounted for 3% of the beneficiaries living in CTFs, respectively 7% of those living in APs. These children and youth lived in every other six CTF and in every other four APs.

Groups of siblings may be found in approximately three quarters of the CTFs and in almost half of the APs. More than one third (35%) of the beneficiaries living in CTFs had one or several brothers/sisters in the same CTF. More generally, half of the children and youth hosted in CTFs had brothers/sisters in the protection system, either in the same CTF, or in other facilities. The situation of children and youth in apartments was similar: 28% had brothers/sisters in the same apartment and, in total, 44% had brothers/sisters in the system.

2C.6. Relevance of the network of small-sized residential-type facilities in the process of closing the care homes for children

Small-sized residential-type facilities are not alternative family-type services. Nevertheless, when compared to care homes, APs and CTFs provide children with conditions much more similar to a family environment.

In consideration of (i) the low capacity of current networks of alternative services (PFP and PFam) to take over children and youth from the care homes scheduled to be closed, (ii) the insufficient number of system exits (through reintegration in the family and adoption), but also (iii) the prevailing profile[111] of children and youth in care homes, the network of small-sized residential-type facilities is, most likely, the most relevant alternative in the process of closing the care homes.

As already indicated in section 4.2, the total number of vacancies in the RezMic network (totaling 1,100 places in apartments and CTFs) is however insufficient, while the geographical distribution thereof – with large concentrations in several counties, localities and groups – is rather unfavorable. The distribution of vacancies per counties is illustrated in Annex 2C. Tables 6 and 7.

[111] Most of the children in care homes (which are intended to be terminated, as part of the deinstitutionalization process) are older than 11 years of age, while one third are 16 or older, more than half of them have a disability certificate or are constantly monitored for a severe chronic illness and 41% have brothers/sisters in the same center. Data from Output #3 within the SIPOCA 2 project (World Bank, 2017d). Furthermore, Output #1 (World Bank, 2017b) revealed that only 31% of the children and youth in care homes have known families, where they may be reintegrated.

The analysis of entry-exist flows in CTFs in the past three years (2015-15 February 2018) reveals that the number of children and youth leaving the system is approximately equal to the number of those entering it, around 1,700 in total in the reference period. More than 90% of entries were children between the ages of 4 and 17. Youth 18+ years of age accounted for a mere 3% of all entries. Conversely, half of all exits were youth 18+ years of age. Correlatively, the most frequent exit methods consist of the expiry of the protection measure, when turning 18, reintegration in the family, transfer to a care home or to an institution for disabled adults. For instance, in 2017, approximately 650 children and youth left the network of CTFs, among which 33% upon reaching the age of 18, 20% were reintegrated in their families, 16% were transferred to care homes for children, and 10% were transferred to institutions for adults. All other exit methods from the CTF network accounted for less than 5% of all exits.

Table 29: Children and youth who left the network of small-sized residential-type facilities in 2017, broken down per exit method (%)

	CTF	AP
Total exits, out of which:	100	100
Reintegration in their family	20	28
Adoption	1	0
Foster family	2	1
Transfer to public or accredited private entity (OPA) services, in particular:	38	25
- - - PFP	4	6
- - - CTF/AP	16	10
- - - care homes for children	4	0
- - - other services for children	4	10
- - - institution for adults	10	0
Death	1	0
Reaching the age of 18	33	43
Other methods	1	1

Source: World Bank, QQ RezMic Documentary assessment questionnaire for RezMic (February-March 2018) (N=266 CTF and 96 APs). The data has been weighted.

Similarly, in case of the apartment network, exists and entries were approximately equal between 2015 and 15 February 2018, with a total number of around 1,100 children and youth. Most entries were children 4-17 years of age, while youth 18+ years of age accounted for approximately one third of all entries. Simultaneously, almost 70% of all exits were youth 18+ years of age. The most often exit methods were similarly to the CTF network. For instance, in 2017, approximately 370 children and youth left the AP network, among which 43% upon reaching the age of 18, 28% were reintegrated in their families, 10% were transferred to care homes for children and other 10% to other facilities for children.

2C.7. Care environment in small-sized residential-type facilities

Most (90%) of the CTFs operate in separate buildings, owned by the General Directorate for Social Assistance and Child Protection, the County Council or an accredited private entity (OPA), having an

average useful area of 23 square meters per beneficiary. Approximately one in four CTFs did not undergo, between 2015 and February 2018, any consolidation, extension, overhaul or upgrading works, either because there were recently built, or because of lack of funds.

The apartments form part of residential buildings, usually blocks of flats, and are owned by the General Directorate for Social Assistance and Child Protection or by the County Council. The average useful area per beneficiary is 14 square meters, and 90% have undergone, in the past three years, overhaul or upgrading works.

At any rate, mention is to be made that there is no clear definition for each type of residential-type service. Consequently, on site, between the counties, and even inside the same county, there is a variety of ways in which CTFs and apartments are designated, declared and registered. Thus, our research team found that the following are designated and registered as CTFs: a group consisting of ground floor and the 2nd floor of a building (please see photo), cabins, wooden huts, duplex houses or even apartments in blocks of flats. This flexibility allowed by the relevant regulations in effect is useful in the current operation of the General Directorates for Social Assistance and Child Protection, in order to be able to apply various standards (quality, cost and personnel) to local, often difficult, conditions (insufficient personnel, insufficient financial resources, etc.). At the same time, however, practices with such variety result in ambiguity and the impossibility to draw up policies with a significant potential impact. It is impossible to draw up an effective policy to encourage the development of CTFs, for instance, when the standards do not support such an approach and it is unclear what a family-type home consists of.

Isolation, segregation, increased access: One in four CTFs and one in five APs face the risk of space isolation, in particular, they are located more than 1.5 km or more than a 15-minute walk, at the same time, from: (1) the nearest school/educational institution, (2) the nearest hospital/doctor and (3) the town hall/center of the locality.

In 5% of the CTFs and 8% of the apartments, beneficiaries have reported that they suffered discrimination or an abuse from their neighbors or members of the community outside the CTF/AP and/or the compound of which the CTF/AP forms part. On the other hand, the neighbors filed complaints (written or verbal, including by telephone) against the beneficiaries living in 6% of the CTFs and 14% of the apartments, in the past 12 months (between 1 and 40 complaints per CTF/AP).

A CTF made up of ground floor + the 2nd floor of a boarding room type building

CTF Case study, Dâmbovița County

Infrastructure: As a matter of rule, CTFs have 3 to 4 bedrooms[112] with an average surface area of 16 square meters,[113] in which 3 beds are available,[114] including 2-3 bathrooms,[115] permanent cold water and hot water supply, a room to play/activities/entertainment/living room[116] and an area where the children and youth eat their meals.[117] Although most CTFs meet all modular requirements proposed in Output #1,[118] a percentage of approximately 8% of CTFs only fall in the category "partially modulated".

A typical apartment contains 3 bedrooms[119] with an average surface area of 10 square meters,[120] where 2 beds are available,[121] with 2 bathrooms,[122] permanent cold water and hot water supply, a room to play/activities/entertainment/living room[123] and an area where the children and youth eat their meals.[124] Consequently, most apartments satisfy all modular requirements proposed in Output #1,[125] nevertheless, approximately 15% of the APs only fall in the category "partially modulated".

The 50 case studies on CTFs have revealed that, in one third, children did not have a personal area outside their bed (shelf, wardrobe, nightstand, office, etc.) and also in one in three CTFs under review the children's area were not individualized with any photos, posters or drawings on the walls near their bed. However, at the general level, the social assistants in the World Bank team together with the case managers of the General Directorate for Social Assistance and Child Protection, who were on site, granted average scores of 9 (on a scale of 1 to 10) for everything relating to infrastructure: condition of the area where the children were accommodated, the available area in the bedrooms (spacious or overcrowded), the general appearance of bedrooms (they are bright, colorful, agreeable or not) and the overall impression of the physical environment in which the children live (warm, friendly, customized, colorful, joyful, clean or not).

Health and security of children: A percentage of 5% of CTFs and 1% of APs face one or several of the following issues: dark bedrooms, no natural light, leaking roofs, damp walls, worn out joinery in need of replacement, cracked walls and/or old paint. And the area available to children and youth is declared by the representatives of the General Directorate for Social Assistance and Child Protection to be insufficient in respect of 5% of the CTFs and 10% of the APs.

Appropriate heating, annual medical examination, permanent access to fruit or snacks are provided in the largest part of the small-sized residential-type facilities. The assessments contained in the case studies have revealed that everything relating to the children's health and security was awarded average scores between 9 and 9.5 (on a scale of 1 to 10) – general cleanliness indoors, around the building and in the courtyard, in toilets and bathrooms, odors, children's level of hygiene, the condition of their clothing and footwear and toiletries (towels, toothbrushes, soap, etc.).

Personnel: The average number of personnel actually working in a CTF is 11 persons,[126] with a minimum of 2 persons and a maximum of 45 persons. Consequently, the ratio employees/beneficiaries

[112] The number of bedrooms in a CTF ranges between 2 and 10.
[113] Standard deviation of 8 square meters. The average surface area varies between 8 and 50 square meters.
[114] Standard deviation of 0.8. The number of beds per bedroom in CTF ranges between 1 and 6.
[115] The number of bathrooms in CTF ranges between 1 and 15.
[116] A number of 12 CTFs contain no such room.
[117] In 27 CTFs, meals are not served inside the CTF, even partially.
[118] World Bank (2017b).
[119] The number of bedrooms in an AP ranges between 1 and 4.
[120] Standard deviation of 4 square meters. The average surface area varies between 7.5 and 23 square meters.
[121] Standard deviation of 0.8. The number of beds per bedroom in AP ranges between 1 and 4.
[122] The number of bathrooms in AP ranges between 1 and 2.
[123] A number of 42 APs (or 14%) contain no such room.
[124] In 13 APs, meals are not served inside the AP, even partially.
[125] World Bank (2017b).
[126] Standard deviation of 6 persons.

is an average of 1.2.[127] Furthermore, in February-March 2018, in one third of the CTFs, there were also 1 to 20 volunteers. Women are a percentage of more than 80% of all personnel.

In apartments, the total personnel per AP is approximately 8 persons in average.[128] There are around 2 employees per beneficiary.[129] In 28% of the APs, at the time of our research, there were 1-20 volunteers per AP.

The personnel shortage, however, is considerable. In respect of 35% of the CTFs and 33% of the apartments, the representatives of the General Directorate for Social Assistance and Child Protection declared that there is an alleged shortage of teaching and caregiving personnel. Moreover, a shortage of specialists was pointed out for almost 40% both of the CTFs and of the APs. Finally, the personnel is believed to be a "weak point" in one in five CTFs, APs respectively.

2C.8. Efficiency of small-sized residential-type facilities

The quality of services provided to the children living in small-sized residential-type facilities (similarly to care homes) is determined not solely by the physical environment, but also by the interactions between the various actors involved in the caregiving. Irrespective of how good the physical conditions available in the CTF/AP or in the care home are, children may however face risks of abuse, and their development may be impaired as a result of their interaction with caregiving personnel, with the other children living in the same residential-type facility, with their brothers and sisters (institutionalized or at home), with their family, with their schoolmates and with their teachers and other persons in the community, which they meet in their everyday life.

This chapter analyzes the quality of caregiving in three tiers: (i) services and activities available in the AP/CTF for child development, (ii) interactions between children and personnel and (iii) case management implementation.

Services and activities available in the AP/CTF for child development: Many CTFs/APs provide various types of services, depending on the specific needs of their beneficiaries, to the extent of the human, material, financial and institutional resources at their disposal. The absence of such services deprives the children from the opportunity to develop their full potential. On the contrary, other institutions treat children without any discrimination and only provide accommodation and food, but not the type of stimulating environment required for child development. Thus, the fewer the services and activities available to the children in a CTF/AP, the greater the limitations for the children's appropriate development, and, consequently, the lower the quality of services supplied by that AP/CTF.

- 73% of CTFs and 67% of APs were licensed, at the time of this research

- APs/CTFs provide almost all children with access to appropriate educational services, but in 30% of CTFs and in 38% of APs there is at least one beneficiary who, in the academic year 2016-2017, repeated the year, flunked certain subjects, abandoned their education or left school.

- Recovery/rehabilitation services are provided to children and youth in 44% of CTFs and 33% of APs.

- In more than three quarters of CTFs, there are homework activities and at least some of the children go on trips and summer camps, and birthdays are celebrated for each child. Furthermore, more than two thirds of the CTFs contain especially arranges areas to facilitate visits, have diversified books, games and toys, at least one working TV, a computer and Internet connection. Additionally, more than 90% of CTFs have a courtyard, a playground outdoors, garden or other means for spending their time outdoors. In total, the research team and the case managers of the General Directorate for

[127] Standard deviation of 0.9. Minimum of 0.3 and maximum of 6.33.
[128] Standard deviation of 4 persons. Minimum number is one person and maximum number is 24 persons.
[129] The employees/beneficiaries ratio ranges between 0.25 and 10, with a standard deviation of 2 persons.

Social Assistance and Child Protection granted average scores of 8.6 to the existing facilities for leisure-educational activities and for the manner in which they are actually used by children.

- In order to supply high-quality services, three quarters of the CTFs cooperate with one or several NGOs.

- Case studies in CTFs have revealed that activities for the development of independent life skills are conducted only in some of the CTFs with children and youth who are 14 years of age and older (Table 30). Furthermore, the Children's Council is only organized in certain CTFs, not all.

Table 30: Activities for the development of independent life skills in the CTFs reviewed as part of the case studies (number of CTFs)

Children and youth who are 14 years of age and older in CTF take part in...	CTFs with no children 14+	No reply	No, the children do not take part	Yes, some children 14+	Da, all children 14+	Total
a. ... menu selection	3	1	8	15	23	50
b. ... food preparation and serving	4	1	6	19	20	50
c. ... cleaning of CTF/AP	4	2	4	12	28	50
d. ... washing and ironing of clothes	4	1	18	14	13	50
e. ... put their own clothes and personal items in wardrobes	4	1	3	16	26	50
f. ... decisions on how to arrange the lodgings, rooms and playgrounds	4	1	9	13	23	50
g. ... use the cooker	4	1	16	20	9	50
h. ... use the stove	5	1	18	19	7	50
i. ... use the washing machine	4	1	20	12	13	50
j. ... know the risks relating to using household appliances (microwave, refrigerator, etc.)	4	1	8	11	26	50
k. ... go shopping and choose their own clothing or footwear	4	1	14	14	17	50
l. ... go shopping for current items alone, when necessary	4	1	20	9	16	50
m. ... have an allowance and know how to use money, to ask for change, receipt, etc.	4	1	11	8	26	50

Source: World Bank, Case studies for CTFs (February-March 2018).

Interaction between children and personnel: As regards the interaction between children and personnel, social assistants in our research team have, by direct observation, written down in the on-site reports signs of positive interaction in 40 out of the 50 CTFs they visited. In the other 10 institutions, negative interaction or indifference was noticed.

> "I liked the children's appearance very much, the interaction between children and personnel, the children's easy manners. Children and youth were very clean, wore

modern, age-appropriate clothes. They were very talkative, offered flowers and cards to the head of the compound and to the case manager, and unreservedly embraced and kissed them, they seemed to have a positive relationship.

What I did not like, however, was the lack of personal items in the area. The children's photos were affixed to the walls only in the living room, any decorations for the walls was contributed by the personnel. ... The main children's dissatisfactions concerned the amount of food, but also the fact that their preferences were disregarded. They said they liked it better when food was cooked in CTF because they played a part. Now they cook pancakes, cookies with ingredients bought from their own money or brought by the personnel from home. Later, the head of the compound was asked about this matter, and she said: "Catering is better. When they cooked at home, they finished the ingredients too quickly. They often ran out of carrots, onions, because they liked eating onion or garlic for every meal." (Case study PFP, county of Argeș, On-site report social assistant Emilia Sorescu)

Cases of suspected abuse were recorded in the past three years (2015-February 2018) in the Register for Incidents. Special incidents were reported by 7% of CTFs and 2% of APs. There was a higher percentage of cases of suspected abuse brought to the attention of Police or Prosecutor's Office, 12% for CTFs, and 4% respectively for APs. Finally, in the same period, in 16 CTFs and 3 apartments, there were employees who were dismissed, seconded, held under disciplinary or criminal liability for child abuse.

Case management implementation: Case management in the network of small-sized residential-type facilities is provided in 17% of CTFs and 40% of APs, by the representatives of the institutions who also supply the services. In other words, there is no independent monitoring and assessment in respect of the quality of services supplied to children and youth in these APs/CTFs. In addition, Table 31 illustrates that case management standards are only partially in place, and consequently, in more than half of the APs/CTFs, the prevailing cases are children and youth whose families have not been identified for (re)integration purposes, including for transfer to family-type foster care with relatives or with other families/persons.

Table 31: Case management for children and youth in APs/CTFs (% total)

		CTF	AP
	Total N	**347**	**311**
	%	**100**	**100**
Who provides case management for children and youth in CTF/AP	Head, social assistant, teaching personnel in CTF/AP	17	40
	CM in the General Directorate for Social Assistance and Child Protection	82	60
	CM other cases	1	0
Children and youth in CTF/AP with PIS	None	0	5
	50-90%	6	9
	All children and youth in CTF/AP	93	86
Children and youth in CTF/AP to whom a case manager is assigned	None	12	17
	50-90%	5	8
	All children and youth in CTF/AP	84	76
Children and youth in CTF/AP, the families of which	None	26	35

have been identified (name, address) for a potential reintegration/integration (there are negotiations in progress with the family or reintegration chances are a known fact)	1-30%	27	13
	31-90%	29	24
	All children and youth in CTF/AP	18	28

Source: World Bank, QQ RezMic Documentary assessment questionnaire for RezMic (February-March 2018) (N=266 CTFs and 96 APs). The data has been weighted.

Best practices

A CTF like a big family

“I can compare our visit to this CTF to a visit to a family with many children. Promoting a family-type care environment, the children’s affection for the personnel, the interaction between them, the leisure activities, partnerships with NGOs or volunteers, individualization of the house with the children’s photos place it in a positive light and is an example of best practice. Each summer, the children go to the seaside, on trips to various sights, and every child’s birthday is celebrated with enthusiasm in various locations out. One child’s story was emotional, who, only 9 years of age had celebrated their birthday for the first time. Mention is to be made that many of the activities referred to above were possible with the sponsors’ support (acquaintances, friends of the employees).

The children’s satisfaction with the food, clothing they received, their delight in talking about the personnel were also reflected in the 10 + scores they gave in the game. To the question what they would like to be when they grow up, most children associated the job to a representative person in their life (one child paints beautifully, he is talented, every week he attends painting classes with a volunteer, and therefore he wishes to become a Painter; another girl wants to become a teacher because she loves her teacher and is among the best students in her class and so on).

CTF personnel promotes and supports the continuation of personal relationships by children and their direct contact with parents, relatives, but also with other persons to which the children grew attached. For instance, every summer holiday or shorter holidays, two families in Italy take the children to Italy. ... I hope that the high-quality life which these children have in this CTF, the way in which they are prepared for an independent life is also repeated in other institutions across the country.”

(Case study PFP, county of Maramureș, On-site report social assistant Mihaela Motoc)

A CTF with PFP

“At the location CTF 3 lives a family, husband - wife, both PFP, who have 4 children under their foster care.... The PFP family has lived in this CTF since 2006, all utilities are paid for by the General Directorate for Social Assistance and Child Protection.

Upon the last PSI (Emergency Inspectorate) inspection in the autumn of 2017, it was found that this house fails to meet the necessary requirements and that a fine would be imposed unless the concerns pointed out in the inspection report are remedied. In order to receive the PSI permit, the family needed smoke sensors and repairs to the heating system. The General Directorate for Social Assistance and Child Protection could not pay the fine, and as such the CTF was scheduled to be closed (November 2017). For the 4 children, 2 families of PFP were found (3 girls with one family and the boy to another family) in the same locality. For all of the 4 children, their transfer files to another PFP are pending. In April, all children will be relocated. To that purpose, the children had a meeting with a psychologist and several meetings with the case manager. Furthermore, the children were taken on an adjustment visit to their new PFP families. They say they like it there, that the rules are the same, but they have a hard time parting after a “life” spent with the family M, which they regard as friends and parents. The General Directorate for Social Assistance and Child Protection proposed the PFP family in the CTF to continue their activity and for the children to be left under their foster care, but at their domicile. They refused and requested their certificate to be withdrawn, so that they may be registered as unemployed. At present, they own a house nearby, recently purchased. At any rate, everything we have seen here meets the requirements for PFP and not for this facility to be classified as CTF.”

(Case study PFP, county of Bistrița-Năsăud, On-site report – Social Worker Nicoleta Pop-Soroceanu)

CTF Case Study, Dolj County

A young man with delinquent behavior living in a small group home

We visit a small group home, located in the outskirts of the county and the outskirts of the country, that seems like a holiday home or a place from where you can't leave by foot.

Thirteen children live in a building with cheerfully painted walls, with clean rooms and equipped with everything they need for daily living.

Beautiful, unselfconscious, neatly-dressed children surrounded us quickly and with curiously. The curiosity was reciprocal, but from the very first minutes, when the sweets brought by the visitors were placed on the table, we began to doubt that everything was in order here: one of the boys, tall and robust, rushed and filled his pockets: "These are for me, I like these, I eat them all."

The group discussion was difficult to carry, the aggressive tone of the young man dominated the discussion, he came out and returned repeatedly. In his opinion, everything in the house is ugly, the food is bad, it is dirty. Anyone who tried to express another opinion was immediately silenced with a high-tone reply, and a sharp look, sometimes accompanied by a threatening position.

We want to photograph his bedroom as the bedroom with the smallest number of children. He's the only one who does not share the room with anyone. There are two other rooms, one with 4 girls and one with 4 boys, the latter being quite small. He sits in the doorway, with arms wide open: "You will not take any pictures here. Do not come in here!". I manage to take a glimpse: the room is spacious, bright, has its own balcony, the walls are painted light green, everything is clean and tidy. No trace of dark walls or dirt, as the young man said in the group discussion.

Our questions have been further clarified by the personnel: abandoned from birth, coming from a family whose adult members are either still in prison or have transitioned through it, the 17-year-old has committed about 300 crimes. He was sentenced to 2 years and six months imprisonment, of which he executed 6 months, being recently released for good behaviour. Returned to the child protection system, he was accommodated in this isolated house, chosen on the grounds that it does not offer the opportunity to practice theft and breaking into cars.

Instead, there are other victims within reach: colleagues of the small group home. He steals their personal belongings, aggresses them, harasses them, does not allow them to have opinions that are different from his. The two girls aged 10 and 12 do not manage to deal with him. They are his favorite victims: he throws their food on the floor, intimidates them, and shoves them. He became an informal leader of the boys, who, on one hand, fear him, on the other hand, imitate him and obediently execute his orders.

In order to limit his "show" during meal time, it was decided that the meals would be served in the series, in the kitchen, so that the girls could eat quietly.

The two younger girls sit next to me during the group talk. They seem to be looking for shelter, particularly the youngest. Towards the end she approaches me and asks, whispering, "Are we allowed to have a puppy in the room? We want a puppy very much." She is the only child out of three brothers present who would like to return home if their parents would have a place to live and if it would be together with her brothers. She hugs me, despite the fact that we first met one hour before...

Outside, our young man is sitting ostentatiously with two other beneficiaries on the hood of the car we are supposed to leave with, as pressure upon the case manager, to make sure that the case manager will not leave without being handed the complaints that the young man has made in writing.

Both the young man with delinquent behaviour and the victims among his colleagues are the results of a child protection system that fails on this mission, lacking the necessary services. There is no communication between the justice system and the child protection system; specialists' opinions are

not requested, and the community resources and its ability to provide the necessary services are not taken into account by the court.

The young man needs multiple services and specific interventions: to prevent relapse by eliminating risk factors (entourage, opportunities to commit crimes) and enhancing protection factors (therapy, education, secure environment, engagement in long-term projects), awareness of the consequences of delinquent behavior, personal development (learning social skills, management of aggressive feelings and behaviors, increase of self-esteem), behavioral change in order to put an end to the criminal career. Unfortunately, there are no such community services in Romania.

On the other hand, all children in the small group home should be given the necessary conditions to develop in a protective environment so that they feel safe and develop to their own potential. Otherwise, institutional abuse will also be added to the history of abandonment, neglect and abuse that these children experienced in their families.

(Case Study, small group home, Dolj county, Field report social worker Emilia Sorescu)

CTF Case Study, Mureș County

Part 3

CHILD PROTECTION CASE MANAGEMENT

PART3. CHILD PROTECTION CASE MANAGEMENT IN ROMANIA

Part 3 of Output #4 analyzes the case management, more precisely the capacity of the current network of case managers to ensure the timely delivery of good-quality services that meet the needs of children and youth in special care. The whole analysis looks at all 35 Romanian counties with at least one placement center for children.

3.1. Data

The analysis we present here draws upon the data collected by the World Bank team in February-March 2018. Data were collected by a team of sociologists, through face-to-face interviews.

For the collection of data on case management implementation at county level, interviews were conducted with DGASPC management representatives (35 interviews with DGASPC directors) and with case managers. In this research, case managers were selected for interviews based on two criteria: (1) the case manager has at least one active case of a child with a special protection measure in place and (2) the case manager is not the service provider. We could exemplify the second criterion as follows: a case manager who is also the head of center is both a case manager and a service provider to those children; instead, a case manager who has active cases of children in residential care, foster care and family care and is also a social worker for those in residential care meets the criterion. Using these two criteria, 785 case managers were identified, but face-to-face interviews were conducted with only 675 of them (see the interview guide IntMc in the methodological report). Statistical data regarding all the case managers from the special care system were collected based on a standardized form – the MC List.

Table 32: Case manager network and interviewed case managers, by county

County	Total number of case managers (MCs)	Number of interviewed case managers (MCs)	% of all interviewed MCs
AB	28	25	3.7
AR	19	19	2.8
AG	19	19	2.8
BH	29	27	4.0
BN	11	11	1.6
BT	20	19	2.8
BV	26	25	3.7
BZ	22	17	2.5
CS	16	16	2.4
CJ	24	20	3.0
CT	16	16	2.4

CV	14	12	1.8
DB	28	22	3.3
DJ	23	22	3.3
GL	33	32	4.7
GJ	19	17	2.5
HR	21	16	2.4
HD	22	17	2.5
IL	26	25	3.7
IS	47	35	5.2
IF	20	13	1.9
MM	21	21	3.1
MH	16	14	2.1
MS	18	10	1.5
NT	32	20	3.0
PH	28	19	2.8
SM	16	16	2.4
SJ	10	10	1.5
SB	18	18	2.7
SV	25	21	3.1
TR	18	13	1.9
TM	32	31	4.6
TL	14	11	1.6
VL	30	28	4.1
CL	24	18	2.7
Total	**785**	**675**	**100**

Source: World Bank, Census of Case Managers, February-March 2018

3.2. Case manager network

The census of case managers carried out in February-March 2018 by the World Bank identified a number of 785 case managers who met the aforementioned two criteria – having an active case of a child with a special protection measure in place and not being a service provider. Interviews were then conducted with 675 case managers. The information included in this section and in Annex 1 Part 3 presents statistical data for the entire network of case managers, whereas the information in sections 3.3 and 3.4 shows the findings relating to the 675 case managers that we interviewed.

Size of the MC network: At county level, the largest networks of case managers (over 30 MCs) are found in the counties of Iași (47 MCs), Galați (33 MCs), Neamț and Timiș (with 32 MCs each) as well as Vâlcea (30 MCs). Only three of these counties (Iași, Neamț, and Vâlcea) have a considerable number of

placement centers.130 The smallest MC networks operate in the counties of Sălaj (10 MCs) and Bistrița-Năsăud (11 MCs).

Composition of the MC network: At national level, the network of case managers is predominantly female (92%) and over three quarters of its members are 30 to 49 years old. Ten of the 35 researched counties have all-female networks of case managers: Arad, Bistrița Năsăud, Cluj, Constanța, Dâmbovița, Hunedoara, Mureș, Prahova, Tulcea, and Călărași. More than half of case managers have a social work degree and 16% of them have a higher education degree in other fields. In seven counties, over 90% of case managers have completed tertiary education in social work. These are: Alba, Bihor, Caraș Severin, Cluj, Iași, Ilfov, and Sălaj. In addition, nationwide, almost a quarter of all case managers have a postgraduate degree in social work. Under Order No. 288 of 6 July 2006, SMO 9 concerning the recruitment and employment of case managers stipulates that for someone to work as a MC, they have to: (i) be a social worker as prescribed by Law No. 466/2004 on the professional status of social workers, with at least two years' experience in child protection services; (ii) hold a higher education degree in humanities, social sciences or health care and at least three years' experience in child protection services; (iii) hold a higher education degree in fields other than humanities, social sciences or health care, a postgraduate degree in social work and at least five years' experience in child protection services. Nonetheless, the census of case managers identified 59 case managers who did not meet the conditions for employment as a case manager or a case handler.

