



Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020

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ISBN 978-973-0-20534-3

Acknowledgments

These inputs into the Government's Strategy on Social Inclusion and Poverty Reduction (2014-2020) were conducted under the supervision of Mr. Andrew Mason, with overall guidance from Ms. Elisabetta Capannelli and Mr. Christian Bodewig.

The report was coordinated by Mr. Emil Teşliuc, Mr. Vlad Grigoraş (task team leaders), and Ms. Manuela Sofia Stănculescu. The document includes contributions from Miglena Abels, Daniel Arpinte, Cosmin Briciu, Bogdan Corad, Diana Chiriacescu, Sabin Chiricescu, Cătălina Iamandi-Cioinaru, Eimar Coleman, Dana Fărcăşanu, Andy Guth, Adrian Hatos, Marcel Ionescu-Heroiu, Ulrich Hoerning, Liviu Ianăşi, Fidelie Kalambayi, Sandor Karacsony, Frank Kavanagh, Mihai Magheru, Monica Marin, Georgiana Neculau, Ana Rădulescu, Irina Râmniceanu, Dumitru Sandu, Alina Sava, Oleksiy Sluchynskyy, Ken Simler, Andreea Trocea and Claudiu Tufiş. Simona Anton, Irina Boeru, and Alexandru Toth helped the team to cover the data collection activities. The team benefitted from the support of Oana Maria Caraba, Corina Grigore, Carmen Laurente, Alina Petric, and Camelia Guşescu. Fiona Mackintosh edited the report. The pictures were taken by the research team, during fieldwork. The report was peer reviewed by Christian Bodewig, Roberta Gatti, Lucian Bucur Pop, Pedro L. Rodriguez and Istvan Vanyolos. Two of the thematic chapters of this volume have been informally peer reviewed by World Bank colleagues working on Romania on those sectors (education by Penny Williams and Janssen Teixeira, and health by Richard Florescu, Cristina Petcu and Marcelo Bortman).

A first draft of this background study was also shared with the counterparts for early feedback in October 2014. Three rounds of early consultations have been carried out: (i) with institutional stakeholders (experts from all key ministries) on October 18, 2014; (ii) with a broad range of stakeholders (NGOs, trade unions, research organizations, and academia) on January 29, 2015, led by the Prime Minister and the Minister of Labor, Family, Social Protection, and the Elderly; and (iii) the Social Service Forum, led by Caritas Confederation with the participation of the Ministry of Labor

and DGASPCs on February 10-11, 2015. First draft versions of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 and the draft Action Plan based on this background study were posted on the website of the Ministry of Labor, Family, Social Protection, and the Elderly on December 26, 2014 for feedback. These consultations have been critical in getting early input on how to fine-tune both the Strategy and this report.

The report's team members would like to express their gratitude to their counterparts in the Ministry of Labor, Family, Social Protection, and the Elderly, in particular to Mr. Codrin Scutaru, Ms. Lăcrămioara Corcheş, Ms. Elena Dobre, Ms. Rodica Cărbăuşu, Mr. Alexandru Alexe, Ms. Gabriela Coman, and Ms. Elena Tudor for the guidance, timely feedback, and continuous support in the development of the report. The report benefitted also from the continued coordination with UNICEF, particularly in the areas of vulnerable children's social problems and integrated services. We also want to thank to Ms. Lidia Onofrei from the Ministry of Health, Ms. Steluta Jalia, Mr. Teofil Gherca and Mr. Bogdan Ghinea from the Ministry of Regional Development and Public Administration, Ms. Dana Gafiţianu from the Ministry of Agriculture and Rural Development, as well as Ms. Viorica Preda from the Ministry of Education who helped us with data and provided feedback on the early versions of the background study. The local authorities from more than 3,100 localities across the country provided information on their social assistance activities, in May 2014. County and local authorities from Arad and Botosani counties helped us in carrying out the qualitative study in July-August 2014. Mayoralties and local people from Vrancea, Bacău and Suceava helped us to understand what are the main problems related to the Guaranteed Minimum Income. The local authorities from 303 cities participated in October 2014 in the survey on social housing. Overall, a very large number of people took time to share with us the main challenges they have faced in tackling poverty and social exclusion in the field, and provided creative ideas on what and how should be changed for the benefit of the poor and vulnerable.

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Acronyms and Abbreviations

ADHD	- Attention deficit hyperactivity disorder	ECDC	- European Center for Disease Prevention and Control
AIDS	- Acquired immune deficiency syndrome	ECEC	- Early childhood education and care
AJOFM	- County Employment Agency	EMCDDA	- European Monitoring Centre for Drugs and Drug Addiction
AJPIS	- County Agencies for Payments and Social Inspection	ERDF	- European Regional Development Fund
ALMP	- Active Labor Market Program	ESF	- European Social Fund
ALOFM	- Local Employment Services	ESI	- European Structural and Investment Funds
ANA	- National Anti-Drug Agency	ESL	- Early School Leaving
ANP	- National Administration of Penitentiaries	ESSPROS	- European System of Integrated Social Protection Statistics
ANPIS	- National Agency for Payments and Social Inspection	EU	- European Union
ANITP	- National Agency against Trafficking in Human Beings	EU-SILC	- European Union Statistics on Income and Living Conditions
AROPE	- People at risk of poverty and social exclusion	FEAD	- Fund for European Aid to the Most Deprived
AROP	- At risk of relative poverty after receiving social transfers	FSA	- Family Support Allowance
CASPIS	- Anti-Poverty and Promotion of Social Inclusion Commission	GD	- Government Decision
CCS	- Community Consultative Structures	GDP	- Gross Domestic Product
CDD	- Community Driven Development	GEO	- Government Emergency Ordinance
CF	- Cohesion Fund	GMI	- Guaranteed Minimum Income
CHNs	- Community Health Nurses	GP	- General Practitioner
CIA	- Centers for Assistance and Care	HB	- Heating Benefit
CITO	- Residential rehabilitation centers for disabled people and centers for occupational therapy (<i>Centrul de Integrare prin Terapie Ocupațională</i>)	HBS	- Household Budget Survey
CJRAE/ CMBRAE	- County Center for Resources and Educational Assistance	HFA	- European Health for All database
CPECA	- Drug Prevention, Assessment, and Counseling Centers	HIC	- Helping Invisible Children, UNICEF project
CRB	- Child Raising Benefit	HIV	- Human immunodeficiency virus infection
CSR	- Country Specific Recommendations	ICT	- Information and Communication Technology
DDAC	- Department of Development and Community Assistance (<i> Direcția de Dezvoltare și Asistență Comunitară</i>)	IEC	- Information-education-communication
DGASPC	- County Directorates of Social Assistance and Child Protection	ILO	- International Labour Organization
DOT	- Direct Observed Treatment	IMF	- International Monetary Fund
DOTS	- Direct Observed Treatment Strategy	ISJ	- County School Inspectorates
DPH	- Department for Protection of Persons with Disabilities (<i>National Authority for Persons with Disabilities</i>)	IVET	- Initial Vocational Education and Training
DSP	- County Directorates for Public Health	LAG	- Local Action Groups
EAFRD	- European Agricultural Fund for Rural Development	LCA	- Latent Class Analysis
EC	- European Commission	LEADER	- Liaison Entre Actions de Développement de l'Économie Rurale (<i>Links between the rural economy and development actions</i>)
		LIOP	- Large Infrastructure Operational Program
		LHDI	- Local Human Development Index
		LLL	- Lifelong learning
		LWI	- Low work intensity Indicator

MARD	Ministry of Agriculture and Rural Development	RHM	- Roma Health Mediator
MDR-TB	- Multidrug resistant cases of tuberculosis	RDP	- Rural Development Project
M&E	- Monitoring and evaluation	ROP	- Regional Operational Program
MIS	- Management Information Systems	RRS	- Regional Roma Survey
MoE	- Ministry of Education	RSDF	- Romania Social Development Fund
MoH	- Ministry of Health	SCA	- State Child Allowance
MLFSPE	- Minister of Labor, Family, Social Protection and the Elderly	SEN	- Special education needs
MRDPA	- Ministry of Regional Development and Public Administration	SIP	- Social Inclusion Project
MSII	- Minimum Social Insertion Income program	SME	- Small and medium-sized enterprises
MTR	- Marginal Tax Rate	SMURD	- Emergency, Intensive Care and Rescue Mobile Service (<i>Serviciul Mobil de Urgență, Reanimare și Descarcerare</i>)
M/XDR-TB	- Multi-drug and extensive drug-resistant tuberculosis	SOP HRD	- Sectoral Operational Program Human Resources Development
NAPCRA	- National Agency for Protection of Children's Rights and Adoption	SP	- Social Pension
NEA	- National Employment Agency	SPAS	- Public Social Assistance Services
NEETD	- Adults who are not in employment, education, training, or disabled	SSH	- Situation of Social Housing Survey
NGO	- Non-Governmental Organization	TB	- Tuberculosis
NRDP	- National Rural Development Program	TIMSS	- Trends in International Mathematics and Science Study
NTP	- National TB Control Program	TVET	- Technical and Vocational Education and Training
NUTS	- Nomenclature of Units for Territorial Statistics	VAT	- Value-Added Tax
OHCHR	- UN's Office of the High Commissioner for Human Rights'	VET	- Vocational education and training
OECD	- Organization for Economic Co-Operation and Development	USAID	- United States Agency for International Development
PAYG	- Pay as you go	UNESCO	- The United Nations Educational, Scientific and Cultural Organization
PES	- Public Employment Service	UNODC	- United Nations Office on Drugs and Crime
PDU	- Problem Drug Users	UNFPA	- United Nations Population Fund
PIRL	- Progress in International Reading Literacy Study	UNICEF	- United Nations Children's Fund
PISA	- Program for International Student Assessment	UNCRPD	- UN Convention on the Rights of Persons with Disabilities
PNDL	- National Local Development Program	WHO-EURO	- WHO Regional Office for Europe
POCU	Operational Program Human Capital Development 2014-2020	UNDP	- United Nations Development Program
PPS	- Purchasing Power Standard	WHO	- World Health Organization
PROST	- Pension Reform Options Simulations Toolkit (WB)		

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INTRODUCTION

Romania aims to be a country in which all citizens are provided with an equal opportunity to participate in society, where their basic needs are met and their differences respected, and where all people feel valued and can live in dignity.

Romania aims to become a country where:

- **All citizens have equal opportunities.**
Everyone deserves the opportunity to participate fully in the economic, social, political, and cultural life of their society and to enjoy the benefits of doing so. Equal opportunities mean that individual circumstances beyond their control do not determine people's outcomes.
- **The basic needs of every citizen are met.**
Along with respect for and protection of fundamental human rights, one of the main preconditions for a decent quality of life is meeting citizens' basic needs for housing, food, sanitation, and security as well as for basic community services such as education, healthcare, and social services. These key elements enable people to live in dignity, to have control over their lives, and to actively participate in the life of their communities. The responsibility for developing their own social integration capacities and for being actively involved in handling difficult situations rests with every individual as well as with his or her family, and public authorities should take action to ensure equal opportunities for all or, in their absence, provide adequate social benefits and services.
- **Differences between individuals are respected.**
Each individual is unique. Individual differences can be along the lines of race, gender, ethnicity, socioeconomic status, age, sexual orientation, and beliefs (religious and otherwise) as well as physical, cognitive, or social abilities. The concept of diversity goes beyond tolerance; it encompasses acceptance and respect. Valuing diversity in a positive and nurturing way increases the chance that everyone

will reach their potential and that communities will pro-actively use this potential.

- **All people feel valued and can live in dignity.**
All human beings are born free and equal in dignity and rights (Article 1 of the UN Declaration of Human Rights). When a person feels valued and lives in dignity, they are more likely to be in control of their lives and to participate in and become an active member of society.

Romania's society is still far from this ideal. At present, according to the European Union's methodology, one in five Romanians lives in relative poverty (is income poor). A large share of income poverty is persistent, meaning that over three-quarters of the poor were poor in the reference year as well as in at least the previous two or three years. According to the national definition of absolute poverty, about 5 percent of the population cannot afford to purchase a minimum consumption level of products and services. One-third of the population is severely deprived materially in the sense of not being able to afford items considered to be desirable or even necessary to lead an adequate life by the standards of the EU member states. There are still children in Romania who have never attended school, and the percentage of youths without an adequate education for the labor market is extremely high. Many people are still inactive or are illegally employed, with little chance of gaining proper access to the labor market. There are major inequalities in primary healthcare coverage, and the majority of the poor continue to have to pay for medicine. To compound matters, there is a significant number of deprived communities in which all of these problems come together, making it almost impossible for the members of those communities to break the exclusion cycle without sustained and integrated external support.

Strategic Actions at the National Level for Reducing Poverty and Promoting Social Inclusion

This document aims to continue the series of strategic actions undertaken in the area of poverty reduction and promotion of social inclusion for the past 20 years. A short historic of the most important phases achieved so far is presented below.

- 1998** Setting up in 1998 of a Commission for Prevention and Fight Against Poverty under the patronage of the Romanian Presidency. The Commission drafted and passed a “Strategy for the Prevention of and Fight against Poverty,” which, although it was not adopted by the government, represented the first strategic document to lay down the principles of social policies.
- 2001** Setting up of an Anti-Poverty and Promotion of Social Inclusion Commission (CASPIIS), which operated between 2001 and 2006. This institution together with the County Commissions under its coordination (which were responsible for developing and implementing social policies at the county level) anticipated Romania’s participation to the EU’s Open Method of Coordination. In the period of CASPIIS operation, several actions were taken to strengthen the fight against poverty: (i) the setting up of a methodology for computing absolute poverty; (ii) the building of a set of national and county indicators to be monitored; and (iii) the development of the first poverty map at the local level. In addition, the Commission drafted the National Anti-Poverty and Social Inclusion Promotion Program and county plans that explained and adapted the national objectives to the local needs.
- 2005** Signing in 2005 of a Joint Social Inclusion Memorandum by the Government of Romania and the European Commission as a first phase of a European social policy to be implemented jointly. The document, coordinated by the Ministry of Labor and drafted jointly by a significant number of relevant actors, aimed to identify the key challenges faced by Romania in promoting social inclusion as well as the needed policy responses.
- 2006** Passing of the Government Decision no. 1217/2006 that contained a national mechanism for promoting social inclusion. The same piece of legislation also set up a National Social Inclusion Committee within the Inter-ministerial Council for Social Affairs, Health, and Consumer Protection. The National Commission includes a representative at the level of secretary of state or president from the ministries, authorities, agencies, and other governmental institutions with responsibilities in the field of social inclusion. It has a consultation role and is managed by the Ministry of Labor, Family, Social Protection, and Elderly.
- 2010** Approval in July 2010 of the Memorandum that contains the final values of the national targets for the Europe 2020 Strategy, including the poverty target according which Romania has committed to lift out of poverty 580,000 people by 2020.¹
- 2011** Approval of the Social Assistance Reform Strategy in 2011, which contained a series of key objectives that have acted as guiding principles for the government in the past few years, namely: (i) targeting social benefits to low-income people; (ii) reducing the costs of access for the recipients of social benefits; (iii) reducing system error and fraud; (iv) reducing the number of working age people who are dependent on social assistance; (v) consolidating social assistance benefits; and (vi) increasing capacity for forecasting, strategic planning, and monitoring and evaluation.
- 2015** Approval of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 and the corresponding Action Plan by the Government of Romania through the Government Decision no. 383 from May 27, 2015. This National Strategy and its Action Plan were drafted based on the background study presented this volume.

¹ The poverty reduction target at the EU-28 level is to reduce the number of people at risk of poverty or social exclusion by 20 million between 2008 and 2020. The Government of Romania has committed itself to contributing to this target by reducing the population at risk of relative poverty after social transfers from 4.99 million in 2008 to 4.41 million by 2020.

The Main Policy Areas Addressed in this Volume

This background study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 sets out a plan to enable Romania to make substantial progress in reducing poverty and in promoting social inclusion for vulnerable individuals, families, and groups over the next seven years. This volume outlines a structured set of policy measures for achieving the Europe 2020 targets for Romania.² The current study has aimed to coordinate and update the set of strategic actions for poverty reduction that have been implemented in Romania so far. Moreover, to ensure complementarities and coordination with other endeavors in this area, the volume incorporates elements from various sectoral strategies and from particular domains of the government's social inclusion policy (such as tackling child poverty, reducing discrimination against Roma, and integrating marginalized communities). The background study has also taken into account the recommendations of the European Commission's 2013 National Reform Program and Convergence Program for 2012-2016, as shown in Box 1.

The Approach of the Volume

To fight social exclusion, the main goal is to make equality of opportunity a reality for Romanian citizens throughout their lifecycles. The final outcome for any individual is the result of two types of influences: circumstances and effort.³ Circumstances are all of the external factors over which the individual has no control, whereas effort comprises all of the factors within the individual's control and sphere of responsibility. Any resulting inequalities related to effort are ethically acceptable, whereas any inequalities due to circumstances are not and should be eradicated. In addition, a growing body of evidence shows that unequal opportunity often leads to wasted productive potential and to the inefficient allocation of resources, thereby undermining economic efficiency. Ensuring that all individuals have an equal opportunity to develop their potential throughout their lifecycle is therefore essential from both a moral and an economic perspective.

Combating poverty and social exclusion requires a taking lifecycle approach to individual needs.

SCHEME 1: Lifecycle Approach



For children
(those between the ages of 0 and 17 years old)

The goal is to ensure that all children have the opportunity to develop their full potential regardless of their social background by ensuring the conditions necessary to develop the skills, knowledge acquisition, and experience needed to achieve their full potential as successful students, confident individuals, responsible citizens, and effective contributors to society's development.



For working age adults

The goal is to ensure that everyone has the opportunity to fully participate in the economic, social, and cultural life of Romania.



For people beyond working age

The goal is to ensure that the elderly are valued and respected, that they remain independent and can participate in all aspects of life as active citizens, and that they enjoy a high quality of life in a safe community.

² Relative poverty (AROP) is the indicator that is used by the Government of Romania to monitor whether the poverty reduction target is being met.

³ Roemer (1993).

BOX 1**Comparative Overview between the European Commission Council Recommendation⁴ and the Policy Areas Addressed in this Volume****Country-specific Recommendations**

Step up reforms in the health sector to increase its efficiency, quality and accessibility, including for disadvantaged people and remote and isolated communities. Increase efforts to curb informal payments, including through proper management and control systems.

Strengthen active labor market measures and the capacity of the National Employment Agency (NEA). Pay particular attention to the activation of unregistered young people. Strengthen measures to promote the employability of older workers. Establish, in consultation with social partners, clear guidelines for transparent minimum wage setting, taking into account economic and labor market conditions.

Increase the quality and access to vocational education and training, apprenticeships, tertiary education and of lifelong learning and adapt them to labor market needs.

Ensure better access to early childhood education and care.

In order to alleviate poverty, increase the efficiency and effectiveness of social transfers, particularly for children, and continue reform of social assistance, strengthening its links with activation measures. Step up efforts to implement the envisaged measures to favor the integration of Roma in the labor market, increase school attendance and reduce early school leaving, through a partnership approach and a robust monitoring mechanism.

Step up efforts to strengthen the capacity of public administration, in particular by improving efficiency, human resource management, the decision-making tools and coordination within and between different levels of government; and by improving transparency, integrity and accountability. Accelerate the absorption of EU funds, strengthen management and control systems, and improve capacity for strategic planning, including the multi-annual budgetary element. Tackle persisting shortcomings in public procurement. Continue to improve the quality and efficiency of the judicial system, fight corruption at all levels, and ensure the effective implementation of court decisions

Policy Areas Addressed in this Volume

2.5.1. Improving Health Equity and Financial Protection

2.5.3. Increasing the Access of Vulnerable Groups to Quality Healthcare

2.1.4. Increasing the Institutional Capacity and Resources of the Public Employment Service

2.1.2. Reducing Informal Employment and Increasing the Productivity of Small and Medium-sized Farms

2.1.3. Reducing the High In-work Poverty Rate

2.4.4. Increasing Access to Lifelong Learning and Training for Disadvantaged Youths and the Working Age Population

2.4.2. Increasing Participation and Improving Outcomes in Primary and Secondary Education for All Children

2.4.1. Improving the Early Childhood Education and Care System

2.2.1. Improving the Performance of the Social Assistance System

2.1.5. Increasing Employment Rates for Vulnerable Groups including Roma

2.4.5. Increasing Access to Quality Education for Children from Vulnerable Groups including Roma Children

4. Strengthening institutional capacity to reduce poverty and promote social inclusion

⁴ European Commission (2014b) COUNCIL RECOMMENDATION on Romania's 2014 national reform program and delivering a Council opinion on Romania's 2014 convergence program (CSR).

Because children who grow up in poor households face a higher risk of poverty in the future, breaking the intergenerational cycle of poverty makes it essential for the government to adopt programs that can tackle both child and adult poverty in the same household simultaneously. Particularly in the case of the persistent poor and the Roma population, the various dimensions of exclusion tend to be mutually reinforcing and perpetuated from generation to generation. The intergenerational cycle of exclusion is perpetuated when low educational achievement and poor health severely limit the labor market opportunities that are accessible to the next generation of children. Breaking the intergenerational cycle of poverty and exclusion will require targeted interventions designed to address the multiple drivers of inequality.

A coordinated approach is needed to the provision of policies, programs, and interventions that are targeted to poor and vulnerable people and poor and marginalized areas. There is already a large spectrum of sector policies, programs, and interventions in existence in Romania aimed at reducing poverty and social exclusion, and the instruments and the experience needed to identify poor people and poor areas have improved in recent years. The key missing ingredient is the coordination between these policies, programs, and interventions. Given the strong correlation between poverty and social exclusion, making progress on both fronts will require more and better social interventions that will connect people with jobs, cash support, and services. It will also be essential to increase capacity for accurately assessing need at all levels and to coordinate social services, employment services, and healthcare services in order to bring the non-working but work-capable beneficiaries of social protection into employment. Thus, this approach to tackling poverty and social exclusion is built on the concept of providing integrated services and on ensuring that different programs and interventions are harmonized and aligned by empowered, well-trained social workers at the level of both the individual and the community.

In delivering interventions, it is important to address both supply-side and demand-side challenges. In poor and marginalized communities, in both rural and urban areas, and among both Roma and non-Roma, merely providing new infrastructure or services will not necessarily mean that they will be used. Demand-side bottlenecks, such as those related to user awareness, financial means, capacity constraints, opportunity costs, social norms, and risks (to safety, dignity, and reputation, for example), all need to be assessed and addressed. Even if a service is provided, people will not use it if they are not aware of its benefits or if it is too costly.

Moreover, even when a service is provided free of charge, people may decide not to access it if they consider the transaction or opportunity costs involved to be too high.