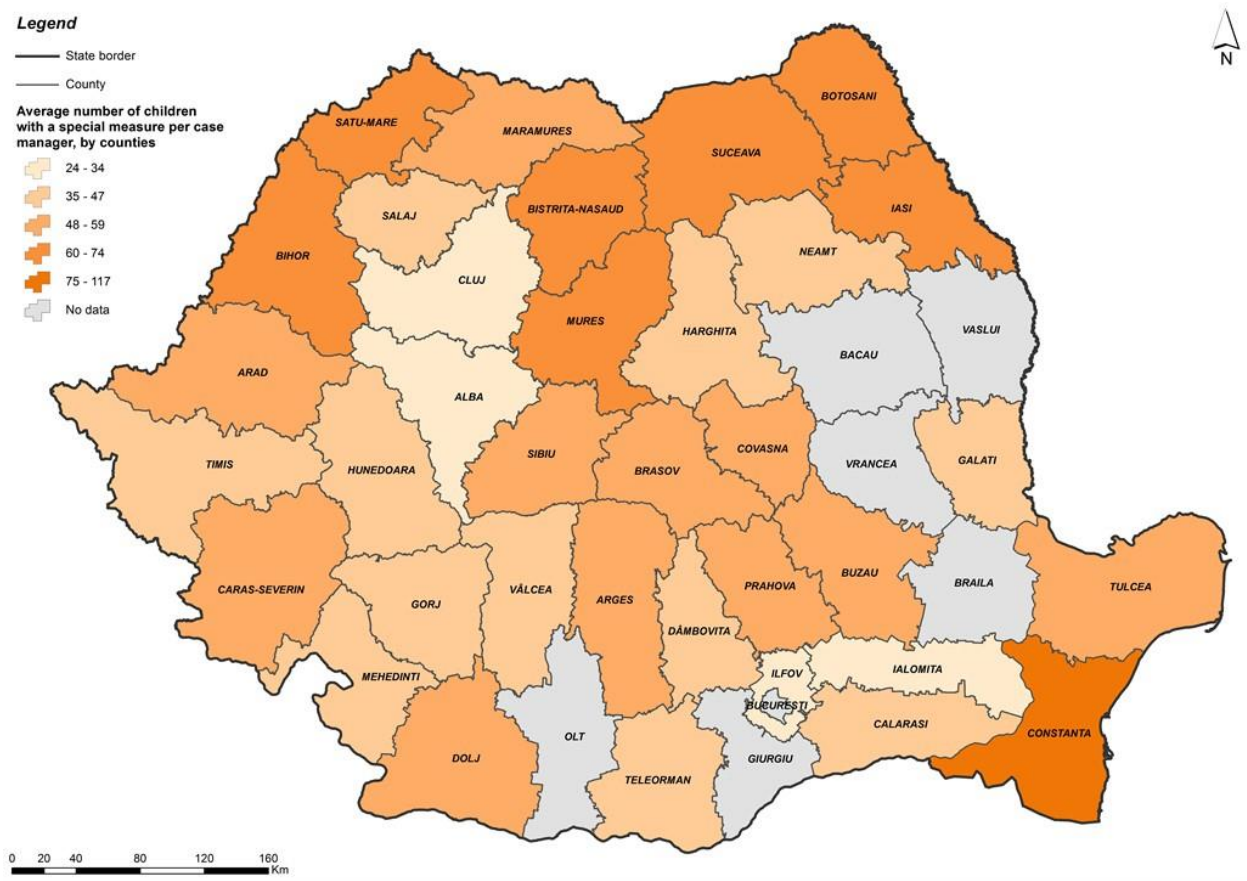
Countrywide, more than half of case managers hold at least 11 years' experience in child protection services. Only 64 case managers have worked in a SPAS/DAS/DAC at local level.

Organization of the MC network: Most of the researched counties (20 counties) have case manager networks organized by service, not by child. This organizational structure impinges on case continuity for if the service changes, so does the child's case manager. This organizational structure is sometimes maintained even in the case of siblings, where the prevailing criteria are the time of entry into care and the service assigned at that time – "They have the same MC if they enter care at the same time; but if one of the siblings has disabilities and is referred to another service, s/he will have a different MC even if they were taken into care at the same time. In residential care however, siblings are placed together and have the same MC". Still, some of the counties which have networks organized by service answered that they "try as much as possible to appoint the same case manager for groups of siblings".

Workload of the MC network: On average, a case manager works with a number of 50 children, which is more than what is stipulated under the compulsory minimum standards (SMO) with regard to the number of active cases. Equal proportions of case managers are responsible for 31 to 50 children and 51 to 80 children with special protection measures, respectively. The compulsory minimum standards prescribe that the number of MCs within a child protection service or the total number of MCs available for the service provider must be high enough to meet customers' needs, to accomplish the mission of the service and to ensure that a MC gets a maximum of 30 active cases. Active cases are considered those which stay open until the post-service monitoring stage; referred cases and those in which the MC devolves some or all of the responsibilities are not considered active cases. The highest number of cases of children with special protection measures assigned to a case manager is 185 and the lowest is 0, in the case of recently appointed case managers. There is a significant variance across counties as well (see the map below).

[130] See Annex 1 Table 2, Placement centers for children in Romania, by county and closure status (as of February 2018, in Part 1 of Output #4.

Map 5: Average number of children with a special measure per case manager, by counties



Source: World Bank, Census of Case Managers, February-March 2018

The information relevant to PIP/PIS objective/goal achievement requires a better systematization. Some of the case managers (40) do not know the number of indirect MC beneficiaries – parents of children with special protection measures who are currently active cases. Moreover, only one third of the interviewed case managers have a list of parents of children with special protection measures who are active cases. One in ten case managers does not know the number of indirect beneficiaries – grandparents, aunts and other relatives within the fourth degree of consanguinity for the children with special protection measures who are currently active cases and only 14% of all the interviewed managers have a list of those relatives. The case studies conducted by randomly selecting a child from each case manager's child list confirmed these findings. Almost a third of the interviewed case managers are unable to promptly identify key information about the child and need more time to consult with colleagues/get an answer from the case handler.

Table 33: Case managers' characteristics

	Number of case managers	% of case managers
Total	**785**	**100**
Gender		
male	59	8

	Number of case managers	% of case managers
female	726	92
Age		
<30 years	43	5
30-39 years	273	35
40-49 years	357	45
50-59 years	103	13
60-69 years	9	1
Education		
no higher education	7	1
in social assistance	490	62
in sociology or psychology	161	21
medical education	1	0
other specializations	126	16
MC/ RC type (education and accumulated service)		
MC who fulfill the standards, of which:	657	84
Social assistance (AS) and 2+ years of accumulated service	452	58
Humanities and Social Sciences 3+ years of accumulated service	146	19
other fields of higher education, post-university AS and 5+ years of accumulated service	59	8
high-school and 2+ years of accumulated service (RC)	69	9
not fulfilling the requirements for MC, or for RC	59	8
Accumulated service in child care services		
0-2 years	61	8
3-5 years	68	9
6-10 years	125	16
11-15 years	242	31
16+ years	289	37
MC type (provision of services)		
MC who is not also the service provider	709	90
MC who is also the service provider	76	10
Number of active cases of children under a special protective measure (February 2018)		
0–30 cases	161	21
31-50 cases	272	35
51-80 cases	271	35
81+	81	10
Average No of cases under protective measure	***0***	
Minimum No of cases under protective measure	***185***	

	Number of case managers	% of case managers
Maximum No of cases under protective measure	***50***	

Source: World Bank, Census of Case Managers, February-March 2018

Note: Case managers who were at the time of the census on parental leave were not included

3.3. Implementation of standards and case management

Case managers mentioned the following case management problems/difficulties related to the current implementation of PIP, PIS, PS (service provision) aimed at ensuring the achievement of PIP/PIS objectives/goals:

- Heavy workload/high caseload. Work overload is due to the high number of cases, the large amount of documents to be completed (a lot of red tape, short timeframes between re-evaluations), concurrent functions/positions ("We are both case managers and case handlers"), and to certain responsibilities which should be assigned to other levels (for example, the initial evaluation contains little information and has to be supplemented/redone, hence the need to extend the timeframe to 30 days; lack of professionals or inefficient collaboration within the multidisciplinary team – "I am the team"). Heavy workload is also fed by the absence of preventive services in the local communities, a systemic shortcoming which keeps the number of children in special care high.

> "We don't implement case management by the book because we have a combination of mixed cases/case managers for some cases and case handlers for completely different cases."
>
> "You don't have a team and you are the only one responsible for everything, you are the case manager and the case handler and the social worker and a civil servant; you make the decisions, but you can't mention that in the PIP because it would show the limited resources of the institution."

- **Challenging cooperation with parents because of distance (parents who work abroad), lack of** interest, low level of education as well as difficulties in identifying the parents' current address. The latter problem is caused by the feeble collaboration with other institutions, especially with population registration offices. Moreover, some case managers also suggest "setting an intermediate goal to address parents' lack of interest if the goal aims at family reintegration and that is impossible to achieve".

> "Even if we submit requests to population registration offices, parents don't actually live at that address, so we call for a social inquiry; we sometimes have to request that for months, even for a year; I have a case where I have been asking for an inquiry for three years and I always get the same answer, namely that the person does not live there."

- Difficult collaboration with the multidisciplinary team. The idea that "usually, the multidisciplinary team is comprised of a single person" was mentioned by case managers from different counties. Where the multidisciplinary team, however, includes several professionals, it is very difficult to cooperate with family physicians and teachers. As regards mainstream education, case managers mentioned teachers' discrimination of children from the special care system. Regarding family physicians, it was pointed out that medical certificates/documents were issued depending on beneficiaries' income.

> "Case managers are on their own: they are the ones doing all the writing and the talking and nobody listens to them; the instructors from residential care facilities ignore the recommendations and the outcomes are bad".
>
> "Some children diagnosed with disabilities but without an established disability level have difficulties in coping with the demands of mainstream education and doctors don't support them in getting curriculum adaptations, saying that the child is lazy".

- Biological family's poverty, including precarious housing conditions. In most cases, these circumstances are permanent and hinder the achievement of the PIP goal aimed at family reintegration. In addition, this setback is also generated by the weak collaboration with SPAS – local authorities don't provide enough support to the families that would like to take their children back.

> "Major lacks – as regards parents: modest people, low IQ, outcasts in the society for various reasons, minimum resources, no jobs, emotional indifference, disinterest".

- Difficult collaboration with local authorities. This is a major difficulty mentioned by case managers from various counties. It could be explained by a lack of social work professionals at local level (and hence of prevention case handlers[131] at SPAS), an excessive bureaucratization of their work, the accumulation of social work responsibilities and other mayoralty-specific tasks, and a certain organizational culture "in some mayoralties – they talk to each other and if one of them does not run the social inquiry, the other one won't either".

> "Collaboration with the services available in the local communities (their involvement); it is unacceptable that I, a county representative, have to go there and point them where a certain family lives".

> "Communication and support between us as a county institution and SPAS – what they write on paper, like when they carry out the inquiry - if they actually do it, is inconsistent with what we find out. They do nothing for children's families to facilitate their reintegration".

> "This division into localities makes up for the staff shortage at SPAS. Being positioned in a poor county means lack of funding".[132]

- Lack of transport resources – insufficient number of vehicles ("we only have one car for 100 case managers", "we have two cars available, but we can only use one of them"), insufficient fuel resources. This leads to a greater number of cases having to be visited over a short period of time and to other constraints regarding visiting times.

> "Fieldwork time is too short to interact with the placement family – the beneficiary. We are five case managers, with 4-5 cases each, traveling in the same car. During our visiting times, children are at school".

- Lack of services for youth leaving care, especially as regards the PIP goal aimed at social and professional integration – "Employers refuse to hire young people from public care. I accompanied many of them to the job fair and young people leave their resumes but are never contacted. Employers justify their decision saying that young people from public care are harder to integrate". Access to housing is also mentioned as problematic for youth leaving the special care system.

- Tough collaboration with beneficiaries (children) because of a difficult relationship with adolescents, a certain dependence of the beneficiaries on the services provided by the system, language barriers in some ethnic communities, children's lack of desire to continue their education. At the same time, this issue is also explained by the deficient collaboration with placement center employees, in particular with educators.

> "Our beneficiaries have a certain underdog mentality – we can't do that, they expect to get things and have things done for them; children in residential care are used to a certain way of doing things, they have no plans for the future and they barely get involved unless they are motivated, accompanied".

- Lack of services and professionals at local level, which is relevant in particular for children in family or foster care in rural areas. Case managers mention as problematic the lack of services for

[131] Under Order No. 288/2006, the prevention case handler is a professional who meets the conditions set out in these standards and coordinates the social assistance activities performed for the best interests of the child living with the family, working to draw up and implement the service plan for the prevention of the child's separation from his or her family. The prevention case handler is employed by the public social assistance service (SPAS). In the case of communes, this role is fulfilled by the social assistance clerk if they meet the conditions specified in these standards. In the case of Bucharest City districts, this professional is employed by the DGASPC.

[132] A view expressed by a DGASPC management representative.

parents (counseling, family planning, parent education), of respite centers for AMPs, of psychologists, case handlers (at the DGASPC and prevention case handlers at SPAS), of neuropsychiatrists or school counselors.

- Difficult collaboration with placement families – also explained in section B of Output #4 regarding the network of family placements with relatives and other families or persons (PFam). Case managers think that it is difficult to reach PIP objectives related to education, partly because of placement persons' low level of education, just as it is to reach the goal of family reintegration (given the generous placement allowance, placement persons' bad relationship with children's parents, the grandparents who do not communicate relevant information about the parents, etc.).

- Deficient collaboration with placement center employees, in particular with educators. Case managers recommend investing in staff training courses at the level of residential care services as "the needs are changing fast and experts are falling behind". In some counties, case managers also mentioned the lack of clear procedures for specific intervention programs (PIS). Anyways, lack of training is reflected in the formal development of PIS.

> "Placement center employees don't formulate the PIS as they should, they write them late, with a copy-paste approach, using vague, generic sentences, instead of personalizing them to each child. Placement centers don't really have specialists or, if they do, those don't take an interest in all that".
>
> "PIS have always posed problems because, until recently, we didn't know who was supposed to write them. There were no clear procedures; they are normally prepared by the employees who work directly with the child, but in our county that was not clear".

- Lack of time. Correlated with heavy workload, the small number of case managers compared to the number of active cases, the large amount of documents requested and insufficient transport resources, case managers mention lack of time as one of the difficulties related to PIP or PIS implementation: "the ideal would be for me to have time to go and see them, talk to them". Also, allocating more time for individual discussions with beneficiaries was identified by case managers as something they could have done better in their case management work.

- The difficult collaboration with other institutions is mentioned by case managers, not only in relation to SPAS but also to population registration offices, schools which "automatically label those placed with different carers" or, more generically, from public care, or institutions from their county as well as from other counties. Regarding the institutions from other counties, the difficult collaboration with other DGASPC is also due to case managers' different work practices – "we do things differently". Apart from the difficult collaboration with other institutions, case managers also draw attention to the tough cooperation with services from within the same institution, for instance insufficient information included in the initial evaluation made by the Emergency Service or the long time taken by the Comprehensive Evaluation Service to process the documents.

The difficulties most frequently mentioned by case managers are related to the challenging collaboration with parents, mayoralties and the multidisciplinary team. Other setbacks concern:

- Lack of logistical resources at the DGASPC (computers, printer – "we lack equipment at work");

- Non-correlation of laws on the compulsory minimum standards for case management in the field of child rights protection with laws on education and health care ("PIS are not designed as working tools for educational and medical institutions.")

- Lack of legal provisions meant to improve the relationship with the parents who are not interested in family reintegration ("no legal framework is in place to make them fulfill their duties; parents are uncooperative and there is nothing you can do for reintegration.")

- Shortage of training for both case managers and AMPs. The recommendations for professional development also include experience exchanges with experts from other counties and courses on PIS and PIP development and implementation, held in a different format where "we can talk about the actual challenges we are facing".

- Lack of case management continuity ("the case gets fragmented all the time"), the lack of real case monitoring by the case manager ("PIP is not prepared and monitored by the person who signs it"), legal changes required for streamlining the preparation of documents for children with disabilities.

DGASPC directors also mentioned difficulties related to SMO 9, Recruitment and Employment – unattractiveness of vacant case manager posts ("a lot of responsibility for low pay") given the low wages paid to civil servants (big pay differences between civil servants and contractual personnel), lack of professionals ("we don't manage to find candidates to fill the vacancies"), staff count limitations ("when two people leave, only one gets hired"), poorly prepared candidates compared with MC requirements ("none of those candidates fulfilled the MC standards"). Problems were also mentioned with respect to:

- High staff turnover;

- Wide dispersion of cases across the county;

- Lack of a training budget and the bad quality of the training courses delivered;

- The need to standardize costs for outsourced MCs;

- The need to develop a unified pay system in the field of social work ("we have a problem if a county council thinks that the social worker is not important and pays the professional the minimum wage");

- Centralization focused on document review, not on the quality of the services delivered – "All inspections from whatever institution are not interested about how children are doing. If your papers are in order, your work is good, otherwise, it is not. We don't have time to write so many papers.";

- Differentiated funding of social services – the difference between the multidisciplinary team which is funded from the county council budget and placement centers and other services which are funded from the state budget;

- The need for legislative clarifications so as to organize case management by child, not by service.

As a conclusion, case managers identified problems/difficulties in reaching PIP/PIS objectives/goals, especially those related to family reintegration. Case management practitioners mention the following specific situations: (i) difficult collaboration with the family, particularly when they lack interest and move frequently, which is also relevant when it comes to reaching the PIP goal aimed at adoption – "the mother does not give her consent for adoption even if she knows that she will never take the child back"; (ii) difficulty in reaching the objectives related to education, especially for children with SEN or in the case of family placements with less educated persons or because of the difficult collaboration with the school/discrimination in school; (iii) difficulties related to social and professional integration generated by employers' refusal to hire young people from public care; (iv) difficulty in reaching the objectives related to health care for children with disabilities, also linked to a lack of local services/professionals; (v) difficulty in reaching the PIP goal related to adoption, especially for children with health problems.

Still, some case managers did not identify any setbacks for the achievement of the objectives. This may be explained by the proper organization of county DGASPC as well as by case managers' lack of responsibility related to the writing/implementation of PIP/PIS – "As a case manager, I have no stress, because I do nothing besides signing. My real work is that of a case handler".

The compulsory minimum standards that MCs fulfill best are SMO 7 concerning monitoring and reevaluation and SMO 4 concerning the detailed/comprehensive evaluation. Apart from these, other standards mentioned as being properly fulfilled were SMO 3 concerning case identification, initial evaluation and takeover and SMO 6 concerning the individual care plan and the service plan.

At the other end of the spectrum, the compulsory minimum standards for case management in the field of child rights protection most difficult to fulfill are Standard 5 regarding the multidisciplinary team and Standard 8 concerning the post-service monitoring and case closure. Both are regarded as falling outside the case manager's control.

Table 34: Compulsory minimum standards (SMO) fulfilled best and most difficult to fulfill by the network of case managers (%)

	Fulfilled best by MCs		Most difficult to fulfill by MCs	
	First option	2nd option	First option	2nd option
1. Conditions for method implementation	4	1	3	2
2. Case management stages	12	5	4	2
3. Case identification, initial evaluation and takeover	18	9	8	6
4. Detailed/comprehensive evaluation	15	15	9	8
5. Multidisciplinary team	6	7	22	9
6. Individual care plan and service plan	13	15	7	7
7. Monitoring and reevaluation	18	25	8	7
8. Post-service monitoring and case closure	1	7	13	13
9. Recruitment and employment	0	1	3	5
10. Role and place of the case manager and of the prevention case handler	1	0	1	3
11. Initial/induction and continuing training	1	1	2	4
12. Supervision	0	1	3	4
Total MCs with non-response[133]	**71**	**93**	**108**	**209**
Total MCs	**100**	**100**	**100**	**100**
N	**675**	**675**	**675**	**675**

Source: World Bank, Census of Case Managers, February-March 2018. N=675 MCs. Unweighted data.

Note: SMO pursuant to Order No. 288 of 6 July 2006.

The difficulty of fulfilling SMO 5, related to the multidisciplinary team, comes from the poor cooperation with disciplinary team members due either to lack of professionals ("we don't have a

[133] They are not familiar with the Order, they don't think standards are properly fulfilled or difficult to fulfill or they don't have a second option.

multidisciplinary team, we are the team"), to the difficulty of scheduling joint meetings with all the professionals or to unresponsiveness, especially that of healthcare and teaching staff. In other cases, professionals are available but their number is too small to cover the actual needs - "we turn to a psychologist only when there is an urgent need, when it is already too late and there is not much we can do anymore" or "the case manager does the doctor's job, too; they have children cared for in different localities where the doctor goes only twice a week and they are very busy and have no time for filling in the papers and discussing the cases".

"For the service plans, we don't work with doctors, they don't get involved and they don't sign any document, they are not bound to sign; we don't even ask them to come because they never come anyway; we work with the psychologist and the placement family".

The problems related to the implementation of SMO 8 concerning post-service monitoring and case closure arise from the difficult collaboration with the local authorities, the lack of social work professionals in local communities or the parents'/children's change of address, especially when they move abroad. This is actually the main explanation mentioned by case managers for the difficult implementation of standards.

"SPAS don't monitor the cases after reintegration and don't respond to requests; monitoring findings are not available because no monitoring is performed; monitoring is irrelevant since the case manager cannot intervene".

"If it is post-service, it means that it is no longer in our records and that the mayoralty is in charge of monitoring; many times, even if we submit written requests for 3-6 months, we don't really get an answer and we don't have enough time to go and check on them post-service".

In general, the explanations provided for the difficult implementation of standards are similar to case management difficulties related to the implementation of PIP, PIS, PS (service provision). Moreover, other problems are mentioned in relation to responsibilities shared with other colleagues/professionals (it is not only the MC's responsibility), lack of professional development courses, lack of external supervision, lack of case file documents, difficulty in identifying the child's relatives.

Figure 26: Explanations for the difficult fulfillment of SMO by the MCs in their everyday work (%)

Source: World Bank, Census of Case Managers, February-March 2018. N=675 MCs. Multiple answers

The causes/reasons why case managers have had to take/accept other measures/decisions than those that they first identified/planned and that they considered best for the child are related to young

people who want to leave public care when they turn 18, children with behavioral disorders, changes in family circumstances (paternity test, biological family members' loss of income), parents' non-involvement hampering the successful reintegration and, hence, having to change the goal from reintegration to adoption. Almost half (46%) of the interviewed case managers stated that, in the previous 12 months, they had had to take/accept such measures/decisions.

Within the same context, it is important to mention that there are also case managers who are not familiar with SMO provisions although they say that they know them. The most frequent inconsistencies are noticed in the open answers related to SMO 9 concerning recruitment and employment (case manager and prevention case handler). A few case managers brought up difficulties in finding a job for young people in public care during the discussions about SMO 9: "recruitment and employment were not successful for any of the children; they are frustrated children lacking self-confidence; you hire them, but they give up easily and want another job" or, also in relation to the same standard, "youth employment is difficult because young people are not willing to search for a job and they are also coddled by their placement families". Still, those difficulties were also mentioned by other case managers with regard to the achievement of the goal aimed at social and professional integration (but not in regard to the implementation of SMO 9).

Table 35: Assessment of the DGASPC's provision of the resources needed for case management implementation

	No. of valid answers	Mean score*
Sufficient number of case managers (meeting conditions for appointment) for children in special care	669	7
Sufficient number of case managers for ethnic communities in the county who know the language and culture of those communities	357	5
Means of transport (car or reimbursement of travel expenses) for field visits	673	8
Logistics (computers, printer, copy machine, phone, etc.)	675	8
Working procedures and methodologies	674	9
Network of professionals for the multidisciplinary team	670	8
Map of current social services at county/national level	608	8
Dedicated areas for the confidential archiving of case files	666	8
Decent salaries for case managers	670	8

Source: World Bank, Census of Case Managers, February-March 2018

Note: * For valid cases

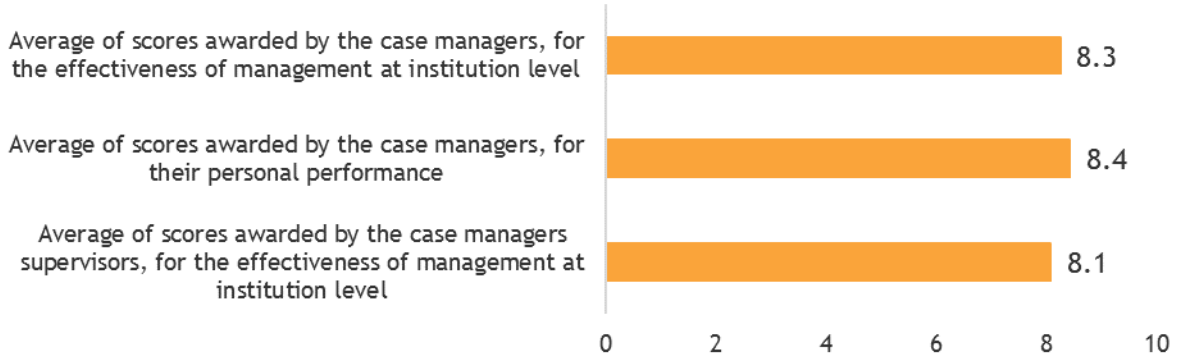
The lowest rated resources provided by the DGASPC are those related to the sufficient number of case managers for ethnic communities in the county who know the language and culture of those communities and the sufficient number of case managers (meeting conditions for appointment) for children in special care. This last resource is relevant to the difficulties mentioned in relation to the case managers' heavy workload (bureaucracy, concurrent responsibilities, lack of the required data, absence of preventive services in local communities, etc.). The lowest scores regarding a properly

sized network of case managers for the number of children in special care are reported in the counties of Satu Mare and Caraș Severin, having 16 case managers each. Still, neither of these two counties record the highest mean caseload/MC.

3.4. Evaluation of case management per-formance

On the whole, case managers' superiors and case managers themselves rate case management performance at institutional level as good (scores above 8). Moreover, case managers rate individual performance slightly better than institutional performance. When it comes to case management effectiveness at the level of the MC's institution, scores vary from 6.5 in the county of Brașov to 9.31 in the county of Dolj. As for the self-assessment of individual performance, the case managers from the county of Constanța give the lowest mean score and those from the county of Ialomița, the highest.

Figure 27: Evaluation of case management performance by case managers and DGASPC management



Source: **World Bank, Census of Case Managers and Interview with DGASPC Director, February-March 2018**

To improve case management performance, a number of recommendations should be formulated based on the implementation of standards which are not among those that are best fulfilled/hard to fulfill, but which could considerably contribute to building the capacity of the current case manager network. We are referring here to SMO 11 related to Initial and Continuing Training and SMO 12 concerning Supervision.

About SMO 11, the general perception is that "initial training should improve and that continuing training is not available". Consequently, although "any type of training is most welcome", case managers identified many specific training needs:

- Domestic violence, crisis management, communication with beneficiaries
- Child psychology, handling adolescents, children with behavioral disorders, and alcohol, tobacco, drug addictions
- Supervision
- Case studies, social work methods and techniques for managing difficult cases, efficient procedures and working methods
- Computer use, ECDL
- Experience exchanges with other counties
- Training on project proposal writing

- Procedures for starting the adoption process
- Law amendments
- Communication in certain communities, for instance Roma communities
- Time management
- Stress management
- Case management in general as well as focused on specific areas, such as parent counseling
- Case-related tools, working methods
- Children's rights
- Personal development
- Training on PIP and PIS writing.

The development of case managers' skills, however, requires an institutional training plan in each DGASPC to change the current situation where "managers do not get any training unless they handle it on their own". Nevertheless, DGASPC directors included among problems the poor quality of the training courses delivered, insufficient training budgets as well as the difficulty of selecting a high-quality training offer under the current public procurement procedure.

Supervision related to the implementation of SMO 12 could efficiently improve the quality of case managers' work. According to SMO 12, case managers and case handlers benefit from supervision from adequately trained and experienced experts, which allows services to work well. In practice however, at present:

"On the ground, you have to make decisions by yourself, you don't know if those decisions are right and your signature can change the course of a child's life".

In this context, DGASPC directors aim to optimize the implementation of the following case management standards through institutional development plans by 2020:

- SMO 1. Improving conditions for method implementation through software development for the registration of all children with special protection measures and/or improving working procedures.
- SMO 5. Improving collaboration with the multidisciplinary team, including through more frequent meetings with CP/AMP teams.
- SMO 6. Raising the targets set for case managers for starting the adoption proceeding.
- SMO 9. Expanding the organizational structure by hiring more case managers and meeting the caseload standard, ensuring a more balanced area coverage or setting a new threshold, closer to the standards ("each MC should work with 50 beneficiaries at most"); filling vacancies; hiring case managers in accordance with SMO; as regards the deinstitutionalization process, the AMP networks could develop, which would lead to a larger team of MCs available for children placed with AMPs.

- SMO 10. Changing the organizational chart by setting up a MC service or reorganizing the MC into a single structure so that a child can have one MC during the entire time spent in special care; clearly separating MC responsibilities from service provision; restructuring the organizational chart based on the recommendations formulated by a Committee of Social Workers and Psychologists responsible for the human resources required for Pfam and AMP (recruitment, evaluation, certification, monitoring).

- SMO 11. Developing initial and continuing training though experience exchanges, various professional training courses, including in the field of supervision, case management, social service quality – "no plans until 2020, only continuing training". Some directors also mention the necessity to train mayoralty employees as well as the need for burnout prevention training ("after a while, they turn into robots, like they are on an automatic mode"). Also motivated by the lack of a training budget, some DGASPC directors suggest experience exchanges to discuss exceptional cases with colleagues from other services.

- SMO 12. Improving MC supervision, "now it is not enough; it may be useful to have more experts or to contract out these services".

Other suggestions made by the DGASPC management concern the direct involvement in the cases of children faced with dropout and violence problems, better prevention, law amendments – "we have to make the 288 a reality", closer examination of family placement alternatives, involvement in specific cases of children faced with dropout and violence problems, MC involvement in the communities by putting up community-based teams of volunteers for leisure activities and for the activation of Community Advisory Structures ("SCC should not only stay on paper, [but used] to facilitate reintegration and set up services at local level").

Good practice

Given the lack of space at the DGASPC offices, we were invited to work in the office of the *Abuse, Neglect and Exploitation Division*. Thus, we witnessed the work carried out by that division.

During the time spent there, two cases came in: a 13-year-old girl who, the night before, had physically assaulted her family because they had refused to give her money for cigarettes. At the beginning of the conversation with the social worker, the grandmother was aggressive, shouting and determined to leave the girl right there, in the office. When she heard her grandmother, the 13-year-old child shouted at her: "Here you go again?!". The grandmother and the niece shoved each other between the desks full of papers as another case came in: a mother with her 6- or 7-year-old girl. She was shouting, saying that she could no longer look after the child and that she wanted to place her in special care for at least three months until she managed to get back on her feet and find a job. The psychologist explained to the mother how complicated it would then be to take her back home, how complicated and unnecessary the entire procedure would be (as it also involved a court of law), and that she would try to find an alternative. The mother continued to sit on a chair, trying to convince the psychologist that that was the best solution for her. The psychologist looked for colored pencils and paper to distract the little girl from the discussion given that she started to cry, scared that her mother would leave her there. She begged her mother, shouting, not to desert her. The mother took her in her arms and completely changed her attitude, comforting her, but went back to her initial attitude once the little girl started to color, thinking or behaving like the child could not hear her.

We tried to finish up work as quickly as possible. We realized how useful a play area would be for the children coming to the DGASPC with their carers or parents.

Source: Field report prepared by researcher Andreea Stănculescu

Part 4

SOURCE COMMUNITIES FOR THE CHILD PROTECTION SYSTEM

PART 4. SOURCE COMMUNITIES FOR THE CHILD PROTECTION SYSTEM

By definition,[134] „source communities" (rural and urban) are areas at locality and sub-locality level from where, in comparison with other localities/areas, a significantly higher number of children enter public care. Sub-locality type areas may refer to a neighbourhood, but also to a street, a group of houses and/or blocks, in urban areas, and to a whole village, to a settlement or just a group of houses in rural areas.

In this chapter we show how we carried out the selection of source communities for the diagnosis of prevention services for the separation of children from their families. Then, in the selected communities we identify the main vulnerable groups of children and young people and we analyze the effectiveness of prevention services and support for children and families available in February-March 2018.

6.1. Selecting the source communities

When discussing the negative impact of separation from parents and how it may be limited, one of the hypotheses is that *preventing the entry into the system is more cost-effective than treating the effects of separation*. Regardless of how tempting this principle is, in theory, the measures taken to prevent a child's entry to public care and their effectiveness depend on the geographical distribution of children at risk of separation. The resources that the child protection system should mobilize and the actions that it should take would be completely different if they were distributed equally across the country, as opposed to the situation where the families at risk are concentrated in compact communities. The multiple situations that may arise from one county to another, or even within the same county, represents one of the reasons why it is difficult to carry out cost-benefit analyses of prevention measures, for them to be extrapolated to other territories. Therefore, the way in which the risk of separation is concentrated or spread at the level or within localities is essential for the formulation and ex-ante evaluation of prevention measures.

A recent study[135] has already shown that, based on CMTIS data,[136] 14% of children in public care come from source communities. Most of them come from rural areas (60%), from all counties, but Brașov, Constanţa, Covasna, Sibiu, Vâlcea and Vaslui prevail.[137]

In the present research, we resumed the analysis of source communities using the data from the diagnosis of the placement centers, presented extensively in Results # 1 and # 2 of the current Agreement.[138] Within the diagnosis study of all placement centers in the country, the locality (and the village where applicable) of origin was registered for each of the children and young people in these centers at 31.10.2016. From the analysis of these data we identified the source communities, meaning the communities with a higher probability of sending children to the child protection system.

[134] Stănculescu et al (2016).
[135] Idem.
[136] The Child Monitoring and Tracking Information System (CMTIS) is the information system for the management of the child protection system in Romania, managed by ANPDCA.
[137] From source communities more boys than girls (54%), of all ethnicities, are coming into public care, but the percentage of Roma people is above average (15% compared to the 10% average).
[138] The Reimbursable Advisory Services Agreement, signed between the International Bank for Reconstruction and Development and the National Authority for the Protection of Children Rights and Adoption (ANPDCA) on May 12, 2016. The agreement relates to the "The Development of Plan for the De-Institutionalization of Institutionalized Children and their Transfer to Community Based Care" - code SIPOCA 2, implemented by the ANPDCA and financed from the European Social Fund, under the Administrative Capacity Operational Programme.

(1) In the first step, the number of mothers with children in placement centers at the level of territorial administrative unit was aggregated. It was not possible to also aggregate at component locality (village) because this information is often not filled in the children's files as shown in Table 36.

Table 36: Data on the localities where the mothers of the children from the placement centers in the country live

Total number of children in placement centers in the country	6.514
Number of children for which there is information on the territorial administrative unit in which the mother currently lives	4.190
Number of mothers for whom there is information about the territorial administrative units where they live, of which:	2.964
- urban	1.017
- rural	1.947
Number of mothers for which there is information about the territorial administrative units in which they live – out of the 35 counties with plasma centers, of which:	2.741
- urban	908
- rural	1.833
Number of communes/localities where the 1.833 mothers live	994

Source: World Bank, Census of child placement centers (October 2016) (N=167 centers with 6.514 children).

In total, we identified 994 communes in which mothers of children from placement centers in the country live. Most of these communities have only 1-2 mothers.

Table 37: The distribution of communes in which mothers of children and young people living in placement centers in the country are according to the number of mothers

Number of mothers	1	2	3	4	5	6	7	8	9	10	11	12	Total
Number of communes	573	227	99	43	22	11	7	5	2	2	2	1	994
% communes	58	23	10	4	2	1	1	1	0	0	0	0	100

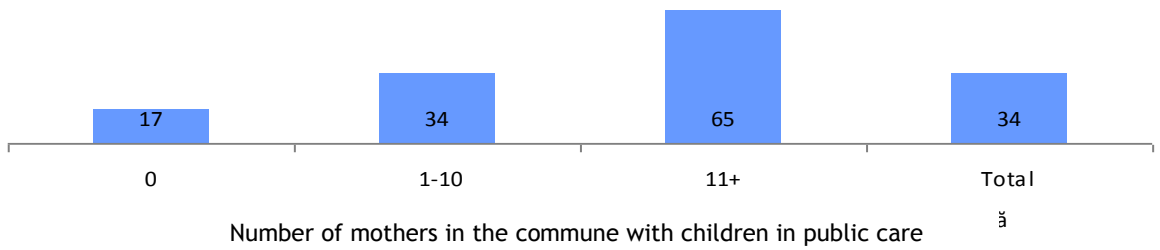
Source: World Bank, Census of child placement centers (October 2016).

Because the information was extremely poor, we tried to identify other options through which we could improve the identification of the communities in which intervention was first needed. To this end, we also added information on the existence of marginalized communities and the percentage of people in marginalized communities in each of the 994 communes. Marginalized areas represent highly disadvantaged areas where the population has at most gymnasium education, earns informal income (especially from agriculture), and lives in precarious housing even after rural standards, which generally have little access to infrastructure and basic utilities (overcrowded houses and/ or lack of access to water or electricity). These marginalized areas are considered "problematic" due to a combination of factors, namely the high number of low income households, the low level of education and skills required on the labor market, the prevalence of single mothers, the high number of children and the high rate of petty crime. To a greater extent than other communities, especially in rural areas, marginalized areas are characterized by poor physical accessibility, unpaved roads, inappropriate housing, exposure to environmental risks (floods, landslides, etc.) and poor quality or absence of public services.[139]

[139] Swinkels et al. (coord.) (2014) *Atlasul Zonelor Urbane Marginalizate* and Teșliuc et al. (coord.) (2015) *Atlasul Zonelor Rurale Marginalizate*.

We have introduced this selection criterion on the basis of our previous study[140] which has proven that there is a strong association between the number of mothers with children in public care and the existence of a marginalized community in the commune.[141] Thus, according to Figure 28, only 17% of the communes without mothers whose children are in public care include at least one marginalized area, but the probability of such an area to exist is much higher in the communes where there are at least 11 mothers (65%).[142]

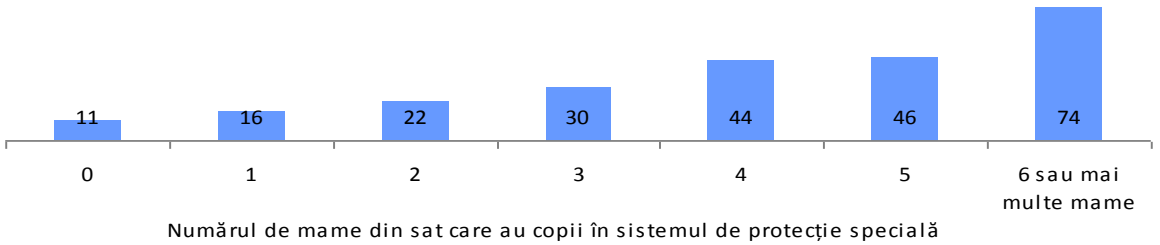
Figure 28: The proportion of communes with marginalized areas according to the number of mothers in the commune with children in public care (%)



Source: CMTIS. Note: The analysis excludes the counties where only a small number of mothers had their addresses registered in CMTIS (Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași and Giurgiu).

Also, at village level, as Figure 30 indicates, the higher the number of mothers in a village who have children in public care, the higher the probability of having a marginalized area in that village.

Figure 29: Proportion of villages with marginalized areas according to the number of mothers in the commune with children in public care (%)



Source: CMTIS. Note: The analysis excludes the counties where only a small number of mothers had their addresses registered in CMTIS (Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași și Giurgiu). Percentage was estimated for mothers whose village name was registered with CMTIS.

By introducing the additional criterion for the existence of a marginalized area, we notice that there are marginalized communities in 42% (or 420) of the 994 communes where mothers with children in placement centers live.

[140] Stănculescu et al (2016).
[141] The analysis of CMTIS data shows that there is a concentration of mothers who have children in the child protection system in several rural localities. Of the total of 2,111 communes included in the analysis, in 59 there are concentrated at least 16 mothers mothers with children in the protection system, while in 103 localities the number of mothers varies between 11 and 15. These 162 rural localities, although only 8% of the total analyzed communes, send 28% of the children that are currently in public care.
[142] The relationship is also confirmed by the correlation between the aggregate percentage of people living in all marginalized areas at the commune level and the number of mothers in CMTIS, aggregated at the same level. For example, in rural communities with less than 2000 inhabitants and with more than 10 mothers having children in public care, 27% of people live on average in marginalized areas, while in the localities with the same sizes, but without children in public care, the percentage of people in marginalized areas is on average only 2%.

Table 38: The distribution of communes where mothers of children in placement centers live according to the number of mothers and the presence of a marginalized area in the commune

Number of mothers	Number of communes	Number of communes with one or more marginalized areas	% communes with one or more marginalized areas	Average population number in marginalized areas/ areas	% Population in the marginalized areas/ areas in the total population of the commune
1	573	224	39	218	6
2	227	92	41	287	7
3	99	46	46	300	7
4	43	22	51	294	6
5	52	36	69	734	13
Total	**994**	**420**	**42**	**272**	**7**

Source: World Bank, Census of child placement centers (October 2016).

Using the data in Table 38, we grouped the communes in which mothers of children from placement centers live into three **categories of source communities**:

- Communes with 5 mothers or more than 5 mothers
- Communes with 3-4 mothers and at least a marginalized community
- Other communes (either with 1-2 mothers, either with 3-4 but without a marginalized community).

	Communes with 5+ mothers	Communes with 3-4 mothers and marginalized community	Other communes	Total comunes
Number of communes:	52	68	874	994

Annex 4. Table 1 shows the distribution of communes by counties and by the three categories of source communities. It can be observed that in the counties with more children in placement centers (the 35 county counties studied) the number of communes is relatively higher, which could be expected considering the data from which we started (regarding the children and youth from the placement centers).

According to the agreement, 30 communities had to be selected out of all the source communities identified in order to produce maps of prevention and alternative services.[143]

The limitations of the method used to identify the source communities come from the fact that the data used were only for children and young people in placement centers and not for all protection services. For this reason, identified communities represent source communities for placement centers (and not for the entire child protection system). Additional information was needed to overcome the limitations of available data. Thus, we adopted a participatory method for selecting the 30 source

[143] Also, in the future stages of the project, data will be collected in these communities for each of the children (to identify those at risk) and a plan to develop services to prevent child separation from the family at community level will be elaborated.

communities. Namely, we included a separate chapter on community selection in interviews with DGASPC directors (see the Methodological report).

DGASPC directors were asked to choose between the source communities identified in the county, taking into account: (1) the communities from where more children are entering the system than from other rural communities in the county (in any protection service), and (2) where DGASPC plans to intervene or believes that the development of community-based support and community-level services targeting the separation of children from their parents would be more stringent. As a rule, if in a county there were communes from the first category - communes with 5+ mothers - the DGASPC director was asked to choose between those. If there are no communes of the first category in the county, the DGASPC director was asked to select from the communes in the second category - communes with 3-4 mothers and a marginalized area. If there were no such communes, to select any commune in the third category - other communes.

In cases where the DGASPC director considered that there are other communes in the county than those on the list that have sent a larger number of children and young people in public care (regardless of the protection service), then, after verifying the option, this new community could be selected. This was the rule especially in the case of counties with few placement centers but with numerous alternative services (AMP, family placements). For example, in Bihor conty, Tinca commune was not on the initial list of source communities, because all children in the system coming from Tinca are in an alternative service and not in a placement center. After checking with DGASPC Bihor, it became obvious that Tinca, with over 140 children sent to the system, is the best choice.

In this way, 32 source communities from 32 counties were selected (of the 35 counties with placement centers).[144] In addition, Tinca commune was added to Bihor County, as was explained earlier. And in the counties of Caraș-Severin and Constanța, a community has been added. Unlike the other communes, these two communes - Mehadica and Cogealac - are source communities identified by DGASPC (not included in the initial source community lists) and, at the same time, represent concentrations of child protection services, meaning they are communes where DGASPC has developed a large number of AMPs and family placements. So, finally, 35 source communities were selected in 32 counties, out of which 2 are also concentrations of child protection services.

Table 39: List of selected source communities

County	Commune	Number of mothers with children in centers	The commune has at least one marginalized community 1 - yes 0 - no	Total population (2011 Census)	Population in the marginalized area in the commune (number of persons)	Percentage of the population in the commune that lives in the marginalized area
AB	CETATEA DE BALTA	1	1	2930	699	24
AR	VLADIMIRESCU	2	0	10710	0	0
AG	CALINESTI	3	1	10872	1139	10
BH	DRAGESTI	3	1	2586	704	27
BH	TINCA	2	1	7793	1117	14
BT	COPALAU	4	1	4053	242	6
BV	APATA	5	1	3169	1604	51
BZ	VERNESTI	7	1	8633	736	9

[144] Source communities were not selectedin counties Bistrița-Năsăud, Ilfov and Suceava. In Ilfov, no potential source communities were even identified.

CL	SPANTOV	4	1	4605	1262	27
CS	BERZOVIA	1	0	3891	0	0
CS	MEHADICA	0	0	870	0	0
CJ	MINTIU GHERLII	1	0	3746	0	0
CT	PESTERA	6	0	3307	0	0
CT	COGEALAC	2	0	5039	0	0
CV	VALCELE	7	1	4475	2176	49
DB	I. L. CARAGIALE	1	1	7697	927	12
DJ	ORODEL	3	1	2731	332	12
GL	MASTACANI	4	1	4606	198	4
GJ	BUSTUCHIN	5	0	3376	0	0
HR	CIUCSANGEORGIU	3	1	4839	316	7
HD	TURDAS	2	0	1801	0	0
IL	TRAIAN	3	1	3168	605	19
IS	VOINESTI	5	1	6815	3218	47
MM	RUSCOVA	1	0	5541	0	0
MH	SIMIAN	1	1	9650	473	5
MS	ALBESTI	1	0	5345	0	0
NT	VANATORI-NEAMT	8	1	7595	537	7
PH	VALEA CALUGAREASCA	7	0	10657	0	0
SJ	NUSFALAU	3	1	3600	379	11
SM	BOTIZ	3	1	3622	237	7
SB	ROSIA	7	0	5241	0	0
TR	BRANCENI	1	1	2881	245	9
TM	SANPETRU MARE	5	0	3145	0	0
TL	TOPOLOG	5	1	4698	782	17
VL	RACOVITA	1	1	1822	307	17

Note: The colored lines show the source communities indicated by DGASPC that were not included in the initial source community lists for the placement centers.

Out of the 35 source communities, 11 are represented by communes with 5+ mothers with children placed in the special protection system, 10 are represented by the second category – communes with 3-4 mothers and marginalized areas, and 14 are represented by communes with 1-2 mothers with or without a marginalized area. Most of the selected source communities – 21 communes – include one or several marginalized areas.

Table 40: Distribution of selected communes by categories of source communities and depending on the presence of a marginalized area within the respective commune

	Number of selected communes		
	Without Marginalized Areas	Without Marginalized Areas	Total
Communes with 5+ mothers of children placed in the protection system	5	6	11

Communes with 3-4 mothers and marginalized area	0	10	10
Other communes	9	5	14
Total communes	**14**	**21**	**35**

Source: World Bank, Census of Foster Care Centers for Children (October, 2016).

Note: "Other communes" refers to communes with 1-2 mothers of children placed in Foster Care Centers or 3-4 mothers without marginalized areas.

Functional micro-area

In order to map prevention services and alternative services in the 35 selected source communities, we introduced the functional micro-area concept. The functional micro-area contains the selected commune and the accessible area within a radius of approximately 30 minutes with some means of transport or possibly by car. So, there must be roads/ access pathways between the villages comprised in a functional micro-area, because otherwise the existence of a social service in the micro-area is not relevant to the population of the selected source community.

The actual delimitation of the functional micro-area for each source community followed three steps. In the first step, the research team compiled an exhaustive list of localities (administrative territorial units and adjacent villages) neighboring the commune selected as a source community. In the second step, an exhaustive list of localities was discussed in the interview with the Mayor of the source community (Deputy Mayor, City Hall Secretary) to identify all the villages in the accessible area within about 30 minutes. Because the selection from the exhaustive list was made at village level, the number of villages contained by the functional micro-areas is lower than the total number of villages in the corresponding ATUs.

In step three, the functional micro-area was mapped and all the data collected referred to:

- source community – selected commune
- the rural micro-area that contains all the neighboring villages that are accessible within a radius of about 30 minutes
- the urban micro-area containing the neighboring cities or municipalities, including villages tied to them administratively.

Table 41: The distribution of selected source communities according to the type of functional micro-area

	Number
Commune with rural micro-area only	9
Commune with urban micro-area only	1
Communes with urban and rural micro-areas	25
Total	**35**

In total, the 35 source communities (with 172 villages) correspond to 151 communes (with 477 villages), in rural micro-areas, and 30 cities and municipalities (which have 83 localities) in the urban micro-areas.

6.2. The data

The analysis presented below is based on the data collected by the World Bank team in February-March 2018. In each of the 32 counties where source communities were selected, the team started with an interview with the DGASPC director regarding the selection of the source community. Then,

within the DGASPC (i) the list of children in public care (regardless of service) in February 2018 originating from the selected source community and was filled in (ii) an interview with the DGASPC specialist / specialists responsible for the selected community was conducted, regarding:

a. Evaluation of services in the selected source community from the DGASPC perspective

b. List of new services that should be developed in the selected source community, in the opinion of DGASPC

Then, during field visits in each of the 35 selected communities, the research team along with the DGASPC specialists designated for this activity conducted:

a. Interview with the mayor (deputy mayor or mayor's secretary)

b. Interview with SPAS, which also included a list of all mothers who sent children in public care in the last 5 years and a check of the list of children who are currently in the system

c. Interview with the coordinating school principal

d. Interview with the family doctor (or community nurse)

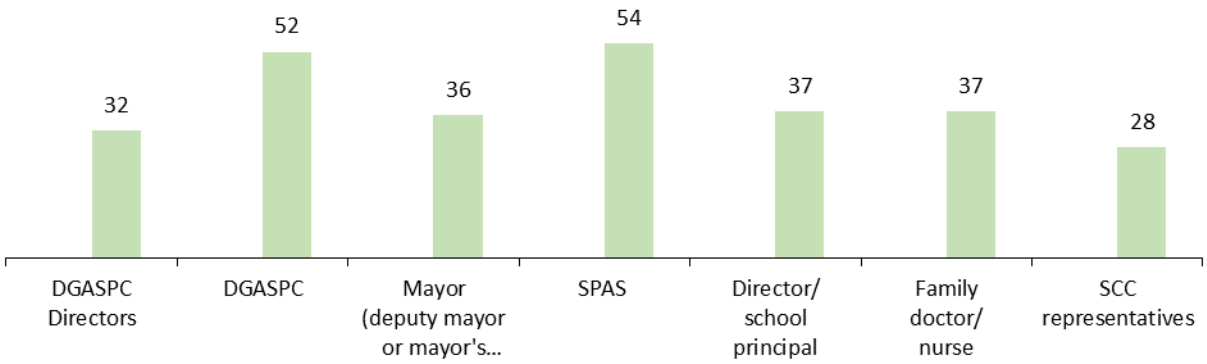
e. Interview with the SCC (Community Consultative Structure) representatives or any other local actor (priest, informal group, policeman, etc.) with initiatives to prevent child separation or protection of the child

f. Sheets for social services identified in the community or in the functional rural micro-area that have only children or adults and children among the beneficiaries.

In total, in 32 DGASPCs and in the 35 source communities, 233 interviews were carried out involving 276 specialists, as shown in Figure 30. The interviews lasted 75 minutes on average.

Moreover, to complement the Social Service Sheets, the social workers part of the research team carried out another 69 interviews with representatives of social services identified in the source communities or their rural micro-areas. [145] The data collection was carried out by a team of 19 professional social workers, members of the CNASR.

Figure 30: Number of participants in interviews conducted in DGASPC and source communities



The data collection was carried out by a team of 19 professional social workers, members of the CNASR. As an additional indicator of the research effort, the research team travelled more than 6,500 km for the field trips.

[145] Sheets did not have to be filled in for social services identified in the urban micro-area or for services that do not have children among the beneficiaries.

6.3. Source Communities and Child Welfare Services

The relationship between source communities and the child welfare services is a rather dual one. On one hand, the source communities send children and young people into the protection system at a rather higher rate than in the case of other local communities. Therefore, both services on the development of prevention of child separation from family and on working with families so as to reintegrate the children already in the protection system should be prioritized. On the other hand, the County General Directorate for Social Welfare and Child Protection (DGASPC) has established protection services (AMP, family placement, CTF, AP, and Foster Care Centers) within certain source communities, where children from other communities and sometimes from the same community are placed under care. The following sections are covering these two dimensions of the relationship between source communities and child welfare system.

6.3.1. Children from Source Communities, placed in the Special Protection System

The data used herein are taken from the Lists of Children from the Special Protection System, children that are coming from the selected communities. Out of those 35 selected communes, over 1000 children from all source communities' categories, with and without marginalized areas (Table 42) are coming from the protection system, on February 2018. The number of children per source community varies from 3 (Brânceni Commune, Teleorman County) to 145 (Tinca Commune, Bihor County). In fact, only 3-14 children and young people are coming from 10 communes, while 12 communes have sent into the protection system between 30 and the maximum number of 145 children and young people.

Table 42: Distribution of the children in the protection system coming from these communes, by source community and by the presence of a marginalized area within the respective commune

	Number of children in the protection system coming from the selected communes		
	Without marginalized area	Without marginalized area	Without marginalized area
Communes with 5+ mothers of children placed in the protection system	120	232	352
Communes with 3-4 mothers and marginalized area	0	205	205
Other communes	315	132	447
Total communes	**435**	**569**	**1004**

Source: World Bank, Census of Foster Care Centers for Children (October, 2016).

Note: "Other communes" refers to communes with 1-2 mothers of children placed in Foster Care Centers or 3-4 mothers without marginalized areas

In order to organize an efficient intervention, it is essential to learn if children separated from their families coming from these communes are spread between the villages or they are concentrated only within some of the villages. Out of the 35 communes:

- 6 communes have only one single village and they have sent 143 children into the protection system. In the case of such communes, it is improper to discuss the spread or concentration of the children presence at village level.

- 8 communes have several villages under their administration (45 villages in total), but there are no available data on the origin of the children. 296 children are coming from these communes into the protection system, but there is no information on their concentration at village level.

- 7 communes have several villages each (50 villages in total), and the 139 children entering the protection system from these communes are spread within all or most of their villages.

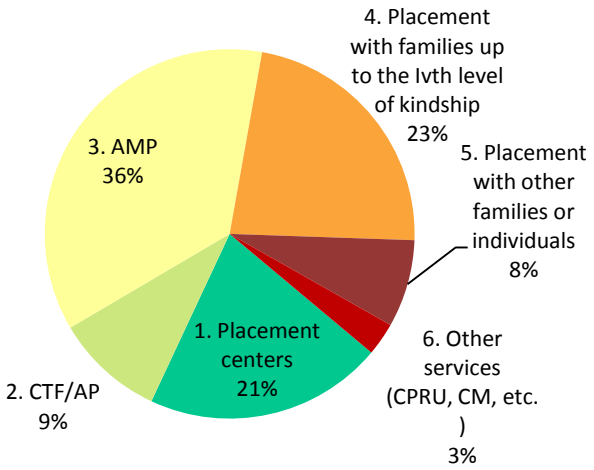
- 14 communes that include in total 71 villages are characterized by a high concentration of children within several villages. Thus, almost 80% of the 426 children separated from their families are coming from 20 such villages (i.e., 325 children and young people).

To conclude, within the source communities, over half of the children and young people from the protection system (569 children and young people) are coming only from 26 villages of 20 communes. Other 139 children and young people are spread within almost 50 villages from 7 communes and in the case of the remaining 296 children and young people, a more thorough research is required to be developed within their 8 communes (totaling 45 villages) so as to identify the concentration level on each village.

The status at the level of source community, and, if that is the case, the list of the villages where children and young people separated from their families are concentrated, are both supplied under Annex 4. Table 4.

On February 2018, children and young people from source communities included in the protection system were spread within all types of special protection services. Although the source communities have been established only by starting from children existing in the Foster Care Centers, Figure 31 shows that the number of children from such communities entering the protection system is higher. Only one out of five children that entered the protection system is located within a Foster Care Center, while the other four are mostly placed under a family care service - either AMP or PFam.

Figure 31: Distribution of children in the protection system coming from the surveyed source communities, by types of protection services



Source: World Bank, Source Communities Study, February-March 2018 (N=1004 children and young people).

The over 1000 children and young people included in the special protection system that are coming from source communities are represented by girls and boys of all ages, as presented in Table 43.

Table 43: Children and young people from the protection system that are coming from the 35 source communities

	Number			%		
	Girls	Boys	Total	Girls	Boys	Total
0-3 years	55	45	100	5	4	10
4-10 years	165	137	302	16	14	30

11-14 years	151	152	303	15	15	30
15-17 years	111	102	213	11	10	21
18+ years	46	40	86	5	4	9
	528	**476**	**1004**	**53**	**47**	**100**

Source: World Bank, Source Communities Study, February-March 2018.

93% of the children and young people in the protection system that are coming from source communities had their mothers known and alive. The mothers of the remaining 7% have been deceased, unknown or missing. In total 586 mothers were known and alive, out of which over two thirds had one child placed in the protection system

Table 44: Children and young people in the protection system that are coming from source communities and their known and alive mothers, depending on the number of children in the system of one mother

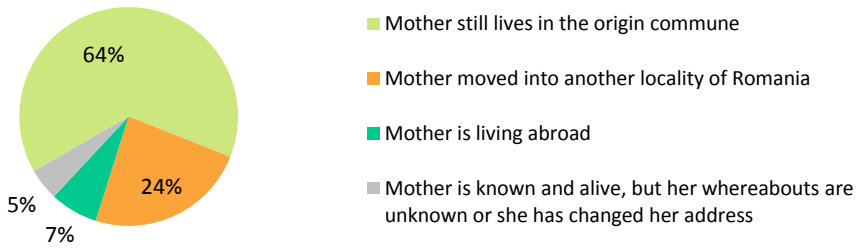
Number of children in the system per mother	Mothers		Children and young people	
	N	%	N	%
1 child	375	64	375	40
2	135	23	270	29
3	40	7	120	13
4-11 children	36	6	169	18
	586	**100**	**934**	**100**

Source: World Bank, Source Communities Study, February-March 2018.

Note: The 70 children and young people with their mothers deceased, unknown or missing are not taken into account.

Most of the mothers are still living within the source community, but one out of three either moved somewhere in the country (usually, within a major city), or left the country to live abroad or, in rare occasions, their current address is unknown. The distribution of children and young people in the protection system that are coming from source communities as per the actual home address of their mothers is presented under Annex 4. Table 5.

Figure 32: Distribution of known and alive mothers depending on their actual home address, in February 2018 (%)



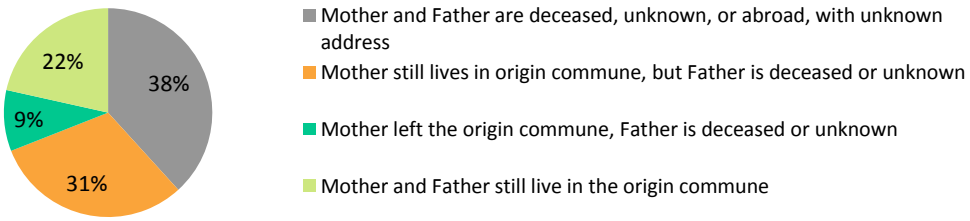
Source: World Bank, Source Communities Study, February-March 2018 (N=934 mothers known and alive).

Annex 4. Table 6 shows that the percentage of mothers still living within the commune varies from 0% to 100%, with significant differences between source communities. The number of mothers with children placed in the protection system was already low within 10 communes, and after some of the mothers moved to other localities or abroad, the number dropped to less than five mothers. In other words, out of the 35 selected source communities, there are 10 communes that couldn't have been considered as source communities in February 2018. Other 5 communities had only 5-6 mothers per

commune, also following the departure of some mothers. Finally, in the case of the remaining 20 source communities, the situation varies between full or halving the number of mothers with children placed in the protection system, but the number is sufficient for such communes to be qualified as source communities.

Over half of children and young people from source communities (51%) had unknown or deceased father. Only 30% of the children have fathers who were still living within the source community in February 2018. The other children had their fathers moved to other localities (14%) or abroad (2%).[146] The distribution of children and young people in the protection system that are coming from source communities by actual home address of their fathers is presented under Annex 4. Table 7.

Figure 33: The distribution of children and young people in the protection system that are coming from source communities by status of parents (%)



Source: World Bank, Source Communities Study, February-March 2018 (N=1004 children and young people).

Only 22% of children and young people from the protection system that are coming from source communities had their parents still living within the commune in February 2018. And 31% have only their mother living in the commune.

6.3.2. Child Welfare Services in the source communities

The selected communes are source communities, but at the same time they are included in the DGASPC county networks of child welfare services. Thus, 700 children and young people (most of them from other communities) placed in family care type protection services (AMP and PFam) or in small residential type protection services (CTF) are living together with the children and young people from families from source communities.

Table 455: The protection services and the children and young people in protection services, within source communities, February 2018

	Number of children and young people in protection services ...			Number of services		
	AMP	PFam	CTF/AP	AMP	PFam	CTF
Source Community	380	287	27	380	287	3
Urban Micro-area	733	1166	802	733	1166	133
Rural Micro-area	441	650	100	441	650	13

Source: World Bank, Source Communities Study, February-March 2018.

[146] 3% of the children and young people have known and living fathers, but their actual home address is unknown or the home address is frequently changed.