The approach is illustrated in a synthetic way in Scheme 2. Thus, this book aims to contribute to better the lives of the poor and vulnerable people by treating in an integrated and comprehensive framework: (i) the actors who will implement the recommended policies; (ii) the targeting of the policies themselves (either people-based/social policies or area-based interventions); and (iii) the main sectoral policies.

Identifying and responding to the particular needs of the poor and vulnerable groups is a key element in the implementation of effective social inclusion policies. Because vulnerable groups face specific problems for which generic policies may not provide a valid solution, the government plans to put in place tailored and integrated services to increase their social or economic participation (especially with the help of the Public Social Assistance Services and community workers).

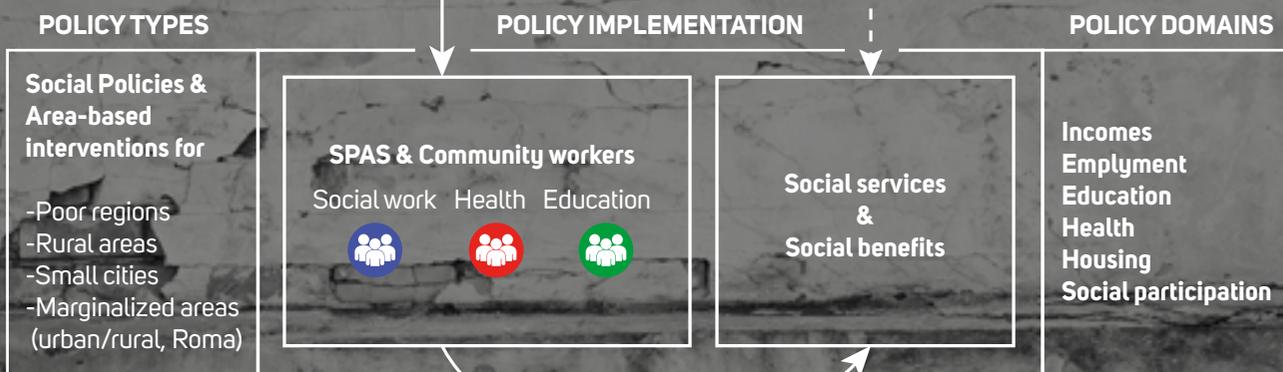
Given the economic and social sectors from which individuals might be excluded, the geographical patterns of exclusion, and the severity of the social problems that many people experience, our study broadly divides the various types of intervention into people-based and area-based policies. In this document, people-based policies cover policies aimed directly at reducing poverty and increasing social inclusion in several key domains: incomes (social benefits and social insurance rights), employment, education, health, housing, social participation, and social services.

Because poverty has a starkly geographical aspect in Romania, one major objective is to ensure that the allocation of resources is accurately correlated with the distribution of need within the country (by developing area-based policies). In Romania, nearly one-half of the population is based in rural areas, and many are heavily disadvantaged in terms both of their monetary incomes and of basic infrastructure and services. There is also a large variation among urban areas as well, with small towns (particularly those whose status changed from rural to urban over the last 15 years) being the most disadvantaged. The government aims to reduce the gaps between rural and urban areas and between poor/undeveloped urban areas and more developed urban areas. In addition, the area-based policies and programs recommended in this volume represent a coordinated effort to substantially reduce poverty and social exclusion in marginalized communities, which are the most disadvantaged communities in Romania (both Roma and non-Roma and in both rural and urban areas).

This document is based on a combination of desk research, qualitative data analysis, new data collected by the World Bank team and analyses of administrative, census and

survey data. A snapshot of the research activities can be found in Annex 1.

SCHEME 2: Policy Response To Reduce Poverty And Promote Social Inclusion



Key Interventions at a Glance

For each policy area covered in this book, we spelled out specific objectives together with challenges and actions to take to tackle each of these problems. This section puts forth a selection of interventions that we think that, among others, could become national priorities for each of these

policy areas in the 2015-2020 period. From the set of policies and interventions covered by the study, the World Bank team has also developed detailed implementation plans for a subset of nine flagship interventions that could have the greatest impact in terms of reducing poverty and promoting social inclusion, which are highlighted in the text.

Employment



(Flagship Initiative #1)

Increase funding for cost-effective active labor market policies, expand access to these services for the inactive poor and vulnerable, and link them with tailored remedial or employment services, through a statistical profiling of the out-of-work but work-capable population from the target group.

Target vulnerable youths, including through EU-wide programs such as the Youth Guarantee.

Use EU funds to strengthen the monitoring and evaluation of these active labor-market policies, to learn what works and how to increase the supply of existing programs.



(Flagship Initiative #2)

Introduce a pro-work benefit formula in the new consolidated means-tested benefit (see the Social Transfers line), that exempts part of the earnings of the households from the definition of the family means.

Improve training for small- and medium-sized farm holdings by: (i) strengthening, professionalizing, and upgrading existing advisory and support institutions for smallholder farmers and family-based subsistence agriculture and (ii) broadening coverage of agricultural vocational schools and technical colleges to improve the skills base of (future) farmers.

Social Transfers



(Flagship Initiative #2)

Consolidate the means-tested programs into a flagship anti-poverty program (the Minimum Social Insertion Income - MSII program). The three small social assistance programs should be replaced with a single and larger program, which would be better targeted towards the poorest 5 million Romanians and would provide incentives for the in-work poor to receive social assistance even while they are earning a wage. The MSII program will be better linked with employment services, education, children's health services, and housing services.

Address demand-side bottlenecks related to access to social assistance benefits and social services, such as those related to user awareness, financial means, opportunity costs, social norms, and risks (safety, dignity, and stigma).

Simplify the access of people with disabilities to the social protection system by harmonizing medical criteria for invalidity pensions and disability allowances and by unifying the institutional framework for assessing disability allowances and invalidity pensions.

Develop reform to provide affordable old age income provisions for the rural population currently without insurance-based pension coverage.

Social Services

Ensure that public funds are available for the development of the social services sector in parallel with funding from the European Union.



(Flagship Initiative #3)

Strengthen and enhance social assistance at the community level by: (i) developing a minimum intervention package as a mandatory responsibility for each local authority; (ii) financing from the state budget a national program - Social Program Opportunity and Responsibility (SPOR) - to ensure that in each locality at least one full-time employee does

social work, has consistent outreach tasks in their job description, and works one-to-one with people in vulnerable situations and their families; (iii) financing from the state budget a national program to train employees with social assistance duties and to draft methodologies, guidelines, and tools to strengthen the implementation of case management at the level of the SPAS, especially in rural and small urban areas; and (iv) developing a strong monitoring and evaluation system of the social assistance services at the community level.

Develop integrated intervention community teams, within the same intervention SPOR, to provide social services (in education, employment, healthcare, social protection, and other public services) and social intermediation and facilitation programs at the local level, especially in poor and marginalized areas, rural and urban areas, and Roma and non-Roma communities by: (i) developing clear methodologies, protocols, and work procedures for community-based workers and (ii) developing, in the larger marginalized areas, multi-functional community centers to provide integrated services primarily though not exclusively to families in extreme poverty.

(Flagship Initiative #5)

Strengthen social services for child protection by: (i) developing and strengthening the capacity of community-based prevention and support services; (ii) reconsidering the ways and means (including cash benefits) of providing family support in order to prevent child-family separations; and (iii) revising the existing child protection services to enhance the quality of care provided while reducing the duration of stays in the child protection system to the minimum necessary.

Develop social services for vulnerable groups by: (i) increasing the financing of social services and improving the procedures for contracting out social services to non-government and private providers and (ii) strengthening the role played by the DGASPCs in strategic planning and methodological coordination and in supporting SPAS at the community level, as well as in monitoring and evaluating service providers within the county.

Education

Extend the network of kindergartens and crèches in order to provide access to all Romanian children.

Design and implement a national program focused on children at risk of dropping out or who have already dropped out of primary and secondary education by: (i) designing a coherent referral system to education, with entry points from all systems dealing with children from vulnerable families; (ii) implementing a monitoring system for those children at highest risk of dropping out of school or skipping enrollment; (iii) tightening the monitoring of schools in order to ensure that these cases are followed-up; and (iv) designing a program that monitors the households of out-of-school children of compulsory school age and provides them with assistance, support, and parental education.

Increase the availability of second-chance programs in rural areas and beyond the lower secondary school level, and provide funding to support disadvantaged groups attending second-chance education to cover their educational costs and other indirect costs.

Increase the access of children with special education needs (SEN) and/or disabilities to quality education by: (i) revising the institutional, financing, and legal arrangements for the education of children with SEN/disabilities, (ii) creating further programs to train parents, tutors, and teaching staff in interacting with and helping children with SEN and/or disabilities, possibly using funds from the Human Capital Operational Program (POCU); (iii) including the topics of tolerance for disabled people and diversity in the educational curriculum in order to reduce the stigma and rejection associated with disability and SEN; (iv) investing in the County Resources and Educational Assistance Centers (CJRAEs) to enable them to become real resource centers for inclusive education; and (v) improving the knowledge base on children with disabilities and SEN and on their access to education.

(Flagship Initiative #4)

Ensure that all children have access to equal opportunities by (i) reviewing the school financing methodology to improve the allocation of resources to children in need, and (ii) ensuring that the money is used to deliver effective interventions that will increase access to and improve the quality of education for vulnerable groups.

Redesign the welfare programs in education in order to increase participation of and the quality of education for poor and vulnerable pupils.

Health

Increase the coverage of basic healthcare service providers (family doctors, community nurses, and Roma mediators) at the local level countrywide.

Design evidence-based health promotion interventions, and implement, monitor, and evaluate these programs. In particular, these would include reducing harmful alcohol consumption, especially in rural areas, with a focus on those who are less well-educated, and focusing more on outreach interventions in specific communities identified as the most vulnerable.

Redesign the National TB Control Program (NTP) against multi-drug and extensive drug-resistant tuberculosis (M/XDR-TB) to include social support and targeted interventions, with a dedicated budget, to meet the needs of poor and extremely vulnerable populations such as injection drug users (IDUs), street children, homeless, prisoners, and Roma.

Housing

Design and finance a social housing program for vulnerable groups who cannot afford to pay rent or utilities, such as the homeless, post-institutionalized youths, ex-prisoners, victims of domestic violence, people evicted from restituted houses, and people with drug dependencies.

Introduce a housing component into the new the Minimum Social Insertion Income (see the Social Transfers line) for families living in social housing in addition to the heating subsidy targeted to low-income families living in their own dwellings. This housing benefit will cover the cost of their rent and a part of their heating-related costs in order to prevent homelessness by reducing evictions.

Shift the emphasis of efforts to reduce homelessness from emergency services to long-term integration programs.

Social Participation

Ensure that open and responsive grievance and complaints mechanisms are built into the institutional organization of social services.

Promote evidence-based awareness and advocacy campaigns about diversity (including various categories of marginalized or discriminated groups) to complement other actions in addressing stigma and discrimination.

Foster civic engagement and volunteering by further improving the law on volunteering and by mobilizing mass media and civil society to raise awareness of best practices and the value of participation.

Area-based Policies

Boost the territorial development of rural, sub-urban, and peri-urban areas around urban growth engines, especially large dynamic cities and growth poles by: (i) defining cities, especially the most dynamic ones, as functional urban areas; (ii) implementing adequate institutional arrangements for the management of functional urban areas to enable them to grow; (iii) expanding metropolitan public transport systems to areas with high population densities and with strong commuter flows; and (iv) investing in the infrastructure of villages incorporated within cities.

Continue to invest in the expansion and modernization of the physical infrastructure in rural areas such as roads and basic utilities (mainly water, sewerage systems, and natural gas).

Provide training and facilitation to the local authorities and other stakeholders of the LEADER program and use the LAG (local action group) framework to make the best use of ESI funds in alleviating poverty and social exclusion in rural areas.

(Flagship Initiative #6)

Develop a tool for geographic targeting, monitoring and evaluating interventions for reducing poverty and promoting social inclusion, with a focus on poor localities and marginalized communities, both rural and urban, and both Roma and non-Roma.

Integrate marginalized communities by implementing packages of integrated social services consisting of integrated intervention community teams and multi-functional community centers providing coordinated access to education, health, employment, and housing services (see the Social Services line).



Strengthening Capacity to Promote Poverty Reduction and Social Inclusion

Establish functional inter-sectoral coordination policies (the MLFSPE, MRDPA, MoE, and MoH) and enhance cooperation between the central and local authorities to foster the integrated approach to reducing poverty and promoting social inclusion policies.

(Flagship Initiative #7)

Expand the coverage and functionality of the social assistance Management Information System (MIS) by: (i) developing local customer relationship management solutions to enable the local authorities to maximize the automation of all local social assistance processes so that they can link all local databases with the social assistance MIS, and (ii) developing a new social assistance MIS to automate processing and to carry out validations (both ex-ante and ex-post).

(Flagship Initiative #8)

Develop a modern payment system that will use modern technologies and service delivery methods to: (i) centralize the payment processing function; (ii) compute automatically the necessary funds; (iii) rationalize budgetary requests from the Treasury; (iv) use modern payment transfer technologies; (v) provide clients with a range of secure and convenient payments channels; (vi) cease making direct payments to third parties; and (vii) incorporate best practice audit and reconciliation functions.

(Flagship Initiative #9)

Strengthen the national capacity to monitor and evaluate the measures under the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 by: (i) improving mechanisms for collecting both administrative and survey data on a regular basis; (ii) building the capacity of staff at different levels to analyze quantitative and qualitative data in the areas of poverty and social exclusion; and (iii) developing a national social inclusion monitoring and evaluation system.

Structure of the Volume

The book is organized in four broad parts. The first part starts with an analysis of the trends in poverty and social exclusion over the past few years and with a poverty forecast for the next five years (2015 to 2020). The section concludes with a short presentation of the main vulnerable groups considered in this background study.

The second part analyzes the sectoral policies that must be implemented to tackle the problems identified in the first part of the volume. Firstly, the subset of policies that have a direct impact on the earnings of the poor and vulnerable are discussed, namely employment and social protection transfer policies (social assistance and social insurance benefits). It continues by presenting the main issues related to poverty and social inclusion in the other relevant

sectors - social services, education, health, housing, and social participation. Special attention is paid to taking an integrated, coordinated, and cross-sectoral approach to the provision of social services in order to respond to the complex challenges of poverty and social exclusion in a more effective way.

The third part turns its focus to area-based policies and discusses regional disparities, urban-rural differences and specific problems in small towns and villages, rural and urban marginalized areas, and Roma and non-Roma communities.

The book continues in the fourth part with a discussion of the actions needed to strengthen the capacity of the public system to reduce poverty and increase social inclusion. Finally, it closes with references and annexes rich in data and methodological notes.

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1. POOR AND VULNERABLE GROUPS

1

POOR AND VULNERABLE GROUPS

Poor and Vulnerable Groups

This chapter presents the main characteristics and the evolution of poor and vulnerable groups in Romania as well as a forecast for the period from 2015 to 2020. The section ends with a succinct presentation of the vulnerable groups at risk of social exclusion.





Chapter Structure

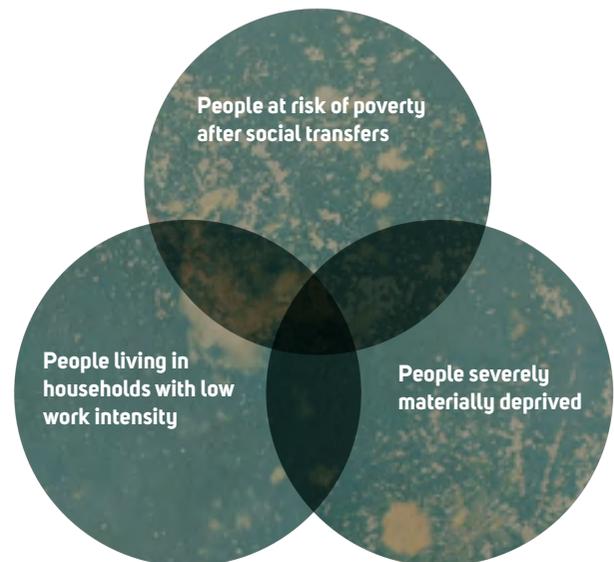
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1.1. Status and Forecasts of Poverty or Social Exclusion

In acknowledgment of the complex nature of poverty and social exclusion, the Government of Romania uses a large set of indicators to measure this phenomenon.⁵ The broadest indicator (ARPE), which is also used to measure whether the European Union's social inclusion target is being met, tracks people at risk of poverty or social exclusion who are in at least one of the following three situations:

- They are at risk of relative poverty after receiving social transfers (AROP indicator). These are people whose annual income (including social protection transfers) is lower than 60 percent of the median income as expressed per adult equivalent. Disposable income is the sum of all revenues (including those from social protection) minus the amount of taxes (income or property-based) and social insurance paid.
- They live in households with very low work intensity, meaning households where the members aged 18 to 59 years old have worked in a paid activity for less than 20 percent of their work potential in a given reference year.
- They are exposed to severe material deprivation, meaning people from households that are in at least four of the following nine situations: (1) they cannot afford to pay their rent, mortgage, or utility bills; (2) they cannot afford to keep their home adequately warm; (3) they cannot meet unexpected expenses; (4) they cannot afford to eat meat or protein every second day; (5) they cannot afford to go on a one-week annual holiday; (6) they cannot afford to purchase a television set; (7) they cannot afford to purchase a washing machine; (8) they cannot afford to run a car; and (9) they do not have a telephone.⁶

SCHEME 3: People at Risk of Poverty or Social Exclusion



BOX 2

Definition and Measurement of Poverty

There is no unitary, generally accepted methodology for identifying poor people – each of the various existing methods holds different assumptions and consequently leads to different results. Generally, two elements are needed to determine poverty levels using a one-dimensional approach: (i) an indicator that reflects household welfare or resources and that makes it possible to make comparisons between households and (ii) a poverty line (a standard level of the household

⁵ The indicators are computed according to a national methodology (Decision no. 488/2005 on the national system of social inclusion indicators) and to Eurostat methodology.

⁶ The indicator distinguishes between individuals who cannot afford a certain item or service and those who do not have this item or service for another reason, for example, because they do not want or need it.

BOX 2 (continued)

welfare indicator against which the wealth level of each household can be compared). In Romania, several methodologies have been tested over time, and two are the most relevant in the context of this volume: (i) a national-level method for calculating absolute poverty and (ii) a Europe-level method for computing relative poverty.

The national-level method for measuring absolute poverty was developed by experts from the World Bank, the National Anti-Poverty and Social Inclusion Commission, and the National Institute of Statistics and was approved by the government in 2005 (Government Decision no. 488/2005). This method aims to identify those households that are unable to meet their basic needs for food, services, and non-food goods by estimating the household's minimum costing needs per adult equivalent. In order to take into consideration the economies of scale (the supplementary costs of each additional person being lower than those for the first person in the household) and the different costs of children compared to adults, the number of adult equivalents in a household is computed as the number of people aged 14 and over plus half of the actual number of people under 14 years old raised to the power 0.9. Moreover, the method uses consumption expenditures, which are better than income for estimating household wealth in the case of Romania (taking into consideration the significant share of non-monetary revenue from informal activities in the total household budget). However, this method has several limitations: (i) the structure of the basket of food and non-food items used to compute the poverty threshold has significantly changed since 2002, which means that indexing it to inflation (in current prices) is not an accurate way to identify the people who are in financial difficulties; (ii) the formula for computing the number of equivalent adults is probably outdated and inadequate for measuring both children's needs and economies

of scale within a household; and (iii) the sampling design used in Households Budget Survey (HBS) to estimate poverty, needs to be readjusted to take account of the results of the 2011 Population and Households Census. In order to ensure that the government has accurate information on the size and profile of the people living in poverty, adequate financial and human resources will need to be allocated to revise the methodology for updating absolute poverty data. The support of key actors such as the National Institute of Statistics, research institutes, and academics with expertise in this field will also be needed. It will also be important to analyze the accuracy of the new normative method of measuring poverty that is being piloted by the EU with the explicit goal of improving the targeting of support for people in need.

According to the relative poverty measurement used by Eurostat, the poverty level (below which a household is considered to be poor) is set at 60 percent of the national annual median disposable income for an adult equivalent. Because this threshold is computed based on individual income at a specific moment, this method tends to reflect a country's inequality measurement without showing whether the poor/non-poor people are able to meet their basic financial needs (for instance, if a country's revenues were to double or half for all individuals in a year, then the number of relative poor people would remain constant). One way to overcome the problem of the relative threshold and consequently of the lack of comparability between years can be solved by comparing the values each year to a line anchored in time (using a line from a previous year expressed in current prices). Nevertheless, the Government of Romania uses this methodology of relative poverty to monitor achievement of the national poverty target so this will be the main method that we will use to identify poor people in this study.

1.1.1. Status and Dynamics of Poverty or Social Exclusion

In this section we will analyze each of the dimensions of the AROPE indicator separately, looking at their evolution over the 2008 to 2012 period and at the socio-demographic profile of the individuals and households at higher risk of poverty or social exclusion.

People at Risk of Poverty

People at risk of poverty after social transfers (AROP) is the first of the three indicators that are used to assess risk of poverty and social exclusion in the European Union and is also the indicator that is used in Romania to monitor whether the country's poverty reduction target is met.

The relative poverty rate (AROP) in Romania has not significantly changed since 2008. Although the poverty rate decreased by 2.3 percentage points between 2008 and 2010, it showed an upward trend between 2010 and 2013 (Table 1). As a result, the decline in poverty between 2008 and 2013 was 0.9 percentage points (representing only 211,000 people rising out of poverty compared with the national target of 580,000).⁷ Not only did the poverty rate not change much during the 2008 to 2012 period,⁸ but the poverty gap (which measures the distance of the poor from the poverty threshold) remained almost constant as well. Anchored poverty, which measures the dynamics of poverty against a poverty line with constant purchasing power in time, indicates that there was a reduction in absolute poverty between 2008 and 2010, followed by a slight increase between 2011 and 2013.

Persistent Poverty

Most of the people living in relative poverty in Romania are in persistent poverty. Among the population living in relative poverty in 2012, 81 percent were in persistent poverty (a person is living in persistent poverty if he/she has had an income below the at-risk-of-poverty threshold in the reference year and in at least two of the preceding three years).⁹ Almost one-third of children live in

persistent poverty, and their risk of being in such a state is much higher than that for any other age group. Moreover, children's risk of being in persistent poverty increased by almost 3 percent between 2008 and 2012, while the risk for all the other age groups increased by less than 1 percent or even decreased.