6.4. Groups of children and young people from source communities, under difficult situations

Aside the children and young people which have been separated from their families and have been included in the protection system, children and young people under difficult situations are also living within the source communities. In order to learn which the vulnerable groups of children and young people from each source community are, we have collected information on 35 such groups during interviews.[147]

At the level of the 35 selected source communities, the following vulnerable groups of children and young people have been mentioned by over half of the interviewees from all respondent groups, more than three quarters of school principals and family doctors respectively:

Vulnerable groups of children and young people, predominant within source communities	With an average estimated frequency of ...
• Children in poverty (including families with many children, single parent families)	120-160 children and young people per community
• Children and young people from marginalized areas	6-100 children and young people per community
• Children with parents abroad	43 children and young people per community
• Minor mothers	8-39 children and young people per community
• Children with disabilities	20 children and young people per community
• Children with Special Education Needs	20 children and young people per community
• Children that have abandoned or left school	15 children and young people per community
• Children of 6-15 years of age, with school abandonment risk	25 children and young people per community
• Children and young people requiring transportation to school from other localities	68 children and young people per community
• Children and young people requiring support to prepare the necessary documentation so as to receive the decision on their disability degree	57 children and young people per community
• Children between 1 and 10 years of age that are	13 children and young people per community

[147]The interviews have been conducted with the representatives of DGASPC, mayor/deputy mayor/mayoralty secretary, Community Consultative Structure (SCC), SPAS, principal of coordinating school, family doctor/medical nurse. Out of the 35 vulnerable groups, the respondents were asked about only 20, while the remaining 15 included vulnerabilities related to education or health.

not meeting the development standards

Source: World Bank, Source Communities Study, February-March 2018.

However, that data supplied during interviews are rather "weak", being merely estimations due to lack of solid information. That is why, in order to base a development plan for the prevention and support services within a community, it is critical to conduct a systematic assessment of the groups of children and young people exposed to different types of vulnerabilities, especially the risk of family separation.

6.5. Efficiency of prevention and support services within the source communities

Pursuant to the provisions of art. 112,paragraph (3), letter a) of the Social Assistance Law no. 292/2011, subsequently amended and supplemented, the local public authorities - DGASPC, the county authorities and commune mayoralties shall "prepare in compliance with the national strategies and identified local needs, the county strategy, and local strategy on the development of social services on medium and long term, after consulting the public and private suppliers, the professional associations and the organizations representative for beneficiaries, and they are responsible with enforcing such strategies". Furthermore, pursuant to the provisions under letter b) of the abovementioned art.:"following consultation with public and private suppliers, professional associations and organizations representative for beneficiaries, (the authorities) shall prepare annual action plans on social services as managed and funded by the budget of county, local, or Bucharest councils, which include detailed data on the number and categories of beneficiaries, existing social services, social services proposed for funding, the schedule of contracting social services from public funds, estimated budget and funding sources."

Therefore, all the authorities of the local public administration have the duty to learn and consider the existing social services while preparing their mandatory local strategies. To this very aim, as part of services mapping, this section presents a summary analysis of the prevention and support services both for child and family, as existed within the selected source communities, in February-March 2018. The analysis is organized by social, educational, and medical services, each of them being seen either as centers or as interventions/actions. Detailed analyses at the level of the community are available within the county authority's own reports.

6.5.1. Social Services

The social services centers are rare within the source communities and within their accompanying rural micro-areas. In total, among the 35 source communities and 151 communes from the rural micro-areas (that include a total of 649 villages), the following facilities were operational in February-March 2018:

- 3 day care centers (one to support integration/reintegration of a child with his/her family, and two for the development of independent life skills),
- 1 counseling center for abused, neglected, and exploited children, plus
- 7 institutions for adults (two within the source community and five within the rural micro-area. (please see Table 46)

The centers are rather numerous within the urban micro-area of those 35 selected micro-areas. However, their number is still low considering the fact that the urban micro-area includes a total number of 30 towns and cities.

The social services, as interventions or actions that may be developed by any institution/organization/units (to include centers) are more, but they are accessible to a limited number of source communities and their accompanying functional micro-areas. Among these services, the poorest represented ones are the social trade enterprises and assistance services aimed at aggressors (please see Table 47).

Table 466: Center-type social services located within source communities and rural/urban functional micro-area (number of source communities)

	Source Community											Rural Micro-area			Urban Micro-area			
	DGASPC								SPAS		YES DGASPC/ SPAS							Are they present within the Source Community or the micro-area (rural or urban)?
	Are they present?		If NOT, Is DGASPC willing to develop such facilities?			If NOT, Should they be developed?			Are they present?		Yes	Are they present?			Are they present?			I do not know
	Yes	No	Yes	No	I do not know	Yes	No	I do not know	Yes	No		No	Yes	No	I do not know	Yes	No	
5. Maternal Center			1	26	8	1	26	8			0	0	28	6	6	10	10	6
6. Other residential services for children (CPRU etc.)	0	35	1	25	9	1	25	9	0	35	0	0	29	5	7	11	8	7
7. Day Care Center for supporting integration/reintegration of child in family	0	35	4	23	8	4	23	8	1	34	1	0	30	4	3	11	12	4
9. Day Care Centers for developing independent life skills	1	34	2	24	8	2	24	8	2	33	2	0	28	6	1	13	12	3
10. Centers for guidance, surveillance, and support of social reintegration of a child that has done criminal acts and is not legally liable	0	35	1	25	9	1	25	9	0	35	0	0	27	7	1	16	9	1
11. Counseling Centers for abused, neglected, and exploited child	0	35	2	25	8	2	25	8	1	34	1	0	28	6	4	12	10	5
13. Protected dwellings	0	35	1	26	8	1	26	8	0	35	0	0	27	7	5	12	9	5
14. Institutions for adults (CITO, CRRN, CIA, medical-social unit, residential center for palliative care services etc.)	1	34	1	26	7	1	26	7	2	33	2	5	24	5	9	9	8	12
15. Day and Night Shelters	0	35	2	26	7	2	26	7	0	35	0	0	27	7	8	10	8	8
16. Centers for prevention, assessment and counseling against drug abuse	0	35	0	26	9	0	26	9	0	35	0	0	27	7	4	12	10	4

Source: World Bank, Source Communities Study, February-March 2018.

Table 477: Interventions/actions-type social services, within source communities and Rural/Urban Micro-areas (number of source communities)

	Source Community	Rural Micro-area	Urban Micro-area	Are they present within the Source Community or the functional micro-area (rural or urban)?
	YES (DGASPC or SPAS or School Principal)	YES (SPAS or School Principal)	YES (SPAS or School Principal)	(YES, in at least one from the other three)
25. Services on prevention of abuse, neglect and exploitation	4	2	5	8
26. Services on counseling for the prevention and fighting against family violence	11	5	7	15
27. Services for the assistance of aggressors	1	0	0	1
28. Food Services – on wheels or social cafeteria	2	1	4	7
55. Social Trade Enterprise	0	0	1	1
71. Social dwelling services (National Housing Agency dwellings, social dwellings, necessity dwellings, etc.)	5	3	7	10
72. Support for renovation or development of their homes	8	0	1	9
81. Legal services	3	4	6	7

Source: World Bank, Source Communities Study, February-March 2018.

6.5.2. Educational Services

The status of education services is better than the status of social ones (Table 48). Pre-schools, primary, and secondary schools are found almost in every source community. A high-school or a vocational high-school is located within the functional micro-area for 21, and for 25 source communities respectively. The educational support services[148] or integrated special education services at the level of primary or secondary schools are available for children from almost half of the selected source communities. Moreover, children from 13 communities have access to a special school existing within the functional urban micro-area.

Counseling and guidance services, as well as sports or club activities are found within more than 30 source communities. After-school services are available within more than a half of the studied communes, and almost one third of these services are "second chance" and services connecting education and labor market (Table 49).

6.5.3. Medical Services

The medical facilities available within source communities and functional rural micro-areas are fewer than the schools, but they are more than social services centers (Table 50).Among these communities, the most frequent ones (but still very few) are the so-called permanent medical centers and the multi-functional centers. Only half of the source communities have access to hospitals and clinics within the urban micro-area. Addiction Rehabilitation Centers, therapeutic community centers, home care services for children, and mobile units are scarce both within rural and urban areas.

Family planning, sexual education for young people, psychological and speech-language pathology services are available within 19-24 source communities. Moreover, only a third of the communities can access kinesiotherapy, and recovery/rehabilitation services, together with parents' education services and home care services for children/families with children, especially within Urban Micro-area. (Table 51).

6.5.4. Experts from the community

The SPAS census conducted by World Bank in 2014 (*Social Services within communities*) has already emphasized the existence of a serious deficit of human resources within the SPAS units from rural localities and from smaller urban ones.[149]The data collected within the source communities in February – March 2018 appear to indicate the fact that the situation has not improved much. Table 52 presents that only 24 out of 35 source communities have a Public Social Welfare Service (SPAS), only 14 have at least one professional social assistance and there isn't at least one individual with social assistance duties available in all units.

[148]The education services for the support of the integration of children/students/young people with special education needs are supplied by itinerant and supporting teachers, together with all involved factors. Usually, the beneficiaries of such educational services are: (1) children/students with school and vocational guidance certificates issued by the School and Vocational Guidance Committee of CJRAE; (2) parents; (3) teachers; (4) children/students with learning, development or school adaption difficulties, which are found at a certain moment under schooling failing situation, school abandonment and they benefit from remedial education/psychological-educational counseling services, as provided by teachers/school counselor/speech-language therapist, etc. Depending on the evolution of the student, the teachers that worked with that student may recommend his/her assessment in front of the School and Professional Guidance Committee of CJRAE, in order to ensure the provision of an itinerant and support teacher.
The support educational services from CJRAE provide: (a) preparation/review of the curriculum adaptation, specific intervention plan, together with the teacher of the student; (b) educational and therapeutic – recovery assistance for children/students with special education requirements as integrated in the regular schools; (c) Compensation with specific therapies for children/students with learning and adaption difficulties, behavioral disorders, or mental, physical, neurological, and sensorial deficiencies, etc.; (d) information and counseling the families with children that have special education requirement on the issues related to the education of their children; (e) information and counseling the teachers on the inclusive education field.
[149] Teșliuc, Grigoraș and Stănculescu (coordinator, 2015).

Table 488: Schools existing within source communities and functional rural/urban micro-areas (number of source communities)

	In Source Community			In Rural Micro-area			In Urban Micro-area			Are they present within Source Community or within the micro-area?
	Yes	No	I do not know	Yes	No	I do not know	Yes	No	I do not know	
51. Kindergarten	35	0	0	31	0	3	17	1	8	35
52. Primary School	31	3	1	30	2	2	17	2	7	32
53. Primary School with support educational services/integrated special education	10	25	0	7	17	10	10	2	14	18
54. Secondary School	31	4	0	26	3	5	17	0	9	33
55. Secondary School with support educational services/integrated special education	7	28	0	4	24	6	11	3	12	15
56. Special School	0	35	0	1	29	4	13	9	4	13
57. High-School	2	33	0	5	26	3	19	3	4	21
58. Vocational High-School	11	24	0	11	19	4	16	3	7	25

Source: World Bank, Source Communities Study, February-March 2018. Interviews of principals of coordinating schools.

Table 499: Interventions/actions-type educational services developed within source communities and in Rural/ Urban Micro-areas (number of source communities)

	Source Community	Rural Micro-area	Urban Micro-area	Are they present within the Source Community or the functional micro-area (rural or urban)?
	YES (DGASPC or SPAS or School Principal)	YES (SPAS or School Principal)	YES (SPAS or School Principal)	(YES, in at least one from the other three)
19. School Counseling and Guidance Services	24	15	18	32
20. Profession/Vocational Counseling and Guidance Services	18	12	16	26
21. Support educational services	17	6	7	19
41. Afterschool Services	7	8	14	19
42. “Second chance”	2	5	9	13
51. Services on assessing the skills required to secure a job position	4	6	9	14
52. Services on labor market counseling and mediation	3	4	11	14
53. Support provided for finding a job, including going together with the individual	2	2	5	7
54. Adults vocational training services	3	4	13	14
61. Actions of school sports club, football team, and alike	25	18	16	30
62. Children Club activities, folk group, other relevant activities to be developed during free time	26	19	17	31

Source: World Bank, Source Communities Study, February-March 2018.

Table 50: Medical Units existing within source communities and within rural/urban functional micro-areas (number of source communities)

	Source Community	Rural Micro-area	Urban Micro-area	Are they present within the Source Community or the functional micro-area (rural or urban)?
	YES (DGASPC or SPAS or Medic/medical nurse)	YES (SPAS or Medic/medical nurse)	YES (SPAS or Medic/medical nurse)	(YES, in at least one from the other three)
8. Day Care Centers for children with disabilities	1	0	13	13
12. Day Care Centers for counseling and support provided to parents and children/pregnant women under difficult conditions	2	0	6	7
17. Addictions Rehabilitation Centers	0	2	3	5
18. Therapeutic Community Centers	0	1	4	5
19. Multi-functional Centers/Services	5	0	6	11
21. Integrated Services Community Centers	3	4	6	8
22. Permanent Medical Centers	11	9	6	18
71. Home Care Units for Children	1	2	5	7
72. Mobile teams	2	1	4	6
73. Hospital, clinic	2	2	14	17

Source: World Bank, Source Communities Study, February-March 2018.

Table 51: Medical Services of intervention/action-type existing within source communities and within rural/urban micro-areas (number of source communities)

	Source Community	Rural Micro-area	Urban Micro-area	Are they present within the Source Community or the functional micro-area (rural or urban)?
	YES (DGASPC or SPAS or School Principal or Medic/medical nurse)	YES (SPAS or School Principal or Medic/medical nurse)	YES (SPAS or School Principal or Medic/medical nurse)	(YES, in at least one from the other three)
14. Parents' Education Services	10	5	7	14
15. Family Planning Services	17	13	15	24
16. Sex Education Services for Young people	19	11	11	23
17. Home Care Services for children/families with children	9	6	10	14
18. Psychological Counseling Services	12	8	16	22
22. Speech-language Therapy Services	10	6	15	19
23. Kinesiotherapy Services	5	5	16	16
24. Other Recovery/Rehabilitation Services	4	1	11	14
29. Social Ambulance	0	1	6	6

Source: World Bank, Source Communities Study, February-March 2018.

Table 52: Types of experts existing within source communities (number of source communities)

	DGASPC			SPAS			School Principal			Medic/medical nurse			YES DGASPC/SPAS/ Director/Medic
	Yes	No	I do not know	Yes	No	I do not know	Yes	No	I do not know	Yes	No	I do not know	I do not know
1. Public Social Welfare Service (SPAS, DAS, DAC etc.)	23	12	0	11	21	3							24
2. Professional Social Worker (one or several)	13	21	1	8	26	1							14
3. Individual responsible for social assistance duties (one or several	29	5	1	28	6	1							32
4. Professional foster care giver(AMC)	17	9	9	16	18	1				14	15	6	20
5. Sanitary Mediator	5	16	14	7	27	1				10	23	2	11
6. Family doctor	34	1	0	33	1	1				34	1	0	35
71. Medical Nurses										33	1	1	33
72. Speech-language Therapist										3	29	3	3
73. Chiropractor										3	28	4	3
74. Occupational therapists										0	32	3	0
7. School Mediator	7	14	14	11	23	1	12	23	0				15
51. School Counselor							12	22	1				12
52. Itinerant and support teacher							14	20	1				14
53. Speech-language teacher							4	30	1				4
54. Teacher for special needs children (other than the speech-language teacher)							0	34	1				0
8. Community Mediator or facilitator	0	20	15	3	31	1	2	33	0				5
9. Community Consultative Structure - SCC (or Community Consultative Council - CCC) -functional	13	13	9	15	17	3	13	19	3	8	22	5	18
10. Support groups for vulnerable children and families	3	20	12	3	29	3	5	27	3	3	24	8	9
11. Religious groups for vulnerable children and families	13	10	12	13	17	5	17	17	1	12	18	5	24
12. Charity Groups	4	12	19	9	24	2	7	26	2	2	24	9	14
13. Child Protection NGOs	9	19	7	8	24	3	9	22	4	3	22	10	12

Source: World Bank, Source Communities Study, February-March 2018. Note: gray cells indicate information that was not requested from the respective respondents.

- The poor development of social care services within the community explains why a SPAS representative has visited at least once in the last 12 months only 56% of the children and young people included in the protection system at the home address of the family (including the extended family). The number of visits per family varies from 1 to 12, with an average of 3-4 visits and with significant differences between communities where an average number of 2 visits is registered and others with an average number of 6 visits paid per year for each family.

- Beside these home visits, SPAS worked with the family "somehow less" (22%) or "at great extent (18%) for even less children and young people separated from their families, after such child left his/her home, so as to increase his/her chances of returning into that family.

- The percentage of children and young people included in the protection system for which SPAS has offered its support during the last 12 months for their families so as to support the reintegration of the respective child, drops even further down to 29%. In most cases, the support offered to these families consisted in granting some benefits (especially VMG and ASF), supplying information and counseling.

Among the health care experts, only family doctor is present in the surveyed source communities. The second in this presence hierarchy are the medical nurses and (only in 10 cases) the community medical nurses.

The experts in the field of education are also scarce. A school mediator and/or a school counselor and/or a support teacher have been reported in only 12-15 communities. Although the Law no. 272/2004 and Governmental Decision no. 49/2011 clearly stipulate the duty of local authorities to establish Community Consultative Structures (SCC),[150]such structures are operational only in half of the source communities. In general, several recent studies have shown that the SCCs do not provide a suitable answer on preventing child separation from his/her family and they are not sufficiently active and efficient in supporting the reintegration process of such children into their families. However, aside SCCs, only religious groups that provide support for vulnerable children and families are somehow higher in number.

[150]Law no. 272/2004 and Governmental Decision no. 49/2011 stipulate the duty of local authorities to establish informal groups for supporting the social protection actions, during the process of identifying the community needs and addressing the social issues of children at local level. Among the members of such SCCs there are some local decision-making factors, like the mayor, the deputy mayor, the mayoralty secretary, social workers, medics, police officers, school representatives and priests.

BIBLIOGRAPHY

1. ANPDCA – National Authority for the Protection of Children's Rights and Adoption (2014) *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*. Available from: http://www.mmuncii.ro/j33/index.php/ro/transparenta/proiecte-in-dezbatere/3172-2014-02-03-proiecthg-strategiecopii
2. ANPDCA (2010-2017) *Buletin statistic în domeniul muncii și protecției sociale. Evoluții în domeniul protecției copilului*. Available at: http://www.mmuncii.ro/j33/index.php/ro/transparenta/statistici/buletin-statistic
3. World Bank (2016) *Supplemental Concept Note Romania*, Reimbursable Advisory Services (RAS) on Development of Plans for De-Institutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care.
4. World Bank (2017a) *Progress Report No. 1. Reporting Period: May 12, 2016 - November 30, 2016*, January 2017, Reimbursable Advisory Services (RAS) on Development of Plans for De-Institutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care.
5. World Bank (2017b) *Output #1: Descriptive Report on the Evaluation of the Existing Resources of Residential Centers*, February 2017.
6. World Bank (2017c) *Output #2: Operational Plan for the Closing of Residential Centers*, May 2017.
7. World Bank (2017d) *Output #3: DIAGNOSTIC STUDY: Evaluation of a representative sample of children from placement centers and analysis of focus groups with various types of beneficiaries with a view to creating alternatives to the closed down placement centers*, November 2017, Reimbursable Advisory Services (RAS) on Development of Plans for De-Institutionalization of Children Deprived of Parental Care and their Transfer to Community-Based Care.
8. European Commission (2013) *2013/112/EU: Commission Recommendation of 20 February 2013 Investing in Children: Breaking the Cycle of Disadvantage*. Available from: http://eur-lex.europa.eu/legal-content/RO/TXT/PDF/?uri=CELEX:32013H0112&from=RO
9. Dărăbuș St., Pop, D., Stegeran, B. and Tohătan, R. (2017) *Închiderea instituțiilor pentru copii. Intervenție, implementare și plan de acțiune*, HHC Romania Printing House. Available from:https://childhub.org/ro/biblioteca-online-protectia-copilului/studiu-hhc-inchiderea-institutiilor-pentru-copii-interventie.
10. EEG - European Expert Group on the Transition from Institutional to Community-based Care (2012) *Common European Guidelines on the Transition from Institutional to Community-based Care*. Brussels. Available from: http://www.deinstitutionalisationguide.eu/
11. Mulheir, G. and Browne, K. (2007) *De-institutionalizing and transforming children's services. A guide to good practice*. Birmingham: University of Birmingham.
12. Paulhus, D. L. (1991) "Measurement and control of response bias". In J. P. Robinson, P. R. Shaver & L. S. Wrightsman (Eds.) *Measures of personality and social psychological attitudes* (pp. 17-59), San Diego, CA: Academic Press, Inc.
13. Stănculescu, M. S. and Marin, M. (2012) *Helping the Invisible Children. Evaluation Report*. UNICEF, Bucharest: Vanemonde. Available from: http://www.unicef.org/romania/Raport_HIC_engleza.pdf
14. Stănculescu, M.S., Grigoraș, V., Tesliuc, E. and Pop, V. (coord.) (2016) *România: Copiii din sistemul de protecție a copilului*. Bucharest: Editura Alpha MDN. Available from: http://www.unicef.ro/wp-content/uploads/Copiii-din-sistemul-de-protectie-a-copilului_UNICEF_ANPDCA_BM_2016.pdf
15. UN - United Nations (2010) *Guidelines for the Alternative Care of Children*. Available from: http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

ANNEXES

ANNEXES

ANNEX Part 1: Statistical data

Annex 1. Table 1: Placement centers for children in Romania (as of February 2018)

Code	County	Locality	Name of residential center
101	ALBA	Blaj	Servicii comunitare pentru protecţia copilului Blaj - Centrul de plasament
201	ARAD	Arad	Centrul de recuperare şi reabilitare pentru copii cu dizabilităţi Arad
202	ARAD	Arad	Centrul de Plasament "Oituz" Arad
203	ARAD	Arad	Centrul de Criză Arad
204	ARAD	Zădăreni	Centrul de Plasament Zădăreni
301	ARGEŞ	Câmpulung	Centru de tip rezidenţial pentru copii cu dizabilităţi - Complexul de Servicii Comunitare pentru Copii cu Dizabilităţi Câmpulung
302	ARGEŞ	Câmpulung	Centru de tip rezidenţial - Complexul de Servicii pentru Copilul în Dificultate Câmpulung
303	ARGEŞ	Costeşti	Centrul de tip rezidenţial pentru copii cu dizabilităţi - Complex de Servicii pentru Copii cu Dizabilităţi Costeşti
304	ARGEŞ	Piteşti	Centru de tip rezidenţial pentru copii cu dizabilităţi şi respite - care - Complex de Servicii pentru Copilul cu Handicap Trivale Piteşti
305	ARGEŞ	Piteşti	Centrul de tip rezidenţial - Complexul de Servicii Comunitare Pentru Copilul în Dificultate Sf. Constantin şi Elena Piteşti
306	ARGEŞ	Piteşti	Centrul rezidenţial pentru copii cu dizabilităţi şi respite-care - Centrul de Copii "SF. Andrei", Piteşti
307	ARGEŞ	Rucăr	Centrul rezidenţial - Complex de Servicii pentru Copilul în Dificultate Rucăr
501	BIHOR	Oradea	Centrul de plasament pentru copii cu dizabilităţi nr.6 Oradea
502	BIHOR	Oradea	Centrul de Plasament Oradea - Modul Dalmaţienii
503	BIHOR	Oradea	Centrul de Plasament Nr.2 Oradea
504	BIHOR	Popeşti	Centrul de plasament pentru copii cu dizabilităţi Popeşti
601	BISTRIŢA NĂSĂUD	Beclean	Centrul de Plasament de tip familial pentru copii din cadrul CPC Beclean
602	BISTRIŢA NĂSĂUD	Năsăud	Centrul de Plasament de tip familial pentru copii din cadrul CPC Năsăud

603	BISTRIȚA NĂSĂUD	Bistrița	Centrul de Plasament de tip familial pentru copilul cu dizabilități din cadrul CPC Bistrița
701	BOTOȘANI	Botoşani	Centrul de plasament Prietenia
702	BOTOȘANI	Pomarla	Centrul de plasament Dumbrava Minunată
703 *	BOTOȘANI	Trusesti	Centru de plasament Sf. Nicolae
801	BRAȘOV	Codlea	Centrul de Plasament "Aurora" Codlea - Complex de servicii Măgura Codlea
802	BRAȘOV	Codlea	Centrul de plasament pentru copilul cu handicap "Speranța" - Complex de servicii Măgura Codlea
803	BRAȘOV	Codlea	Centrul de reabilitare şcolară "Albina" - Complex de Servicii Măgura Codlea
804	BRAȘOV	Făgăraș	Centrul de Plasament "Casa Maria" - Complex de Servicii Făgăraș
805	BRAȘOV	Făgăraș	Centrul de reabilitare Şcolară "Floare de Colț" Făgăraș - Complex de Servicii Făgăraș
806	BRAȘOV	Ghimbav	Centrul "Sfântul STELIAN" Ghimbav
807	BRAȘOV	Jibert	Complex de servicii "Dacia"
808	BRAȘOV	Rupea	Centrul de Plasament "Casa Ioana" Rupea
810	BRAȘOV	Săcele	Centrul de plasament Ghiocelul - Complex de Reabilitare Şcolară Brădet
811	BRAȘOV	Victoria	Centrul de Plasament "Azur" Victoria - Complex de servicii Victoria
812	BRAȘOV	Codlea	Centrul de plasament Alice - Complex de servicii Măgura Codlea
1001	BUZĂU	Beceni	Centrul rezidenţial pentru recuperarea şi reabilitarea copilului cu tulburări de comportament nr. 5 Beceni
1002	BUZĂU	Buzău	Serviciul rezidenţial pentru copilul aflat în dificultate socială , din cadrul Complexului de servicii comunitare nr. 2, Buzău
1003	BUZĂU	Buzău	Centrul rezidenţial din cadrul Complexului de servicii pentru copilul cu handicap sever nr. 8, Buzău
1004	BUZĂU	Buzău	Centrul rezidenţial pentru copiii cu handicap nr. 9, Buzău
1101	CARAȘ SEVERIN	Caransebeș	Centrul "Bunavestire" Caransebeș fost Complexul de servicii sociale "Bunavestire" Caransebeș - Modulul Centrul de plasament pentru copii cu dizabilități
1102	CARAȘ SEVERIN	Reșița	Centrul "Speranța" Reșița fost Centrul de Plasament "Speranța" Reșița - Modulul Centrul de plasament
1103	CARAȘ SEVERIN	Zăgujeni	Centrul "Casa Noastra" Zăgujeni fost Centrul de Plasament "Casa Noastră" Zăgujeni - Modulul Centrul de plasament
1201	CLUJ	Cluj Napoca	Complexul de servicii destinat protecției copilului nr. 2-Centre rezidențiale pt. copilul separat temporar sau definitiv de părinții

			săi: centre de plasament
1202	CLUJ	Cluj Napoca	Complex de servicii pentru recuperarea copiilor cu handicap uşor şi mediu nr. 9 "Ţăndărică"- Centre rezidenţiale pt. copilul separat temporar sau definitiv de părinţii săi
1203	CLUJ	Cluj Napoca	Complex de servicii pentru recuperarea copiilor cu handicap neuropsihic sever nr. 10 "Pinochio" - Centre rezidenţiale pt. copilul separat temporar sau definitiv de părinţii săi: centre de plasament
1301	CONSTANȚA	Agigea	Centrul de Plasament "Delfinul"
1302	CONSTANȚA	Constanța	Centrul de plasament "Antonio"-componenta modulată
1303	CONSTANȚA	Constanța	Centrul de plasament "Ovidiu"
1304	CONSTANȚA	Constanța	Complex de servicii comunitare "Cristina"
1305	CONSTANȚA	Constanța	Complex de servicii comunitare "Orizont"
1306	CONSTANȚA	Constanța	Centrul de plasament "Traian"
1307	CONSTANȚA	Techirghiol	Complex de servicii comunitare "Sparta Rotterdam"- Componenta modulată (D)
1401	COVASNA	Baraolt	Centrul rezidenţial pentru copii cu dizabilităţi Baraolt - funcţionează în cadrul Complexului de servicii comunitare Baraolt
1402	COVASNA	Olteni	Centru de plasament nr. 6 Olteni
1403	COVASNA	Tg. Secuiesc	Centru de plasament "Borsnyay Kamilla" Tg Secuiesc
1501	DÂMBOVIȚA	Găești	Complexul de Servicii Sociale Găeşti, Centrul de plasament pentru copilul cu dizabilităţi
1601	DOLJ	Craiova	Centrul de plasament "Noricel"
1602	DOLJ	Craiova	Centrul de plasament "VIS DE COPIL"
1603	DOLJ	Craiova	Centrul de Plasament "PRICHINDEL"
1605	DOLJ	Craiova	Centru de plasament "Sf Apostol Andrei"
1702	GALAȚI	Galaţi	Centrul de asistenţă pentru copilul cu cerinţe educative speciale Galata
1703	GALAȚI	Galaţi	Centrul de plasament nr.3 Galaţi
1704	GALAȚI	Munteni	Centrul de reabilitare şi reintegrare socială a copilului- Casa "David Austin" Munteni
1705	GALAȚI	Tecuci	Centrul de asistenţă pentru copilul cu cerinţe educative speciale Tecuci
1801	GORJ	Tg. Cărbuneşti	Centrul de Plasament destinat protecţiei rezidenţiale a copiilor - din cadrul CSC-CD Tg-Cărbuneşti

1802	GORJ	Tg. Jiu	Centrul de plasament destinat protecţiei rezidenţiale a copiilor cu dizabilităţi-din cadrul CSC-CNS Tg. Jiu (copii cu dizabilităţi)
1803	GORJ	Tg. Jiu	Centrul de plasament destinat protecţiei rezidenţiale a copiilor cu dizabilităţi -din cadrul CSC-CH Tg-Jiu (copii cu dizabilităţi)
1901	HARGHITA	Bilbor	Centru de plasament Bilbor
1902	HARGHITA	Cristuru Secuiesc	Centru de plasament pentru copii cu handicap sever Cristuru Secuiesc
1903	HARGHITA	Ocland	Centru de plasament Ocland
1904	HARGHITA	Subcetate	Centru de plasament Subcetate
1905	HARGHITA	Toplița	Centru de plasament pentru copii cu handicap sever Toplița
2001	HUNEDOARA	Brad	Centrul de plasament Brad
2002	HUNEDOARA	Hunedoara	Casa familială pt copilul cu dizabilităţi Hunedoara
2003	HUNEDOARA	Hunedoara	Centrul specializat pt copii cu dizabilităţi Hunedoara
2004	HUNEDOARA	Lupeni	Centrul de Plasament Lupeni
2101	IALOMIȚA	Slobozia	Centrul de Plasament nr. 2 Slobozia
2102	IALOMIȚA	Slobozia	Centrul de Plasament nr. 3 Slobozia
2103	IALOMIȚA	Urziceni	Complex de Servicii Urziceni (Serviciul Rezidențial)
2201	IAŞI	Horlesti	Complex de Servicii Comunitare "Bogdănești'
2202	IAŞI	Iaşi	Complex Servicii Comunitare Bucium
2204	IAŞI	Iaşi	Complex de servicii comunitare "Sf. Andrei"
2205	IAŞI	Iaşi	Centrul de recuperare pentru copilul cu handicap sever Galata - Casa Modulară SERA
2206	IAŞI	Iaşi	CP "Ion Holban" Iaşi
2207	IAŞI	Iaşi	CP "CA Rosetti" Iași
2208	IAŞI	Paşcani	Complexul de servicii" M. Sadoveanu" Paşcani
2209	IAŞI	Paşcani	Subunitatea Sf. Stelian
2210	IAŞI	Paşcani	Complex de servicii "Sf. Nicolae" Paşcani
2211	IAŞI	Tg. Frumos	Complex de servicii sociale Tg. Frumos Centrul "Sf. Spiridon"
2301	ILFOV	Periş	Centrul de Plasament nr. 5 Periş
2302	ILFOV	Periş	Centrul de Plasament nr. 1 Periş