Regional Disparities

In Romania, whether a household is in an urban or a rural area is a significant predictor of its level of social exclusion or poverty. Unfortunately, the EU-SILC does not distinguish between urban and rural locations so we have had to approximate this distinction with a variable that distinguishes between three levels of urbanization - densely populated areas, intermediate areas, and thinly populated areas.¹⁰ For simplicity of analysis, we have decided to group together densely populated areas and intermediate areas and refer to them as urban areas.¹¹

Poverty is three times more likely in rural areas than in urban areas. The differences that characterize the urban/rural divide in Romanian society can be identified in the very large difference between the values of the AROP indicator for the two areas. In 2012, while only 11 percent of people living in densely or intermediate populated areas were at risk of poverty, 38 percent of those living in thinly populated areas faced such a risk (see Figure 1).

Much of the difference in poverty can be easily explained by the structural characteristics of a typical rural locality in present-day Romania. The rural population has a lower share of working age individuals than urban areas (62.5 percent versus 70.9 percent) where people tend to have significantly lower poverty rates than the population as a whole (Annex Table 2.1). Also, rural areas tend to have aging populations with few sources of monetary income. Also, the percentage of self-employed workers in agriculture is much higher in rural areas than in urban areas (15.8 percent versus only 2.3 percent), the self-employed being one of the groups with the highest risk of poverty in general (Annex Table 2.2). Even between residents with the same characteristics, there is still a significant difference in poverty rates between those in rural areas and those in urban areas. For example, while 11.6 percent of rural employees were in poverty in 2012, only 3.5 percent of employees living in urban areas were poor. This may be

⁷ Relative poverty is the indicator that is used by the Government of Romania to monitor whether the poverty reduction target is being met.

⁸ Because of some problems of survey comparability between 2013 and the other years, the 2012 EU-SILC survey will be the most recent year used in this chapter.

⁹ In Romania, the persistent at-risk-of-poverty rate is almost double the EU-28 rate - 18.2 percent compared with only 10.2 percent.

¹⁰ In 2012, 33.7 percent of the population was living in densely populated areas, 23.9 percent in intermediate areas, and 42.5 percent in thinly populated areas.

¹¹ Because of a change in the definition of densely populated, intermediate, and thinly populated areas in 2012, the 2008-2011 and 2012-2013 data are not comparable.

TABLE 1: Relative Poverty Rate and Poverty Gap, 2008–2013

	2008	2009	2010	2011	2012	2013
Relative poverty rate	23.3	22.4	21	22.1	22.5	22.4
Poverty gap	8.3	8.2	7.1	7.9	8.2	
Anchored poverty rate*	23.4	18.2	16.2	17.9	19.9	20.4

Source: World Bank calculations using data from the 2008–2013 EU-SILC.

Note: *Anchored at the 2008 poverty line.

FIGURE 1: Relative Poverty Rates by Residential Area and Development Region, 2012

Source: World Bank calculations using data from the 2012 EU-SILC.

explained by differences in education and in past and current labor market opportunities (Annex Table 2.2).

There are huge differences between Romania's regions in the probability of being poor. As of 2012, the lowest proportion of people at risk of poverty was recorded in the Bucharest-Ifov region where only 3 percent of people were AROP (Figure 1). The North-West, Center, and West regions also had lower proportions than the national average. The regions with the highest percentages of people at risk of poverty were the North-East (33 percent) and South-East (29 percent) regions (Moldova and Dobrogea) plus the South-West region (Oltenia). Although part of the differences were due to the shares of people living in rural areas (as the regions with the highest poverty rates also have the largest rural populations), inequalities seem to exist for people living in similar areas as well.

Children and Youths in Poverty

One-third of Romanian children live in poverty, and this percentage has not decreased over time. Over the 2008 to 2012 period, the poverty rate for children was consistently much higher than the overall national rate (by about 10 percentage points). Also, the risk of being in poverty was by far the highest among all age groups (Table 2). Moreover, while the overall poverty rate decreased (although only slightly) over those five years, the poverty rate among children actually increased by approximately 1 percentage point. One in every two children in rural areas lives in poverty. In 2012, more than 50 percent of children in rural areas were living in poverty, while only 17 percent of children in urban areas were in this situation. This large discrepancy coupled with an approximately even

TABLE 2: Poverty Rates by Age, 2008–2012

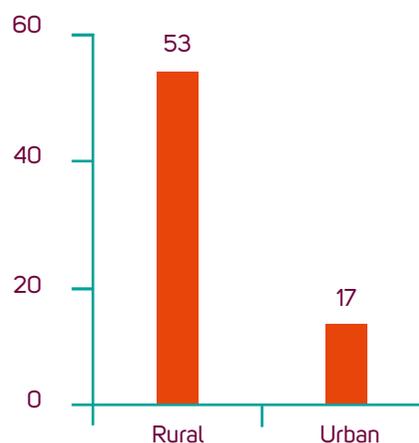
	2008	2009	2010	2011	2012
0-17	32.8	32.3	31.6	32.6	34.0
18-24	24.4	25.6	25.6	28.5	31.4
25-49	20.5	20.6	20.1	22.0	21.8
50-64	17.4	16.2	14.8	16.1	16.4
65+	25.4	20.6	16.4	13.9	14.9

Source: World Bank calculations using data from the 2012 EU-SILC.

distribution of children between urban and rural areas means that over 74 percent of poor children live in rural areas (see Figure 2 and Annex Table 2.3). What is alarming, as can be seen in detail in the sectoral chapters, is that the absence of material resources coupled with the lack of access to basic services (health and education) and an inefficient labor market increases the vulnerability of these children to persistent poverty even after they grow into adults.

Households with many children are more prone to poverty. In 2012, households with no children had a marginally lower poverty rate than the national rate (Annex Table 2.4). However, as the number of children increases, poverty incidence also increases significantly. Although the poverty rate for households with only one child is not significantly higher than the national poverty rate, households with two children have a poverty rate more than 10 percent higher than the national rate. Approximately 20 percent of children live in households with three children or more (Annex Table 2.5), which have a risk of poverty of 57 percent (the risk is even higher for such children living in thinly populated areas).

Youths have the second highest poverty rate, being the main group affected by the economic crisis. In 2012, youths aged between 18 and 24 years old had an extremely high poverty rate (31.4 percent),¹² very close to the high risk of poverty encountered by children. What is worrying is that, in the case of youths, the poverty rate has increased significantly over time. For example, the poverty rate for those aged between 18 and 24 increased by 7 percentage points between 2008 to 2012, while the increase was only 1.2 percentage points for children over the same period. This increase may have been due to the growing vulnerability and risk faced by young people in the labor market during those years.

FIGURE 2: Poverty Rates for Children (0-17 years old), 2012

Source: World Bank calculations using data from the 2012 EU-SILC.

The Elderly in Poverty

Although for all other age groups the situation remained the same or deteriorated, the poverty rate for the elderly significantly declined. In 2008, the elderly, defined as those aged 65 or older, had the second highest poverty rate after children (25 percent). However, two years later, after a massive increase in the levels of contributory and social pension benefits, the poverty rate for the elderly had been reduced to such an extent that it was lower than that for any other age group (see Table 3).

¹² The same conclusions apply to the 16 to 26 age group.

TABLE 3: Relative Poverty Rates at the Household Level by Number of Elderly People (aged 65 and over)

Number of Elderly Household Members	2008	2009	2010	2011	2012
0	20.5	20.7	20.9	21.9	22.8
1	30.1	25.3	21.6	20.5	21.2
2	19.9	14.8	10.1	6.3	6.9
Total	22.8	21.2	19.9	19.9	20.7

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

The presence of elderly members decreases household poverty incidence. In 2012, the poverty incidence among households with one elderly member (21.2 percent) was 1.6 percentage points lower than the incidence of poverty in households with no elderly members (see Table 3). By the same token, the incidence of poverty among households with two elderly members in 2012 was only 6.9 percent. It is important to note that in 2008 the situation for households with one elderly member was actually worse than for households with no elderly members. Similarly, households with two or more elderly members experienced only a marginally lower incidence of poverty in 2008 than households with no elderly members. However, the situation of households with one elderly member improved dramatically between 2008 and 2009¹³ because of the significant increases in the real value of the pension in 2008 and 2009 (Annex Table 2.6).

Although the relative welfare of the elderly has improved over the years, there is a large gender gap within that age group. The difference in poverty between men and women aged 65 and over is 10 percentage points (19.3 percent

for women against 9.2 percent for men). The difference is even larger for people aged 80 and over (Annex Table 2.7). Although single women represent only 16 percent of the population aged 65 and over, they constitute 28 percent of the poor aged 65 and over (Annex Table 2.8). This is because the poverty rate for single women aged 65 and over is much higher than that of elderly people living in any other type of household (see Table 4).

This gender difference is explained by the difference in pension incomes (see Section 2.2 on Social Transfers) as women on average have worked fewer years than men (if at all). More importantly, urban versus rural residence is an important predictor of poverty for the elderly. Single elderly women in rural areas have the highest poverty rate within their age group. For other elderly people, the pension probably acts as a safety net that keeps them from having a higher poverty rate than other types of households. As shown before, it is noteworthy that households with no elderly members (in other words, with no old person contributing a pension to the household budget) have a higher poverty rate than all other types of households.

TABLE 4: Relative Poverty Rate at the Household Level for Different Types of Households, 2012

Households with...	Total	Densely populated/ Intermediate areas	Thinly populated areas
Lone elderly (65+), out of whom...	25.8	9.9	39.5
- Single men aged 65 and over	13.8	6.0	20.9
- Single women aged 65 and over	30.2	11.3	46.1
- Elderly couple (both 65+ and married)	5.8	2.4	9.1
- Other types of households with elderly members	14.4	7.0	21.9
- Households with no elderly members	22.7	11.6	43.4

Source: World Bank calculations using data from the 2012 EU-SILC.

¹³ Because of the reference period of the survey, the EU-SILC data for a specific year refer to the previous year; in other words, the poverty rates in 2008 reflect the economic situation in 2007.

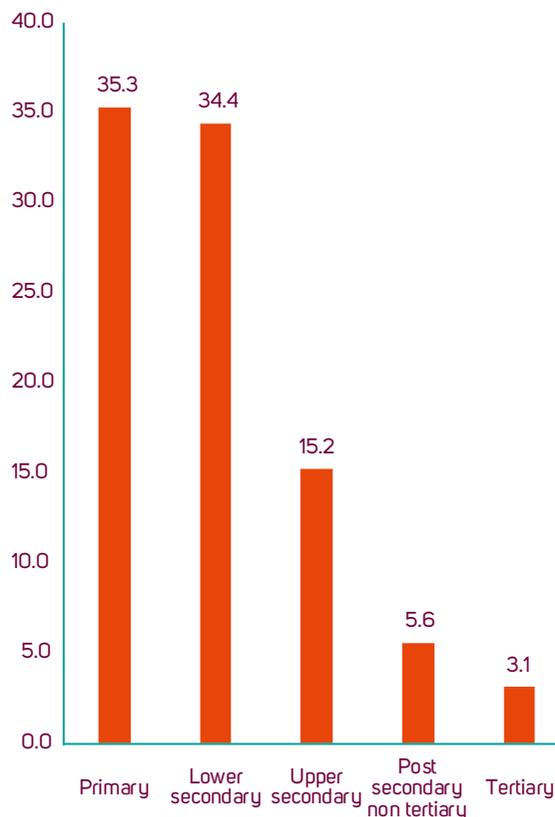
Individuals with Low Levels of Education and Those who are Out of the Labor Market or Self-employed in Poverty

Education has a strong relation both to the AROP and to the anchored poverty indicators. More than one-third of the people who managed to complete only lower secondary education are at risk of poverty. The percentage drops significantly to only 15 percent among those who managed to complete high school and/or some post-secondary school and drops even further to only 6 percent among those who have obtained a college degree (see Figure 3). Interestingly, between 2008 and 2012, the incidence of relative poverty among those with a primary education declined but still remained quite high compared with the national average (Annex Table 2.9).

Another strong predictor of poverty is the respondent's occupational status. Among employees aged between 15 and 64, only 5.6 percent are considered to be at risk of poverty, a percentage close to that of employers (see Figure 4). At the lower end, only 8.4 percent of retired people aged between 15 and 64 are at risk of poverty. The self-employed in agriculture are in the worst situation, as more than half of them are at risk of poverty. An extremely high percentage of the unemployed are at risk of poverty as well. This is not surprising given that the reference social indicator, which is used for determining unemployment benefits, is only RON 500 (2014 value) and that unemployment benefits are paid on the basis of people's wage levels in their last job and of the number of years during which they had contributed to the pension system. Inactive people (such as housewives or the disabled) are also at high risk of being in poverty.

Our analysis indicates that people with the same occupational status can have different poverty rates depending on whether they live in a rural or an urban area. The poverty rate for employees aged between 15 and 64 is 11.6 percent in rural areas, whereas for those living in urban areas the poverty rate is only 3.5 percent. This happens because the incomes are generally lower in rural areas even for people with similar occupational statuses but also because poverty is estimated at the household level and, consequently, takes into account the incomes of the other household members as well (Annex Table 2.10). During the 2008 to 2012 period, two groups registered a high increase in poverty – the unemployed (from 41.5 percent to 52.1) and the self-employed with no employees (from 34.5 to 41), as shown in Annex Table 2.11.

FIGURE 3: Relative Poverty Rate by Education among People over 16 Years Old, 2012



Source: World Bank calculations using data from the 2012 EU-SILC.

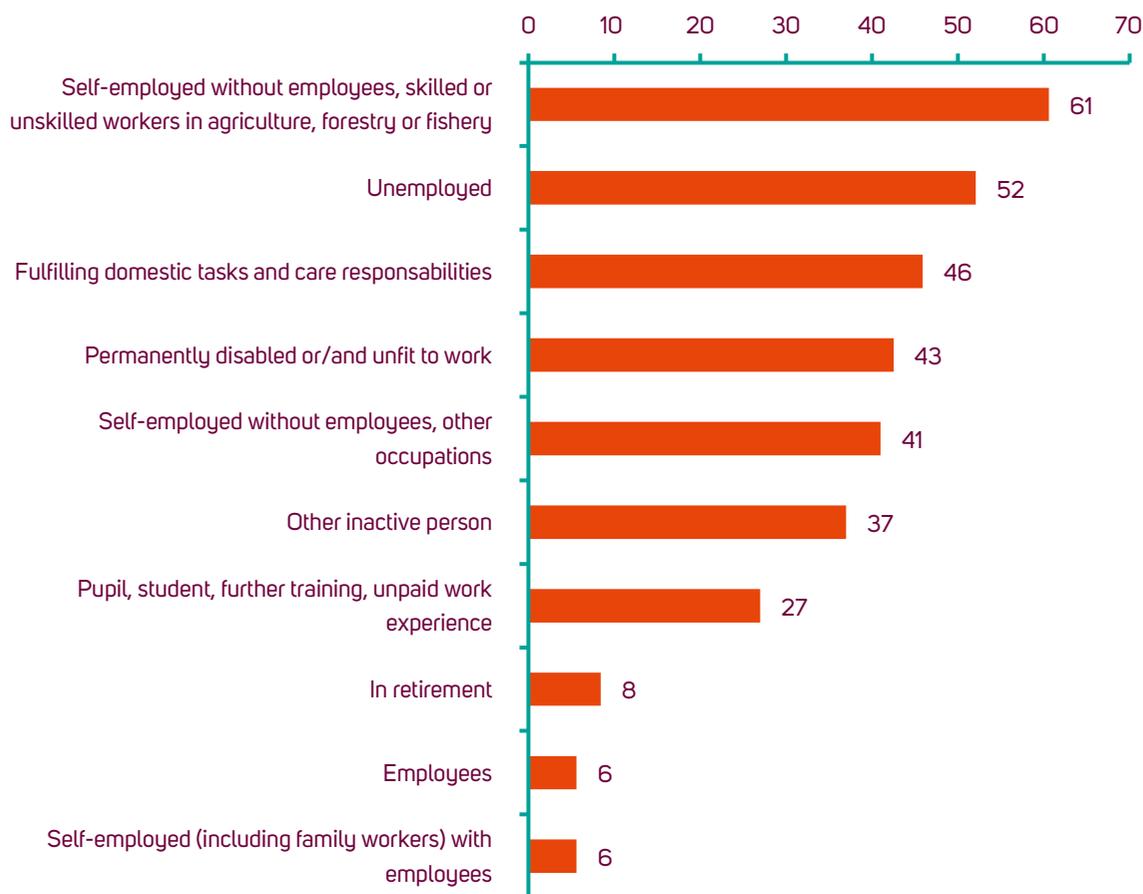
Roma in Poverty

Roma have a much higher risk of being in poverty than the general population regardless of their age, education, or area of residence (Table 5). Based on the national absolute poverty threshold measured using the consumption level from 2013, Roma have a 10 times higher risk of being poor than non-Roma, with 33 percent of Roma being in absolute poverty in 2013 while only 3.4 percent of non-Roma were below the poverty line. The difference between Roma and non-Roma does not change significantly whether the individuals live in rural or in urban areas (Annex Table 2.12). What is worrying is that the poverty risk is extremely high for Roma children – their poverty rate is 37.7, whereas the national poverty rate is only 4.3 percent.

TABLE 5: National Poverty Rate by Age and Ethnicity, 2013 (%)

	Non-Roma	Roma
0-17 year olds	5.6	37.7
18-64 year olds	3.1	31.5
65+ year olds	1.7	17.7
Total	3.4	33.1

Source: World Bank calculations using data from the 2013 HBS.

FIGURE 4: Relative Poverty Rates among the Working Age Population (15 to 64 years old) by Occupational Status, 2012


Source: World Bank calculations using data from the 2012 EU-SILC.

In-work Poverty

Despite Romania's relatively low unemployment rate, the country has a very high rate of poverty for in-work people, with 18 percent of employed workers being below the relative poverty threshold in 2010. This is double the EU-27 rate (9 percent).

In-work poverty affects one in two adults in Romania. A profile of the working poor summarized in Table 6 indicates that 92 percent of them are located in rural areas, 95 percent of them have at most secondary education, with a large share having only primary or lower secondary education (50 percent of the total), and most of them live in sparsely populated areas. The typical family of in-work poor has two adults with two or more children (57

percent), which is larger than the average household in Romania (4.4 people compared with 2.8). Another quarter of them are families with no children. Slightly over half of all in-work poor families have only one earner, but another 43 percent have two earners striving to make a living but remaining poor nonetheless. The large majority of in-work poor combine earnings with the receipt of social protection transfers (80 percent of the total), child allowances being the most common form of support. Two-thirds of the in-work poor individuals are male and one-third female.

In-work poverty is the direct result of low productivity, the scarcity of formal employment, and weak overall labor demand in the economy. In-work poverty is concentrated in rural areas, mainly in the agriculture sector.

TABLE 6: Distribution of Characteristics across Samples of 2100 EU-SILC Cross-section Data, 2011

		Working age ^{a/}	Out-of-work ^{b/}	Working poor ^{c/}
Working adult	No	27.9	36.5	32.4
	Yes	72.1	63.5	67.6
Work experience	Never worked	11.2	34.1	1.0
	Less than 2 months	19.9	58.2	3.9
	2 or more months	69.0	7.7	95.1
Self-assessed physical incapacity	Strongly limited	4.8	12.8	1.8
	None/limited	95.2	87.2	98.2
Age groups	16-24 years old	8.2	8.3	13.8
	25-34 years old	25.6	18.0	24.1
	35-59 years old	57.4	50.2	59.3
	60-64 years old	8.8	23.5	2.8
Gender	Male	50.2	32.7	64.7
	Female	49.9	67.3	35.3
Education	Primary	22.9	33.7	50.2
	Secondary	58.0	54.0	44.6
	Tertiary	15.5	7.1	0.9
	NA	3.6	5.2	4.4
Residential Area	Urban	40.3	37.5	7.7
	Rural	59.7	62.5	92.3
Working spouse	Yes	48.2	35.5	42.7
	No	21.7	33.3	24.9
	NA	30.1	31.2	32.4
Spouse economic status	Working	48.2	35.5	42.7
	Unemployed	1.7	1.8	1.5
	Retired	11.5	26.3	4.3
	Inactive	8.5	5.1	19.1

TABLE 6 (continued)

Spouse economic status	Student/military	0.1		
	NA	30.1	31.2	32.4
Household size	Number of persons	3.8	3.7	4.4
Tenancy status	Owner	96.3	96.6	97.0
	Tenant	1.2	0.9	0.5
	Reduced rate	0.9	1.0	0.9
	Free	1.6	1.5	1.7
Household composition	One person	4.8	6.7	3.8
	Single parent	1.0	0.6	1.8
	2+ adults with no children	38.3	43.2	25.3
	2+ adults with 1 child	14.3	9.1	12.0
	2+ adults with 2+ children	41.7	40.4	57.1
		Working age ^{a/}	Out-of-work ^{b/}	Working poor ^{c/}
Parents in the household	At least one	9.7	8.0	11.4
	Both parents	14.2	10.6	13.7
	None	76.2	81.4	74.9
Children under the age of 6		17.7	20.8	22.9
Three or more children		3.6	3.6	9.5
Elderly household members (over 64)		15.0	17.1	10.1
Ever worked	No	11.2	34.1	1.0
	Yes	20.2	60.8	99.1
	NA	68.6	5.1	
Years of work experience		19.0	25.5	16.5
Worked in last year	2 or more months	69.0	7.7	95.1
	Less than 2 months	31.0	92.3	4.9
Able to keep dwelling warm	No	15.5	19.8	24.7
	Yes	84.5	80.2	75.3
Degree of urbanization	Densely populated	39.1	36.2	7.5
	Intermediate area	1.2	1.4	0.3
	Sparsely populated	59.7	62.5	92.3
Region	RO1 - Nord-Vest, Centru	24.4	23.5	17.4
	RO2 - Nord-Est, Sud-Est	28.9	28.8	45.9
	RO3 - Sud, Bucharest-Ilfov	28.0	28.4	15.4
	RO4 - Sud-Vest, Vest	18.7	19.4	21.4
Any benefits		63.1	76.5	80.8

Source: World Bank calculations based on cross-section data from 2011 EU-SILC for Romania.

Note: Individuals aged 16 to 24 who are out of work and enrolled in education (1.5 million individuals) are excluded from the sample. a/ The working age population aged 16 to 64 years old, excluding those who are out of work and those aged 16 to 24 years old in education. b/ Inactive or unemployed individuals aged 16 to 64 years old, excluding those who are out of work and those aged 16 to 24 years old in education. c/ Working age individuals who are at work and live in poor households where equivalized disposable income is lower than 60 percent of the median.

Low Work Intensity

The second component of the AROPE aggregated indicator measures the proportion of the population that lives in households with very low work intensity (LWI). According to this indicator, very low work intensity households are those in which adult members aged between 18 and 59 have worked less than 20 percent of their maximum work potential during the year preceding the survey.¹⁴ The importance of this indicator lies in the fact that being out of work can be a source of both poverty (through lost income) and social exclusion (less money means fewer opportunities to socialize with friends and/or family, while being out of work can mean losing some social connections).

The EU-SILC data show that only 7.4 percent of the Romanian population under the age of 60 lived in households with very low work intensity in 2012. In comparison, the average for the European Union as a whole was 10.4 percent. A possible explanation for Romania's unexpectedly good showing on this indicator may be the large number of Romanians working in other European Union countries. While the official Romanian statistics on this topic are not very reliable, the number can be approximated from official data from Italy and Spain, the most common work migration destinations for almost 2.5 million Romanians who live abroad. Furthermore, the Romanian labor market is characterized by an extremely large number of people working in informal self-employment in subsistence agriculture whose income returns are extremely low, thus making them very likely to be thrown into either absolute or relative poverty. This oversized agricultural sector combined with the absence of those who have migrated abroad for work reduces the pressure on a labor market that is already unable to offer jobs to everyone and, thus, leads automatically to an artificially low score for Romania on the low work intensity indicator.

The influence of temporary work migration and of subsistence agriculture on the LWI indicator can also be seen in how the value of the indicator varies among different population subgroups and does not conform to the trend observed in the case of the other indicators. The difference between people living in densely populated areas and

people living in thinly populated areas, for instance, is only 3.5 percent (Annex Table 2.13). Normally, it might be expected that the percentage of people with LWI would be significantly higher in thinly populated areas than the actual 9 percent.

Regional differences also follow the same surprising trend. Only 5 percent of people living in the North-East region are considered to live in a very low work intensity household, even though this is the region that holds the Romanian record for the highest percentage of people at risk of poverty (33 percent) and the highest percentage of people who are severely materially deprived (37 percent). This apparent contradiction might be explained by the fact that the North-East region has probably the highest number of workers migrating elsewhere for work in Romania and is also one of the regions with a very high number of people working in agriculture. Conversely, the South-East region, which has the lowest percentage of people working abroad, also has the highest level of LWI - 13 percent.

The data show that the probability of living in a very low work intensity household is negatively associated with education. Eighteen percent of people aged between 16 and 59 with a primary education live in such households, a value that drops to 9.6 percent in the case of those with a lower secondary education, to 6.6 percent in the case of high school graduates, and to only 3.8 percent in the case of people with a tertiary education (Annex Table 2.14).

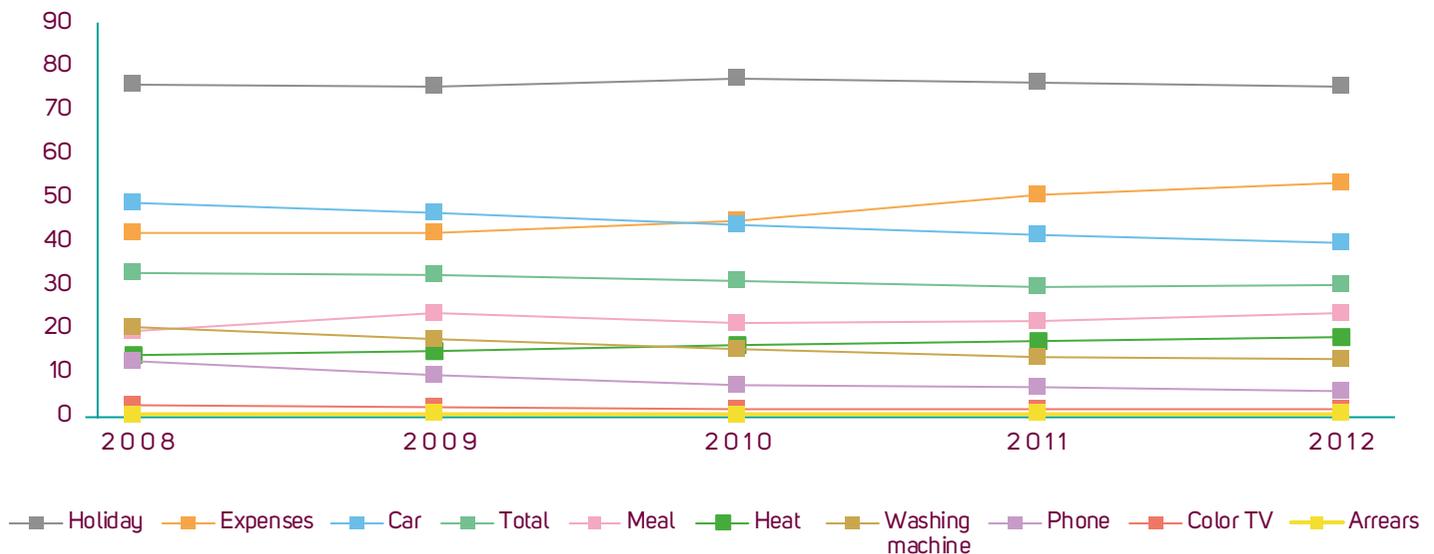
Multiple Deprivation

The indicator of the population at risk of poverty and social exclusion (AROPE), as defined at the beginning of this chapter, focuses not only on poverty as defined in terms of financial resources but also on employment status and on material deprivation as primary causes of both poverty and social exclusion. Thus, people suffering from severe material deprivation¹⁵ are also targeted by the EU's measures for reducing poverty and social exclusion.

The EU-SILC data for 2008 to 2012 point to a series of characteristics that explain the distribution of all indicators used for assessing poverty and material deprivation. Policymakers should take these characteristics into account

¹⁴ Households comprised only of children, of students under 25 years old, and/or people aged 60 or over were completely excluded from the indicator calculations.

¹⁵ The indicator adopted by the Social Protection Committee (the EU advisory policy committee for the Employment and Social Affairs Ministers in the Employment and Social Affairs Council) measures the percentage of the population that meets at least four of the following nine criteria: (1) they cannot afford to pay their rent, mortgage, or utility bills; (2) they cannot afford to keep their home adequately warm; (3) they face unexpected expenses; (4) they cannot afford to eat meat or other protein regularly; (5) they cannot afford to go on holiday; (6) they cannot afford to purchase a television set; (7) they cannot afford to purchase a washing machine; (8) they cannot afford to run a car; and (9) they do not have a telephone. The indicator distinguishes between individuals who cannot afford a certain item or service and those who do not have this item or service for another reason, for example, because they do not want or need it.

FIGURE 5: Percentage of People Suffering from Severe Material Deprivation

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

when designing new poverty reduction strategies or when modifying and fine-tuning the existing ones.

Between 2008 and 2012, the value of the multiple deprivation indicator slightly decreased. The overall indicator dropped by 3 percentage points from 32.9 percent to 29.9 percent, but the decrease was not uniform for all of its components (Annex Table 2.15). The nine items of material deprivation can be categorized into three groups. The first group consists of coping with unexpected expenses, being able to afford meat with meals, avoiding arrears, and keeping the home adequately warm. Between 2009 and 2012, this set of indicators has worsened. The second group (being able to afford a holiday or a color TV) remained more or less constant over the four years. Finally, the third group of indicators (owning a car, a phone, or a washing machine) improved over the four-year period.

Romania is also characterized by huge disparities associated with levels of urbanization. For the entire 2008 to 2012 period, the EU-SILC data show that people living in thinly populated areas are 3.5 times more likely to be at risk of poverty and 1.5 times more likely to be severely materially deprived than those in more densely populated urban areas (in urban areas 24.8 percent of individuals are

materially deprived, while in rural areas the percentage is 36.9). The differences between rural and urban areas persist for almost all items included in the deprivation index (except for arrears and heat) but are close to or larger than 10 percent for five of the nine items (being able to afford a holiday, a car, meals with meat, or a washing machine), as shown in Annex Table 2.16.

Geographically, Romania is affected by uneven development, with a significant gap between the Eastern and Western regions of the country. The Eastern part of the country (the North-East and South-East regions) is characterized by the highest levels of poverty and severe material deprivation. The Southern part (South Muntenia and South-West Oltenia) also contains pockets of poverty and material deprivation levels that are either higher than the national average or at least at the same level. The Central and Western regions have poverty and material deprivation levels that are below the national average.

Education is probably the most effective individual-level factor that can help a person to avoid both poverty and severe material deprivation. The data show a very consistent pattern across all nine items of material deprivation: the higher the education level, the lower the

chances that the respondent is unable to afford a particular item from the list.¹⁶ For example, while virtually all college graduates can afford three of the items (a color TV, a phone, and a washing machine), the percentage of people with a primary education who cannot afford one of these items rises to 38 percent. The differences in material deprivation among people with varying levels of educational attainment did not decrease significantly between 2008 and 2012 (Annex Table 2.17).

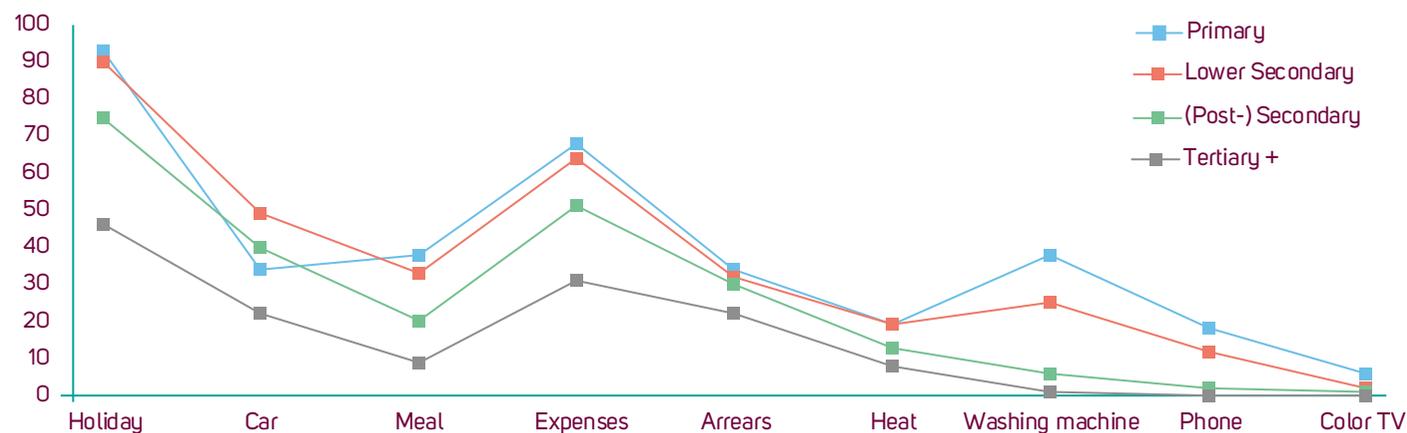
Only children under 18 years old are affected by severe material deprivation to a higher extent than the general population. In this age group, the percentage of severely materially deprived people was 37.9 percent in 2012, whereas in all other age categories, it was around 28 percent. The household structure is also a factor that significantly influences the risk of poverty and social exclusion. The only type of household in a better situation than households with no child members is that composed of two adults and a single child. The type of household that has the greatest chance of being materially deprived comprises two adults and three or more children. Virtually

all people living in this type of household (96 percent) cannot afford a one-week holiday away from home. The percentage of people unable to afford four other items (having a car, dealing with unexpected expenses, having a meal with meat every other day, and avoiding arrears) is 49 percent or higher. Two other, less common types of households - single parent households and households composed of three adults and at least one child - are also having difficulties avoiding material deprivation.

The social and economic inclusion of Roma is essential if Romania is to meet its Europe 2020 targets. Roma are not only significantly poorer than non-Roma but are also at a higher risk of social exclusion. In fact, the vast majority of Roma in Romania, as in other Eastern European countries, continue to live in poverty, while as many as 90 percent of Roma households face severe material deprivation (compared with 54 percent of their non-Roma neighbors living in the same or nearby communities and compared with the Romanian national average of 32 percent).¹⁷

The EU is currently testing new indicators of material deprivation based on the additional indicators used in the

FIGURE 6: Core Material Deprivation Indicators by Levels of Education, 2012



Source: World Bank calculations using data from the 2012 EU-SILC.

Note: The figure presents the proportion of population (by category) living in households that cannot afford a given item even this is wanted or needed.

¹⁶ The only case that contradicts this pattern is the intersection between having a car and primary education. It seems that people with only a primary education own cars in significantly higher proportion than might be expected. In fact, the percentage of people not owning a car among this group (34 percent) is smaller even than among high school graduates (40 percent). The explanation might be data-driven but is most likely to be a result of people with only a primary education attaching greater importance to owning a car than high school graduates.

¹⁷ World Bank calculations using data from the 2011 EU-SILC and the 2011 UNDP/World Bank/EC Regional Roma Survey.

2013 round of the EU-SILC survey.¹⁸ These indicators are likely to become the main instrument for monitoring and evaluating the population at risk of poverty and social exclusion for the purposes of the Europe 2020 targets. We strongly recommend that the Government of Romania draw up strategies to maximize the chances that Romania will improve its ranking on the new indicators. Otherwise, when the new measure is implemented across the EU, Romania will continue to be in last place in the ranking of member states.

Our analysis of multiple deprivation identified two priority areas on which the government could focus in order to achieve the 2020 poverty targets. These intervention areas are expected to lead to the highest poverty reduction for the lowest amount of money spent. Based on both the core indicators and the indicators included in the material deprivation module in the 2009 EU-SILC, it seems that the most cost-efficient investments aimed at reducing multiple deprivation and that would avoid adverse or unintended consequences in the economy at large would be: (i) a piped water supply to people's homes and (ii) the acquisition of outdoor leisure equipment for children. About two-thirds of Romanians who are at risk of poverty or social exclusion do not have indoor plumbing (the absence of an indoor flushing toilet as well as a bath or shower). In the poorest regions of the country (the East and the South), more than one-half of all people, not only the poor (AROPE), have

no indoor plumbing. If the government in cooperation with local authorities developed a plan to finance this type of infrastructure, this is likely to have a significant effect not only in reducing the number of people at risk of poverty but also in improving the quality of life for both individuals and communities.

People at Risk of Poverty or Social Exclusion (AROPE)

We used the three indicators discussed above to construct a single, aggregated indicator that indicates people at risk of poverty or social exclusion (AROPE). According to this indicator, a person is considered to be AROPE if he or she fulfills at least one of the three component indicators: (i) he/she is at risk of monetary poverty (AROP); (ii) lives in a very low work intensity household (LWI); or (iii) is severely materially deprived (SMD). People at risk of poverty or social exclusion constitute the main target group for the programs devised by the EU and its member states to reduce poverty, and progress towards the Europe 2020 poverty reduction target is assessed in terms of the number of people in that group.

The data for 2012 show that, of the total population, 42 percent of Romanians are considered to be at risk of poverty or social exclusion. During the 2008 to 2012 period, the percentage of AROPE slightly decreased, from 44.2 percent

TABLE 7: Percentage of People at Risk of Poverty or Social Exclusion by Individual Indicators, 2008–2012

	2008	2009	2010	2011	2012
People AROP ONLY	8.2	7.8	7.7	8.2	8.8
People in LWI households ONLY	2.1	2.0	1.9	1.7	2.0
People SMD ONLY	17.4	17.4	17.3	15.5	16.1
People AROP and in LWI households ONLY	0.9	1.0	0.8	0.9	1.0
People AROP and SMD ONLY	11.8	11.6	10.9	11.1	11.0
People in LWI households and SMD ONLY	1.2	1.1	1.1	0.9	1.0
People AROP, in LWI households, and SMD	2.4	2.0	1.7	1.8	1.7
People at risk of poverty or social exclusion AROPE	44.2	43.1	41.4	40.3	41.7

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

¹⁸ Three items - the inability to afford a washing machine, a TV, and a telephone - have no impact on the proportion of people who are deprived in most EU member states (Nolan and Whelan, 2011:83-86). For this reason, these three items are being dropped, and the inability to afford seven new items will be included within the core definition. These are (for adult individuals): (1) new clothes; (2) two pairs of shoes; (3) some pocket money for oneself; (4) leisure activities; and (5) a drink or meal out monthly; and (for households): (6) the ability to replace worn-out furniture and (7) ownership of a computer and access to the Internet. In addition, the list of items retained in the multiple deprivation indicator related to the child population (aged 1 to 15) will include 13 new items (besides the two new household items already mentioned), namely the inability to afford: (1) new clothes; (2) two pairs of shoes per child; (3) fresh fruit and vegetables daily; (4) meat, chicken, or fish daily; (5) suitable books; (6) outdoor leisure equipment; (7) indoor games; (8) a place for doing homework; (9) leisure activities; (10) celebrations; (11) inviting friends over; (12) school trips; or (13) a holiday (Eurostat, 2012a: 81-82).

in 2008 to 41.7 percent in 2012. Material deprivation is the main cause of being considered at risk of poverty or social exclusion, followed by AROP, and then, making only a minor contribution, LWI (see Table 7 and Annex Table 2.18).

1.1.2. Relative Poverty Forecasts (AROP)

In our calculations for the for the current background study, we used a micro simulation model to predict the evolution of relative income poverty and anchored poverty between 2012 and 2020. We used the model to assess under what conditions Romania would achieve its poverty target (a reduction in relative income poverty of 580,000 people by 2020 as measured by the EU-SILC) and what combination of economic growth, employment, wage growth, and policies aimed at increasing the earnings and transfer income of the poor would secure the achievement of the target. With the model, we used 2012 EU-SILC data to simulate the at-risk-of-poverty and anchored poverty indicators for 2013 to 2020.

This section is divided into two parts: (i) a description of the assumptions (exogenous variables) of the model, which spell out the likely paths of overall economic growth, of employment, productivity, and wages, of demography, and of the expected coverage and generosity of the pension system over the forecasting period and (ii) an analysis of three scenarios of economic and employment growth that assume that all other policies prevailing in 2012 will not change significantly over the 2013 to 2020 period. In addition, in the Employment and Social Transfers chapters, we will describe other scenarios that take into account the expected impact of the key poverty reduction policies recommended in the volume (the targeted employment measures, the Youth Guarantee program, the increased social assistance resources targeted to the relative income poor, and the increased resources allocated to marginalized urban and rural areas).

The key message of our modeling work is that, in the absence of the measures recommended in the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, economic and employment growth will not be sufficient to achieve the poverty target except under the very optimistic but highly unlikely scenario of high economic and employment growth. Therefore, in order to achieve its poverty target, the Government of Romania will need to put in place the Strategy's recommendations aimed at increasing the

employment and wage rates of the poor and at augmenting the volume of social protection funds available to the poorest quintile of the population.

(A) Assumptions of the Model

The simulation model used to forecast the reduction in relative and anchored income poverty included a set of macroeconomic and demographic assumptions.¹⁹

Three possible economic growth scenarios were modeled - a low, a base, and a high economic growth scenario (Table 8, middle panel). The forecasts correspond to the forecasts of the IMF, the World Bank, and the European Union as of September 2014. Under the low economic growth scenario, Romania's per capita GDP is expected to grow by 2.2 to 2.5 percent per annum over the forecasting period. Under the high economic growth scenario, per capita GDP growth is forecast to increase gradually from 3 percent in 2014 to 5 percent between 2018 and 2020.

There are also three employment growth scenarios that correspond to each economic growth scenario (Table 8, first panel). Under the low scenario, the share of employed people in the 20 to 64 year old cohort is expected to grow from 63.8 percent in 2012 to 64.9 percent by 2020 or by 1 percentage point over the eight years. This forecast is consistent with the weak employment growth achieved during the previous decade. Under the base scenario, employment is expected to grow by 3.6 percentage points. Under the high (rather optimistic) growth scenario, the employment rate is expected to increase gradually to reach 70 percent by 2020, which is Romania's EU 2020 employment target (a total increase of 6.2 percentage points over eight years). Labor productivity is assumed to be the same in all cases, while we assume that Romania will meet its EU 2020 national education targets by 2020.

We then incorporated the assumed changes in economic growth, employment, labor productivity, and educational attainment from Table 8 into a microeconomic model using data from Romania's 2012 EU-SILC survey, the same survey that is used to track progress toward the relative income poverty target (AROP). For each of the forecast years, we changed the income of the households in the survey sample using the assumed changes in education distribution, employment, labor productivity, and expected GDP growth. The model also adjusted the education distribution of individuals in the 20 to 34 age group to reflect the projected education distribution in that particular

¹⁹ The details of the simulated model are discussed in Annex 2, Section II.

year. The employment rates of the 20 to 64 age group in each year were also adjusted by switching the status of the unemployed/inactive individuals with the highest probability of being employed until the total number of employed people reached the projected employment level for that year.

We imputed earnings for these individuals who were predicted to move from inactivity to employment based on their level of education, sector of activity, work experience, and other variables from the survey data. All individuals employed (or predicted to move from inactivity to employment) received a flat increase in their earnings equal to the assumed increase in labor productivity. The value of the social protection transfers received by households was assumed to remain at the same level in real terms (increased only in line with expected inflation). Having changed the incomes of the sample households according to these assumptions, the model generated a new, simulated income distribution for each year of the forecast period.

The model was also calibrated with predicted changes in demographics and labor market participation. The demographic forecast was taken from the National Institute for Statistics. Other demographic changes, such as change in formal employment, informal employment, and the change in the number of pensioners and the real value of their pension, was simulated using the World Bank's PROST (Pension Reform Options Simulation)

model. Between 2012 and 2020, Romania will experience significant changes in the numbers and structure of the population (see Table 9), with the total population expected to fall by 177,000 people. This change will be distributed differently across age groups. While the old age cohort (people aged 65 years old and older) is expected to increase by 436,000 people, the working age population (those aged 20 to 64) will shrink by 557,000 people, and the number of children (up to 20 years old) by 56,000. Over time, the working age population will decline while the elderly population will increase, putting further strains on government revenues derived from income taxes and leading to an increasing demand for pensions, health care, and elder care.

In the micro model, the employed population was derived from the predicted working age population (Table 9) and the low, base, and high employment rates (Table 8). We used further assumptions about the rate of unemployment to estimate the number of unemployed over the forecasting period. The sum of the employed and the unemployed represented the total active population in each year. We introduced changes in the size of the employed and the unemployed groups in the micro model by altering the weights of the respective categories.