2303	ILFOV	Periș	Centrul de Plasament "Piticot"
2304	ILFOV	Voluntari	Centrul de Plasament nr. 6 Voluntari
2401	MARAMUREŞ	Sighetu Marmației	Centrul de plasament, asistență și sprijin a tinerilor care părăsesc sistemul de protecție
2501	MEHEDINȚI	Dr. Tr. Severin	Centrul de plasament pentru copilul cu dizabilități 0-7 ani (funcționează în cadrul complexului de servicii sociale pentru copilul preșcolar)
2502	MEHEDINȚI	Dr. Tr. Severin	Centrul de plasament pentru copilul cu dizabilități
2503	MEHEDINȚI	Dr. Tr. Severin	Centru de plasament "Sf. Nicodim "
2601	MUREŞ	Sighișoara	Complex de servicii pentru copilul cu deficiențe neuropsihiatrice Sighișoara - Serviciul Rezidențial
2701	NEAMȚ	Piatra Neamț	Modulul Casa "Traian" funcționează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamț
2702	NEAMȚ	Piatra Neamț	Modulul Casa "Floare de Colț" funcționează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamț
2703	NEAMȚ	Piatra Neamț	Modul Casa "Călin" funcționează în cadrul Complexului de servicii "Elena Doamna", Piatra Neamț
2704	NEAMȚ	Piatra Neamț	Modul Casa "Smărăndița" funcționează în cadrul Complexului de servicii "Elena Doamna", Piatra Neamț
2705	NEAMȚ	Piatra Neamț	Centrul rezidențial pentru copilul cu dizabilități Piatra Neamț
2706	NEAMȚ	Roman	Complex de servicii "Romanița", Roman
2707	NEAMȚ	Piatra Neamț	Modulul Casa "DECEBAL" funcționează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamț
2901	PRAHOVA	Băicoi	Complexul de Servicii Comunitare “Rază de Soare” Băicoi-Centru de plasament
2902	PRAHOVA	Câmpina	Complexul de Servicii Comunitare «Sf. Filofteia» Câmpina, Centru de plasament
2903	PRAHOVA	Câmpina	Centrul de Plasament Câmpina - Centru de Plasament
2904	PRAHOVA	Filipeștii de Târg	Centrul de Plasament Filipeștii de Târg - Centru de plasament
2905	PRAHOVA	Ploiești	Complexul de Servicii Comunitare «Sf. Andrei» Ploiești, Centru de plasament
2906	PRAHOVA	Plopeni	Centrul de Plasament Plopeni - Centru de plasament
2907	PRAHOVA	Sinaia	Centrul de Plasament Sinaia - Centru de plasament
2908	PRAHOVA	Vălenii de Munte	Complexul de Servicii Comunitare “Sf. Maria” Vălenii de Munte, Centru de plasament

3001	SATU MARE	Halmeu	CPC ”Floare de colț” Halmeu
3002	SATU MARE	Hurezu Mare	CPC “Roua” Hurezu Mare
3101	SĂLAJ	Cehu Silvaniei	Centru de Plasament din cadrul Complexului de Servicii Sociale Cehu Silvaniei
3102	SĂLAJ	Jibou	Centru de Plasament din cadrul Complexului de Servicii Sociale Jibou
3103	SĂLAJ	Şimleul Silvaniei	Centru de Plasament din cadrul Complexului de Servicii Sociale Şimleu Silvaniei
3201	SIBIU	Agîrbiciu	Centrul de Plasament Agârbiciu
3202**	SIBIU	Cisnădie	Centrul de plasament pentru copilul cu dizabilități "Tavi Bucur" Cisnădie
3204	SIBIU	Orlat	Centrul de plasament Orlat
3205**	SIBIU	Sibiu	Centrul de plasament Gulliver, Sibiu
3206	SIBIU	Sibiu	Centrul de plasament pentru copilul cu dizabilități "Prichindelul" Sibiu - Complexul de servicii "Prichindel" Sibiu
3207	SIBIU	Turnu Roşu	Centrul de plasament pentru copilul cu dizabilităţi Turnu Roşu
3301	SUCEAVA	Siret	Servicii pentru copilul aflat în dificultate Siret - Centrul terapeutic modular pentru copilul cu nevoi speciale "Ama Deus" Siret
3302	SUCEAVA	Solca	Centrul de plasament "Mihail şi Gavril" Solca
3303	SUCEAVA	Suceava	Centrul de plasament "Speranţa" Suceava
3401	TELEORMAN	Alexandria	Centrul de recuperare pentru copilul cu nevoi speciale "Pinochio" din cadrul Complexului de servicii pentru copilul cu nevoi speciale
3501	TIMIŞ	Găvojdia	Centrul de plasament Găvojdia
3502	TIMIŞ	Lugoj	Centrul de plasament Logoj
3503	TIMIŞ	Lugoj	Serviciul de îngrijire de tip rezidențial pentru copilul cu dizabilități din cadrul Centrului de Recuperare și Reabilitare Neuropsihiatrică pentru Copilul cu Handicap Lugoj
3504	TIMIŞ	Recaş	Centrul de plasament pentru copilul cu dizabilități Recaș
3505	TIMIŞ	Timișoara	Serviciul de îngrijire de tip rezidențial din cadrul Centrului de recuperare și reabilitare neuropsihiatrică pentru copii Timișoara
3601	TULCEA	Mahmudia	Centrul de plasament Mahmudia
3603	TULCEA	Tulcea	Centrul de plasament pentru recuperarea şi reabilitarea copilului cu handicap sever Pelican
3604	TULCEA	Tulcea	Centrul de plasament Speranţa

3605	TULCEA	Sulina	Centrul de plasament Sulina
3606	TULCEA	Topolog	Centrul de plasament Sâmbăta Nouă
3607	TULCEA	Somova	Centrul de plasament Somova
3802	VÂLCEA	Băbeni	Casa "Pinocchio" Băbeni
3803	VÂLCEA	Rm. Vâlcea	Centrul de Plasament "Andreea"
3804	VÂLCEA	Rm. Vâlcea	Centrul de Plasament "Ana "
3805	VÂLCEA	Rm. Vâlcea	Serviciul de tip rezidenţial pentru recuperarea copilului cu dizabilităţi Rm. Vâlcea
3806	VÂLCEA	Rm. Vâlcea	Centrul pentru Copilul cu Dizabilităţi Rm. Vâlcea
3807	VÂLCEA	Rm. Vâlcea	Centrul pentru copilul abuzat, neglijat, exploatat
3808	VÂLCEA	Rm. Vâlcea	Serviciul de tip familial pentru deprinderi de viață și integrare socioprofesională a tinerilor din sistemul de protecție - componenta rezidențială
5101	CĂLĂRAŞI	Călărași	Serviciul rezidenţial în cadrul Centrului de Servicii Sociale pentru Copil şi Familie ”SERA”
5102	CĂLĂRAŞI	Călărași	Serviciul Rezidenţial (în cadrul Complexului de servicii comunitare pentru copilul cu handicap sever Călărași)
5103	CĂLĂRAŞI	Oltenița	Serviciul rezidenţial pentru copilul cu handicap sever - din cadrul C.S.C. Oltenița

Source: World Bank (N=147). The city of Bucharest is not included.

Note: * CP created through the merger of Traian Rural Group Home and Decebal Rural Group Home. ** The placement centers: Centrul de plasament Gulliver, Sibiu and Centrul de plasament "Tavi Bucur" Cisnădie are not under the same complex of services anymore (Complex de Servicii Sibiu). Currently the two placement centers are autonomous institutions. Moreover, the one from Cisnădie was turned into a placement center for children with disabilities.

Annex 1. Table 2: Placement centers for children in Romania, dissolved between October 31st, 2016 and February 1st, 2018

Code	County	Locality	Name of residential center
401	BACĂU	Bacău	Centrul rezidențial "Henri Coandă" Bacău CP closed down with support from HHC.
704	BOTOȘANI	Trusesti	Casa Rurală Decebal comasat cu Casa Rurală Traian Centru de plasament Sf. Nicolae
809	BRAȘOV	Săcele	Centrul de plasament Brânduşa - Complex de Reabilitare Şcolară Brădet CP burned down and CTFs built with support from SERA.
1005	BUZĂU	Buzău	Centrul rezidențial pentru copilul cu deficiențe de auz nr. 10, Buzău CP closed down and turned into school residence under the ISJ.
1006	BUZĂU	Buzău	Centrul rezidențial pentru copilul cu deficiențe de vedere nr. 11, Buzău CP closed down and turned into school residence under the ISJ.
1204	CLUJ	Huedin	Centrul de plasament nr. 8 "Speranța" - Centre rezidențiale pt. copilul separat temporar sau definitiv de părinții săi CP closed down and CTFs built with support from SERA.
1701	GALAȚI	Galaţi	Centrul de plasament "Negru Vodă" CP closed down with support from SERA.
1706	GALAȚI	Tecuci	Centrul de asistență pentru copilul cu deficiențe neuromotorii
2203	IAȘI	Iași	Complex Servicii " Veniamin Costache" CP closed down with support from HHC.
3203	SIBIU	Mediaș	Centrul de plasament pentru copilul cu dizabilități Mediaș - Complexului de servicii "Sf. Andrei"
3801	VÂLCEA	Băbeni	Centrul Rezidențial de recuperare a tinerilor cu afecțiuni neuropsihiatrice Băbeni CP closed down and a CTF built with support from SERA.
3901	VRANCEA	Focșani	Centrul rezidențial pentru copii cu dizabilități Focșani

Source: World Bank (N=12).

Annex 1. Table 3: Placement centers for children in Romania, by county and closure status (as of February 2018)

	CP that the DGASPC (and the CJ) does not want to close down now or in the future	CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage)	CP which the DGASPC says it is in the process of closure (process underway)	Total
ALBA	1	0	0	0	1
ARAD	4	0	0	0	4
ARGES	2	3	2	0	7
BIHOR	2	1	1	0	4
BISTRITA NASAUD	0	1	1	1	3
BOTOSANI	1	0	1	1	3
BRASOV	1	4	0	6	11
BUZAU	1	0	2	1	4
CALARASI	3	0	0	0	3
CARAS SEVERIN	0	3	0	0	3
CLUJ	3	0	0	0	3
CONSTANTA	1	2	0	4	7
COVASNA	1	1	0	1	3
DAMBOVITA	1	0	0	0	1
DOLJ	4	0	0	0	4
GALATI	2	0	2	0	4
GORJ	1	0	2	0	3
HARGHITA	0	1	4	0	5
HUNEDOARA	4	0	0	0	4
IALOMITA	0	3	0	0	3
IASI	2	1	1	6	10
ILFOV	0	4	0	0	4
MARAMURES	0	0	0	1	1
MEHEDINTI	2	0	1	0	3

MURES	1	0	0	0	1
NEAMT	4	0	0	3	7
PRAHOVA	4	1	1	2	8
SALAJ	0	2	0	1	3
SATU MARE	2	0	0	0	2
SIBIU	4	1	1	0	6
SUCEAVA	1	0	1	1	3
TELEORMAN	0	0	0	1	1
TIMIS	0	1	2	2	5
TULCEA	4	0	1	1	6
VALCEA	0	2	0	5	7
Total	56	31	23	37	147

Source: World Bank. The city of Bucharest is not included.

Annex 1. Table 4: List of placement centers with relatively high chances of being closed down

Code	County	Locality	Name of residential center	CP for whose closure the DGASPC has undertaken talks, negotiations, actions (process in the initial stage)	CP which the DGASPC says it is in the process of closure (process underway)
302	ARGEŞ	Câmpulung	Centru de tip rezidenţial - Complexul de Servicii pentru Copilul în Dificultate Câmpulung	1 (b)	
307	ARGEŞ	Rucăr	Centrul rezidenţial - Complex de Servicii pentru Copilul în Dificultate Rucăr	1 (b)	
503	BIHOR	Oradea	Centrul de Plasament Nr.2 Oradea	1	
601	BISTRIŢA NĂSĂUD	Beclean	Centrul de Plasament de tip familial pentru copii din cadrul CPC Beclean	1	
602	BISTRIŢA NĂSĂUD	Năsăud	Centrul de Plasament de tip familial pentru copii din cadrul CPC Năsăud		1
702	BOTOŞANI	Pomarla	Centrul de plasament Dumbrava Minunată	1	
703 (*)	BOTOŞANI	Trusesti	Centru de plasament Sf. Nicolae		1 (b)
801	BRAŞOV	Codlea	Centrul de Plasament "Aurora" Codlea - Complex de servicii Măgura Codlea		1 (b)
803	BRAŞOV	Codlea	Centrul de reabilitare şcolară "Albina" - Complex de Servicii Măgura Codlea		1 (a)
805	BRAŞOV	Făgăraş	Centrul de reabilitare Şcolară "Floare de Colţ" Făgăraş - Complex de Servicii Făgăraş		1 (b)
810	BRAŞOV	Săcele	Centrul de plasament Ghiocelul - Complex de Reabilitare Şcolară Brădet		1 (a)
811	BRAŞOV	Victoria	Centrul de Plasament "Azur" Victoria - Complex de servicii Victoria		1 (a)
812	BRAŞOV	Codlea	Centrul de plasament Alice - Complex de servicii Măgura Codlea		1 (b)
1001	BUZĂU	Beceni	Centrul rezidenţial pentru recuperarea şi reabilitarea copilului cu tulburări de comportament nr. 5 Beceni	1 (b)	
1002	BUZĂU	Buzău	Serviciul rezidenţial pentru copilul aflat în dificultate socială , din cadrul Complexului de servicii comunitare nr. 2, Buzău	1	
1004	BUZĂU	Buzău	Centrul rezidenţial pentru copiii cu handicap nr. 9, Buzău		1 (a)

1301	CONSTANŢA	Agigea	Centrul de Plasament "Delfinul"		1 (a)
1303	CONSTANŢA	Constanţa	Centrul de plasament "Ovidiu"		1 (a)
1304	CONSTANŢA	Constanţa	Complex de servicii comunitare "Cristina"		1 (a)
1305	CONSTANŢA	Constanţa	Complex de servicii comunitare "Orizont"		1 (a)
1402	COVASNA	Olteni	Centru de plasament nr. 6 Olteni		1 (b)
1702	GALAŢI	Galaţi	Centrul de asistenţă pentru copilul cu cerinţe educative speciale Galata	1 (b)	
1703	GALAŢI	Galaţi	Centrul de plasament nr.3 Galaţi	1 (b)	
1802	GORJ	Tg. Jiu	Centrul de plasament destinat protecţiei rezidenţiale a copiilor cu dizabilităţi-din cadrul CSC-CNS Tg. Jiu (copii cu dizabilităţi)	1	
1803	GORJ	Tg. Jiu	Centrul de plasament destinat protecţiei rezidenţiale a copiilor cu dizabilităţi -din cadrul CSC-CH Tg-Jiu (copii cu dizabilităţi)	1	
1901	HARGHITA	Bilbor	Centru de plasament Bilbor	1 (b)	
1902	HARGHITA	Cristuru Secuiesc	Centru de plasament pentru copii cu handicap sever Cristuru Secuiesc	1 (b)	
1904	HARGHITA	Subcetate	Centru de plasament Subcetate	1 (b)	
1905	HARGHITA	Topliţa	Centru de plasament pentru copii cu handicap sever Topliţa	1	
2201	IAŞI	Horlesti	Complex de Servicii Comunitare "Bogdăneşti'		1 (a)
2202	IAŞI	Iaşi	Complex Servicii Comunitare Bucium		1 (b)
2205	IAŞI	Iaşi	Centrul de recuperare pentru copilul cu handicap sever Galata - Casa Modulară SERA	1	
2206	IAŞI	Iaşi	CP "Ion Holban" Iaşi		1
2207	IAŞI	Iaşi	CP "CA Rosetti" Iaşi		1 (b)
2209	IAŞI	Paşcani	Subunitatea Sf. Stelian		1 (b)
2211	IAŞI	Tg. Frumos	Complex de servicii sociale Tg. Frumos Centrul "Sf. Spiridon"		1
2401	MARAMUREŞ	Sighetu Marmaţiei	Centrul de plasament, asistenţă şi sprijin a tinerilor care părăsesc sistemul de protecţie		1
2503	MEHEDINŢI	Dr. Tr. Severin	Centru de plasament "Sf. Nicodim "	1 (b)	

2703	NEAMŢ	Piatra Neamţ	Modul Casa "Călin" funcţionează în cadrul Complexului de servicii "Elena Doamna", Piatra Neamţ		1
2704	NEAMŢ	Piatra Neamţ	Modul Casa "Smărăndiţa" funcţionează în cadrul Complexului de servicii "Elena Doamna", Piatra Neamţ		1
2706	NEAMŢ	Roman	Complex de servicii "Romanița", Roman		1 (a)
2906	PRAHOVA	Plopeni	Centrul de Plasament Plopeni - Centru de plasament		1 (a)
2907	PRAHOVA	Sinaia	Centrul de Plasament Sinaia - Centru de plasament		1 (a)
2908	PRAHOVA	Vălenii de Munte	Complexul de Servicii Comunitare “Sf. Maria” Vălenii de Munte, Centru de plasament	1 (b)	
3102	SĂLAJ	Jibou	Centru de Plasament din cadrul Complexului de Servicii Sociale Jibou		1 (b)
3204	SIBIU	Orlat	Centrul de plasament Orlat	1	
3302	SUCEAVA	Solca	Centrul de plasament "Mihail şi Gavril" Solca		1
3303	SUCEAVA	Suceava	Centrul de plasament "Speranţa" Suceava	1 (b)	
3401	TELEORMAN	Alexandria	Centrul de recuperare pentru copilul cu nevoi speciale "Pinochio" din cadrul Complexului de servicii pentru copilul cu nevoi speciale		1
3501	TIMIŞ	Găvojdia	Centrul de plasament Găvojdia		1 (a)
3502	TIMIŞ	Lugoj	Centrul de plasament Logoj	1	
3503	TIMIŞ	Lugoj	Serviciul de îngrijire de tip rezidențial pentru copilul cu dizabilități din cadrul Centrului de Recuperare și Reabilitare Neuropsihiatrică pentru Copilul cu Handicap Lugoj		1 (a)
3505	TIMIŞ	Timișoara	Serviciul de îngrijire de tip rezidențial din cadrul Centrului de recuperare și reabilitare neuropsihiatrică pentru copii Timișoara	1	
3603	TULCEA	Tulcea	Centrul de plasament pentru recuperarea și reabilitarea copilului cu handicap sever Pelican	1 (b)	
3604	TULCEA	Tulcea	Centrul de plasament Speranţa		1 (a)
3803	VÂLCEA	Rm. Vâlcea	Centrul de Plasament "Andreea"		1 (b)

3804	VÂLCEA	Rm. Vâlcea	Centrul de Plasament "Ana "		1 (b)
3805	VÂLCEA	Rm. Vâlcea	Serviciul de tip rezidenţial pentru recuperarea copilului cu dizabilităţi Rm. Vâlcea		1
3806	VÂLCEA	Rm. Vâlcea	Centrul pentru Copilul cu Dizabilităţi Rm. Vâlcea		1 (b)
3807	VÂLCEA	Rm. Vâlcea	Centrul pentru copilul abuzat, neglijat, exploatat		1
Total				23	37

Source: World Bank (N=60). The city of Bucharest is not included.

Notes: (*) CP created through the merger of Traian Rural Group Home and Decebal Rural Group Home. (a) The DGASPC says it will apply for ROP funding under the call launched in February 2018 to finance the closure of this CP. (b) The DGASPC says it will apply for ROP/OP HC funding under future calls to finance the closure of this CP.

Annex 1. Table 5: List of placement centers with small or zero chances of being closed down

Code	County	Locality	Name of residential center	CP whose closure is envisaged at some point in the future, but the DGASPC has done nothing yet	CP that the DGASPC (and the CJ) does not want to close down now or in the future
101	ALBA	Blaj	Servicii comunitare pentru protecţia copilului Blaj - Centrul de plasament		1
201	ARAD	Arad	Centrul de recuperare şi reabilitare pentru copii cu dizabilităţi Arad		1
202	ARAD	Arad	Centrul de Plasament "Oituz" Arad		1
203	ARAD	Arad	Centrul de Criză Arad		1
204	ARAD	Zădăreni	Centrul de Plasament Zădăreni		1
301	ARGEŞ	Câmpulung	Centru de tip rezidenţial pentru copii cu dizabilităţi - Complexul de Servicii Comunitare pentru Copii cu Dizabilităţi Câmpulung		1
303	ARGEŞ	Costeşti	Centrul de tip rezidenţial pentru copii cu dizabilităţi - Complex de Servicii pentru Copii cu Dizabilităţi Costeşti	1	
304	ARGEŞ	Piteşti	Centru de tip rezidenţial pentru copii cu dizabilităţi şi respite - care - Complex de Servicii pentru Copilul cu Handicap Trivale Piteşti	1	
305	ARGEŞ	Piteşti	Centrul de tip rezidenţial - Complexul de Servicii Comunitare Pentru Copilul în Dificultate Sf. Constantin şi Elena Piteşti	1	
306	ARGEŞ	Piteşti	Centrul rezidenţial pentru copii cu dizabilităţi şi respite-care - Centrul de Copii "SF. Andrei", Piteşti		1
501	BIHOR	Oradea	Centrul de plasament pentru copii cu dizabilităţi nr.6 Oradea		1
502	BIHOR	Oradea	Centrul de Plasament Oradea - Modul Dalmaţienii		1
504	BIHOR	Popeşti	Centrul de plasament pentru copii cu dizabilităţi Popeşti	1	
603	BISTRIŢA NĂSĂUD	Bistriţa	Centrul de Plasament de tip familial pentru copilul cu dizabilităţi din cadrul CPC Bistriţa	1	
701	BOTOŞANI	Botoşani	Centrul de plasament Prietenia		1
802	BRAŞOV	Codlea	Centrul de plasament pentru copilul cu	1	

			handicap "Speranţa" - Complex de servicii Măgura Codlea		
804	BRAŞOV	Făgăraş	Centrul de Plasament "Casa Maria" - Complex de Servicii Făgăraş	1	
806	BRAŞOV	Ghimbav	Centrul "Sfântul STELIAN" Ghimbav		1
807	BRAŞOV	Jibert	Complex de servicii "Dacia"	1	
808	BRAŞOV	Rupea	Centrul de Plasament "Casa Ioana" Rupea	1	
1003	BUZĂU	Buzău	Centrul rezidenţial din cadrul Complexului de servicii pentru copilul cu handicap sever nr. 8, Buzău		1
1101	CARAŞ SEVERIN	Caransebeş	Centrul "Bunavestire" Caransebeş fost Complexul de servicii sociale "Bunavestire" Caransebeş - Modulul Centrul de plasament pentru copii cu dizabilităţi	1	
1102	CARAŞ SEVERIN	Reşiţa	Centrul "Speranţa" Reşiţa fost Centrul de Plasament "Speranţa" Reşiţa - Modulul Centrul de plasament	1	
1103	CARAŞ SEVERIN	Zăgujeni	Centrul "Casa Noastra" Zăgujeni fost Centrul de Plasament "Casa Noastră" Zăgujeni - Modulul Centrul de plasament	1	
1201	CLUJ	Cluj Napoca	Complexul de servicii destinat protecţiei copilului nr. 2-Centre rezidenţiale pt. copilul separat temporar sau definitiv de părinţii săi: centre de plasament		1
1202	CLUJ	Cluj Napoca	Complex de servicii pentru recuperarea copiilor cu handicap uşor şi mediu nr. 9 "Ţăndărică"- Centre rezidenţiale pt. copilul separat temporar sau definitiv de părinţii săi		1
1203	CLUJ	Cluj Napoca	Complex de servicii pentru recuperarea copiilor cu handicap neuropsihic sever nr. 10 "Pinochio" - Centre rezidenţiale pt. copilul separat temporar sau definitiv de părinţii săi: centre de plasament		1
1302	CONSTANŢA	Constanţa	Centrul de plasament "Antonio"- componenta modulată	1	
1306	CONSTANŢA	Constanţa	Centrul de plasament "Traian"	1	
1307	CONSTANŢA	Techirghiol	Complex de servicii comunitare "Sparta Rotterdam"- Componenta modulată (D)		1
1401	COVASNA	Baraolt	Centrul rezidenţial pentru copii cu dizabilităţi Baraolt - funcţionează în cadrul Complexului de servicii comunitare Baraolt		1
140	COVASNA	Tg.	Centru de plasament "Borsnyay Kamilla"	1	

3		Secuiesc	Tg Secuiesc		
1501	DÂMBOVIȚA	Găești	Complexul de Servicii Sociale Găești, Centrul de plasament pentru copilul cu dizabilități		1
1601	DOLJ	Craiova	Centrul de plasament "Noricel"		1
1602	DOLJ	Craiova	Centrul de plasament "VIS DE COPIL"		1
1603	DOLJ	Craiova	Centrul de Plasament "PRICHINDEL"		1
1605	DOLJ	Craiova	Centru de plasament "Sf Apostol Andrei"		1
1704	GALAȚI	Munteni	Centrul de reabilitare și reintegrare socială a copilului- Casa "David Austin" Munteni		1
1705	GALAȚI	Tecuci	Centrul de asistență pentru copilul cu cerințe educative speciale Tecuci		1
1801	GORJ	Tg. Cărbunești	Centrul de Plasament destinat protecției rezidențiale a copiilor - din cadrul CSC-CD Tg-Cărbunești		1
1903	HARGHITA	Ocland	Centru de plasament Ocland	1	
2001	HUNEDOARA	Brad	Centrul de plasament Brad		1
2002	HUNEDOARA	Hunedoara	Casa familială pt copilul cu dizabilități Hunedoara		1
2003	HUNEDOARA	Hunedoara	Centrul specializat pt copii cu dizabilități Hunedoara		1
2004	HUNEDOARA	Lupeni	Centrul de Plasament Lupeni		1
2101	IALOMIȚA	Slobozia	Centrul de Plasament nr. 2 Slobozia	1	
2102	IALOMIȚA	Slobozia	Centrul de Plasament nr. 3 Slobozia	1	
2103	IALOMIȚA	Urziceni	Complex de Servicii Urziceni (Serviciul Rezidențial)	1	
2204	IAȘI	Iași	Complex de servicii comunitare "Sf. Andrei"	1	
2208	IAȘI	Pașcani	Complexul de servicii" M. Sadoveanu" Pașcani		1
2210	IAȘI	Pașcani	Complex de servicii "Sf. Nicolae" Pașcani		1

2301	ILFOV	Periş	Centrul de Plasament nr. 5 Periş	1	
2302	ILFOV	Periş	Centrul de Plasament nr. 1 Periş	1	
2303	ILFOV	Periş	Centrul de Plasament "Piticot"	1	
2304	ILFOV	Voluntari	Centrul de Plasament nr. 6 Voluntari	1	
2501	MEHEDINŢI	Dr. Tr. Severin	Centrul de plasament pentru copilul cu dizabilităţi 0-7 ani (funcţionează în cadrul complexului de servicii sociale pentru copilul preşcolar)		1
2502	MEHEDINŢI	Dr. Tr. Severin	Centrul de plasament pentru copilul cu dizabilităţi		1
2601	MUREŞ	Sighişoara	Complex de servicii pentru copilul cu deficienţe neuropsihiatrice Sighişoara - Serviciul Rezidenţial		1
2701	NEAMŢ	Piatra Neamţ	Modulul Casa "Traian" funcţionează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamţ		1
2702	NEAMŢ	Piatra Neamţ	Modulul Casa "Floare de Colţ" funcţionează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamţ		1
2705	NEAMŢ	Piatra Neamţ	Centrul rezidenţial pentru copilul cu dizabilităţi Piatra Neamţ		1
2707	NEAMŢ	Piatra Neamţ	Modulul Casa "DECEBAL" funcţionează în cadrul Complexului de servicii "Ion Creangă", Piatra Neamţ		1
2901	PRAHOVA	Băicoi	Complexul de Servicii Comunitare “Rază de Soare” Băicoi-Centru de plasament		1
2902	PRAHOVA	Câmpina	Complexul de Servicii Comunitare «Sf. Filofteia» Câmpina, Centru de plasament		1
2903	PRAHOVA	Câmpina	Centrul de Plasament Câmpina - Centru de Plasament	1	
2904	PRAHOVA	Filipeştii de Târg	Centrul de Plasament Filipeştii de Târg - Centru de plasament		1
2905	PRAHOVA	Ploieşti	Complexul de Servicii Comunitare «Sf. Andrei» Ploieşti, Centru de plasament		1
3001	SATU MARE	Halmeu	CPC ”Floare de colţ” Halmeu		1
3002	SATU MARE	Hurezu Mare	CPC “Roua” Hurezu Mare		1
3101	SĂLAJ	Cehu Silvaniei	Centru de Plasament din cadrul Complexului de Servicii Sociale Cehu	1	

			Silvaniei		
3103	SĂLAJ	Șimleul Silvaniei	Centru de Plasament din cadrul Complexului de Servicii Sociale Șimleu Silvaniei	1	
3201	SIBIU	Agîrbiciu	Centrul de Plasament Agârbiciu		1
3202	SIBIU	Cisnădie	Centrul de plasament pentru copilul cu dizabilități "Tavi Bucur" Cisnădie		1
3205	SIBIU	Sibiu	Centrul de plasament Gulliver, Sibiu		1
3206	SIBIU	Sibiu	Centrul de plasament pentru copilul cu dizabilități "Prichindelul" Sibiu - Complexul de servicii "Prichindel" Sibiu	1	
3207	SIBIU	Turnu Roşu	Centrul de plasament pentru copilul cu dizabilități Turnu Roşu		1
3301	SUCEAVA	Siret	Servicii pentru copilul aflat în dificultate Siret - Centrul terapeutic modular pentru copilul cu nevoi speciale "Ama Deus" Siret		1
3504	TIMIŞ	Recaș	Centrul de plasament pentru copilul cu dizabilități Recaș	1	
3601	TULCEA	Mahmudia	Centrul de plasament Mahmudia		1
3605	TULCEA	Sulina	Centrul de plasament Sulina		1
3606	TULCEA	Topolog	Centrul de plasament Sâmbăta Nouă		1
3607	TULCEA	Somova	Centrul de plasament Somova		1
3802	VÂLCEA	Băbeni	Casa "Pinocchio" Băbeni	1	
3808	VÂLCEA	Rm. Vâlcea	Serviciul de tip familial pentru deprinderi de viață și integrare socioprofesională a tinerilor din sistemul de protecție - componenta rezidențială	1	
5101	CĂLĂRAȘI	Călărași	Serviciul rezidențial în cadrul Centrului de Servicii Sociale pentru Copil și Familie ”SERA”		1
5102	CĂLĂRAȘI	Călărași	Serviciul Rezidențial (în cadrul Complexului de servicii comunitare pentru copilul cu handicap sever Călărași)		1
5103	CĂLĂRAȘI	Oltenița	Serviciul rezidențial pentru copilul cu handicap sever - din cadrul C.S.C. Oltenița		1
	Total			31	56

Source: World Bank (N=87). The city of Bucharest is not included.

ANNEX Part 2A: Statistical data on the professional foster carers (AMPs)

Annex 2A. Table 1: Data used for the analysis

County	QSefAMP Interview with the head of the AMP Service	List of AMPs AMP census (Number of AMPs)	QQ AMP Desk-research on a sample of AMPs (Number of AMPs)	CS AMP case studies: AMP evaluation on site (Number of AMPs)
AB	Yes	96	19	1
AR	Yes	102	20	1
AG	Yes	242	12	2
BH	Yes	367	19	0
BN	Yes	137	18	3
BT	Yes	213	20	2
BV	Yes	95	20	2
BZ	Yes	195	20	2
CS	Yes	419	18	0
CJ	Yes	131	10	1
CT	Yes	271	20	2
CV	Yes	131	20	2
DB	Yes	285	12	1
DJ	Yes	248	12	2
GL	Yes	315	12	4
GJ	Yes	152	20	0
HR	Yes	208	12	1
HD	Yes	146	20	1
IL	Yes	75	19	1
IS	Yes	795	9	1
IF	Yes	76	20	2
MM	Yes	255	19	1
MH	Yes	158	20	0
MS	Yes	233	11	1
NT	Yes	426	20	2
PH	Yes	216	20	2
SM	Yes	238	19	2
SJ	Yes	76	18	2

SB	Yes	144	20	2
SV	Yes	381	12	0
TR	Yes	192	11	3
TM	Yes	555	18	2
TL	Yes	171	20	0
VL	Yes	305	20	2
CL	Yes	198	12	1
Total	35	8,247	592	51

Annex 2A. Table 2: Number of AMP and number of children with special protection measure at the AMP, in the 35 counties with placement centers, between 2010-2018

	Number of children with special protection measure at the professional foster carers			Number of DGASPC professional foster carers		
County	31.12.2010	31.12..2017	February-March 2018 (*)	31.12..2010	31.12..2017	February-March 2018 (*)
AB	214	166	165	140	91	96
AR	160	136	123	106	109	102
AG	431	360	369	294	241	242
BH	687	650	646	395	365	367
BN	268	248	243	163	137	137
BT	456	423	420	237	206	213
BV	351	170	172	182	100	95
BZ	424	318	322	230	199	195
CS	607	497	498	535	443	419
CJ	222	193	201	148	134	131
CT	459	478	478	298	264	271
CV	322	239	242	161	132	131
DB	735	539	524	380	295	285
DJ	326	379	382	178	257	248
GL	797	615	610	486	320	315
GJ	167	215	220	131	154	152
HR	426	437	437	209	209	208
HD	362	244	237	182	153	146
IL	125	93	93	104	76	75

IS	1,199	1,486	1,462	850	824	795
IF	115	114	116	81	77	76
MM	410	332	328	318	258	255
MH	251	279	269	177	166	158
MS	446	431	419	252	238	233
NT	617	565	568	503	429	426
PH	448	383	385	303	220	216
SM	433	466	469	252	239	238
SJ	173	112	111	111	79	76
SB	445	277	274	273	150	144
SV	670	581	582	472	381	381
TR	345	359	361	187	193	192
TM	1101	1016	1001	607	574	555
TL	275	296	298	203	175	171
VL	547	478	471	379	318	305
CL	418	243	229	350	210	198
Total	15,432	13,818	13,725	**9.877**	**8.416**	8,247

Source: www.copii.ro, ANPDCA (2010-2017). (*) World Bank, Census of professional foster carers

Annex 2A. Table 3: Foster carers distribution, by gender and county (%)

County	Women	Men	Total
AB	8	92	100
AR	16	84	100
AG	3	97	100
BH	9	91	100
BN	8	92	100
BT	4	96	100
BV	11	89	100
BZ	2	98	100
CS	18	82	100
CJ	5	95	100

CT	4	96	100
CV	7	93	100
DB	7	93	100
DJ	14	86	100
GL	3	97	100
GJ	1	99	100
HR	4	96	100
HD	9	91	100
IL	0	100	100
IS	15	85	100
IF	9	91	100
MM	9	91	100
MH	6	94	100
MS	6	94	100
NT	6	94	100
PH	2	98	100
SM	4	96	100
SJ	1	99	100
SB	11	89	100
SV	5	95	100
TR	4	96	100
TM	19	81	100
TL	0	100	100
VL	1	99	100
CL	4	96	100
Total	8	92	100

Source: World Bank, Census of professional foster carers (February-March 2018)

Annex 2A. Table 4: Foster carers distribution, by age groups and county (%)

County	21-30	30-39	40-49	50-59	60-69	70-81	Total
AB	0	4	19	60	17	0	100
AR	1	11	32	43	14	0	100
AG	1	10	36	49	5	0	100
BH	1	11	44	39	5	0	100
BN	1	12	37	48	3	0	100
BT	0	10	39	48	4	0	100
BV	0	3	27	59	11	0	100
BZ	0	10	38	48	3	0	100
CS	0	7	41	35	15	1	100
CJ	0	8	37	30	23	2	100
CT	1	10	36	41	12	0	100
CV	0	5	27	44	24	0	100
DB	0	7	43	48	2	0	100
DJ	2	12	44	35	7	0	100
GL	0	8	37	41	14	0	100
GJ	2	20	37	38	3	0	100
HR	1	13	38	40	8	0	100
HD	1	8	33	51	8	0	100
IL	0	5	40	53	1	0	100
IS	1	14	47	29	9	0	100
IF	0	1	37	47	14	0	100
MM	0	9	38	40	14	0	100
MH	2	15	33	41	9	0	100
MS	0	9	42	45	4	0	100
NT	1	7	38	39	15	0	100
PH	0	1	27	59	13	0	100
SM	0	8	39	44	9	0	100
SJ	1	11	36	51	1	0	100

SB	0	8	26	47	17	1	100
SV	2	10	41	45	3	0	100
TR	2	7	42	44	5	0	100
TM	1	9	31	37	21	2	100
TL	0	12	42	44	2	0	100
VL	0	5	46	48	1	0	100
CL	1	5	35	48	12	0	100
Total	1	9	38	42	10	0	100

Source: World Bank, Census of professional foster carers (February-March 2018)

Annex 2A. Table 5: Foster carers distribution, by level of education and county (%)

County	Primary (grades 1-4)	Lower secondary (grades 5-8)	Vocational, first step of high school (grades 9-10)	High school (grades 9-12)	Post-secondary education, foreman school	Faculty (including MA and PhD)	Total
AB	0	14	41	39	2	5	100
AR	0	13	38	45	3	2	100
AG	0	6	36	55	0	2	100
BH	0	5	31	59	3	2	100
BN	0	4	60	31	4	2	100
BT	0	2	54	40	1	2	100
BV	0	13	42	43	0	2	100
BZ	0	11	52	36	0	1	100
CS	1	24	18	51	4	1	100
CJ	0	14	47	37	1	2	100
CT	0	14	39	44	1	2	100
CV	0	15	40	40	3	2	100
DB	0	5	46	47	0	2	100
DJ	0	1	42	53	0	4	100
GL	0	12	54	32	0	2	100
GJ	0	3	15	76	2	4	100
HR	0	11	44	42	2	1	100
HD	1	8	36	47	5	3	100
IL	0	3	25	71	0	1	100
IS	1	24	48	25	1	1	100
IF	0	9	42	39	0	9	100
MM	0	15	47	33	3	2	100
MH	1	11	25	56	3	4	100
MS	0	8	55	35	2	0	100
NT	0	12	56	28	1	2	100
PH	0	13	50	35	1	1	100
SM	0	40	11	44	2	3	100

SJ	0	0	43	50	3	4	100
SB	0	5	49	42	1	3	100
SV	0	6	57	34	2	1	100
TR	0	1	24	72	2	2	100
TM	1	16	45	33	2	5	100
TL	0	11	49	37	0	3	100
VL	0	5	40	50	3	2	100
CL	0	12	43	39	3	3	100
Total	0.2	12	42	42	2	2	100

Source: World Bank, Census of professional foster carers (February-March 2018)

Annex 2A. Table 6: AMPs' distribution based on the number of children in their care in February 2018 and those cared for in the past (since their first certification as an AMP), by county (%)

County	No of children cared for by the AMP network in February 2018	Total number of children taken care of by the current AMPs (since the first certification), between 1998-2018 (*)	
	(A)	(B)	(A)%(B)
AB	165	454	36
AR	123	478	26
AG	369	757	49
BH	646	1,052	61
BN	243	420	58
BT	420	835	50
BV	172	519	33
BZ	322	933	35
CS	498	719	69
CJ	201	531	38
CT	478	1,050	46
CV	242	464	52
DB	524	1,508	35
DJ	382	1,045	37
GL	610	1,101	55
GJ	220	543	41

HR	437	893	49
HD	237	556	43
IL	93	204	46
IS	1,462	2,416	61
IF	116	309	38
MM	328	539	61
MH	269	472	57
MS	419	673	62
NT	568	842	67
PH	385	1,159	33
SM	469	855	55
SJ	111	278	40
SB	274	480	57
SV	582	1,532	38
TR	361	789	46
TM	1,001	1,549	65
TL	298	608	49
VL	471	1,090	43
CL	229	450	51
Total	13,725	28,103	49

Source: World Bank, Census of professional foster carers (February-March 2018)

Note: (*) children cared for by the AMP in February 2018 are included.

Annex 2A. Table 7: How the county AMP networks are used (%)

	AMP that throughout their career have taken care only of the children that were still with them in February 2018	AMPs that apart from the children in their care in February 2018 have also taken care of ... more 1 child	... 2 children	... 3 children	....between 4 and 12 other children	Total %	Total N
AB	28	11	10	9	41	100	96
AR	20	7	17	16	41	100	102
AG	40	24	11	9	17	100	242
BH	44	28	15	7	7	100	367
BN	43	20	21	7	9	100	137
BT	33	23	13	11	20	100	213
BV	24	15	12	6	43	100	95
BZ	18	13	18	11	39	100	195
CS	67	21	8	2	2	100	419
CJ	28	14	16	11	31	100	131
CT	34	18	13	14	21	100	271
CV	37	18	16	15	14	100	131
DB	14	12	15	18	41	100	285
DJ	36	14	8	8	33	100	248
GL	34	23	21	10	12	100	315
GJ	34	13	20	11	23	100	152
HR	25	19	24	13	19	100	208
HD	41	12	15	8	24	100	146
IL	27	32	19	13	9	100	75
IS	41	28	15	6	9	100	795
IF	34	17	8	13	28	100	76
MM	49	32	11	4	4	100	255
MH	41	30	15	5	9	100	158
MS	48	20	16	8	7	100	233
NT	57	29	8	3	2	100	426
PH	12	12	18	15	44	100	216

SM	39	25	14	6	16	100	238
SJ	25	18	21	14	21	100	76
SB	40	27	12	8	13	100	144
SV	18	23	22	16	22	100	381
TR	36	14	18	9	24	100	192
TM	50	22	16	7	5	100	555
TL	34	20	15	12	19	100	171
VL	18	27	20	19	15	100	305
CL	45	25	15	10	6	100	198
Total for the 35 counties	37	22	15	9	16	100	8,247

Source: World Bank, Census of professional foster carers (February-March 2018)

Note: Coloured cells show significantly higher values

Annex 2A. Table 8: Average number of years spent by a child with the same AMP, by county

County	Total number of children taken care of by the current AMPs (since the first certification), between 1998-2018(*)	No of AMPs in February 2018	Number of years spent by a child with the same AMP			
			Average	Standard deviation	Minimum	Maximum
AB	454	96	4.2	3.7	0.5	16
AR	478	102	2.6	2.6	0	14
AG	757	242	6.7	5.1	0	17
BH	1.052	367	7.5	4.5	0	20
BN	420	137	6.0	5.1	0	17
BT	835	213	4.8	4.1	0	17
BV	519	95	3.9	4.1	0.3	15
BZ	933	195	3.0	2.0	0.5	13
CS	719	419	8.9	4.7	0	18
CJ	531	131	3.9	4.0	0	18
CT	1.050	271	3.7	3.6	0	18
CV	464	131	6.0	4.4	0.5	16
DB	1.508	285	4.0	3.4	0	20
DJ	1.045	248	2.5	2.4	0	16
GL	1.101	315	5.3	4.0	0.3	17
GJ	543	152	3.1	3.2	0	16
HR	893	208	4.6	3.6	0	19
HD	556	146	5.6	4.7	0	16
IL	204	75	6.8	3.7	1	15
IS	2.416	795	5.9	4.3	0	18
IF	309	76	5.0	4.3	0	18
MM	539	255	8.6	4.8	0	19
MH	472	158	6.4	4.6	0.6	19
MS	673	233	6.4	4.5	0	18
NT	842	426	8.5	4.5	0	18
PH	1.159	216	4.2	3.4	0.3	16

SM	855	238	6.8	4.8	0	18
SJ	278	76	4.8	3.9	0	16
SB	480	144	6.9	5.1	0.3	18
SV	1.532	381	4.8	3.5	0.4	18
TR	789	192	4.5	3.8	0	17
TM	1.549	555	6.7	4.6	0	18
TL	608	171	3.8	3.6	0	16
VL	1.090	305	6.4	3.7	1	18
CL	450	198	8.5	5.0	0	18
Total	28.103	8,247	5.8	4.5	0	20

Source: World Bank, Census of professional foster carers (February-March 2018)

Note: (*) children cared for by the AMP in February 2018 are included. For the children still in public care, average duration regers to the number of years since the foster care measure was introduced until February 2018

Annex 2A. Table 9: Case managers for AMPs, by county

County	Number of AMPs	Number of case managers (CMs) for AMP	AMP/CM ratio
AB	96	10	10
AR	102	2	51
AG	242	7	35
BH	367	21	17
BN	137	4	34
BT	213	10	21
BV	95	7	14
BZ	195	8	24
CS	419	16	26
CJ	131	4	33
CT	271	0	-
CV	131	6	22
DB	285	7	41
DJ	248	4	62
GL	315	18	18
GJ	152	8	19
HR	208	11	19
HD	146	2	73
IL	75	5	15
IS	795	23	35
IF	76	0	-
MM	255	7	36
MH	158	4	40
MS	233	5	47
NT	426	11	39
PH	216	7	31
SM	238	3	79
SJ	76	4	19

SB	144	5	29
SV	381	4	95
TR	192	11	17
TM	555	17	33
TL	171	2	86
VL	305	30	10
CL	198	7	28
Total	8.247	290	28

Source: World Bank, Interview with the heads of the AMP Service (or similar) from DGASPC (February-March 2018)

Annex 2A. Table 10: List of localities with AMP territorial concentrations

County	SIRSUP		Number of AMPs	Number of children placed with AMPs
		Total network	8.247	13.725
		- Total in the urban area (233 towns), of which territorial concentrations in:	2.945	4.586
BH	26564	ORADEA	31	51
BT	35731	BOTOSANI	71	140
CS	50790	RESITA	70	74
CT	60419	CONSTANTA	66	112
CV	63394	SFINTU GHEORGHE	30	51
DB	65342	TIRGOVISTE	32	51
DJ	69900	CRAIOVA	46	66
GL	75098	GALATI	120	215
IL	92658	SLOBOZIA	44	51
IS	95060	IASI	68	95
IS	95355	HIRLAU	69	115
MM	106318	BAIA MARE	57	66
MH	109773	DROBETA-TURNU SEVERIN	54	79
SM	136483	SATU MARE	37	64
SM	136526	CAREI	28	52
SM	136642	TASNAD	25	57
SV	146539	FALTICENI	51	62
SV	148006	DOLHASCA	51	84
TR	151790	ALEXANDRIA	40	61
TR	151870	ROSIORI DE VEDE	55	98
TM	155243	TIMISOARA	65	89
TM	155350	LUGOJ	44	70
TL	159614	TULCEA	51	77
VL	167473	RAMNICU VALCEA	72	96
CL	92569	CALARASI	119	135
		Total AMP concentrations in urban areas	1.396	2.111

		- Total in the rural area (1,129 communes), of which territorial concentrations in:	5.302	9.139
AG	14673	BOTENI	16	29
AG	18242	PRIBOIENI	12	20
AG	18527	RUCAR	35	49
BH	27686	BRATCA	22	34
BH	27757	BRUSTURI	14	21
BH	28335	CEICA	13	24
BH	29154	DOBRESTI	15	27
BH	30229	OLCEA	15	25
BH	31510	SUNCUIUS	17	28
BH	31789	TINCA	38	67
BH	31841	TULCA	15	30
BH	31878	TETCHEA	7	20
BN	34280	REBRISOARA	39	73
BT	38063	MIHAI EMINESCU	12	24
BT	39391	TUDORA	11	21
BZ	45003	BECENI	23	40
BZ	46377	COCHIRLEANCA	13	23
CS	52115	CORNEA	22	30
CS	52856	FOROTIC	14	21
CS	53274	MEHADIA	21	24
CS	53327	MEHADICA	46	61
CJ	55918	BAISOARA	16	23
CT	61372	COGEALAC	55	98
CV	64318	GHELINTA	12	22
DB	67773	LUCIENI	33	65
DB	68565	PUCHENI	15	29
DB	68921	TATARANI	11	21

DB	179640	VULCANA-PANDELE	19	37
DB	179891	RACIU	45	87
DJ	71910	COTOFENII DIN DOS	15	26
DJ	72383	GALICEA MARE	34	60
GL	75356	BERESTI-MERIA	15	30
GL	76139	CUCA	20	42
GL	76353	FUNDENI	13	26
GL	76969	PECHEA	11	23
GL	77288	SUCEVENI	13	27
GJ	79834	CRASNA	16	21
HR	83981	CIUCSINGEORGIU	26	53
HR	84102	CARTA	15	30
HR	85760	SINDOMINIC	47	95
HR	85788	SANMARTIN	20	43
HR	86453	TOMESTI	9	20
HD	92177	ZAM	14	29
IS	95792	BALTATI	11	22
IS	96147	CEPLENITA	18	31
IS	96192	CIORTESTI	9	24
IS	96593	COZMESTI	43	79
IS	96904	DOLHESTI	36	73
IS	97009	ERBICENI	13	23
IS	97063	FOCURI	16	31
IS	97189	GORBAN	23	39
IS	97875	MIRONEASA	11	22
IS	97919	MIROSLAVA	13	27
IS	98202	MOSNA	52	108
IS	98505	POPRICANI	16	27
IS	98649	PROBOTA	20	34

IS	98685	RADUCANENI	33	64
IS	98916	SCANTEIA	43	85
IS	98998	SCOBINTI	48	89
IS	99290	SCHEIA	21	40
IS	99780	TIBANESTI	17	30
IS	99879	TIGANASI	13	26
IS	100317	FANTANELE	23	41
IF	100969	BALOTESTI	15	22
MM	107546	CALINESTI	23	28
MM	108035	DUMBRAVITA	15	26
MM	109041	SUCIU DE SUS	26	33
MH	112370	ISVERNA	17	39
MH	112879	PATULELE	13	24
MS	115520	BATOS	12	24
NT	121732	BORLESTI	17	20
NT	123371	PASTRAVENI	59	101
NT	124616	TAZLAU	29	39
NT	125016	VINATORI-NEAMT	28	35
PH	131835	GURA VITIOAREI	14	26
PH	133214	FILIPESTII DE TIRG	12	20
PH	133795	IZVOARELE	15	25
PH	134050	MAGURENI	11	21
PH	134096	MANECIU	25	44
SM	137540	CULCIU	16	35
SM	138208	MOFTIN	12	25
SM	138280	ODOREU	13	23
SM	138663	SANISLAU	24	54
SJ	140208	BANISOR	27	38
SB	145961	VALEA VIILOR	11	20

SV	146904	BAIA	39	64
SV	147054	BOGDANESTI	53	76
SV	147465	BUNESTI	18	34
SV	148097	DOLHESTI	14	20
TR	153605	PLOSCA	18	35
TR	155092	BEUCA	10	20
TM	155546	BALINT	24	46
TM	155840	BETHAUSEN	40	79
TM	156106	BOLDUR	35	69
TM	156473	COSTEIU	14	24
TM	157246	GIARMATA	10	20
TM	158181	PISCHIA	50	94
TL	160644	JURILOVCA	20	34
TL	160724	MAHMUDIA	12	22
TL	161035	NICULITEL	15	29
TL	161302	SOMOVA	15	26
VL	171539	MUEREASCA	15	27
VL	173061	SLATIOARA	28	46
VL	173533	STROESTI	10	20
VL	173686	SIRINEASA	17	26
VL	173935	TOMSANI	15	25
		Total AMP concentrations in the rural area	2.279	4.071

Source: World Bank, Census of professional foster carers (February-March 2018)

Annex 2A. Table 11: Characteristics of children in foster care

	Number	Percentage
Total	**420**	**100**
Gender		
male	205	49
female	215	51
Age		
0-3 years	71	17
4-10 years	155	37
11-14 years	119	28
15-17 years	58	14
18+ years	17	4
Children with disabilities	92	22
Children with SEN	57	14
Children with any other special needs	57	14
Children with siblings placed with the same AMP	152	36

Source: the World Bank, Census of professional foster carers (conducted between February and March 2018).

Annex 2A. Table 12: Number of petitions/complaints against AMPs, by county

	Throughout the years, 1998-2018(*)	During the past 12 months (**)	Is there a clear and transparent procedure for those cases in which complaints are filed against an AMP? (**)	On a scale from 1 to 10, how well do the AMPs properly know and understand this procedure (**)
AB	0	0	Yes	9
AR	0	0	Yes	10
AG	20	0	No	-
BH	0	0	Yes	NR
BN	31	8	Yes	9
BT	11	2	Yes	9
BV	5	2	Yes	7
BZ	10	0	NR	-
CS	93	2	No	-
CJ	13	1	Yes	8
CT	0	0	Yes	NR
CV	0	0	Yes	8
DB	24	1	Yes	9
DJ	21	4	Yes	8
GL	0	1	Yes	NR
GJ	0	0	Yes	9
HG	0	1	Yes	8
HD	0	0	Yes	8
IL	0	0	Yes	10
IS	88	NR	Yes	8
IF	0	0	Yes	9
MM	27	1	Yes	9
MH	0	3	Yes	6
MS	42	0	Yes	8
NT	43	1	Yes	9
PH	0	0	Yes	7
SM	0	2	No	-

SJ	0	0	Yes	8
SB	22	1	Yes	9
SV	32	0	Yes	8
TR	0	2	No	-
TM	0	1	Yes	8
TL	9	1	Yes	10
VL	61	0	Yes	9
CL	0	0	Yes	9
	552	34		8.5

Source: World Bank, (*), QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted. (**) Interview with the heads of AMP Services within DGASPC on AMP-related county practices (February-March 2018) (N=35).

Note: Even cases/suspicions of abuse, neglect or child exploitation involving AMP's family, relatives, neighbors or members of the community shall be deemed as complaints/ petitions/allegations against the AMP, irrespective of their source. NR = No response

Annex 2A. Table 13: Training of the AMP network in 2017, by county

County	Number of AMPs	Additional training was organized in 2017 for the AMPs (*)	% AMPs were trained in 2017 (**)	Average no of training hours per AMP, in 2017 (**)	% AMPs for which training needs have been identified (**)
AB	96	Yes	90	17	47
AR	102	Yes	100	21	95
AG	242	No	8	60	0
BH	367	Yes	100	19	89
BN	137	Yes	100	8	83
BT	213	No	75	12	90
BV	95	Yes	15	40	30
BZ	195	Yes	85	3	55
CS	419	Yes	100	3	61
CJ	131	Yes	50	15	70
CT	271	No	0		0
CV	131	Yes	100	21	10
DB	285	No	0		50
DJ	248	Yes	83	40	25
GL	315	Yes	58	7	8
GJ	152	Yes	85	4	0
HR	208	Yes	50	60	92
HD	146	Yes	10	2	100
IL	75	Yes	100	10	48
IS	795	Yes	44	14	11
IF	76	No	0		5
MM	255	No	0		0
MH	158	No	0		10
MS	233	Yes	73	4	100
NT	426	Yes	100	6	0
PH	216	No	0		25
SM	238	No	0		89

SJ	76	Yes	95	17	67
SB	144	Yes	100	28	100
SV	381	Yes	100	6	92
TR	192	No	73	60	82
TM	555	Yes	89	19	33
TL	171	No	0		20
VL	305	No	0		15
CL	198	Yes	50	6	67
Total	8.247		56	15	43

Source: World Bank, (*) Interview with the heads of AMP Services within DGASPC on AMP-related county practices (February-March 2018) (N=35). (**), QQ AMP Desk research survey of AMPs (February-March 2018) (N=8,247 AMP). Data is weighted.

Note: Average no of hours calculated only for the AMPs that received training. NR = No response

ANNEX Part 2B: Statistical data on family-type foster care (PFam)

Annex 2B. Table 1: Data used in the analysis

County	QSefPFam Interview with the Head of the PFam Department	List of PFam PFam Census (number of PFam)	QQ professional foster parent Documentary assessment of a sample of PFam relatives (number of PFam relatives)	QQ professional foster parent Documentary assessment of a sample of PFam not relatives (number of PFam not relatives)	SC professional foster parent Case studies: Assessment of professional foster parent on site (number of PFam relatives)
AB	Yes	306	20	5	1
AR	Yes	335	18	5	1
AG	Yes	244	12	5	2
BH	Yes	438	19	5	1
BN	Yes	208	17	6	2
BT	Yes	365	20	5	2
BV	Yes	400	20	6	2
BZ	Yes	338	20	5	3
CS	Yes	190	9	6	1
CJ	Yes	213	14	7	1
CT	Yes	612	20	5	2
CV	Yes	229	20	5	2
DB	Yes	339	12	5	1
DJ	Yes	438	11	6	2
GL	Yes	284	11	6	2
GJ	Yes	234	20	5	2
HR	Yes	124	13	4	1
HD	Yes	443	20	5	2
IL	Yes	238	19	5	1
IS	Yes	705	11	5	1
IF	Yes	284	19	6	2
MM	Yes	346	18	6	1
MH	Yes	202	20	5	0
MS	Yes	438	11	5	1
NT	Yes	334	19	6	2
PH	Yes	449	18	7	2

SM	Yes	275	20	5	2
SJ	Yes	220	18	5	2
SB	Yes	216	20	7	4
SV	Yes	409	19	5	1
TR	Yes	141	11	5	1
TM	Yes	423	17	6	2
TL	Yes	189	19	6	2
VL	Yes	345	20	5	2
CL	Yes	346	11	3	1
Total	35	11,300	586	188	57

Annex 2B. Table 2: Number of children subject to special protection measure in family-type foster care in the 35 counties with care homes, between 2010 and 2018

	Number of children subject to protection measure in foster care with relatives up to the fourth degree			Number of children subject to protection measure in foster care with other families or persons			Number of foster care arrangements ... in February-March 2018	
County	31 December 2010	31 December 2017	Feb.-March 2018 (*)	31 December 2010	31 December 2017	Feb.-March 2018 (*)	... with relatives	... with other families/ persons
AB	377	316	331	65	67	59	260	46
AR	342	287	273	114	159	169	203	132
AG	257	223	212	56	92	90	164	80
BH	394	288	292	184	274	263	229	209
BN	364	194	188	46	70	66	150	58
BT	510	362	353	98	115	121	260	105
BV	747	371	371	162	182	160	277	123
BZ	335	326	320	106	114	117	239	99
CS	422	193	213	54	59	40	158	32
CJ	338	227	224	70	52	54	172	41
CT	915	902	601	232	312	181	452	160
CV	306	268	258	41	45	29	203	26
DB	392	349	334	80	83	106	256	83
DJ	390	486	463	79	108	127	334	104
GL	624	214	215	97	152	144	161	123

GJ	353	234	252	38	31	34	207	27
HR	287	123	126	75	38	30	95	29
HD	595	465	456	95	108	102	361	82
IL	396	259	250	48	64	59	186	52
IS	1,078	713	710	161	222	213	528	177
IF	204	305	228	48	53	110	178	106
MM	464	372	379	142	90	86	284	62
MH	283	207	199	38	54	66	150	52
MS	618	406	393	132	201	173	306	132
NT	581	340	328	122	82	84	256	78
PH	518	436	426	79	135	139	331	118
SM	320	273	269	70	88	91	200	75
SJ	502	244	227	55	53	48	181	39
SB	168	167	171	80	136	139	117	99
SV	334	383	376	110	127	128	299	110
TR	147	81	99	94	121	87	70	71
TM	525	433	414	246	116	132	319	104
TL	102	155	154	48	79	69	125	64
VL	633	305	313	82	115	109	252	93
CL	323	326	324	37	109	120	238	108
Total	15,144	11,233	10,742	3,284	3,906	3,745	8,201	3,099

Source: www.copii.ro, National Authority for the Protection of the Rights of the Child and Adoption (NAPRCA) (2010-2017). (*) World Bank, Census of family-type foster care.