Finally, the model incorporated the predicted changes in the coverage and real value of the old age pension as forecast by the PROST model. Between 2014 and 2020, the share of the old age population receiving pensions

TABLE 8: Growth Scenarios for Romania

	Employment rate (20-64 years old)			GDP Growth rate			Labor productivity (growth rate, per hour)	% of 18-24 with at most lower secondary education	Tertiary educational attainment in 30- 34 age group
	Low	Base	High	Low	Base	High			
2012	63.8	63.8	63.8						
2013	63.6	64.1	64.5	3.5	3.5	3.5	1.5	14.8	20.2
2014	64.0	64.6	65.2	2.5	2.7	3.0	1.7	14.3	21.3
2015	64.4	65.1	65.9	2.6	3.1	3.5	2.0	13.8	22.1
2016	64.6	65.6	66.7	2.5	3.7	4.0	2.4	13.3	23.0
2017	64.7	66.1	67.4	2.5	3.9	4.5	2.7	12.8	24.0
2018	64.8	66.5	68.1	2.5	4.0	5.0	2.7	12.3	25.0
2019	64.8	66.8	68.9	2.2	4.1	5.0	2.7	11.8	26.0
2020	64.9	67.4	70.0	2.2	4.1	5.0	2.7	11.3	26.7

Source: World Bank estimations based on multiple sources. The economic growth forecasts are based on IMF, World Bank, and EU projections as of September 2014. The low case scenario is based on the forecast of the EU Active Aging Working Group and the Ministry of Finance, Romania. Employment growth for the base and high scenarios, for productivity, and for educational attainment are World Bank projections.

is forecast to decline slightly, by about 1 percent, due to an increase in the uninsured population in rural areas, especially among individuals who derive their incomes from informal agriculture. This relatively small change was not incorporated into the model. The ratio of the average pension to the average wage, however, is predicted to fall by about 10 percent between 2014 and 2020 as a result of the Swiss indexation formula used in the first pillar of the pension system in Romania. This change was incorporated into the model.

(B) Poverty Forecasts Based on Economic Growth and Employment Growth

We used the model described above to predict relative and absolute poverty in each year. The simulations took into consideration three scenarios. The low scenario was based on the EU Aging Working Group (AWG) projections, the high scenario took into account employment adjustments to achieve the 2020 target, while the base scenario was an average of the low and high scenarios. The model implicitly assumed that employment and social protection policies would not change between 2012 and 2020.

Relative poverty changed only marginally between the different growth scenarios. Our simulations indicate that poverty is likely to increase slightly between 2012 and 2020 in the low growth and moderate growth scenarios (by 0.6 percentage points and 0.2 percentage points respectively). Figure 7 shows the trends, while Annex Table 2.19 displays the detailed figures. Only in the high growth (optimistic) scenario, in which the employment target is met (when 70 percent of the working age population is

employed), is the relative poverty level likely to decrease. If the population size does not change and the optimistic scenario occurs, the number of poor people is expected to decrease by 181,000 people between 2012 and 2020 (Annex Table 2.20). Moreover, if we take into account the expected evolution of the population over the 2012 to 2020 period (as predicted by the PROST model using census data), the number of people in poverty will be reduced only by 237,000 (as the number will be reduced by 56,000 alone due to the expected population decrease).

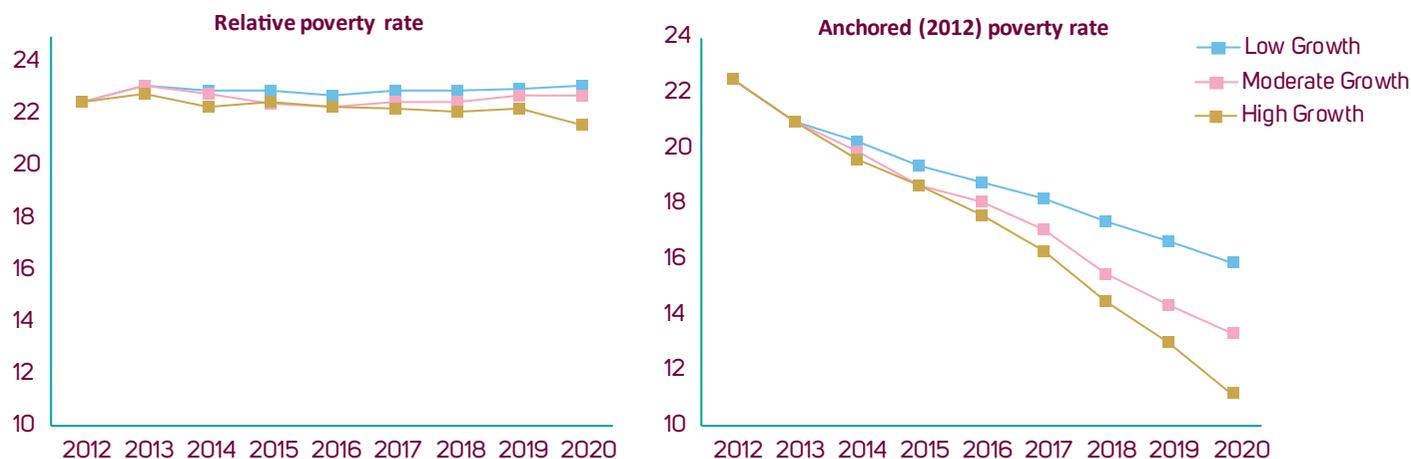
The expected economic and employment growth over the 2014 to 2020 period is not enough to achieve the poverty target except under the very optimistic but highly unlikely scenario of high economic and employment growth. Therefore, in order to achieve this target, the Government of Romania will need to put in place the policies recommended in this volume that are aimed at increasing the employment and wage rates of the poor and augmenting the volume of social protection funds available to the poorest quintile of the population.

Anchored poverty declines in all three growth scenarios. Because the poverty line itself changes with income distribution over time, we fixed the poverty line at the 2012 level and estimated absolute poverty using the 2012 poverty line. Poverty will decline by 6.6 percentage points between 2012 and 2020 if the low growth scenario prevails (see Figure 7 for trends or Annex Table 2.19 for detailed figures). Importantly, in this scenario, the anchored poverty rate is expected to reach 15.9 percent in 2020, which implies that, even at that point, about 16 percent of the population will have real incomes lower than the 2012 poverty line. The high growth scenario is expected to make a larger impact, but poverty is still projected to be at about 11 percent in 2020.

TABLE 9: Main Demographic Changes, 2014–2020 (in thousand people)

Age-groups	Year							Change 2014-2020
	2014	2015	2016	2017	2018	2019	2020	
0-14	3,133	3,127	3,117	3,116	3,117	3,113	3,110	-24
15-19	1,093	1,088	1,092	1,090	1,081	1,071	1,061	-32
20-64	12,464	12,368	12,270	12,174	12,083	12,002	11,907	-557
65+	3,297	3,381	3,457	3,524	3,592	3,656	3,733	436
Total	19,987	19,964	19,935	19,904	19,873	19,842	19,810	-177

Source: World Bank's PROST model for Romania.

FIGURE 7: Projected Relative and Anchored Poverty Rates, 2012–2020

Source: World Bank calculations using data from EU-SILC in the three main scenarios.

1.2. Main Vulnerable Groups

A number of groups face various forms of social exclusion or are at high risk of exclusion in ways that are sometimes but not always associated with poverty. Because vulnerable groups face particular problems for which generic policies may not work, they often need tailored and integrated services in order to increase their social and economic participation. Identifying and appropriately responding to the particular needs of vulnerable groups is essential for designing and implementing effective social inclusion policies.

All vulnerable groups, irrespective of their size, should be offered similar opportunities to reach their potential and

become an active part of society. Table 10 summarizes the main vulnerable groups in Romania.²⁰ Some are extremely large, while others are much smaller in number (not exceeding a few hundred people nationwide). For example, in 2012 to 2013, the group of vulnerable people included an estimated 1.85 million Roma,²¹ about 1.4 million poor children (aged between 0 and 17), over 725,000 people aged over 80 years old, 687,000 children and adults with disabilities living in households and another 16,800 living in institutions, more than 62,000 children in special protection (either in residential centers or in family-type care), and approximately 1,500 children abandoned in medical units.

²⁰ In addition to the groups listed in Table 10, another vulnerable group consists of injured and disabled troops and survivors of deceased soldiers. This vulnerable group comprises fewer than 200 people. Besides the existing social protection measures, the injured and disabled are young and need medical care, such as orthoses, prostheses, and other medical devices, while survivors of the deceased require psychological and material support. However, regarding this group, we consider that allocating a discretionary budget to the Ministry of National Defense would be more efficient for developing a dedicated system of home-based medical care and social services for those who are immobile and without a family.

²¹ Given the likelihood that many Roma respondents do not report their ethnicity on the national census, an alternative set of expert estimates is commonly used. According to the Strategy of the Government of Romania for the Inclusion of Romanian Citizens Belonging to Roma Minority 2012–2020, estimates range from 535,140 (2002 Census), to 730,000–970,000 (Sandu, 2005), to 619,000 (the 2011 Census), and to 1.85 million (European Commission, 2011a).

TABLE 10: The Main Vulnerable Groups in Romania

Main group ^{a/}	(Sub)groups
1. Poor people	Poor children, especially those living in families with many children or in single-parent families In-work poor, especially under-skilled (mainly rural) workers; the self-employed in both agriculture and non-agriculture Young unemployed and NEETs ^{b/} People aged 50-64 years out of work and excluded from benefits schemes Poor elderly, especially those living with dependent household members, and lone elderly
2. Children and youths deprived of parental care and support	Children abandoned in medical units Children living in large or low-quality placement centers Youths leaving residential care Children and youths living on the streets Children with parents working abroad, especially those with both parents abroad and those confronted with long-term separation from their parents Children deprived of liberty Teenage mothers
3. Lone or dependent elderly	Elderly living alone and/or with complex dependency needs
4. Roma	Roma children and adults at risk of exclusion from households without a sustainable income
5. People with disabilities	Children and adults with disabilities, including invalids, and with a focus on those with complex dependency needs
6. Other vulnerable groups	People suffering from addiction to alcohol, drugs, and other toxic substances People deprived of liberty or on probation Homeless people Victims of domestic violence Victims of human trafficking Refugees and immigrants
7. People living in marginalized communities	Rural poor communities Urban marginalized communities Roma impoverished and marginalized communities

Notes: Each of the vulnerable groups has specific problems and should be offered similar opportunities. Therefore, the order in which they are listed does not reflect any particular ranking of the vulnerable groups. a/ Some of the groups may overlap. For example, a child living in a single-parent family may experience poverty and/or multiple deprivations as well. b/ NEET stands for “Not in Education, Employment, or Training.”

This document does not analyze²² each group separately but focuses on defining area-based and people-based (sectoral) interventions to meet their needs, discussing the specificities of each vulnerable group whenever needed. For example, in the education chapter, in addition to the general social inclusion aspects of the sector, special attention is paid to poor children (who do not have the means to

attend school), Roma (mainly because of their segregation/discrimination problems), and children with disabilities (because of the lack of educational services adapted for their needs). Table 11 offers a birds’ eye view of the chapters in which the specific problems of each of the vulnerable problems are tackled.

²² An analysis of these groups was included in the socioeconomic analysis for programming the European funds for 2014-2020, which was carried out in November 2012 by Romania’s Technical Working Group on Social Affairs and Social Inclusion, coordinated by the MLFSPE.

TABLE 11: Specific Analyses in Each Chapter of Each Vulnerable Group

Chapters	Poor people	Children and youths deprived of parental care and support	Lone or dependent elderly	Roma	People with disabilities	Other vulnerable groups	People living in rural and urban marginalized communities
Employment							
Social Protection							
Social Services							
Education							
Health							
Housing							
Social Participation							
Integrated Services							
Area-based Policies							

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2. PEOPLE-BASED POLICIES

2

PEOPLE-BASED POLICIES



2.1. Employment

To tackle poverty and social exclusion in the labor market, we recommend that the government create employment opportunities and promote equality of opportunity by: (i) increasing the skills, education, and labor market experience of people who are income-poor and of those from other vulnerable groups; (ii) increasing the employment rate of this segment of population; and (iii) putting in place measures that could increase the wage rate of the target group (such as measures aimed at reducing discrimination). However, these measures will only be partially effective if they are not accompanied by economic policies on the demand side that create well-paid and sustainable jobs.

The main priority in this area should be increasing the employment of the poor and vulnerable by expanding active labor market programs.



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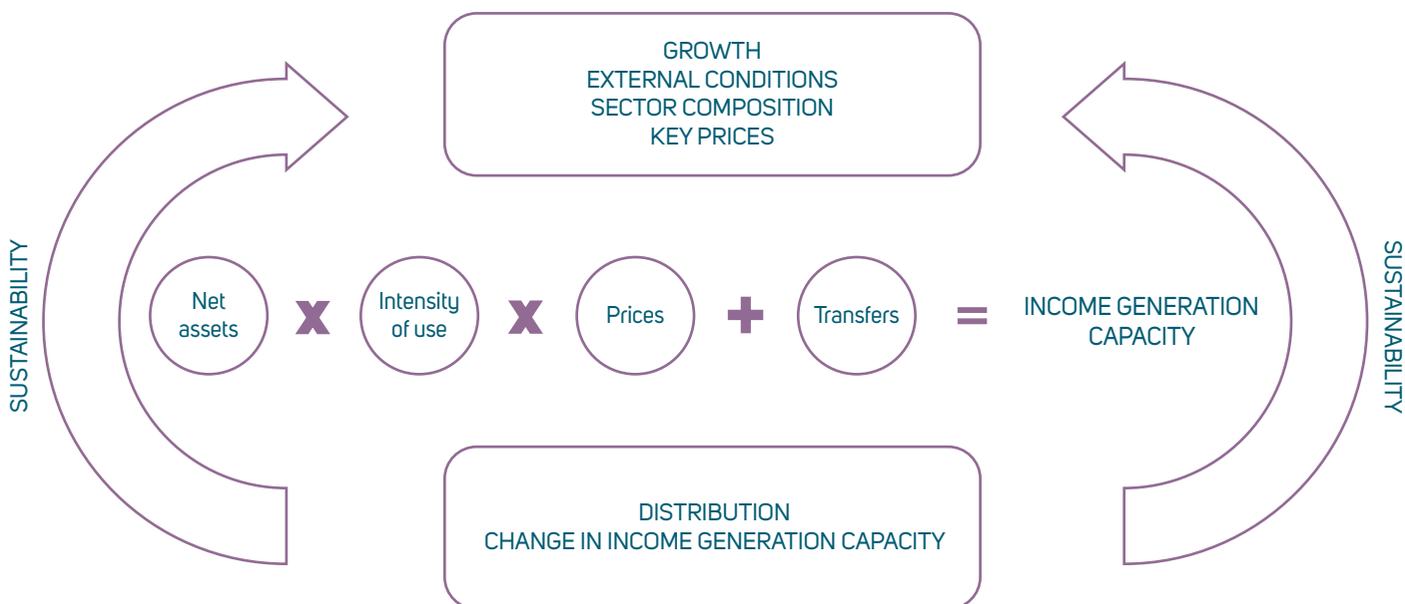
2.1. Employment

To lift 580,000 people out of income poverty between 2008 and 2020, the government will need to enact measures to increase the income-generating capacity of the poorest 4.8 million Romanians so that their incomes will grow faster than the average income. The total income of the population is the sum of household earnings plus social and private transfers. Household earnings, in turn, depend on the productive assets that households own (labor, capital goods, livestock, or land), the intensity of their use, and their actual market value (Scheme 4). To reduce relative income poverty, our strategy is to enhance the income-generating capacity of the poorest segment of the population over the programming period. In practical

terms, this means: (i) increasing the skills, education, and labor market experience of the income-poor (net assets); (ii) increasing the employment rate of this segment of population (intensity of use); and (iii) putting in place measures that could increase the wage rate of the target group (such as measures aimed at reducing discrimination). Based on the same approach, the other assets of poor households, namely land (smallholdings) and livestock, could be increased.

The other factors that determine the total income of poor households are transfers, whether private or from social protection programs. These topics will be addressed in Section 2.2 on Social Transfers.

SCHEME 4: Conceptual Framework for Reducing Relative Income Poverty



Source: World Bank (Bussolo and Lopez-Calva, 2014).

2.1.1. Activating People in Poverty not in Education, Employment, or Training

Romania's changing demographics between 2014 and 2020 will dramatically alter the labor market. By 2020, the number of individuals of working age is predicted to have declined by 4.5 percent, while the elderly are likely to have increased by 13 percent. Romania will have to mobilize all of its potential workers and to invest in their education and skills to make them more productive. This makes it vital to mobilize all of the working age adults in the poorest quintile who are currently not working although they are capable of doing so. This group represents 26 percent of the total number of adults in the quintile (approximately 730,000 people). One-third of these adults who are not in employment, education, training, or disabled (NEETD) or in early retirement could resume working relatively quickly, whereas another one-third would need the assistance of active labor market programs (ALMPs) and social services to access the labor market, while the last third is very unlikely to become employed. International studies estimate that about 10 to 23 percent of non-working adults in the poorest quintile could join the labor market by 2020 if they were to receive assistance from ALMPs and social services and if they were allowed to combine their labor earnings with social assistance benefits.²³

To see to what extent the increase in ALMPs would reduce poverty, we simulated the effects of such a program on the beneficiaries of Romania's new consolidated means-tested program, the Minimum Social Insertion Income program (MSII), which is described in the next section. International evidence suggests that the work incentives offered as part of a new benefit formula for MSII beneficiaries supplemented by tailored job intermediation services and ALMPs could help between 10 and 23 percent of those who currently do not work to work while receiving social assistance benefits. About two-thirds of this effect can be attributed to the new benefit formula of the MSII

and the remaining one-third to the provision of tailored job intermediation services and ALMPs. In the optimistic scenario in which 23 percent of MSII beneficiaries who are not in employment, education, training, or disabled (NEETD) find work, relative poverty would decrease by 3 percentage points in 2016, while in the pessimistic scenario (assuming that only 10 percent of the NEETD find work), relative poverty would decrease by 1.4 percent.

Employment in return for decent wages is the surest path out of poverty. This background study sets out a number of policies aimed at increasing the labor market participation of the poor, reducing the seasonality of their employment, and augmenting their income either by increasing their earnings or by allowing the working poor to combine their relatively low earnings with cash assistance.

However, ALMPs can only grease the wheels of the labor market, making social protection more effective, for example, by improving the chances of some vulnerable individuals entering the labor market at the expense of others. They cannot be the principal engine behind job creation, and they cannot combat a lack of labor demand when the economy is weak.²⁴ In order to be effective, ALMPs need to be accompanied by economic policies influencing the demand side, in other words, that create jobs.²⁵

A Profile of the Working Age Population in the Poorest Quintile

In 2016, the government plans to implement a new social assistance program for the poor, the Minimum Social Insertion Income (MSII) program, with the goal of providing assistance to those in the bottom quintile of the Romanian population while improving work incentives for workable adults.²⁶ To achieve this goal, the new program will merge the three existing means-tested programs into a single one, will reduce the implicit marginal tax rate (MTR) on earnings to enable program beneficiaries to combine receiving social assistance with working, and will increase the availability and relevance of the ALMPs for this target group. Importantly, the MSII program will also serve as a tool for identifying the poor population.

²³ The assumptions behind this forecast are detailed in Bachas (2013) and Gerard (2013).

²⁴ OECD (2013a: 40).

²⁵ Such policies can range from macroeconomic and fiscal policies to policies affecting the investment climate, sectoral policies, labor mobility and migration policies, and business development policies (International Labour Office and the Council of Europe, 2007).

²⁶ This section draws heavily from Bachas (2013).

This subsection identifies the characteristics of the targeted population, while the next subsection suggests some activation policies tailored to those groups.

The at-risk-of-poverty (AROP) population is approximated in this chapter by the bottom quintile of the income distribution, in other words, the poorest 20 percent of individuals ranked according to their income (including any social protection transfers) per adult equivalent. Within the bottom quintile of Romania's income distribution, there is a particular focus on NEETD individuals. These are individuals with the capacity to work and for whom the policy priority must be to improve their work incentives and increase their access to the labor market. To achieve this goal, it is crucial to understand the characteristics of the NEETD population and the barriers that they face in trying to access the labor market.

A lack of employment opportunities and low labor earnings are strongly associated with poverty. There is a pronounced and persistent employment gap between the work-able population in the poorest quintile and those in the top three quintiles²⁷ (Figure 8). Among prime-age men (aged between 35 and 44 years old), the employment rate is 16 percent lower among those in the lowest quintile than among those

in the top three. This gap is even larger for women - about 30 percentage points. Among the 2.8 million working age adults in the poorest quintile (Figure 9), 50 percent are employed (mostly self-employed or in agriculture), about 20 percent are in education, disabled, or in early retirement, and another 26 percent are either inactive or unemployed. About 70 percent of those who are unemployed or inactive rely on social assistance to supplement their income. Among those who work, three-quarters are self-employed, many holding seasonal jobs in agriculture or construction, which reduces their annual earnings.

In addition to large disparities in total employment, the type of occupation varies greatly across quintiles. Table 12 shows the occupation status for those in the bottom quintile, the second quintile, and the top three quintiles. As previously seen, the share of the inactive population - the sum of the unemployed and housewives - is much larger in the bottom quintile than in the other quintiles. Another important feature of the bottom quintile is the very large share of self-employment at 35 percent and the small share of salaried employment at 15 percent (the percentage of employers is marginal). As a comparison, self-employment in the top three quintiles is 10 percent and salaried employment is 54 percent.

BOX 3

Data and Methodology for the Analysis of the NEETDs

The data analysis in this chapter is based on the 2011-2013 rounds of the Romanian Household Budget Survey (HBS). This survey was used rather than the EU-SILC as the questionnaire is much richer and allows for a more detailed analysis. The HBS was conducted at the household level and was representative of the Romanian population. It collected extensive information on individual characteristics, expenditures, and income sources. In order to obtain the maximum sample size, we pulled together cross-sections of the HBS, and, based on adult equivalent consumption, we separated the Romanian population into five quintiles.

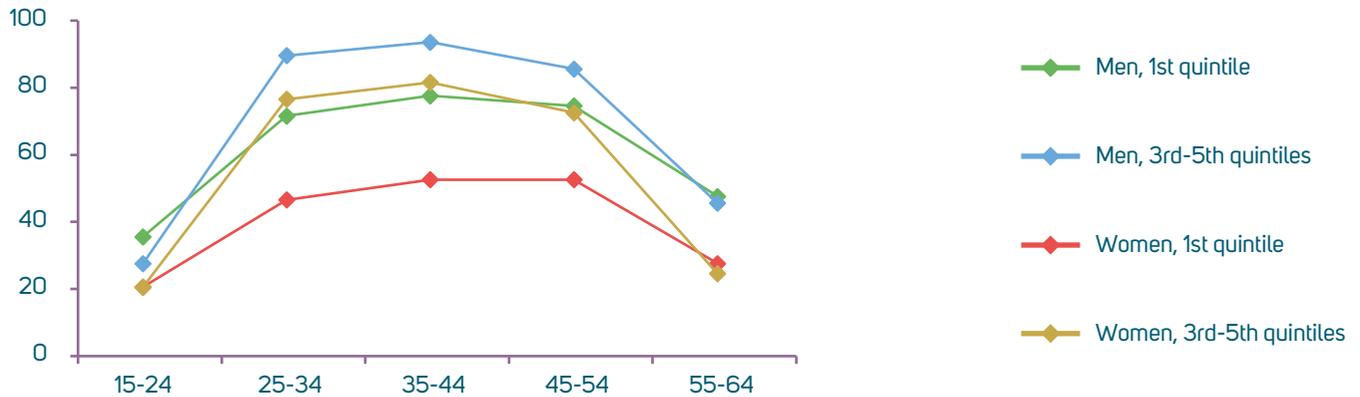
The analysis was carried out at the individual level because activation policies target individuals. Even though some labor market challenges are shared by at the household level (such as rural location with low labor demand), human capital and the search for employment principally involve individual investment and effort.