Annex 2B. Table 3: Stages in setting up the family-type foster care network and time spent by a child in family-type foster care, per counties

	PFam which had received the first child in their care (%)			Total		Duration (in years) spent by a child in family-type foster care		
	1994-2004	2005-2014	2015-2018	%	N	Min	Max	Average
AB	4	52	44	100	306	0	19	4.7
AR	6	62	32	100	335	0	19	5.1
AG	5	55	40	100	244	0	16	4.9
BH	13	42	45	100	438	0	20	5.1

BN	0	63	37	100	208	0	12	5.3
BT	3	52	45	100	365	0	20	4.5
BV	2	53	45	100	400	0	17	4.8
BZ	6	53	41	100	338	0	18	4.7
CS	7	62	31	100	190	0	22	5.8
CJ	5	58	37	100	213	0	19	5.3
CT	2	54	44	100	612	0	17	4.4
CV	2	53	45	100	229	0	20	4.2
DB	11	41	48	100	339	0	23	4.2
DJ	1	41	58	100	438	0	17	3.2
GL	16	48	36	100	284	0	20	5.6
GJ	5	59	36	100	234	0	16	5.4
HR	8	65	27	100	124	0	20	6.2
HD	1	50	49	100	443	0	18	3.8
IL	4	51	45	100	238	0	16	4.5
IS	15	54	31	100	705	0	20	5.8
IF	2	36	63	100	284	0	17	3.4
MM	16	52	32	100	346	0	21	5.8
MH	1	64	35	100	202	0	15	5.1
MS	16	50	34	100	438	0	19	5.3
NT	17	52	31	100	334	0	20	6.1
PH	7	55	38	100	449	0	20	5.2
SM	0	47	53	100	275	0	12	3.9
SJ	14	58	28	100	220	0	19	6.7
SB	7	41	51	100	216	0	19	3.9
SV	3	56	41	100	409	0	19	4.4
TR	16	50	33	100	141	0	21	5.7
TM	1	58	40	100	423	0	15	4.6
TL	1	39	60	100	189	0	15	3.4

VL	22	40	38	100	345	0	19	6.0
CL	4	40	55	100	346	0	18	4.0
Total	7	51	42	100	11,300	0	23	4.8

Source: World Bank, PFam Census (February-March 2018).

Annex 2B. Table 4: Distribution of family-type foster care arrangements per types of PFam and counties (%)

	Foster care with relatives up to the fourth degree	Foster care with other families/persons	Mixed foster care	Total Pfam %	Total Pfam N
AB	84	15	1	100	306
AR	61	39	0	100	335
AG	67	33	0	100	244
BH	52	48	0	100	438
BN	72	28	0	100	208
BT	70	29	1	100	365
BV	68	31	1	100	400
BZ	70	29	1	100	338
CS	83	17	0	100	190
CJ	81	19	0	100	213
CT	73	26	0	100	612
CV	89	11	0	100	229
DB	75	24	1	100	339
DJ	75	24	1	100	438
GL	56	43	1	100	284
GJ	88	12	1	100	234
HR	73	23	3	100	124
HD	81	19	0	100	443
IL	78	22	0	100	238
IS	74	25	1	100	705
IF	62	37	0	100	284
MM	82	18	1	100	346
MH	73	26	1	100	202

MS	69	30	1	100	438
NT	76	23	1	100	334
PH	73	26	1	100	449
SM	72	27	0	100	275
SJ	81	18	1	100	220
SB	52	46	2	100	216
SV	73	27	0	100	409
TR	48	50	1	100	141
TM	75	25	0	100	423
TL	66	34	0	100	189
VL	73	27	0	100	345
CL	68	31	1	100	346
Total %	72	27	1	100	
N	8,133	3,099	68	11,300	

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons. The color-marked cells point to the significantly higher values.

Annex 2B. Table 5: Groups of PFam and PFam with professional foster parents in the same households, per counties (%)

	Only one PFam in the household	Several PFam in the household	PFam and professional foster parent in the household	Total Pfam %	Total Pfam N
AB	99.3	0.7	0.0	100	306
AR	96.1	0.0	3.9	100	335
AG	100.0	0.0	0.0	100	244
BH	98.9	0.7	0.5	100	438
BN	100.0	0.0	0.0	100	208
BT	98.4	0.0	1.6	100	365
BV	99.3	0.5	0.3	100	400
BZ	97.3	1.2	1.5	100	338
CS	99.5	0.0	0.5	100	190
CJ	99.1	0.9	0.0	100	213
CT	98.7	1.1	0.2	100	612

CV	100.0	0.0	0.0	100	229
DB	96.8	3.2	0.0	100	339
DJ	98.6	0.9	0.5	100	438
GL	100.0	0.0	0.0	100	284
GJ	100.0	0.0	0.0	100	234
HR	99.2	0.8	0.0	100	124
HD	98.9	1.1	0.0	100	443
IL	99.6	0.0	0.4	100	238
IS	98.9	0.3	0.9	100	705
IF	99.3	0.7	0.0	100	284
MM	99.4	0.0	0.6	100	346
MH	99.5	0.0	0.5	100	202
MS	98.2	1.4	0.5	100	438
NT	98.2	1.2	0.6	100	334
PH	100.0	0.0	0.0	100	449
SM	98.2	1.1	0.7	100	275
SJ	98.6	1.4	0.0	100	220
SB	99.1	0.5	0.5	100	216
SV	97.6	0.2	2.2	100	409
TR	95.7	0.0	4.3	100	141
TM	99.8	0.2	0.0	100	423
TL	97.4	2.6	0.0	100	189
VL	95.7	1.2	3.2	100	345
CL	98.8	0.9	0.3	100	346
Total %	98.7	0.7	0.7	100	
N	8,133	3,099	68	11,300	

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons. The color-marked cells point to the significantly higher values.

Annex 2B. Table 6: Categories of family-type foster care

	PFam with relatives up to the fourth degree		PFam with other families or persons		Mixed PFam		Total PFam	
	Number	%	Number	%	Number	%	Number	%
Total, out of which:	8133	100	3099	100	68	100	11300	100
PFam to a single person (not married, divorced, separated, widow/widower)	3041	37	880	28	27	40	3948	35
- woman	2756	34	741	24	25	37	3522	31
- man	285	4	139	4	2	*	426	4
PFam to a married person or part of a civil union	1790	22	766	25	18	26	2574	23
- woman	1580	19	654	21	16	24	2250	20
- man	210	3	112	4	2	*	324	3
PFam to a couple (family)	3302	41	1453	47	23	34	4778	42
Total Pfam where the children live in fact in a family	5092	63	2219	72	41	60	7352	65

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons. * Cells with less than 5 cases.

Annex 2B. Table 7: Distribution of family-type foster care depending on the caregiver of child/children subject to special protection measure (%)

	PFam to a person	PFam to a family	PFam to a single person (not married, divorced, separated, widow/widower)	PFam to a married person or part of a civil union	PFam to a couple (family)	Total PFam %	Total PFam N
BH	82	18	21	18	61	100	306
GL	41	59	25	15	60	100	335
BN	62	38	27	48	25	100	244
IF	35	65	29	16	55	100	438
IS	73	27	31	15	54	100	208
MS	42	58	32	24	44	100	365
DJ	43	57	32	27	41	100	400
SJ	71	29	33	24	43	100	338
AR	65	35	33	8	59	100	190
TM	51	49	33	33	35	100	213
BV	67	33	33	10	57	100	612
CT	53	47	34	33	33	100	229
SB	69	31	34	40	25	100	339
PH	58	42	34	17	48	100	438
NT	41	59	35	18	47	100	284
SV	55	45	35	23	41	100	234
CL	64	36	35	25	40	100	124
MM	62	38	36	25	39	100	443
SM	86	14	36	24	40	100	238
AB	46	54	36	45	18	100	705
GJ	45	55	36	18	45	100	284
BT	61	39	37	4	58	100	346
CV	63	37	38	16	47	100	202
AG	57	43	38	23	39	100	438
DB	53	47	38	31	31	100	334
BZ	51	49	38	33	28	100	449

HR	61	39	39	27	34	100	275
IL	55	45	40	46	14	100	220
MH	74	25	40	23	37	100	216
TL	59	41	40	19	41	100	409
CJ	62	38	40	11	49	100	141
TR	65	35	40	21	38	100	423
CS	61	39	43	22	35	100	189
HD	59	41	45	18	37	100	345
VL	60	40	46	13	41	100	346
Total %	57	43	35	23	42	100	
N	6,496	4,804	3,948	2,574	4,778	11,300	

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

Annex 2B. Table 8: Distribution of caregivers in family-type foster care, per gender and counties (%)

County	Women	Men	Total %	Total N
AB	75	25	100	362
AR	60	40	100	534
AG	68	31	99	340
BH	60	40	100	703
BN	72	28	100	260
BT	61	39	100	578
BV	61	39	100	627
BZ	73	27	100	433
CS	65	35	100	257
CJ	58	42	100	317
CT	71	29	100	811
CV	65	35	100	336
DB	67	33	100	443
DJ	64	36	100	618
GL	59	41	100	454
GJ	65	35	100	340

HR	69	31	100	166
HD	68	32	100	609
IL	79	21	100	271
IS	61	39	100	1,087
IF	60	40	100	440
MM	68	32	100	481
MH	68	32	100	277
MS	65	35	100	631
NT	64	36	100	491
PH	63	37	100	666
SM	68	32	100	384
SJ	66	34	100	315
SB	72	27	100	271
SV	67	33	100	578
TR	65	35	100	195
TM	68	32	100	569
TL	67	33	100	266
VL	67	33	100	486
CL	67	33	100	483
Total	66	34	100	16,079

Source: World Bank, PFam Census (February-March 2018).

Annex 2B. Table 9: Distribution of caregivers in family-type foster care, per gender and types of PFam (%)

	Women	Men	Total	N
Foster care provided by relatives up to the fourth degree	67	33	100	11,435
Foster care provided by other families/persons	63	37	100	4,553
Mixed foster care	70	30	100	91
Only one PFam in the household	66	34	100	15,870
Several PFam in the household	69	31	100	101
PFam and professional foster parents in the household	67	33	100	108
PFam provided by a person	88	12	100	6,536
PFam provided by a family	50	50	100	9,543
PFam provided by a single person (not married, divorced, separated, widow/widower)	89	11	100	3,949
PFam provided by a married person or part of a civil union	87	13	100	2,574
PFam provided by a couple (family)	50	50	100	9,556
Total	66	34	100	16,079

Source: World Bank, PFam Census (February-March 2018).
Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

Annex 2B. Table 10: Distribution of caregivers in family-type foster care, per age groups and counties (%)

County	17-30 years	30-39 years	40-49 years	50-59 years	60-69 years	70-90 years	Total	Average age (years)
AB	1	6	23	27	36	8	100	56
AR	1	9	25	35	24	6	100	53
AG	1	7	20	26	34	12	100	57
BH	2	15	29	26	23	4	100	51
BN	3	7	18	27	37	10	100	56
BT	3	7	18	29	31	12	100	56
BV	1	9	16	32	35	7	100	55
BZ	3	6	19	30	33	9	100	56
CS	2	6	16	29	40	7	100	57
CJ	1	8	18	33	30	9	100	56
CT	3	7	23	30	30	7	100	54
CV	1	4	18	30	34	11	100	57

DB	2	7	19	28	33	11	100	56
DJ	2	8	22	29	28	11	100	55
GL	1	6	21	23	40	9	100	57
GJ	2	4	18	33	30	13	100	57
HR	1	4	25	28	30	12	100	57
HD	2	8	20	31	30	8	100	55
IL	5	6	16	36	31	6	100	54
IS	2	7	19	27	34	12	100	57
IF	3	15	30	25	21	7	100	51
MM	3	8	21	29	29	10	100	55
MH	1	7	22	26	38	7	100	56
MS	1	7	19	31	33	9	100	56
NT	2	10	18	28	30	13	100	56
PH	3	8	22	27	30	10	100	55
SM	1	14	28	25	24	7	100	52
SJ	3	5	20	33	31	8	100	56
SB	3	9	21	30	31	7	100	54
SV	3	5	21	24	35	12	100	57
TR	1	8	17	27	36	11	100	56
TM	1	7	21	28	33	9	100	56
TL	1	5	22	29	34	8	100	56
VL	2	5	20	33	28	12	100	56
CL	1	6	20	23	39	10	100	57
Total	2	8	21	29	31	9	100	55

Source: World Bank, PFam Census (February-March 2018).

Annex 2B. Table 11: Average age of caregivers in family-type foster care, per types of PFam (years)

	N	Average age (years)
Foster care provided by relatives up to the fourth degree	11,435	57
Foster care provided by other families/persons	4,553	52

Mixed foster care	91	56
Only one PFam in the household	15,870	55
Several PFam in the household	101	56
PFam and professional foster parents in the household	108	53
PFam provided by a person	6,536	57
PFam provided by a family	9,543	55
PFam provided by a single person (not married, divorced, separated, widow/widower)	3,949	
- Women	3,523	60
- Men	426	56
PFam provided by a married person or part of a civil union	2,574	
- Women	2,252	53
- Men	322	53
PFam provided by a couple (family)	9,556	55
Total	16,079	55

Source: World Bank, PFam Census (February-March 2018).
Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

Annex 2B. Table 12: Distribution of caregivers in family-type foster care, per levels of education and types of PFam (%)

	NR	No more than secondary school	Post-secondary school or high-school	More than high-school	Total
Foster care provided by relatives up to the fourth degree	1	61	34	4	100
Foster care provided by other families/persons	0	26	55	19	100
Mixed foster care	0	75	23	2	100
Only one PFam in the household	1	52	39	8	100
Several PFam in the household	5	53	37	5	100
PFam and professional foster parents in the household	0	11	86	3	100
PFam provided by a person	1	58	35	6	100
PFam provided by a family	1	47	42	10	100
PFam provided by a single person (not married, divorced, separated, widow/widower)	1	62	32	6	100
PFam provided by a married person or part of a civil union	1	53	40	6	100
PFam provided by a couple (family)	1	47	43	10	100
Service life of PFam: - 1994-2004	1	57	37	5	100
- 2005-2014	1	55	38	6	100
- 2015-February 2018	1	46	42	11	100
Total	1	51	40	8	100

Source: World Bank, PFam Census (February-March 2018) (N=16.079 persons in PFam).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons. NR = No reply.

Annex 2B. Table 13: Distribution of caregivers in family-type foster care, per level of education and county (%)

County	NR	No education	Primary school (I-IV)	Secondary school (V-VIII)	Vocational school, first cycle of high-school (IX-X)	High-school (IX-XII)	Post-secondary school, foreman school	University (including Master's, PhD degree)	Total
AB	0	12	20	23	24	14	1	5	100
AR	2	14	16	21	10	28	2	8	100
AG	9	1	13	24	25	17	4	6	100
BH	0	2	19	14	21	26	2	15	100
BN	0	5	17	24	28	20	1	5	100
BT	0	0	12	34	33	15	2	3	100
BV	0	5	12	30	27	18	3	6	100
BZ	0	10	23	30	16	17	1	4	100
CS	0	3	16	44	10	24	1	2	100
CJ	0	10	15	28	23	12	2	11	100
CT	0	11	16	37	13	16	1	6	100
CV	0	12	41	24	13	9	1	1	100
DB	0	2	14	35	25	17	3	3	100
DJ	0	19	18	24	14	17	1	7	100
GL	0	5	10	29	27	20	3	6	100
GJ	0	5	13	22	27	27	1	5	100
HR	0	5	11	31	24	25	3	1	100
HD	0	7	13	35	18	19	3	5	100
IL	0	14	26	28	19	9	2	3	100
IS	0	2	18	34	31	9	1	6	100
IF	0	4	3	35	14	23	1	20	100
MM	0	9	17	30	21	17	2	4	100
MH	0	2	27	31	9	23	1	6	100
MS	0	9	16	27	29	9	4	6	100
NT	0	3	20	35	23	10	2	6	100
PH	0	4	12	24	32	13	5	10	100
SM	16	10	14	20	14	17	1	9	100

SJ	0	7	29	24	19	16	2	3	100
SB	0	13	12	25	16	22	3	9	100
SV	0	2	17	27	31	17	1	4	100
TR	3	2	14	25	25	31	0	1	100
TM	1	6	11	30	22	19	2	10	100
TL	0	5	19	31	28	13	1	3	100
VL	7	4	8	22	23	31	3	2	100
CL	0	4	25	35	19	13	1	2	100
Total	1	6	16	29	22	17	2	6	100

Source: World Bank, PFam Census (February-March 2018) (N=16,079 persons in PFam).

Note: NR = No reply.

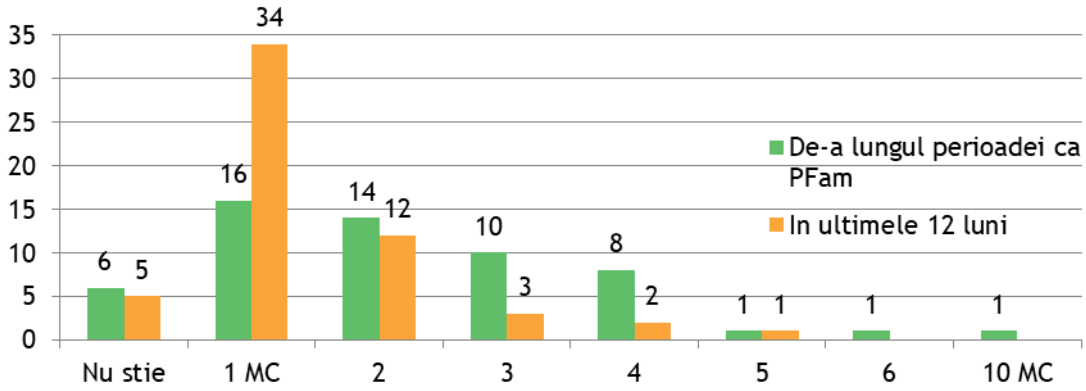
Annex 2B. Table 14: Case managers for children in family-type foster care, broken down per counties

County	Number of children in PFam to relatives	Number of children in PFam to other families or persons	Number of case managers (CM) for professional foster parents	Ratio children in PFam/CM
AB	331	59	12	33
AR	273	169	19	23
AG	212	90	5	60
BH	292	263	8	69
BN	188	66	5	51
BT	353	121	7	68
BV	371	160	16	33
BZ	320	117	5	87
CS	213	40	4	63
CJ	224	54	4	70
CT	601	181	14	56
CV	258	29	5	57
DB	334	106	22	20
DJ	463	127	24	25
GL	215	144	9	40
GJ	252	34	6	48
HR	126	30	6	26

HD	456	102	9	62
IL	250	59	26	12
IS	710	213	10	92
IF	228	110	11	31
MM	379	86	No reply	No reply
MH	199	66	6	44
MS	393	173	2	283
NT	328	84	11	37
PH	426	139	8	71
SM	269	91	4	90
SJ	227	48	6	46
SB	171	139	10	31
SV	376	128	7	72
TR	99	87	4	47
TM	414	132	17	32
TL	154	69	3	74
VL	313	109	29	15
CL	324	120	8	56
Total	10,742	3,745	341	42

Source: World Bank, Interviews with Heads of the CM Department or of PFam (or similar) Department within the General Directorate for Social Assistance and Child Protection (February-March 2018).

Annex 2B. Figure 1: Number of case managers with which PFam worked since it received the child and in the past 12 months (number)



Source: World Bank, Case studies for PFam (February-March 2018) (N=57).

Annex 2B. Table 15: Distribution of family-type foster care per types of PFam and residential environment

	Urban	Rural	Total %	Total N
Foster care provided by relatives up to the fourth degree	44	56	100	8133
Foster care provided by other families/persons	49	51	100	3099
Mixed foster care	41	59	100	68
Only one PFam in the household	45	55	100	11149
Several PFam in the household	45	55	100	76
PFam and professional foster parents in the household	39	61	100	75
PFam provided by a person	48	52	100	6495
PFam provided by a family	41	59	100	4804
PFam provided by a single person (not married, divorced, separated, widow/widower)				
- Women	51	49	100	3520
- Men	46	54	100	426
PFam provided by a married person or part of a civil union				
- Women	45	55	100	2250
- Men	38	62	100	324
PFam provided by a couple (family)	41	59	100	4778
Service life of PFam:- 1994-2004	49	51	100	4778
- 2005-2014	46	54	100	4778
- 2015-February 2018	44	56	100	4778

Total	45	55	100	11300
	5,104	6,196	11,300	

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons. The color-marked cells point to the significantly higher values.

Annex 2B. Table 16: List of localities that are territorial concentrations of PFam

County	SIRSUP		Number of PFam	Number of children in PFam
		Total network	11,300	14,487
		- Total in the URBAN environment (320 towns), of which territorial concentrations in:	5,104	6,369
AB	1017	ALBA IULIA	56	73
AR	9262	ARAD	97	125
BH	26564	ORADEA	112	125
BN	32394	BISTRITA	53	65
BT	35731	BOTOSANI	89	106
BV	40198	BRASOV	107	127
BV	40438	SACELE	42	66
BZ	44818	BUZAU	80	101
CJ	54975	CLUJ-NAPOCA	60	82
CT	60419	CONSTANTA	127	149
CT	60847	MEDGIDIA	47	65
DB	65342	TIRGOVISTE	59	70
DJ	69900	CRAIOVA	161	212
GL	75098	GALATI	125	144
HD	87059	LUPENI	53	72
IS	95060	IASI	170	210
MM	106318	BAIA MARE	130	163
MH	109773	DROBETA-TURNU SEVERIN	56	75
MS	114319	TIRGU MURES	54	66
NT	120726	PIATRA NEAMT	64	82
PH	130534	PLOIESTI	121	153
SM	136483	SATU MARE	81	99

SB	143450	SIBIU	46	60
TM	155243	TIMISOARA	141	163
VL	167473	RAMNICU VALCEA	65	72
CL	92569	CALARASI	80	92
		Total urban concentrations of PFam	2,276	2,817
		- Total in the RURAL environment (1,930 communes), of which territorial concentrations in:	6,196	8,118
AB	4927	IGHIU	9	12
AB	6761	ROSIA MONTANA	9	10
AB	7099	SASCIORI	10	13
AR	10293	BUTENI	8	10
AR	10827	FELNAC	7	13
AR	11423	MISCA	9	14
AR	11842	SAVIRSIN	5	10
AR	12368	SIRIA	8	11
AG	18527	RUCAR	13	15
BH	26582	SINMARTIN	19	23
BH	27383	BATAR	15	19
BH	28335	CEICA	8	14
BH	29154	DOBRESTI	11	16
BH	29662	HUSASAU DE TINCA	11	17
BH	29813	LAZARENI	12	15
BH	30149	NOJORID	9	15
BH	30274	OSORHEI	7	10
BH	30568	POPESTI	8	11
BH	31789	TINCA	33	43
BH	31976	VADU CRISULUI	4	10
BN	33989	NIMIGEA	8	11
BN	34690	SIEU-MAGHERUS	11	19
BN	35090	TIHA BIRGAULUI	8	10

BT	36756	CORNI	11	11
BT	36907	CRISTESTI	8	12
BT	36952	CRISTINESTI	9	11
BT	37324	FRUMUSICA	7	11
BT	37912	LUNCA	5	11
BT	38544	POMIRLA	11	19
BT	38893	SANTA MARE	6	11
BT	39872	VORONA	9	14
BV	40526	APATA	17	22
BV	40955	FELDIOARA	10	13
BV	41088	HARMAN	7	15
BV	42003	TARLUNGENI	8	10
BZ	45003	BECENI	7	10
BZ	45753	CALVINI	5	10
BZ	47300	LUCIU	8	10
BZ	47453	MEREI	10	12
BZ	49484	SIRIU	4	10
BZ	49894	ULMENI	7	10
BZ	50102	VERNESTI	11	14
CS	52696	DOGNECEA	9	12
CJ	58259	JUCU	5	12
CT	60945	ALBESTI	6	10
CT	61005	ALIMAN	9	12
CT	61210	CHIRNOGENI	10	10
CT	61283	CIOCIRLIA	7	10
CT	61318	COBADIN	10	10
CT	61372	COGEALAC	18	29
CT	61513	CORBU	14	19
CT	61620	CUMPANA	25	31

CT	61871	INDEPENDENTA	10	14
CT	62191	MIHAIL KOGALNICEANU	10	14
CT	62253	MIHAI VITEAZU	8	10
CT	62280	MIRCEA VODA	9	12
CT	62538	OSTROV	11	13
CT	62878	SACELE	10	11
CT	63125	VALU LUI TRAIAN	9	13
CT	63152	LUMINA	11	16
CV	63802	BATANI	10	15
CV	63866	BELIN	13	15
CV	64041	BRADUT	15	24
CV	64096	BRETCU	11	13
CV	64942	VILCELE	11	12
DB	67167	CRINGURILE	14	19
DB	67737	I. L. CARAGIALE	5	12
DB	67773	LUCIENI	10	14
DB	68002	MANESTI	8	12
DB	68789	SALCIOARA	6	11
DB	69526	VOINESTI	7	10
DB	179640	VULCANA-PANDELE	10	13
DJ	70637	AMARASTII DE JOS	6	12
DJ	70744	ARGETOAIA	7	10
DJ	71457	CALOPAR	7	10
DJ	72383	GALICEA MARE	13	14
DJ	73996	SADOVA	9	12
DJ	74554	URZICUTA	9	12
GL	75356	BERESTI-MERIA	7	13
GL	76157	CUDALBI	12	15
GL	76353	FUNDENI	6	10

GL	76601	IVESTI	9	13
GL	76807	NICORESTI	5	10
GJ	78873	BENGESTI-CIOCADIA	7	11
IL	92989	BORDUSANI	7	13
IL	94795	VLADENI	5	12
IL	100852	ALEXENI	6	11
IL	180064	BARBULESTI	7	10
IS	95293	TOMESTI	12	15
IS	95499	ION NECULCE	7	12
IS	95747	ARONEANU	13	18
IS	95792	BALTATI	8	11
IS	95872	BELCESTI	8	10
IS	96254	CIUREA	14	16
IS	96904	DOLHESTI	12	15
IS	97009	ERBICENI	7	10
IS	97189	GORBAN	11	18
IS	97606	LESPEZI	8	14
IS	97875	MIRONEASA	30	45
IS	97919	MIROSLAVA	11	14
IS	98505	POPRICANI	13	16
IS	98685	RADUCANENI	14	23
IS	98916	SCANTEIA	12	17
IS	99290	SCHEIA	6	12
IS	99780	TIBANESTI	19	28
IS	99879	TIGANASI	12	15
IS	100148	VLADENI	12	23
IS	100219	VOINESTI	11	15
IF	100834	AFUMATI	7	10
IF	101298	BRANESTI	11	11

IF	101742	CERNICA	11	15
IF	103130	GANEASA	9	11
IF	179249	CHIAJNA	10	10
IF	179383	JILAVA	8	11
IF	179463	MOGOSOAIA	10	18
MM	107001	ARDUSAT	2	10
MM	107733	COPALNIC-MANASTUR	11	11
MM	179846	COLTAU	7	10
MH	112030	GRUIA	12	21
MH	112879	PATULELE	8	10
MS	114382	SINCRAIU DE MURES	9	11
MS	115389	BAND	8	11
MS	115575	BAGACIU	13	17
MS	116493	DANES	12	15
MS	116652	ERNEI	10	13
MS	117042	GHINDARI	7	12
MS	117113	GLODENI	11	15
MS	117426	HODAC	8	12
MS	118799	PETELEA	8	14
MS	120254	VINATORI	11	18
NT	120771	DUMBRAVA ROSIE	7	10
NT	121732	BORLESTI	10	15
NT	123914	RAUCESTI	8	12
NT	124616	TAZLAU	7	10
NT	124938	ALEXANDRU CEL BUN	9	12
PH	130678	BLEJOI	8	10
PH	132574	CERASU	8	12
PH	133964	LIPANESTI	9	11
SM	138164	MICULA	8	11

SM	138280	ODOREU	13	17
SM	138869	SOCOND	8	15
SJ	140280	BOBOTA	11	12
SB	143557	SELIMBAR	11	25
SB	144152	BAZNA	9	16
SB	144303	BLAJEL	6	12
SV	146904	BAIA	8	12
SV	151344	ZVORISTEA	5	10
TM	156213	CARPINIS	5	11
TM	157246	GIARMATA	10	11
TM	158181	PISCHIA	10	18
TM	159213	VARIAS	4	10
TM	159473	TOMNATIC	9	11
TL	160993	NALBANT	8	13
TL	161035	NICULITEL	11	12
TL	161384	TOPOLOG	8	10
TL	161561	VALEA TEILOR	10	12
VL	170514	IONESTI	10	13
VL	172153	PERISANI	8	11
VL	172509	RACOVITA	17	22
VL	173374	STOILESTI	13	15
VL	174290	ZATRENI	4	10
CL	92587	MODELU	15	19
CL	93281	CUZA VODA	8	10
CL	93370	DOR MARUNT	12	18
CL	93487	DRAGALINA	12	17
CL	94312	ROSETI	7	10
CL	102419	CURCANI	10	14
CL	102945	FRUMUSANI	11	17

CL	104181	MANASTIREA	18	22
CL	105605	ULMENI	4	10
		Total rural concentrations of PFam	1,647	2,364

Source: World Bank, PFam Census (February-March 2018).

Annex 2B. Table 17: Features of children in family-type foster care, depending on the type of PFam

	PFam with relatives up to the fourth degree		PFam with other families or persons		Mixed foster care		Total PFam	
	Number	%	Number	%	Number	%	Number	%
Total, of which:	10580	100	3745	100	162	100	14487	100
- boys	5392	51	1818	49	79	49	7289	50
- girls	5188	49	1927	51	83	51	7198	50
- 0-3 years	451	4	305	8	7	4	763	5
- 4-10 years	3082	29	890	24	63	39	4035	28
- 11-14 years	3145	30	975	26	46	28	4166	29
- 15-17 years	2670	25	1044	28	42	26	3756	26
- 18+ years	1232	12	531	14	4	*	1767	12
Disabled children	797	8	532	14	13	8	1342	9
Children with special educational requirements	589	6	381	10	7	4	977	7
Children with any other special needs	351	3	218	6	6	4	575	4
Children having a sibling in the same foster family	4175	39	748	20	105	65	5028	35
In the foster care of...								
- relatives of the second degree	8327	79	0	0	69	43	8396	58
- relatives of the third degree	2208	21	0	0	15	9	2223	15
- relatives of the fourth degree	45	0	0	0	1	*	46	0
- other relatives	0	0	59	2	1	*	60	0
- not relatives	0	0	3686	98	76	47	3762	26

Source: World Bank, PFam Census (February-March 2018).