The total dataset contains 85,242 individuals. Among these, 55,952 are of working age (defined as those between 15 and 64 years old). Of these, 7,527 individuals belonged to the NEETD group - not in employment, education, training, disabled, in early retirement, or mothers with children under the age of 2 years old.



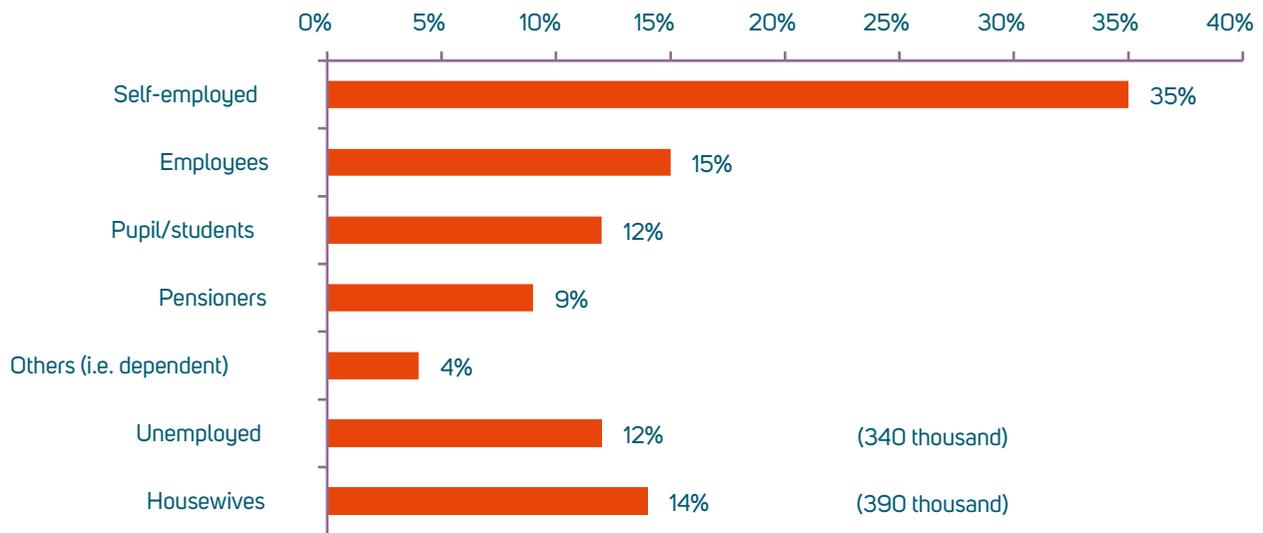
²⁷ The definition of quintiles used in these estimations is slightly different than the ones used in the data from the EU-SILC. However, the results are very similar regardless of these definitions.

FIGURE 8: Employment and Gender Gap by Income Level, 2011-2012



Source: World Bank calculations based on data from the 2012-2013 HBS.
 Note: Quintile of consumption per adult equivalent.

FIGURE 9: Working Age Individuals from the Poorest Quintile by Occupation, 2011-2012 (total = 2.8 million)



Source: World Bank calculations based on data from the 2012-2013 HBS.
 Note: Quintile of consumption per adult equivalent.

TABLE 12: Occupational Status of 15–64 Years Old by Quintiles, 2012–2013

	1st quintile	2nd quintile	3-5th quintiles	Total
Employee/employer	15	30	54	41
Self-employed in non-agriculture	9	5	3	5
Self-employed in agriculture	26	19	7	13
Unemployed	12	9	5	7
Pensioner	8	12	14	13
Pupil/student	12	12	10	11
Housewife	14	10	6	8
Others	4	2	1	2
Total	100	100	100	100

Source: World Bank calculations using data from the 2012–2013 HBS.

Low employment rates among prime-aged adults in the poorest quintile drive higher NEETD rates among the poor. Table 13 below displays the breakdown of NEETD individuals by consumption quintile. NEETD individuals represent 13 percent of the working age population and

are concentrated in the bottom quintiles of the population. The share of NEETD individuals decreases monotonically by quintile from 26 percent in the bottom quintile to 20 percent, 15 percent, 10 percent, and 5 percent in the fourth, third, second, and top quintile respectively.

TABLE 13: Share of NEETD in the Total Population and in Quintiles, 2011–2012

	1 st quintile	2 nd quintile	3 rd quintile	4 th quintile	5 th quintile	Total
Non NEETD in the working age total population	10.2	13.7	16	20.7	25.9	86.6
NEETD in the working age total population	3.5	3.4	2.8	2.3	1.4	13.5
Share of NEETD in the total working age population from each quintile	25.8	19.7	15.1	10	5.2	13.5

Source: Bachas (2013) using data from the 2011–2012 HBS.

Since many NEETD individuals are concentrated in the bottom quintile, a social assistance program targeted to the bottom quintile would need to address the specific barriers that prevent them from accessing employment in addition to improving work incentives in order to be effective. At the same time, the large share of self-employment and small share of salaried employment in that quintile suggests a need for strategies to encourage entrepreneurship and capital accumulation.

Homogenous Groups of NEETD Adults in the Poorest Quintile

Given the heterogeneity of the NEETDs and the need for tailored policies to increase their chances to become activated, we used the statistical method of latent class analysis (LCA)²⁸ to separate the NEETD population in the bottom quintile into homogeneous groups. LCA is

²⁸ The advantage of LCA over other clustering techniques is that cases are not absolutely assigned to classes but have a probability of belonging to each class. In addition, it can deal with both continuous and categorical data. The optimal number of classes can be found by using the AIC and BIC criteria to measure how well the model fits.

one of several kinds cluster analysis methods that assign observations into subsets (called clusters) according to each cluster's common characteristics. LCA uses clustering algorithms in data analysis and statistical (rather than mathematical) methodology to construct the clusters. It is based on the concept that observations within a group share similar values for a latent (unobserved) variable that can be inferred from observed characteristics. LCA estimates the likelihood that an observation with specific characteristics (observed variables) belongs to one of the defined clusters. It estimates parameters for class profiles (the description of each class) and class size.

In profiling NEETD individuals, the latent variable can be thought of as barriers to accessing the labor market. Using observed characteristics such as gender, location, education, number of children, and minority status, the LCA algorithm generated eight clusters that can be described as follows:²⁹

- **Educated urban unemployed men** are the largest NEETD group from the poorest quintile, representing 24 percent of the sample. Eighty-six percent of the men in this group are actively looking for a job, 15 percent have been inactive for less than six months, while 33 percent report they would accept a job paying 1,000 RON or less per month and 63 percent say they would take a job paying 1,500 RON or less per month. Therefore, this group is actively trying to access the labor market and already has some human capital since 65 percent have a high school degree or more.
- **Married middle-aged rural women** represent 18 percent of the sample. Sixty-two percent have a high school or higher education, and most of these women have one child under the age of 15. Although they face few constraints in accessing the labor market, this group is not actively looking for work, though 62 percent would accept a job if it was offered with an attractive enough wage.
- The group consisting of **uneducated idle youths** (17 percent) contains a majority of women who, despite not having children to take care of, have low educational levels. A large part of this group is not actively looking for work, though 30 percent report that they are prepared to work. Thirty percent of the people in this group are Roma.
- **Young rural women with families** (11 percent of the sample) have an average of two to three children, one of whom tends to be between 2 to 6 years old. Ninety percent have only reached middle school and then dropped out. The members of this group are typically married to self-employed men and currently receive benefits.
- The **single Roma youths** group (10 percent of the sample) is entirely composed of young adults under the age of 25 who dropped out of school early. Most have at least one child and are currently on social assistance. Only 10 percent are looking for job, but half say they are ready to begin work if given the opportunity.
- The **educated rural unemployed** group represents 8 percent of the sample. Ninety-one percent of them have a high school education, and 64 percent have vocational or technical training. A majority are single men. Therefore, this group faces fewer constraints to finding work than other groups because of its potential mobility and existing human capital. The whole group is actively looking for work but has fairly high expectations since 89 percent said that they would only accept wages of 1,000 RON and up.
- **Urban Roma women with families** (7 percent of the sample) are young women often with three children, two of them young (between 2 and 6 years old). All of them have low education (only middle school or less), and their husbands are self-employed. They are not looking for work and have been inactive for at least two years.
- The group of **young urban couples** (5 percent of the sample) consists of individuals with two children, including one under the age of 6, that have recently become inactive in the labor force. A majority of those in this group are actively seeking to reintegrate themselves into the labor market. However, only half of them have completed high school.

²⁹ More details about the key characteristics of the NEETD groups in the bottom quintile can be found in Annex Table 3.1. See also Sundaram et al. (2014).

This categorization offers a clearer picture of the subgroups composing the inactive population in the bottom quintile. It highlights the heterogeneity of their situations and constraints in accessing the labor market. Grouping together clusters 1, 6, and 8 representing 37 percent of the inactive population in the bottom quintile these are individuals actively seeking to return to the labor market and for whom job assistance policies could prove effective. However, at least some of them might look for a job abroad or even work for a few months

abroad per year. Another category consisting of groups 3 and 5 represents 27 percent of this inactive population but critically lacks the human capital needed to successfully integrate into the labor market. This group is not actively looking for work but most would accept a job offer. Finally, the remaining 36 percent from groups 2, 4, and 7 are mainly women who are inactive by choice and are looking after their children. Tax incentives and childcare policies might be necessary to increase their labor force participation.

TABLE 14: Description of the NEETD Groups in the Bottom Quintile

<p>G1: Educated urban unemployed (size: 24%, # 151,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 75% are men <input type="checkbox"/> Middle-aged but few children <input type="checkbox"/> 61% have high school or vocational education <input type="checkbox"/> Half have been unemployed for less than two years, half are in long-term unemployment. <input type="checkbox"/> 34% would take a job for 1,000 RON or less 	<p>G2: Married middle-aged rural women (size: 18%, # 114,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 46% have high school or vocational education <input type="checkbox"/> 1 child of school age <input type="checkbox"/> 10% take care of a disabled person <input type="checkbox"/> Not looking for work, but 1/3 would work for 1,000 RON or less
<p>G3: Uneducated idle youths (size: 17%, # 110,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 71% are women <input type="checkbox"/> 75% have a middle school education or less <input type="checkbox"/> 67% are urban <input type="checkbox"/> 73% are unmarried, no children <input type="checkbox"/> Not looking for job, but 30% are ready to work <input type="checkbox"/> 30% are Roma 	<p>G4: Young rural family women (size: 11%, # 70,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 2 or 3 children under 15 <input type="checkbox"/> Often 1 child between 2-6 years old <input type="checkbox"/> 90% have a middle school education or less <input type="checkbox"/> Self-employed husband <input type="checkbox"/> Receiving social assistance
<p>G5: Roma youths (size: 10%, # 63,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Half are under 25, 70% unmarried <input type="checkbox"/> 62% are women <input type="checkbox"/> 100% have a middle school education or less <input type="checkbox"/> 1 child <input type="checkbox"/> Only 10% are looking for a job but half are ready to take work <input type="checkbox"/> Currently on social assistance 	<p>G6: Educated rural unemployed (size: 8%, # 50,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 67% Men <input type="checkbox"/> 64% have vocational/technical training, all have high school education <input type="checkbox"/> Single, no children <input type="checkbox"/> Looking for job but will only accept higher wages
<p>G7: Urban Roma family women (size: 7%, # 44,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 3 children, 2 between 2-6 years old <input type="checkbox"/> 100% have a middle school education or less <input type="checkbox"/> Self-employed husband <input type="checkbox"/> Inactive for at least two years, not looking for work 	<p>G8: Urban young couples (size: 5%, # 32,000)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 2 children, 1 between 2-6 years old <input type="checkbox"/> 11% take care of a disabled person <input type="checkbox"/> Half have a high school education, half have a middle school education <input type="checkbox"/> Recently inactive <input type="checkbox"/> 2/3 looking for work but not through government agency

Source: World Bank calculations using data from the 2012-2013 HBS.

Activation Policies for the NEETDs from the Poorest Quintile

Figuring out the composition of the bottom quintile particularly that of inactive individuals with the capacity to work, will enable the Romanian government to develop coherent labor market policies tailored to particular subgroups of NEETD individuals. All policies aimed at improving matching in the labor market are referred to as “activation” policies. Activation policies can take various forms, ranging from vocational education and training programs to counseling and work subsidies.³⁰ This section reviews evidence of the effectiveness of activation policies in a variety of contexts in Romania and globally and suggests a range of policies tailored to the previously identified subgroups of the targeted population.

One of the key priorities of the government is to increase access to jobs for all job seekers, including the poor and vulnerable. Such policies are referred to as activation and graduation policies. More specifically, activation policies are defined as social protection and labor policies that help inactive individuals to find jobs and that increase the earnings of active individuals. “Graduation policies” refer to policies targeted to individuals receiving social security with the goal of increasing their income to the extent that they no longer require social assistance. Activation and graduation policies are necessary complements to the successful implementation of social assistance programs, together with the appropriate “parameters” of social assistance programs (benefit level, marginal tax rates, restrictions, and co-responsibilities).

Overall, the international literature³¹ indicates that activation programs have yielded modest but significant benefits and

tend to be cost-effective. It is important to keep in mind that these programs are least effective in situations where the informal sector is large,³² the targeted population is rural and lacks mobility, and labor demand is low because of macroeconomic conditions. These caveats are particularly relevant for the bottom quintile of the Romanian population. This reinforces the need for a carefully designed and comprehensive reform of labor market and social assistance policies in Romania that includes a strong activation policy component.

Activation policies aim to improve the match between labor demand and labor supply. Their objective is to fix failures specific to the labor market and help individuals to overcome constraints in their access to human and physical capital. Labor market issues often fall into one of the following categories:

- **Human capital constraints:** Insufficient skills and a mismatch between the job seekers’ skills and employers’ needs.
- **Information frictions:** On the supply side a lack of knowledge of job opportunities and on the demand side signaling and adverse selection.
- **Physical capital constraints:** Credit constraints and little support for entrepreneurship.

Each constraint calls for different activation policy responses.

Table 15 below illustrates the variety of activation programs that exist around the world and gives examples from several countries. In addition Box 4 presents some experimental studies that have been regularly cited in the economics literature together with lessons drawn from review studies.

³⁰ Kuddo (2012).

³¹ Almeida et al (2012) is an extensive review of activation policies in developing countries and draws on several country studies and examples of ongoing programs. The meta-analysis by Card et al (2010) looked at 97 studies containing 199 program evaluations of activation policies in Europe and North America and drew conclusions about their efficiency.

³² Parlevliet and Xenogiani (2008).

TABLE 15: Programs and Barriers to Work

Type of Program	Selected Programs	Constraints/ Barriers to work
Stand Alone Wage Subsidies		
	<input type="checkbox"/> A Youth Wage Subsidy Experiment (South Africa) <input type="checkbox"/> Bonificacion a la Contratacion de Mano de Obra-Chile Solidario (Chile) <input type="checkbox"/> Jovenes con Mas y Mejor trabajo (Argentina) <input type="checkbox"/> Idmaj (Morocco) <input type="checkbox"/> Stage d'initiation a la vie professionnelle (Tunisia)	Lack of skills / experience and lack of information
Skills building/ signaling		
Comprehensive Training Programs for Youths	<input type="checkbox"/> Kenya Youth Empowerment Program (Kenya) <input type="checkbox"/> Youth Internship Subprojects Program (Argentina) <input type="checkbox"/> Juventud y Empleo (Dominican Republic) <input type="checkbox"/> Taehil (Morocco)	Lack of skills / experience and lack of information
General Technical and Vocational Training	<input type="checkbox"/> ProbeCat (Mexico) <input type="checkbox"/> ISKUR Public Employment Agency vocational training (Turkey)	
Second Chance	<input type="checkbox"/> Afghanistan Primary Education Program – APEP (Afghanistan)	
Certification	<input type="checkbox"/> Chilecalifica (Chile) <input type="checkbox"/> Lifelong Learning and Training Project (Argentina)	
Employment Services		
	<input type="checkbox"/> Red CIL Pro Empleo (Peru) <input type="checkbox"/> Career Guidance Services (Slovenia, Lithuania) <input type="checkbox"/> Jobs Clubs (Lithuania) <input type="checkbox"/> Vacancy and Job Fairs (Azerbaijan)	Lack of information and lack of working capital
Entrepreneurship Support Programs		
Education	<input type="checkbox"/> Fomento del Espiritu Empresarial (Colombia) <input type="checkbox"/> Concours de Plans d'affaires Entreprendre et Gagner (Tunisia) <input type="checkbox"/> Know About Business Program (Syria)	Lack of skills / experience; lack of working capital; lack of entrepreneurial skills; lack of information
SME support	<input type="checkbox"/> Apprenticeship Training Program and Entrepreneurial Support for Vulnerable Youth (Malawi) <input type="checkbox"/> Northern Uganda Social Action Fund (NUSAF) (Uganda) <input type="checkbox"/> Economic Empowerment of Adolescent Girls (EPAG) (Liberia)	
Microfranchising	<input type="checkbox"/> Vodacom Community Services: Rural Telephone Access (South Africa)	

Source: Almeida et al (2012).

BOX 4

Lessons Learned from Experimental Studies on Activation Policies

Human Capital: Vocational Training and Second Chance Education

Despite increasing youth unemployment, both in Europe and in many developing countries, few studies have used a random design to evaluate vocational education programs. These programs typically train young inactive adults in a specific trade or practice. They tend to last from a couple of months to a year and are often coupled with a short internship. Two experiments in Latin America have had different results. On the one hand, a study of the **Juventud y Empleo** vocational education program in the Dominican Republic (Card et al, 2010) found that the program had yielded moderate increases in earnings for participants (10 percent), though this result masked a wide heterogeneity in results. Only youths living in cities with a higher initial level of education benefitted from the program. Furthermore, it is unclear whether the subsidized training provided by the program was cost-effective or not. On the other hand, a study of **Jovenes en Accion**, a similar program in Colombia, (Attanasio et al, 2009) found larger returns to this program's vocational training - 12 percent overall and 18 percent for women. In addition, the program was found to be cost-effective. The fact that the Dominican Republic program was only implemented in cities might help to reconcile the results from the two studies.

These low but positive returns are supported by the meta-analysis in the Card et al (2010) study. The authors found that most classroom and on-the-job training programs have a positive but insignificant short-term impact on earnings and probability of employment but a significant and larger medium-term impact. In any case, the success of these programs is very dependent on the content provided and the extent to which the skill needs of the local labor market are integrated into the curriculum. In addition, successful programs provide employment information to trainees before they graduate and are coupled with programs that help graduates with their job search at the end of the training period.

Employment Services and Information Programs

Two global examples of successful counseling services have been evaluated by researchers - the Restart

program in the UK (Dolton and O'Neil, 2002) and the Job Fair Program in the Philippines (Beam, 2013).

The Restart program was launched in 1987 in the UK with the aim of reducing welfare dependency. The program combined counseling and encouragement to job seekers with tighter enforcement of the conditions necessary to qualify for unemployment benefits. The Restart program was composed of an interview lasting approximately 20 minutes, which served as a stepping-stone to accessing other services such as courses, training, and job clubs. In addition, since the interview was mandatory, individuals who failed to attend faced the possibility of having their benefits withdrawn. The authors compared a treatment group who attended the interview with a control group who were phased into the program six months later. Importantly the "control" group received the same treatment but by was on welfare benefits for six additional months. Therefore, the long-run effect reflected the impact of an additional six months of inactivity on future employment. The authors used administrative data for five years after the start of individuals' participation in the scheme. Interestingly, the program had a strong short-term effect on employment but also a significant medium-term effect. The short-term impact of the Restart program generated a 10 percent higher probability that the control group would be unemployed than the treatment group. When the control group was phased into the program, the effect was reduced, but it increased again two years later and the treatment group continued to have a 6 percent lower probability of being unemployed. This result suggests that the long-term cost of inactivity and welfare dependence is high.

The Restart program was implemented in the UK's developed and principally urban economy. By contrast, the experiment described in Beam (2013) took place in rural areas in the Philippines. In her experiment, the author gave individuals vouchers enabling them to attend a job fair where recruiters provided them with job information and conducted short preliminary interviews. Although providing them with information increased people's knowledge of the needs and conditions of the labor market, it did not increase their job search effort or the probability of them becoming employed. However, the vouchers to attend the job fair had a large impact



BOX 4 (continued)

both on their job search effort and their employment probability. Job seekers changed their focus from searching for work within their province to the capital, Manila, where job searches more than doubled. Even more strikingly, 10 months after the voucher program, the probability of those in the treatment group being in formal employment increased by 4.7 percent, which was a 38 percent increase from the baseline. Therefore, this study showed that information and job fairs have the potential to generate a significant change in the behavior of rural job seekers with few initial opportunities.

The positive results from these experimental studies on job assistance programs are supported by the non-experimental studies reviewed in Card et al (2010) and Almeida et al (2012), who argued that job assistance programs are generally cost-effective and yield short-term benefits to job seekers.

Wage Subsidies

Public employment and wage subsidy programs have been much less successful in general at sustaining positive labor market outcomes for recipients. Card and Hyslop's (2005) evaluation of the Canadian Self Sufficiency Project (SSP) provides an illustration of this. The SSP offered welfare recipients a large subsidy for three years in return for finding full-time work within 12 months. A total of 5,600 single parents were separated in half between a treatment and a control group. The figure below shows that the program produced a significant short-term increase in the number of beneficiaries graduating from income assistance. However, once the subsidies disappeared, the gap in employment between the treatment and control groups fell back to zero. Welfare recipients who did not receive the incentive merely took longer to obtain a job, which was consistent with the fact that they had less of an incentive to find a job quickly. The results also showed

that the additional employment gained by the SSP group was reimbursed at a rate close to the minimum wage, and there was no significant wage growth over time. This result contradicts the on-the-job capital accumulation theory that predicts that, when workers acquire experience and skills, they progress in the labor market and obtain higher wages over the long term. Therefore, the substantial public spending on work incentives in the SSP had only a short-term effect that had dissipated entirely by the end of the program.