Note: Mixed foster care is foster care with several children, among which some in the foster care of relatives and others of other families/persons.

ANNEX Part 2C: Statistical data on small-sized residential-type

Annex 2C. Table 1: Evolution in the number of children and youth in small-sized residential-type facilities, broken down per types, between 31 December 2010 and 31 December 2017

	Number of public institutions		Number de children and youth in public institutions		Ratio children/public institution	
	AP	CTF	AP	CTF	children/ AP	children/CTF
31-Dec-10	412	427	2566	4902	6	11
31-Dec-11	415	418	2731	4956	7	12
31-Dec-12	415	433	2642	5155	6	12
31-Dec-13	395	431	2504	5250	6	12
31-Dec-14	387	428	2514	5183	6	12
31-Dec-15	386	431	2410	5124	6	12
31-Dec-16	386	424	2270	4985	6	12
31-Dec-17	383	427	2225	4619	6	11

Source: www.copii.ro, National Authority for the Protection of the Rights of the Child and Adoption (NAPRCA) (2010-2017).

Annex 2C. Table 2: Number of small-sized residential-type facilities and number of children and youth subject to special protection measures in such facilities, in the 35 counties with care homes, in February-March 2018

County	Total number of AP	Total number of CTF	Number of AP in operation	Number of CTF in operation	Number of children and youth in AP	Number of children and youth in CTF
AB	6	14	5	14	23	163
AR	0	17	0	17	0	175
AG	16	4	16	4	97	40
BH	2	16	2	16	4	127
BN	0	3	0	3	0	27
BT	29	7	28	7	164	88
BV	0	12	0	12	0	109
BZ	8	9	8	9	66	137
CS	31	2	18	2	48	23
CJ	9	20	9	19	45	148

CT	1	11	1	11	4	127
CV	3	12	2	12	14	140
DB	1	4	0	4	0	39
DJ	21	4	17	4	98	51
GL	10	2	10	2	84	34
GJ	10	5	10	4	43	35
HR	6	39	6	37	42	297
HD	1	7	1	7	6	69
IL	0	6	0	6	0	80
IS	13	12	13	12	80	129
IF	0	0	0	0	0	0
MM	0	27	0	27	0	257
MH	32	0	10	0	37	0
MS	7	36	7	35	33	340
NT	10	1	9	1	54	15
PH	0	3	0	3	0	57
SM	0	13	0	13	0	137
SJ	0	12	0	11	0	111
SB	0	4	0	4	0	28
SV	14	19	14	19	71	231
TR	64	1	27	1	246	12
TM	2	2	2	2	6	13
TL	8	7	8	7	55	64
VL	7	3	4	3	21	32
CL	0	13	0	13	0	159
Total	311	347	227	341	1341	3494

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Note: Facilities in operation are those that hosted children in February-March 2018.

Annex 2C. Table 3: The data used for analysis

County	List of AP Census of AP	List of CTF Census of CTF	QQ RezMic Documentary	QQ RezMic Documentary	SC RezMic Case studies:

	(number of APs)	(number of CTFs)	assessment of a sample of AP (number of APs)	assessment of a sample of CTF (number of CTFs)	On-site assessment of CTFs (number of CTFs)
AB	6	14	5	13	1
AR	0	17	0	16	1
AG	16	4	5	4	2
BH	2	16	2	15	1
BN	0	3	0	3	2
BT	29	7	6	7	2
BV	0	12	0	12	2
BZ	8	9	5	9	2
CS	31	2	5	2	2
CJ	9	20	3	12	1
CT	1	11	1	11	1
CV	3	12	2	12	2
DB	1	4	0	4	1
DJ	21	4	5	4	2
GL	10	2	5	2	0
GJ	10	5	5	4	2
HR	6	39	3	12	2
HD	1	7	1	7	2
IL	0	6	0	5	1
IS	13	12	5	11	1
IF	0	0	0	19	0
MM	0	27	0	0	1
MH	32	0	5	0	0
MS	7	36	5	11	1
NT	10	1	4	1	1
PH	0	3	0	3	2
SM	0	13	0	13	2
SJ	0	12	0	11	2

SB	0	4	0	4	2
SV	14	19	5	13	1
TR	64	1	5	1	1
TM	2	2	2	2	2
TL	8	7	8	7	2
VL	7	3	4	3	2
CL	0	13	0	13	1
Total	311	347	96	266	50

Annex 2C. Table 4: List of localities where there are territorial concentrations of CTFs

County	SIRSUP		Number of CTFs	Number of children living in CTF
		Total network	347	3,494
		- Total in the URBAN environment (73 towns), with territorial concentrations in:	239	2,397
AR	12091	SANTANA	5	52
IL	92658	SLOBOZIA	4	53
AB	1017	ALBA IULIA	5	54
HR	83525	CRISTURU SECUIESC	10	58
MS	114319	TARGU MURES	5	59
TL	159614	TULCEA	6	61
IS	95060	IASI	3	62
BT	35731	BOTOSANI	6	63
AR	9574	LIPOVA	8	78
SV	146584	GURA HUMORULUI	7	78
BH	26564	ORADEA	11	86
MM	106559	SIGHETU MARMATIEI	9	88
HR	83320	MIERCUREA CIUC	12	90
MM	106318	BAIA MARE	10	94
CT	60419	CONSTANTA	8	95
BZ	44845	RAMNICU SARAT	7	98
		Total urban concentrations of PFP	116	1,169

		- Total in the RURAL environment (63 communes), with territorial concentrations in:	108	1,097
AB	7767	STREMT	1	20
HR	85582	SECUIENI	2	21
BN	34985	TEACA	2	22
CL	94606	ULMU	2	22
CV	64194	CERNAT	1	23
SJ	142337	PLOPIS	2	23
BT	38544	POMIRLA	1	25
DJ	72052	DIOSTI	2	25
PH	132404	BREBU	1	26
IS	98051	MIROSLOVESTI	3	31
SV	148765	FUNDU MOLDOVEI	1	33
MS	115959	CEUASU DE CIMPIE	3	34
IS	97517	HORLESTI	6	36
HR	84415	FRUMOASA	3	46
MS	114382	SINCRAIU DE MURES	12	91
CL	94223	PERISORU	8	103
		Total rural concentrations of CTF	50	581

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Annex 2C. Table 5: List of localities that are territorial concentrations of APs

County	SIRSUP		Number of APs	Number of children living in AP
		Total network	311	1,341
		- Total in the URBAN environment (41 towns), with territorial concentrations in:	306	1,314
NT	120860	ROMAN	10	54
IS	95060	IASI	10	63
TR	151790	ALEXANDRIA	21	65
BZ	44818	BUZAU	8	66
GL	75098	GALATI	9	76
AG	13169	PITESTI	13	81
DJ	69900	CRAIOVA	21	98
BT	36006	DOROHOI	27	154
TR	151870	ROSIORI DE VEDE	41	181
		Total urban concentrations of APs	160	838

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Annex 2C. Table 6: Distribution of vacancies in the CTF network, per counties

	CTFs out of operation in February-March 2018			CTFs in operation, with vacancies, in February-March 2018		
	Number of filled places	Capacity (number of places)	Number of vacancies	Number of filled places	Capacity (number of places)	Number of vacancies
AB			0	135	170	35
AR			0	72	89	17
AG			0	28	36	8
BH			0	77	100	23
BN			0	14	23	9
BT			0	63	72	9
BV			0	72	85	13
BZ			0	28	32	4
CS			0	11	12	1
CJ	0	8	8	116	159	43
CT			0	32	38	6
CV			0	57	61	4
DB			0	39	56	17
DJ			0	26	28	2
GL			0			0
GJ	0	8	8	9	10	1
HR	0	14	14	168	233	65
HD			0	45	72	27
IL			0			0
IS			0	49	63	14
IF			0			0
MM			0	208	276	68
MH			0			0
MS	0	6	6	92	112	20
NT			0	15	16	1
PH			0	26	28	2

SM			0	33	38	5
SJ	0	10	10	44	51	7
SB			0	19	27	8
SV			0	138	177	39
TR			0	12	16	4
TM			0	13	18	5
TL			0	31	42	11
VL			0	20	24	4
CL			0	73	84	11
Total			46			483

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Note: Number of filled places = the number of beneficiaries subject to a special protection measure at the time of our research in that residential-type facility (children and youth actually present were counted, plus those who were temporarily at school, treatment or absent for various other reasons). Number of vacancies = Capacity - Number of filled places.

Annex 2C. Table 7: Distribution of vacancies in the AP network, per counties

	APs out of operation in February-March 2018			APs in operation, with vacancies, in February-March 2018		
	Number of filled places	Capacity (number of places)	Number of vacancies	Number of filled places	Capacity (number of places)	Number of vacancies
AB	0	6	6	12	17	5
AR			0			0
AG			0	36	44	8
BH			0			0
BN			0			0
BT	0	6	6	34	45	11
BV			0			0
BZ			0	7	8	1
CS	0	48	48	46	80	34
CJ			0	33	49	16
CT			0	4	6	2
CV	0	7	7			0
DB	0	6	6			0
DJ	0	24	24	66	83	17
GL			0	7	8	1
GJ			0	4	5	1
HR			0	13	15	2
HD			0			0
IL			0			0
IS			0	10	12	2
IF			0			0
MM			0			0
MH	0	52	52	19	26	7
MS			0	7	10	3
NT	0	6	6	15	18	3
PH			0			0

SM			0			0
SJ			0			0
SB			0			0
SV			0	11	17	6
TR	0	214	214	118	162	44
TM			0	6	10	4
TL			0	19	23	4
VL	0	18	18	3	6	3
CL			0			0
Total			387			174

Source: World Bank, Census of small-sized residential-type facilities (February-March 2018).

Note: Number of filled places = the number of beneficiaries subject to a special protection measure at the time of our research in that residential-type facility (children and youth actually present were counted, plus those who were temporarily at school, treatment or absent for various other reasons). Number of vacancies = Capacity - Number of filled places.

ANNEX Part 3: Statistical data regarding child protection case managers (MCs)

Annex 3. Table 1: Distribution of case managers, by gender and county (N)

County	Women	Men	Total
AB	1	27	28
AR	0	19	19
AG	2	17	19
BH	1	28	29
BN	0	11	11
BT	3	17	20
BV	1	25	26
BZ	3	19	22
CS	2	14	16
CJ	0	24	24
CT	0	16	16
CV	5	9	14
DB	0	28	28
DJ	1	22	23
GL	1	32	33
GJ	1	18	19
HR	2	19	21
HD	0	22	22
IL	2	24	26
IS	3	44	47
IF	2	18	20
MM	2	19	21
MH	1	15	16
MS	0	18	18
NT	2	30	32
PH	0	28	28
SM	1	15	16
SJ	2	8	10

SB	1	17	18
SV	7	18	25
TR	4	14	18
TM	4	28	32
TL	0	14	14
VL	5	25	30
CL	0	24	24
Total	59	726	785

Source: World Bank, Census of Case Managers, February-March 2018.

Annex 3. Table 2: Distribution of case managers, by age group and county (N)

County	Age < 30	Age 30-39	Age 40-49	Age 50-59	Age 60-69	Total
AB	0	14	12	2	0	28
AR	3	7	7	2	0	19
AG	2	10	7	0	0	19
BH	0	9	17	2	1	29
BN	0	8	2	1	0	11
BT	0	6	11	3	0	20
BV	0	9	11	5	1	26
BZ	3	4	11	4	0	22
CS	2	6	5	2	1	16
CJ	1	10	10	3	0	24
CT	0	3	7	6	0	16
CV	1	8	2	3	0	14
DB	0	9	15	4	0	28
DJ	2	9	9	3	0	23
GL	0	12	19	2	0	33
GJ	1	4	12	2	0	19
HR	1	7	8	5	0	21
HD	2	8	10	2	0	22
IL	2	6	15	3	0	26
IS	4	18	21	4	0	47
IF	5	10	5	0	0	20

MM	0	6	11	4	0	21
MH	0	6	8	2	0	16
MS	3	9	4	2	0	18
NT	1	10	19	1	1	32
PH	1	11	11	4	1	28
SM	1	5	8	2	0	16
SJ	0	8	2	0	0	10
SB	2	6	8	1	1	18
SV	0	8	12	5	0	25
TR	1	3	12	2	0	18
TM	2	6	18	4	2	32
TL	1	4	4	5	0	14
VL	0	11	13	6	0	30
CL	2	3	11	7	1	24
Total	43	273	357	103	9	785

Source: World Bank, Census of Case Managers, February-March 2018.

Annex 3. Table 3: Distribution of case managers, by academic achievement and county (N)

	Higher education					
County	No	Yes, social work	Yes, sociology or psychology	Yes, health care	Yes, other specialization	Total
AB	0	27	0	0	1	28
AR	0	17	1	0	1	19
AG	0	12	3	0	4	19
BH	0	29	0	0	0	29
BN	0	8	3	0	0	11
BT	0	16	4	0	0	20
BV	0	10	11	0	5	26
BZ	0	18	1	0	3	22
CS	0	16	0	0	0	16
CJ	0	22	2	0	0	24
CT	0	5	3	0	8	16
CV	0	8	3	0	3	14
DB	0	16	7	0	5	28
DJ	1	13	4	0	5	23
GL	0	5	7	0	21	33
GJ	0	11	4	0	4	19
HR	0	13	5	0	3	21
HD	0	6	11	0	5	22
IL	3	5	13	0	5	26
IS	0	44	2	0	1	47
IF	0	19	0	0	1	20
MM	0	18	2	0	1	21
MH	0	14	1	0	1	16
MS	0	13	5	0	0	18
NT	0	21	9	0	2	32
PH	0	19	7	0	2	28
SM	1	9	2	0	4	16
SJ	0	9	1	0	0	10
SB	0	7	4	1	6	18
SV	0	13	5	0	7	25

TR	1	1	8	0	8	18
TM	0	23	4	0	5	32
TL	0	8	5	0	1	14
VL	0	7	12	0	11	30
CL	1	8	12	0	3	24
Total	7	490	161	1	126	785

Source: World Bank, Census of Case Managers, February-March 2018.

ANNEX Part 4: Statistical data

Annex 11. Table 1: Distribution of communes by types of source communities (defined by the number of mothers of children in public care and the existence of a marginalized area in the commune), by counes (No of communes)

	Communes with 5+ mothers	Communes with 3-4 mothers and a marginalized area	Other communes	Total communes
ALBA			6	6
ARAD			13	13
ARGES		3	41	44
BIHOR		1	22	23
BISTRITA-NASAUD	1		31	32
BOTOSANI		1	27	28
BRASOV	4	5	25	34
BUZAU	4	6	43	53
CARAS-SEVERIN			12	12
CLUJ			20	20
CONSTANTA	2	2	34	38
COVASNA	2	4	22	28
DIMBOVITA			23	23
DOLJ		1	33	34
GALATI		1	36	37
GORJ	1		25	26
HARGHITA		4	22	26
HUNEDOARA			6	6
IALOMITA		1	21	22
IASI	24	17	41	82
MARAMURES			3	3
MEHEDINTI			27	27
MURES			16	16

NEAMT	9	5	37	51
PRAHOVA	2	2	58	62
SATU_MARE		1	13	14
SALAJ		6	23	29
SIBIU	1	3	25	29
SUCEAVA		1	18	19
TELEORMAN			11	11
TIMIS	1		44	45
TULCEA	1	1	25	27
VILCEA			43	43
CALARASI		3	28	31
Total	**52**	**68**	**874**	**994**

Source: World Bank, Census of Placement Centers for Children (October, 2016).

Note: "Other communes" refers to communes with 1-2 mothers of children placed in Foster Care Centers or 3-4 mothers without marginalized areas.

Annex 4. Table 2: Number of localities within functional micro-areas of the source communities

			Urban Micro-area		Rural Micro-area	
County	Name of source commune	Number of villages present within the Source Community	Number of urban territorial and administrative divisions	Number of urban localities included in the community	County	Name of source commune
ALBA	CETATEA DE BALTA	4	1	4	5	26
ARAD	VLADIMIRESCU	4	1	1	4	11
ARGES	CALINESTI	12	2	10	4	10
BIHOR	DRAGESTI	5	0	0	4	28
BIHOR	TINCA	5	1	1	5	23
BOTOSANI	COPALAU	3	1	5	6	21

BRASOV	APATA	1	0	0	3	4
BUZAU	VERNESTI	11	1	1	5	35
CALARASI	SPANTOV	3	1	1	3	5
CARAS-SEVERIN	BERZOVIA	3	1	1	4	11
CARAS-SEVERIN	MEHADICA	1	0	0	2	5
CLUJ	MINTIU GHERLII	6	2	9	4	25
CONSTANTA	PESTERA	5	1	3	4	18
CONSTANTA	COGEALAC	5	0	0	5	16
COVASNA	VALCELE	4	1	3	4	10
DIMBOVITA	I. L. CARAGIALE	3	1	1	5	14
DOLJ	ORODEL	5	0	0	5	9
GALATI	MASTACANI	2	1	3	3	6
GORJ	BUSTUCHIN	8	0	0	3	3
HARGHITA	CIUCSANGEORGIU	9	1	4	5	12
HUNEDOARA	TURDAS	4	1	1	0	0
IALOMITA	TRAIAN	1	1	2	5	15
IASI	VOINESTI	5	1	1	4	13
MARAMURES	RUSCOVA	1	0	0	4	4
MEHEDINTI	SIMIAN	8	1	1	4	8
MURES	ALBESTI	9	1	5	2	7
NEAMT	VANATORI-NEAMT	4	1	4	3	11
PRAHOVA	VALEA CALUGAREASCA	15	0	0	5	24
SALAJ	NUSFALAU	2	1	4	7	30
SATU MARE	BOTIZ	1	2	6	3	11
SIBIU	ROSIA	6	2	2	4	12

TELEORMAN	BRANCENI	1	1	1	4	6
TIMIS	SANPETRU MARE	2	1	1	7	10
TULCEA	TOPOLOG	7	0	0	12	13
VILCEA	RACOVITA	7	1	8	4	21
	TOTAL	172	30	83	151	477

Annex 4. Table 3: Number of respondents in the interviews conducted for the 35 source communities

		Respondents						
County	Source Community	DGASPC	Mayor/ Deputy Mayor/ Mayoralty Secretary	SPAS	Director/ School Secretary	Medic/ medical nurse	SCC	Total Number
ALBA	Cetatea de Baltă	2	1	2	1	1	1	8
ARAD	Vladimirescu	1	1	1	1	1	1	6
ARGEȘ	Călinești	2	1	1	1	1	1	7
BIHOR	Drăgești	2	1	1	1	2	0	7
BIHOR	Tinca	2	1	2	3	1	1	10
BOTOȘANI	Copălău	1	1	3	1	1	1	8
BRAȘOV	Apața	2	1	2	1	1	1	8
BUZĂU	Vernești	2	1	2	1	1	2	9
CĂLĂRAȘI	Spanțov	1	1	1	1	1	1	6
CARAȘ-SEVERIN	Berzovia	2	1	1	1	1	1	7
CARAȘ-SEVERIN	Mehadica	2	1	1	1	1	1	7
CLUJ	Mintiu Gherlii	2	1	2	1	1	1	8
CONSTANȚA	Cogealac	1	1	1	1	1	0	5
CONSTANȚA	Peștera	1	1	1	1	1	0	5
COVASNA	Vâlcele	1	1	2	1	1	1	7

DÂMBOVIȚA	I. L. Caragiale	2	1	2	1	1	1	8
DOLJ	Orodel	2	1	1	1	2	0	7
GALAȚI	Măstăcani	1	1	2	1	1	1	7
GORJ	Bustuchin	1	1	1	1	1	1	6
HARGHITA	Ciucângeorgiu	2	1	2	1	1	1	8
HUNEDOARA	Turdaș	1	1	1	1	1	0	5
IALOMIȚA	Traian	1	1	2	1	1	0	6
IAȘI	Voinești	1	1	2	1	1	2	8
MARAMUREȘ	Ruscova	1	1	1	1	1	1	6
MEHEDINȚI	Șimian	1	1	2	1	1	1	7
MUREȘ	Albești	2	1	2	1	1	1	8
NEAMȚ	Vânători-Neamț	1	1	3	1	1	1	8
PRAHOVA	Valea Călugărească	2	1	2	1	1	0	7
SĂLAJ	Nușfalău	1	1	1	1	1	1	6
SATU MARE	Botiz	2	1	1	1	1	1	7
SIBIU	Roșia	1	1	1	1	1	0	5
TELEORMAN	Brânceni	1	1	2	1	1	1	7
TIMIȘ	Sânpetru Mare	1	1	1	1	1	1	6
TULCEA	Topolog	2	1	1	1	1	0	6
VÂLCEA	Racovița	2	2	1	1	1	1	8
	Total	52	36	54	37	37	28	244

Source: World Bank, Source Communities Study, February-March 2018.

Annex 4. Table 4: Concentration of children and young people separated from their families at the level of the villages from surveyed source communities

County	Name of source commune	Number of children and young people in the protection system, February 2018	Number of villages from Source Community	Is there information on the origin village of the children and young people from the system?	Is there a concentration of children and young people separated from their families at the level of some villages from the commune?
AB	CETATEA DE BALTA	18	4	Yes	Yes, Cetatea de Balta village
AR	VLADIMIRESCU	19	4	No	It is unknown
AG	CALINESTI	40	12	Yes	No concentration
BH	DRAGESTI	19	5	Yes	Yes, Drăgești village
BT	COPALAU	19	3	Yes	Yes, Copălău village
BV	APATA	46	1	One single village in the commune	
BZ	VERNESTI	27	11	Yes	Yes, Cândești village
CS	BERZOVIA	8	3	Yes	No concentration
CJ	MINTIU GHERLII	8	6	Yes	No concentration
CT	PESTERA	13	5	Yes	No concentration
CV	VALCELE	38	4	Yes	Yes, Vâlcele, Hetea and Araci villages
DB	I. L. CARAGIALE	30	3	No	It is unknown
DJ	ORODEL	9	5	Yes	Yes, Orodel village
GL	MASTACANI	35	2	Yes	Yes, Mastacani village
GJ	BUSTUCHIN	10	8	No	It is unknown
HG	CIUCSANGEORGIU	22	9	No	It is unknown
HD	TURDAS	15	4	Yes	Yes, Turdaș village
IL	TRAIAN	14	1	One single village in the commune	
IS	VOINESTI	73	5	Yes	Yes, Slobozia and

					Voinesti villages
MM	RUSCOVA	6	1	One single village in the commune	
MH	SIMIAN	52	8	Yes	Yes, Cerneti, Simian and Dudasu villages
MS	ALBESTI	24	9	No	It is unknown
NT	VANATORI-NEAMT	34	4	Yes	Yes, Vânători Neamț village
PH	VALEA CALUGAREASCA	27	15	Yes	No concentration
SJ	NUSFALAU	16	2	No	It is unknown
SM	BOTIZ	14	1	One single village in the commune	
SB	ROSIA	41	6	Yes	Yes, Nou and Rosia villages
TR	BRANCENI	3	1	One single village in the commune	
TM	SANPETRU MARE	29	2	Yes	No concentration
TL	TOPOLOG	14	7	Yes	No concentration
VL	RACOVITA	29	7	Yes	Yes, Balota village
CS	MEHADICA	60	1	One single village in the commune	
BH	TINCA	145	5	No	It is unknown
CT	COGEALAC	30	5	No	It is unknown
CL	SPANTOV	17	3	Yes	Yes, Spantov village
	Total	1004	172		

Source: World Bank, Source Communities Study, February-March 2018.

Annex 4. Table 5: Distribution of children within source communities by actual home address of their mothers, February 2018 (number of children and young people from protection system)

County	Name of source commune	Mother still lives in the origin commune in February 2018	Mother moved to another locality in Romania	Mother is living abroad	Mother is known and alive, but her whereabouts are unknown or she is changing her home address	Mother is deceased, unknown, missing	Total
AB	CETATEA DE BALTA	12	1	0	5	0	18
AR	VLADIMIRESCU	10	3	0	4	2	19
AG	CALINESTI	30	5	0	0	5	40
BH	DRAGESTI	14	0	0	1	4	19
BT	COPALAU	4	12	1	0	2	19
BV	APATA	22	15	7	1	1	46
BZ	VERNESTI	20	5	0	0	2	27
CS	BERZOVIA	5	3	0	0	0	8
CJ	MINTIU GHERLII	2	4	1	0	1	8
CT	PESTERA	10	3	0	0	0	13
CV	VALCELE	33	3	0	0	2	38
DB	I. L. CARAGIALE	30	0	0	0	0	30
DJ	ORODEL	0	3	0	0	6	9
GL	MASTACANI	23	1	7	3	1	35
GJ	BUSTUCHIN	8	1	0	0	1	10
HG	CIUCSANGEORGIU	22	0	0	0	0	22
HD	TURDAS	7	6	0	0	2	15
IL	TRAIAN	8	5	1	0	0	14
IS	VOINESTI	27	20	19	7	0	73
MM	RUSCOVA	1	0	0	0	5	6
MH	SIMIAN	42	10	0	0	0	52

MS	ALBESTI	21	3	0	0	0	24
NT	VANATORI-NEAMT	16	5	2	2	9	34
PH	VALEA CALUGAREASCA	19	2	0	6	0	27
SJ	NUSFALAU	15	0	0	0	1	16
SM	BOTIZ	4	4	0	0	6	14
SB	ROSIA	24	3	0	12	2	41
TR	BRANCENI	3	0	0	0	0	3
TM	SANPETRU MARE	10	18	0	0	1	29
TL	TOPOLOG	2	8	0	0	4	14
VL	RACOVITA	17	9	2	1	0	29
CS	MEHADICA	5	49	2	2	2	60
BH	TINCA	112	6	20	0	7	145
CT	COGEALAC	17	10	0	0	3	30
CL	SPANTOV	6	6	4	0	1	17
	Total	601	223	66	44	70	1004

Source: World Bank, Source Communities Study, February-March 2018.

Annex 4. Table 6: Source Communities by number of mothers with children in the protection system

County	Name of source commune	Number of children and young people in the protection system, February 2018	Number of mothers known and alive with children in the protection system	Number of mothers with children in the protection system in February 2018 who still have their home addresses in the commune
AB	CETATEA DE BALTA	18	15	9
AR	VLADIMIRESCU	19	12	6
AG	CALINESTI	40	18	14
BH	DRAGESTI	19	9	8
BT	COPALAU	19	10	3
BV	APATA	46	30	16
BZ	VERNESTI	27	16	11
CS	BERZOVIA	8	4	2
CJ	MINTIU GHERLII	8	7	2
CT	PESTERA	13	8	6
CV	VALCELE	38	21	18
DB	I. L. CARAGIALE	30	16	16
DJ	ORODEL	9	1	0
GL	MASTACANI	35	19	12
GJ	BUSTUCHIN	10	8	7
HG	CIUCSANGEORGIU	22	14	14
HD	TURDAS	15	9	5
IL	TRAIAN	14	9	6
IS	VOINESTI	73	45	17
MM	RUSCOVA	6	1	1
MH	SIMIAN	52	31	24

MS	ALBESTI	24	18	16
NT	VANATORI-NEAMT	34	19	11
PH	VALEA CALUGAREASCA	27	15	10
SJ	NUSFALAU	16	9	9
SM	BOTIZ	14	4	3
SB	ROSIA	41	24	13
TR	BRANCENI	3	3	3
TM	SANPETRU MARE	29	15	6
TL	TOPOLOG	14	8	2
VL	RACOVITA	29	23	15
CS	MEHADICA	60	29	2
BH	TINCA	145	86	71
CT	COGEALAC	30	18	10
CL	SPANTOV	17	12	4
	Total	1004	586	372

Source: World Bank, Source Communities Study, February-March 2018.
Note: the highlighted cells show the 10 communes that no longer qualified as source communities in February 2018.

Annex 4. Table 7: Distribution of children within source communities by actual home address of their fathers, February 2018 (number of children and young people from protection system)

County	Name of source commune	Father still lives in the origin commune in February 2018	Father moved to another locality in Romania	Father is living abroad	Father is known and alive, but his whereabouts are unknown or he is changing his home address	Father is deceased, unknown, missing	Total
AB	CETATEA DE BALTA	3	2	0	1	12	18
AR	VLADIMIRESCU	4	4	0	2	9	19
AG	CALINESTI	16	17	0	0	7	40
BH	DRAGESTI	4	0	0	6	9	19
BT	COPALAU	9	1	0	0	9	19
BV	APATA	9	6	2	1	28	46
BZ	VERNESTI	15	0	0	0	12	27
CS	BERZOVIA	0	1	0	0	7	8
CJ	MINTIU GHERLII	2	0	0	0	6	8
CT	PESTERA	7	1	0	0	5	13
CV	VALCELE	11	2	0	1	24	38
DB	I. L. CARAGIALE	15	5	0	0	10	30
DJ	ORODEL	0	0	0	0	9	9
GL	MASTACANI	20	3	0	1	11	35
GJ	BUSTUCHIN	7	2	0	0	1	10
HG	CIUCSANGEORGIU	4	0	0	0	18	22
HD	TURDAS	8	3	0	0	4	15
IL	TRAIAN	1	1	1	1	10	14
IS	VOINESTI	16	9	3	0	45	73
MM	RUSCOVA	0	5	0	0	1	6
MH	SIMIAN	24	3	0	1	24	52

MS	ALBESTI	4	3	0	0	17	24
NT	VANATORI-NEAMT	10	3	4	1	16	34
PH	VALEA CALUGAREASCA	13	3	4	3	4	27
SJ	NUSFALAU	4	4	0	0	8	16
SM	BOTIZ	3	1	0	0	10	14
SB	ROSIA	14	4	0	0	23	41
TR	BRANCENI	2	0	0	0	1	3
TM	SANPETRU MARE	8	4	0	3	14	29
TL	TOPOLOG	7	5	0	0	2	14
VL	RACOVITA	2	5	1	0	21	29
CS	MEHADICA	0	28	0	9	23	60
BH	TINCA	40	9	4	2	90	145
CT	COGEALAC	13	3	0	2	12	30
CL	SPANTOV	7	3	1	0	6	17
	Total	302	140	20	34	508	1004

Source: World Bank, Source Communities Study, February-March 2018.

Competence makes a difference!
Project selected under the Administrative Capacity Operational Program, co-financed by European Union from the European Social Fund

„Development of Plans for the De-Institutionalization of Children Deprived of Parental Care and their Transfer to Community-Based Care, SIPOCA 2”

The International Bank for Reconstruction and Development
February 2017