The SSP program is one of many subsidy and training programs that have had only limited effects. Card et al (2010) concluded that public and private subsidies for employment rarely generated large sustained improvements in labor market outcomes among the sample used in their meta-analysis.

Almeida et al (2012) concluded that providing certification for qualifications and organizing job fairs and career guidance are inexpensive policies with potentially high returns. This opinion is supported both by Card et al (2010) and by several experimental studies that found that employment services are preferable to public employment and wage subsidies that yield very low long-term returns and are much more expensive. Providing opportunities for inactive individuals to accumulate human capital is a useful and cost-effective policy tool that yields low short-term returns but often produces much larger medium-term returns. Physical capital accumulation and entrepreneurship support programs have also been successful, especially those that include an integrated mixture of grants, microfinance opportunities, and livelihood improvement components (Dieckmann, 2008; Helmut et al, 2013). These programs help entrepreneurs to set up businesses and to achieve sustainable increases in earnings. Another program that has the potential to yield great benefits in Romania is the provision of childcare facilities in order to enable mothers to enter the labor market.

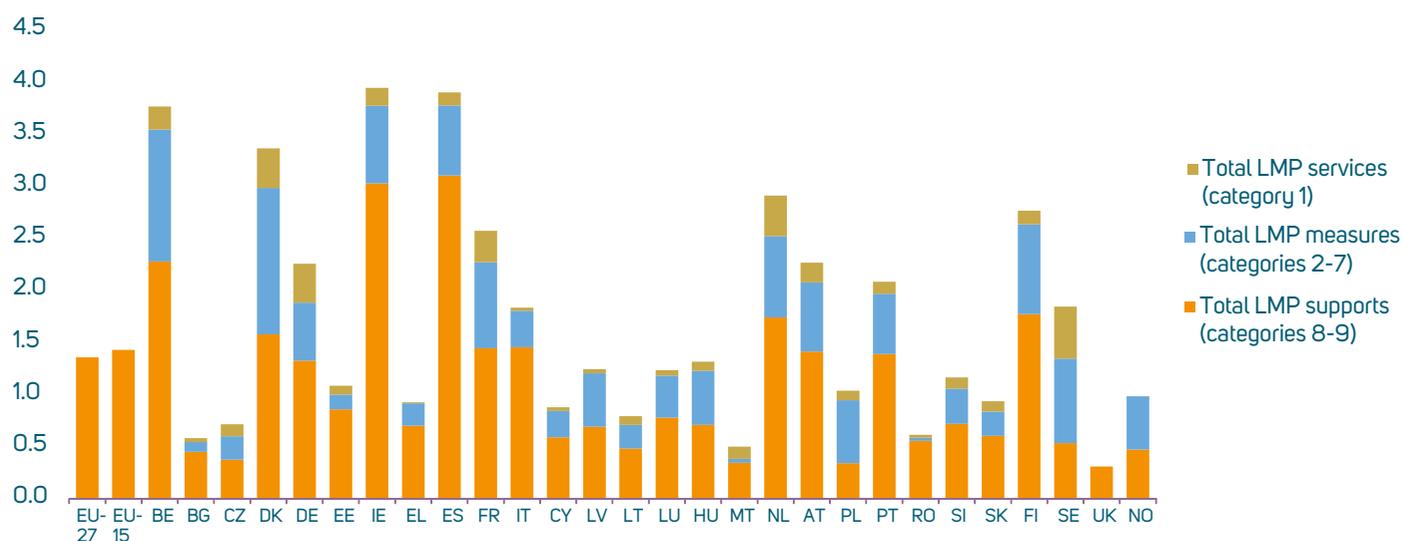
Studies have found that these various activation initiatives often yield modest but significant returns. Because these programs typically cost little to provide, low but positive returns are sufficient for them to be cost-effective. This conclusion is important since Romania currently spends a very low share of its GDP on activation policies. Figure 10 shows that Romania's spending on labor market policies is among the lowest in the EU. In particular, the difference between Romania and the other EU countries widens in the case of labor market services (in yellow) and labor market measures (blue). These categories are defined as job support, training, and incentives and therefore can be included in the definition of activation policies.

It is likely, therefore, that increasing spending on activation policies could play an important role in enabling poor and vulnerable groups to find employment. Table 16 suggests specific activation policies for each subgroup of the groups of NEETD in the bottom quintile who were identified in the previous sections. Offering vocational and apprenticeship programs tailored to these subgroups is crucial to increasing their human capital. However, these groups often face additional barriers to accessing the labor market related to their minority status and to having many children per household. Column 1 of Table 16 contains the group description and Column 2 the size of the group in

relation to the Romanian population. Column 3 shows the probability of individuals in each of the designated groups being employed (either self-employed or an employee) using a probit specification. This provides an indicator of an individual's distance from the labor market and probability of employment. Column 4 suggests activation policies for each group. The largest two groups, educated urban unemployed men and married middle-aged rural women, often have education and previous work experience and live relatively close to the labor market. Job search assistance and short training courses could be particularly effective for them. However, groups constituted of inactive youths are often much further from the labor market so they need help to build their human capital and to reach the labor market.

Over the programming period between 2015 and 2020, the government should gradually incorporate these techniques into the practice of the National Employment Agency (NEA). First, it should offer job intermediation services and ALMPs to the work-able beneficiaries of the MSII program and should introduce co-responsibilities associated with the receipt of benefits for this target group. Second, the beneficiaries need to be categorized into groups with similar characteristics, for whom the Public Employment Service (PES) to develop and provide tailored packages of services.

FIGURE 10: LMP Expenditure as a Percentage of GDP, 2010



Source: Eurostat (2012b:14).

TABLE 16: Subgroups of NEEDT in the Bottom Quintile and Relevant Activation Policies

Group	Employment Probability		Group size	Type of Activation Policy
Educated rural unemployed	76%	High	50,000	Job search assistance
Married middle-aged rural women	68%	High	114,000	Childcare, retraining, part-time work
Uneducated idle youths	67%	High	110,000	Human capital
No. of individuals – high probabilities			274,000	
Educated urban unemployed men	63%	Medium	151,000	Retraining, job counseling
Young rural family women	60%	Medium	70,000	Childcare, part-time work
No. of individuals – medium probabilities			221,000	
Single Roma youths	51%	Low	63,000	Integration, human capital
Young urban couples	48%	Low	32,000	Job services, human capital
Urban Roma family women	33%	Low	44,000	Integration, childcare
No. of individuals – low probabilities			139,000	

Source: World Bank calculations using data from the 2012-2013 HBS.

2.1.2. Reducing Informal Employment and Increasing the Productivity of Small and Medium-sized Farms

Unemployment in Romania is relatively low. In mid-2014, the unemployment level was 7.3 percent and had increased only modestly since the 2008/09 economic crisis. The unemployment rate was 5.8 percent in 2008 and 6.9 percent in 2009.

Informal employment, in contrast, is widespread and is concentrated in rural areas. About 70 percent of those who are employed are self-employed, the large majority in subsistence or small-scale agriculture. Self-employed farmers face a higher poverty risk than the unemployed because of low productivity, low enterprise density, the absence of local markets, and limited income support. Their higher risk is also related to the fact that many do not contribute to the health insurance system or to the social insurance system to secure a pension.

In order to reduce the imbalance between urban and rural areas, it is vital to increase productivity in agricultural

production, to increase the density of the enterprise structure in rural areas, and to enhance the availability of rural services and infrastructure. The government has committed itself in its various strategies (from rural development to competitiveness) to many policies that will improve the situation of rural farmers, including more and better value-added food processing and agricultural production (including forests, fisheries, and bio-mass), increasing farmers' knowledge and qualifications through technical colleges and agricultural extension services, and the further consolidation of agricultural enterprises. All of these initiatives will have an immediate impact in terms of increasing social inclusion by providing employment opportunities in rural areas. Chapter 3.1 reviews the measures needed to reduce the imbalances between rural and urban areas, as well as the rural development policies needed to reduce poverty and social exclusion.

In line with the government's National Employment Strategy, two key measures will be needed to reduce informal employment: (i) reducing the fiscal and administrative pressures on formal employment (for example, reducing the tax burden and the paperwork related to formal employment) and (ii) offering fiscal incentives to attract the unemployed and people from other vulnerable groups (who are more likely to be forced to work in the informal sector) to enter the formal labor market. The introduction of the MSII program, which will exempt 25 percent of the estimated value of beneficiaries' agricultural output or 50 percent of their formal earnings, will allow poor

small farmers to receive social assistance while earning agricultural or formal wages, which will increase their income (see Section 2.2: Social Transfers).

In order to reduce the rural-urban imbalance in terms of employment opportunities, between 2014 and 2020 the government should aim to: (i) improve training for owners of small and medium-sized farm holdings by reestablishing modern versions of agricultural outreach and farmer training schools and by professionalizing farm operations; (ii) provide investment facilities (such as access to credit) for value-added activities of food production or other agriculture-related economic activities; (iii) continue promoting the consolidation of subsistence farm holdings in the interests of increasing their productivity and sustainability; and (iv) introduce a national program for young specialists in agriculture.

2.1.3. Reducing the High In-work Poverty Rate

Despite Romania's relatively low unemployment rate, the country has a very high rate of poverty for in-work people, with 18 percent of employed workers being below the relative poverty threshold in 2010. This is double the EU-27 rate (9 percent). In-work poverty affects one in two adults in Romania (Figure 9). In-work poverty is a direct result of low productivity, the scarcity of formal employment, and weak overall labor demand in the economy. In-work poverty is concentrated in rural areas, mainly in the agriculture sector. Thus, in Romania, having a job is not enough to rise out of or escape poverty.

To partially address this issue, the government has gradually increased the minimum wage. The gross wage was increased from RON 800 on July 1st, 2013 to RON 850 on January 1st, 2014, then to RON 900 on July 1st, 2014 and RON 975 on January 1st 2015. As the minimum wage increased, a larger share of employees received the minimum wage, from an estimated 12 percent in July 2013 to 27 percent in January 2015. A proposed increase of the minimum wage to RON 1,050 in July 2015 will increase further the share of employees on the minimum wage to one-third of the total. At this level, additional increases in the minimum wage might reduce employment in the private sector for those jobs with a lower marginal productivity of labor than the (increased) minimum wage. Thus, the poverty reduction impact of this measure could be offset by

the loss of employment among low-productivity, low-wage workers.

To reduce the extent of this problem, the government should aim to: (i) reform the means-tested benefits to include incentives to find formal work and extend the coverage of these benefits to households with low work intensity through the MSII program; (ii) invest in the education and skills of low-income workers, either through on-the-job training or through lifelong learning; and (iii) create labor market regulations and social dialogue to support the ability of workers to negotiate for wages commensurate with their productivity and to mitigate the lack of control that many workers currently have over what they earn.

A key measure aimed at reducing in-work poverty is the introduction of a 50 percent earning disregard in the MSII benefit formula (described in the next chapter). This measure will make it possible for beneficiaries to receive social assistance support while working for low wages, effectively extending the coverage of this program to the in-work poor and raising their total income. This will be an improvement over the current design of the means-tested programs, which, in the case of the GMI, implicitly tax any extra earnings. Over time, the MSII beneficiaries could qualify and obtain tailored ALMPs. This measure, which is described in Section 2.2.1, will also help to increase their skills and wages.

2.1.4. Increasing the Institutional Capacity and Resources of the Public Employment Service

The NEA and professional training institutions (such as vocational training centers) currently do not have enough staff to be able to serve all job seekers, the unemployed, people who have not found a job after finishing school, those who have a job but would like to change it, refugees or people who are protected by international agreements and are looking for jobs, and people who cannot find a job after being repatriated or released from prison. Spending on active labor market programs (ALMPs) in Romania is among the lowest in the EU (0.029 percent of GDP in 2011). Furthermore, there are few institutional links between labor market services, economic development promotion, and education institutions.

The first two sections of this chapter have illustrated that about half of all work-able prime-aged adults in Romania are in the poorest quintile. Currently, only a small fraction of them are covered by the GMI program, are receiving benefits with job-search co-responsibilities, and/or have access to ALPMs. When the MSII program begins in 2016, it will extend benefits with job-search co-responsibilities and access to ALMPs to almost all poor working age adults. This could result in an increase in the employment rate of the poor of between 7 and 17 percent by 2020. In order to ensure this is achieved, the NEA's resources – both staff and operational – and the budget allocations for ALMPs will have to be increased.

The administrative capacity of the NEA could be strengthened if it were to create local partnerships to implement ALPMs, especially in marginalized urban communities, and to contract out some of its services to NGOs. These and other measures are included in the NEA Strategy and the government's Operational Program Human Capital Development 2014-2020 (POCU). Given the limited resources allocated to the NEA from the state budget, all of these interventions will have to be supported by the European Social Fund (ESF) through POCU 2014-2020, priority axis 3.

The needs of the long-term unemployed and the future recipients of the MSII program could be better met by the development of specialized local employment services (ALOFM) in marginalized urban areas. These ALOFMs would be designed to be client-focused with services tailored to marginalized job seekers who want to work but have given up hope of ever getting a real job in the formal economy. Therefore, although beneficiaries of the MSII would be required to attend their nearest ALOFM in return for receiving social assistance, they are likely to see this as a positive development rather than a negative conditionality.

Creating local employment services in or near disadvantaged communities would require a major management effort on behalf of the NEA. This effort (including extensive management and operational staff

development) would need to be made at both the county and central levels. The NEA would have to develop operational guidelines for how clients should be treated in the guidance and counseling process. The NEA would need to develop or extend its contracting skills and its capacity to build local partnerships. This would not be just a question of sub-contracting to a local NGO (although NGOs would be an important part of the model). A national structure and vision would be needed to make it happen if the government were to decide to pilot these local employment services.

In rural areas, especially in marginalized communities with a high share of non-working adults, it will be necessary for the Public Social Assistance Services (SPAS) to provide job seekers with information about job intermediation and to refer them to ALMPs. Because this will increase their workload, the SPAS will need more staff who will need to receive training in how to access the NEA's e-services (for example, in job mediation).

A lower-cost alternative to creating local employment services would be to support social inclusion through ICT development. Modern customer-orientated ICT systems and "virtual PES" systems can enable PES staff to spend more time on their more demanding and needy clients. The NEA's ICT systems have all the necessary elements, but they need to be harmonized and coordinated. For example, it would be useful to scale up nationwide the current project-based initiatives such as the call center and electronic-clerk booths that have been introduced in Cluj (Box 5) and few other counties. International reviews suggest that many people are happy to use self-service tools to access good quality information and guidance tools, to conduct self-assessments, and to pursue job vacancies instead of having to come in to the PES office. One or more of these self-service options should be available to most clients either because they own a mobile phone or because they can access the Internet in libraries, cafes, at home, or in school. The recent surge in the use of mobile phones in Romania has opened up possibilities for social inclusion because now most of the unemployed have access to them even if their incomes are low.

BOX 5**The ICT-supported Pilots of the Cluj County Employment Agency**

The financial and economic crisis in 2008 led to a sharp increase in unemployment in Romania, with a resulting increase in demand for unemployment benefits and employment services. It was necessary to deploy ICT solutions to enable the National Employment Agency (NEA) to cope with the crisis. In addition, the agency's administration system – which relied heavily on face-to-face contact and paper-based processes – was weak and open to manipulation and abuse.

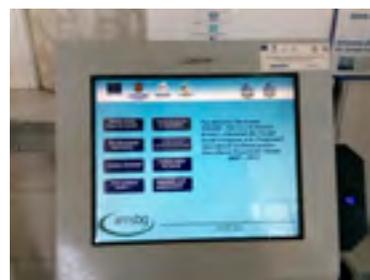
A new strategic ICT system, integrating passive measures (such as paying benefits and compiling job listings) with active measures (such as job-matching, job-counseling, and training), was developed with €4 million of support from the EU. This new system makes heavy use of technologies such as automated kiosks and a dedicated call-center that helps clients with job matching, interviews, and training. In addition, the conditionalities associated with the receipt of cash benefits was tightened and now include the requirement that the local Town Hall verifies that recipients have been abiding by conditionality by working in local employment schemes. Essentially, most face-to-face contact with clients was ceased in favor of an automated relationship.

Jobs Database

The new ICT system revolves around an Internet-based database of jobs advertised by employers in the territory covered by the Cluj County Branch of the NEA and another 10 counties (sso.ajofmcj.ro). It is mandatory for employers to post all job vacancies on the county employment agency's website within 24 hours, though they are also free to also use private sector recruitment firms. Employers register with the NEA and obtain an account name and password and then post details of their vacancies. The system has apps for users (both employers and job seekers) to download and facilitate job searches. Employers with no IT facilities can come to the NEA's office and use the kiosks to advertise their vacancies. All job seekers (including those not receiving unemployment benefits) can also use the agency's website to find jobs.

Kiosks

The Cluj employment agency has rolled out the kiosk system in six offices throughout the county. Job seekers can use the kiosks or the website to search the vacancies list. People who are receiving unemployment benefit must log in at a kiosk on a given date each month. The log-in procedure involves using a fingerprint and a compact disk, which cross-check with each other to verify the person's identity. The compact minidisk holds the fingerprint, and a reader attached to the kiosk reads the fingerprint and cross-checks with the inserted mini-disk. The fingerprint and minidisk are recorded and set up when the job seeker first registers as unemployed.

The Electronic Clerk System Piloted in Cluj County**Call Center**

Once job seekers are logged into the kiosk, they automatically receive a printout with the details of vacancies and employers for which they qualify. The employment agency's call center follows up by arranging interviews. The call center also follows up on cases where the system identifies any training that might be suitable for the job seeker in question. The call center's database records and tracks all job-counseling activities undertaken in respect of the registered job seeker.



BOX 5 (continued)

The call center operators all have qualifications in job counseling. Interestingly, the call center does not accept calls from job seekers or employers. It acts as a mediator and uses the job vacancy and unemployment register databases to connect job seekers with employers and vice versa. The call center's system automatically sends an SMS text message (including text to speech format) to the job seeker as a follow-up after every phone call.

Extension of the System

The present system is not designed to cover seasonal employment or self-employed people who have contracts with their employers. In addition, legal loopholes mean that vacancies in certain job categories, for example, teachers, do not have to be reported to the database. There are plans to extend the kiosk service to all town halls in the county, probably within the context of the new Electronic Center for the Mediation of Work Project – 2014-2020 to be funded by the EU.

Sustainability

The Cluj employment agency's current management information system (MIS) is quite complex and impressive. It features a blend of relatively sophisticated automation and skilled manual interventions. The job-matching function is client-oriented and seems to work well. The call center function uses specialized call center software and relies on skilled staff to operate the system. While the Cluj County branch of the NEA has a total of 50 staff, the majority of the staff involved in managing the kiosk technology and the call center are private sector contractors, the costs of whom are being funded by the EU project.

Source: Notes of the World Bank team mission's visit to the Cluj County Employment Agency.

connect to and access private agency job websites (in real time) both in-country and abroad. On the one hand, this has the potential to radically increase the number of vacancies available via the NEA's system through the extension of the agency's already positive partnerships with private agencies and with newspapers. Currently, if somebody wants to register with the NEA for benefits, they must visit an NEA office to complete a registration form, which is a curriculum vitae (CV) with some added questions related to the NEA's guidance interview. If all job seekers could register online directly, then this would result in savings in terms of both money and staff time. Employment mediators at the call center could also give live advice directly to clients over the Internet using voice-over IP. Then when clients go into the NEA office to see an officer, their electronically completed registration would already be in the system, thus making the interview more efficient in terms of both resources and time. This approach is used in Sweden and Belgium and has been implemented in the call center in Cluj. A further extension of this approach would be to allow job seekers to complete a "profiling" tool online as is discussed in Annex 3 Section II.

The NEA has carried out no systematic outcome and impact evaluations of ALMPs, but there is a wealth of data in the NEA ICT system as well as data that can be accessed through the system's connections with other national databases. It is crucial that such evaluations are done to maximize the efficiency of investments in ALMPs and to ensure that the ALMPs are increasing social inclusion. It is currently possible to calculate the job placement rate achieved by ALMPs using existing ICT systems. If the payroll tax database were added, a longitudinal cost-benefit analysis could be done. Since such a range of high-quality data is available, it is therefore recommended that the government explore the possibility of introducing the placement calculation approach from outlined in Annex 3, Section III. The more common approach taken in many European countries is to assess the effectiveness of ALMPs by conducting follow-up surveys of a representative sample of those who completed their participation several months previously. These surveys also gather data on a range of qualitative indicators such as the participants' perceptions of the quality of the ALMP, the extent to which they used the skills acquired during their participation in the ALMP in their subsequent employment, and their perception of the extent to which the ALMP helped them to find work. The NEA could gradually adopt this survey approach.

In conclusion, policymakers should make the activation of the inactive and unemployed a high priority in the design and delivery of services for the socially excluded. Given

Using ICT to deliver job search services expands the number of job opportunities available to job seekers and increases the efficiency of employment services. In Europe, public employment offices generally display only a small proportion of the vacancies available nationally in the labor market on any given day (with some exceptions such as Sweden and Germany). It is now technically possible to

the low resource endowment of the NEA, it is difficult to implement effective activation programs. Despite the low labor demand on the Romanian labor market at the moment, policymakers should aim to engage the inactive, the underemployed, and the in-work poor as well as registered unemployed job seekers. This is especially important in light of the high poverty risk to which many inactive and out-of-work individuals are exposed, such as non-working women in rural areas, the long-term unemployed, and beneficiaries of the Guaranteed Minimum Income program.³³

There is a need to increase the resource allocation to - and improve the management of - labor market institutions and activation programs for socially vulnerable groups and the in-work poor. Improving the functioning of the Public Employment Service and associated institutions such as secondary schools, TVET institutions, technical colleges, and social assistance offices will require increasing funding from the state budget, making better use of resources from the European Structural and Investment Funds (by increasing the absorption rate while using them more strategically), broadening access and service channels to the NEA (including via ICT), and developing assistive devices and technologies for work-related situations, particularly for people with disabilities. It will also be necessary to increase the NEA's administrative, managerial, and informational capacity to design, deliver, and monitor labor market programs for job seekers and vulnerable groups. This might include the creation of a delivery unit team to support NEA management as well as a customer segmentation and analysis unit.

2.1.5. Increasing the Employment Rates of Vulnerable Groups

Many marginalized groups in Romania, especially Roma, people with disabilities, NEETD youths, and the long-term unemployed, have markedly lower employment rates than the rest of the population. This is also the case for women, with the gender employment gap in Romania being 3.7 percent higher than in the EU-28.

Roma

The Roma are a young population, and an increasing share of new labor market entrants come from Roma families. Children and youths aged between 0 and 14 years old - the new generation of labor market entrants - make up almost 40 percent of the total Roma population but only 15 percent of the general population. At the same time, about 17 percent of the general population in Romania is 65 or older, a proportion that is projected to grow rapidly in the near future. The youthful nature of the Roma population thus stands in stark contrast to the fast-aging profile of Romania's general population. Depending on the estimates of the Roma population, between 6 percent and 20 percent of labor market entrants in Romania today are Roma. As the overall working age population in Romania is projected to fall by 30 percent by 2050, the Roma share is expected to grow.

Roma men and women are largely excluded from labor market opportunities in Romania. Roma are employed far less often than non-Roma, even when comparing Roma to their non-Roma neighbors in the same regional labor markets.³⁴ This reflects their low labor market attachment, which in turn stems from their discouragement about their limited prospects of finding work. The labor force participation rates of working age Roma (57 percent among men and 34 percent among women) are lower those of their non-Roma neighbors (67 percent among men and 42 percent among women). Romanian Roma also have higher unemployment rates, meaning that many of them are looking for work without being able to find it. Moreover, among those who are employed, the jobs they hold are for the most part unstable and informal. Household survey data show that only about 35 percent of Roma employment is formal (based on a written contract or legal business documents) or covered by health and pension insurance, in contrast with 81 percent of employment among non-Roma living nearby. Many of the jobs held by Roma require only low skill levels - probably as a result of their lack of skills - and are poorly paid. For example, many working Roma are employed in low-paying agricultural jobs.

In a typical Roma household, only €101 per month is brought in as income from employment compared to €218 in non-Roma neighboring households. Roma households typically have a lower share of income coming from employment than do their non-Roma neighbors. Their

³³ World Bank (2014: 5).

³⁴ de Laet et al (2012) based on the regional UNDP/World Bank/EC regional Roma survey (2011).

alternative income sources are also very limited. For example, Roma people have fewer assets that could be used to develop an agricultural livelihood. Most Roma own plots of arable land smaller than half a hectare. Furthermore, they report that due to the discriminatory restitution procedure, they tended to receive low-quality land in unfavorable locations that is of little use for cultivation. Traditional trades were strongly discouraged by the former socialist regime and, consequently, have almost disappeared. Many Roma resort to other activities such as collecting empty bottles, paper, or scrap metal and returning them for refunds or selling used clothes, livelihoods that are time-consuming, poorly paid, and extremely vulnerable.

Roma marry young, begin childbearing early, and have high dependency ratios. About 28 percent of Roma between the ages of 15 and 19 years are married, as opposed to only 2 percent in the general Romanian population. According to the Regional Roma Survey (RRS) of 2011, the mean desired age to start having children is 21 years old for Roma women compared with 26 years old for non-Roma women. In part because of early marriage and childbearing, the Roma population has a higher dependency ratio than the population at large, meaning that more people who are not in the labor force depend on community or family members who are gainfully employed. This, coupled with low employment rates, exacerbates poverty levels.

Unemployed Roma benefit from the same labor market policies as any other group of the population. The NEA does not have a separate budgetary allocation for programs aimed at Roma, thus ensuring non-discriminatory access. While this non-discriminatory approach is based on the right principles, it results in a lack of budget and capacity at the local level to deal with issues that are specific to poor, unskilled job seekers, including many Roma. However, it is important to note that 72,222 Roma were mediated in 2013 according to NEA records but only 4,655 were actively placed in jobs. Since many Roma do not declare their ethnicity, it is highly likely that more NEA Roma placements have happened but were not recorded as such.

The NEA delivers some existing ALMPs that target Roma among other groups. These include Open Days, Job Fairs, Employment Caravans, and "Program 140" for communities with a large Roma population, which focuses on disseminating information, mediation, and counseling, as well as on the promotion of dialogue between the NEA and local Roma representatives. As these programs have no

budget, they are unevenly implemented at the local level. Each county employment office may decide to implement one or more of these programs or not depending on local conditions and needs. In partnership with civil society organizations, the county employment agencies have provided support and programs designed to meet the job-seeking needs of Roma women in particular.

The participation of Roma in professional training is low compared with that of non-Roma and amounts to approximately 3 percent of the registered unemployed. In addition, only 5 percent of Roma succeed in finding employment (compared with 33 percent of non-Roma). The evidence suggests that the main causes for the low participation of Roma in professional training are: (i) Roma find it difficult to enroll in training programs, mostly because the prerequisite is to have attended school up to 8th grade (although some courses are available in vocational and technical colleges for low-education entrants such as the baking, textiles, and confectioner's training courses in Calarasi); (ii) there is no financial support available for these courses; (iii) there is a mismatch between the skills being learned in the training and the jobs available for Roma; (iv) many Roma cannot afford the costs related to the transportation needed to obtain the documents required for enrollment; and (v) there has not been enough marketing of the potential benefits of the training and of a marketable certification.

Given that discrimination is a barrier to the employment prospects of most Roma, the NEA plays a key bridging role between prospective employers and Roma job seekers. Other actors that can provide a bridging function include municipal authorities, churches, community-based organizations, NGOs, social workers, community mediators, and Roma mediators. It is important to set realistic but ambitious targets for the inclusion of Roma in the labor market and to provide adequate human and financial resources to the NEA in order to meet those targets.

Low participation in and restricted access to stable, gainful employment reinforce precarious incomes, a high risk of poverty, and social exclusion among Romanian Roma and limit the opportunities available to their children. In 1992, it was estimated that 63 percent of Roma families lived in absolute poverty. Another 18 percent had total income greater than the minimum subsistence level but not enough for a decent life.³⁵ Since then, both the incidence and the depth of poverty have remained disproportionately high

³⁵ Zamfir and Zamfir (coord., 1993).

among the Roma population. High rates of joblessness and job instability not only restrict income and perpetuate poverty among adults but also take a toll on children, leading to absenteeism and dropping out of school, malnutrition, and chronic diseases. These in turn perpetuate the limited labor market opportunities that Roma currently face. Because of the low and irregular incomes that they earn from work, many Roma households end up relying on child allowances and on irregular and low-value streams of informal income. In some cases, school-aged children are expected to contribute to their family's income by working within the household or by seeking informal work.

Increasing the social inclusion of Roma is not only a moral imperative but is also smart economics for Romania. With an aging population, pension and health care costs are bound to increase in the near future. Ensuring more equal labor market opportunities could enable faster productivity growth and could yield fiscal benefits in terms of increased revenue from taxes and lower social assistance spending. According to a World Bank estimate based on 2008 data, assuming an equal number of working age Roma men and women and assuming that average wages in the economy remain unchanged, equalizing labor market earnings in Romania for Roma could result in potential economic benefits ranging between €887 million and €2.9 billion annually and in fiscal benefits ranging between €202 million and €675 million annually.³⁶ While these numbers are based on overly simplified assumptions about adjustments in the economy and the labor market, they illustrate the economic potential of Roma inclusion. The challenges related to narrowing the very large gap in labor market outcomes become more significant in light of the aforementioned demographic trends in which Romania will experience a substantial increase in the proportion of elderly people and a shrinking of the size of the working age population. Ensuring the labor market inclusion of the younger Roma population could help to address the fiscal and economic challenges presented by these demographic trends.

People with Disabilities

In Romania, a very low percentage of people with disabilities are active in the labor market - only 7.25 percent of people with disabilities between the ages of 18 and 64.

The main reasons for this are: (i) the administration of the disability assessment; (ii) the unpredictable result of

this assessment from one year to another; and (iii) the connection between the individual's work capacity and disability status. Thus, the disability indemnity and the complementary budget are the main sources of income for most Romanians with disabilities.

The most common situation encountered by the families of people with disabilities is that one of the parents (usually the mother) has to quit her or his job and becomes the personal caregiver for the child or adult with a disability. The minimum income paid to this assistant, along with the disability-related cash benefits, barely cover the costs incurred by such families. When these families have two children with disabilities, the situation is even more critical.

People with disabilities have the same right to work as all other citizens, but they often need additional support in order to prepare for, find, access, retain, or regain employment. As in the field of education and access to all other services of the community, in the labor sector people with disabilities often need modifications to the work environment to enable them to perform the essential functions of the job. People with disabilities may need any or all of the following types of support services for employment: (i) assistance with job seeking; (ii) mediation for employment; (iii) a job coach after they have been hired; (iv) individualized support and supervision in the workplace; (v) sign language interpretation; (vi) assistive devices and technologies; and (vii) the adaptation of the workplace to create a barrier-free environment with accessible transportation, buildings, public areas, and information.

In Romania, during the previous regime, support services for employment and work for the disabled were almost non-existent. Adults with disabilities worked in sheltered workplaces (organized in residential institutions, special schools, cooperatives for the disabled, or specific sections in psychiatric hospitals). The spectrum of professions for the disabled and of the corresponding vocational training programs organized in the public special schools was very limited in the previous regime, usually consisting of cooking, painting, woodwork, and crafts, the making of brushes, the operation of telephones, packaging, and massage (usually in the case of people with sight impairments). These qualifications still exist in the curricula of many professional special schools in the country. Many disabled people were assessed as being "incapable" of working or told that the only option available to them was the sheltered work. The entire system of vocational and professional training

³⁶ World Bank (Anan et al, 2014).

was segregated into special schools, professional special schools, and sheltered workshops.

Nowadays, despite many obstacles, people with disabilities can enter the open (and highly competitive) labor market. A study by the Motivation Foundation and the Academic Society of Romania (SAR) from 2009 showed that only 1 percent of employed people with disabilities were working in sheltered units at that time, and most were choosing to find work on the open labor market. A quota system exists in Romania, as in the majority of EU member states. Romanian law specifies that companies with more than 50 employees must ensure that at least 4 percent of their staff are comprised of people with disabilities. If not, they need to pay an amount equivalent to half of the minimum income for all positions that are not occupied by people with disabilities or to buy products from the sheltered units. This system was designed to create an estimated 140,000 positions for people with disabilities. However, the current number of disabled people in formal employment is only approximately 29,000. The penalties that are collected go into the general state budget and not in a budget that might be used to stimulate the creation of jobs or to adapt workplaces for disabled people.

People with complex dependency needs, challenging functional limitations, or severe medical conditions have the option of working in sheltered units. It is important to avoid the perception that this type of employment is associated with people with disabilities. In all European countries, sheltered units are designed as a solution for any individuals who have very little ability to function in the competitive labor market.

NEETD Youths and the Youth Guarantee Program

Although unemployment stood at 7.3 percent in 2012 and had barely increased after the 2009 economic crisis, youth unemployment and the proportion of young people not in education, employment, or training (NEET) had both increased since 2009 as a result of the economic crisis (to 22.7 percent and 16.8 percent respectively in 2012). Both figures have recently started to decline, but the NEET rate is still well above the EU average (13.2 percent in 2012).

The Youth Guarantee is a European Union program for tackling youth unemployment by providing tailored

access to jobs, apprenticeships, traineeships, or continued education. Romania is actively implementing the measure, and the NEA will play a central role in its implementation, although it will not directly manage it. The “guarantee” is that all young people under 25 – whether registered with employment services or not – get a good-quality, concrete job offer within four months of them leaving formal education or becoming unemployed. The offer should be for a job, apprenticeship, traineeship, or continued education and should be adapted to each individual’s needs and situation. Under the latest Youth Guarantee initiatives, the government aims to ensure the delivery of 7,000 apprenticeship places during 2014 and 2015.

This has important resource implications for the NEA and other implementing agencies. The NEA will be the main catalyst for the implementation of the Youth Guarantee initiatives. In a departure from past approaches, the new Youth Guarantee Centers are to be directly managed by the MLSFPE jointly with the Ministry of Education and Youth, and the registration database is being expanded to capture more data from the educational institutions and other services. The Youth Guarantee database will ultimately be integrated into the NEA’s ICT system. As a joint initiative, the Youth Guarantee will require an effective and coordinated management structure. The PES are expected to be the main Youth Guarantee service providers, but local authorities will also play a vital role in terms of providing education and training services as will the new regional authorities to be established following the planned reorganization of the territorial administration. Currently, a significant number of local authorities are involved in the implementation of projects under the previous Social Operational Program, Human Resources Development 2007-2013.

According to the EU Commission,³⁷ the most important challenges that will need to be overcome in order to deliver the Youth Guarantee in Romania are:

- There is insufficient administrative capacity in the PES to offer individualized services to all young unemployed and to unregistered NEETs.
- There is too little flexibility and diversity in terms of activation services and of the training and education available to young people.

³⁷ European Commission (2014d).

- There are not enough outreach activities to non-registered young NEETs and in particular to young Roma.
- There is a lack of genuine involvement by the private sector in providing apprenticeships, dual training initiatives, and traineeships for university graduates.

The main NEA measure providing customized support to disadvantaged and socially marginalized youths, including those leaving institutional care, is the Solidarity Agreement Program. Through this, the NEA provides young job seekers with professional guidance and mediation services and matches them with suitable employers. In 2014, the NEA's target was to place 1,400 young people in jobs through mediation, job fairs, referral to specialized providers, the provision of basic skills training, and the provision of subsidies to employers. The program placed 894 youths in jobs in 2013 and 1,221 in 2012. The companies are also provided with a bonus when they award an indefinite employment contract to a job seeker after the end of the solidarity agreement.

During the preparation of this of this background study, a set of simulations was used to estimate the impact of introducing this program on young high school and university graduates who are NEET. The simulations showed that fully implementing the Youth Guarantee³⁸ would reduce the overall poverty rate by 0.4 percentage points by 2016. The impact was even more significant when the analysis focused on the Youth Guarantee target group - youths aged between 18 and 25 - for whom poverty would decline by 1.7 percentage points, with the decrease being much greater for men than for women.

Work-able GMI Beneficiaries

The availability and quality of activation services are of particular importance to the current beneficiaries of the GMI program and will continue to be so for the beneficiaries of the MSII program after 2016. The GMI clients of the PES are not a homogenous group. Generally GMI beneficiaries include older people living on their own, unemployed people, the homeless, young people leaving institutional care, and those who have never been employed. Job intermediation and ALMP services need to be more tailored in order to take this heterogeneity into account.

BOX 6



Characteristics of Successful Active Labor Market Programs for Young People

The OECD Employment Outlook for 2006 suggested that successful programs appear to share some characteristics as follows:

- Job-search assistance programs are often the most cost-effective among ALMPs in terms of providing positive returns in the form of higher earnings and employment. Some wage and employment subsidy programs have yielded positive returns, but these measures tend to perform poorly in terms of their net impact on participants' future employment prospects.
- Training programs are most successful when they are carefully tailored to local or national labor market needs. In this respect, mobilizing and involving the private sector and community leaders to assess local or national demand for skills is important.
- Good targeting is important. For instance, there is a need to distinguish between teenagers and young adults and to devote particular attention to early school leavers. The most desirable solution to the employment problems of teenagers is to help them to remain in (or return to) school, whereas for young adults in their twenties, it is more important to help them to acquire work experience.
- It is important to make participation in programs compulsory after young people have been looking for a job search for no more than six months. While this may increase costs and reduce the average effectiveness of the programs, making participation compulsory is likely to be the only way to ensure that the programs will reach the adults and youths who are most at risk of social exclusion.

Source: OECD (2006).

³⁸ In this simulation, the assumption was that all school graduates (high school and university) are offered continuous education, training, or jobs. The focus of the simulations was on those individuals who had finished school in the previous year (the cohort aged 18 to 25 years old) who are unemployed or are out of the labor force. For those with a high school education, we assumed that two-thirds would move into continuous education and one-third into jobs (we estimated wage levels for the individuals most likely to find jobs). For those who finished university, the assumption was that 20 percent would go on to training and 80 percent would move into jobs (the same methodology was used to estimate their wages).

The inconsistent way in which social assistance and employment services at the local level deal with GMI recipients is one reason for the apparent lack of positive employment outcomes for these beneficiaries. The SPAS refer GMI beneficiaries to the county employment agencies (AJOFM) where they are required to register every three months to demonstrate that they are seeking work. For both GMI beneficiaries and recipients of other types of social assistance, a SPAS occasionally by-passes the AJOFM and contacts employers directly about particular clients. The lack of a coordinated approach between the two services may be because some AJOFM staff assume that GMI beneficiaries lack the motivation to look for a job and are only signing on to qualify for the transfer and to access other benefits such as health services. Some hard-pressed AJOFM local staff feel that scarce ALMP resources might be better spent where in their view a result is more likely to be achieved. At the same time, some SPAS social workers feel very dissatisfied with the services provided by some AJOFM offices. SPAS representatives believe that GMI beneficiaries would be employable if

more resources were available to fund more intensive pre-employment preparation of clients (such as basic social and technical skills training or remedial education). However, no incentives exist for the NEA and SPAS to support the higher-cost GMI beneficiaries. Introducing a differentiated cost-per-placement budgeting system that takes into account the higher cost of serving the GMI clients could make it financially possible to reallocate some of the AJOFM services toward this group.

The decentralization of responsibility for GMI clients to the counties means that the approach taken varies widely across the country. Stronger central coordination at the national level, perhaps in the form of a joint working group involving representatives of both the SPAS and the CEAs, might improve processes and outcomes as would linking their ICT systems to facilitate the tracking and case management of GMI clients. In addition, a customized holistic multi-agency approach, with perhaps a specialized employment service, will be needed to maximize the number of GMI clients (and future MSII clients) who can enter or re-enter the labor market.

TABLE 17: Number of GMI Beneficiaries Registering with the NEA, 2013–2014

	2013	1 st quarter of 2013	1 st quarter of 2014
Registration inflows	826,142	180,189	214,265
GMI registrant inflows	117,484	29,947	41,993
Proportion of GMI registrants	14.2	16.6	19.6

Source: National Employment Agency Head Office.

The tracking of the employment outcomes of GMI job seekers is currently weak, and the NEA does not provide such disaggregated data. In order to do such an analysis, it would be necessary to access the databases of the National Agency for Payments and Social Inspection (ANPIS), which manages the GMI, and the databases of the Labor Inspection Institution, which manages all labor contracts signed in Romania. Analysts would first have to check the database of ANPIS for job seekers who benefitted from the GMI in 2013, for example, and then crosscheck this list with the Labor Inspection database for

the years 2013 and 2014 to track which GMI clients had found employment. This would be in line with the OECD approach that: “the effectiveness of measures for activating non-employment-benefit recipients will often be enhanced by improved coordination - or even integration - of the main PES organization with welfare services and disability employment services. Where separate administrations exist, they may not regularly share client information and resources such as job vacancies, and they may have different management views on issues such as work-availability requirements.”³⁹

³⁹ Carcillo and Grubb (2006: 42).

Support Services for the Employment of Vulnerable Groups

The system of support services for employment is not clearly regulated and receives only limited public funds. Job coaches have occupational standards, but there are none for mediators or counselors yet. Nor are there any training programs for these professions at the national level, except for some provided by NGOs.

There is a case to be made for PES to be staffed by specialists who have been trained to address the particular needs of Roma job seekers. This is the practice in some national PES, for example, in the Czech Republic. The outsourcing of employment services for Roma is also common in many PES, and there have been some examples of outsourcing in Romania such as the RUHAMA foundation in Bihor County.⁴⁰ The government's main role should be to set realistic but ambitious targets for Roma inclusion in the labor market and to provide adequate and specifically targeted budgets for ALMPs. The actual provision of job search services, guidance and counseling, self-employment, and training services can be contracted out to a network of specialized providers.

For people with disabilities, the approach taken in many European countries has been to include them in mainstream employment services. If this approach were taken in Romania, it would require all NEA mediators and counselors to be trained to deal with people with disabilities as part of their mainstream services. Support could be provided by the existing cadre of regional specialist centers for people with disabilities, which could also in turn, take on more mainstream mediation roles if required and if time were available. A Guidance Resource Center (GRC) for job seekers is available in some counties, and some may also be able to provide for people with disabilities. Most of these resource centers are very sparsely staffed with insufficient numbers of trained guidance counselors. For example, there is only one GRC in Bucharest, and its resources in terms of both staff and space are limited. The current National Employment Strategy 2014-2020 proposes to increase the numbers of and resources for such centers. The provision of one-on-one guidance and counseling for people with disabilities seems to be quite sparse, mainly as a result of the shortage of human and physical resources. The main

services designed to facilitate access to employment for people with disabilities in Romania are the following:

- Mainstream services for vocational training and employment including:
 - Vocational training
 - County Employment Agencies (CEAs)
 - Annual workplace fairs (târgul locurilor de muncă)
 - Fiscal incentives for employers who hire people with disabilities (196 were funded in 2013 according to the NEA)
 - A quota system (the requirement that all institutions with over 50 employees must hire people with disabilities)
- Specific services for people with disabilities including:
 - Special professional schools
 - Public Occupational Centers (CITO/ DPPD)
 - Sheltered units
- Services to support inclusion:
 - Job search assistance and mediation for employment
 - Supported employment
 - Job coaching during the working period in semi-sheltered units
 - Individualized support and supervision in the workplace
 - Sign language interpreters
 - Easy-to read information
 - Adapted transportation
 - ICT and assistive devices for employment.

In Romania, several NGOs, as well as a small number of DGSACPs have initiated or supported employment projects aimed at securing long-term employment for people with disabilities. The Center for Resources and Information for the Social Professions (CRIPS) has taken the first steps to ensure that "job coach" is a recognized profession in the Romanian Classification of Occupations. Several NGOs have created social enterprises that employ disabled people such as toy factories, bakeries, printing, packaging, tailoring, and craft activities and have had significant results

⁴⁰ www.carierebihor.ro

(including Pentru Voi in Timisoara, Alpha Transilvana in Targu Mures, Alaturi de Voi in Iasi, Motivation in Clinceni, and Hans Spalinger in Simeria). The Corporate Social Responsibility has gradually become an instrument for including people with disabilities in the labor market or for financing projects related to supported employment.

Romania could consider contracting out services with performance-based staged payments as a way to target resources to the long-term unemployed or to other specific disadvantaged or vulnerable groups. This has been tried in Germany, the Netherlands, the USA, and Australia and is currently being introduced in Ireland. In Australia, the government contracts out the placement of clients to either private organizations or NGOs and pays their fees in stages according to how many of the contractor's clients stay in their placements. If a client remains in the placement for, say, six months, then the government pays the contractor the full placement fee, whereas if a client leaves the job after, say, only three months, the government pays the contractor only 60 percent of the fee. The fees are also based on the client's distance from the labor market. In the case of Romania, the government could specify that it will pay maximum fees for successful placements for GMI beneficiaries and Roma, for example. Intermediate payments could also be made based on the achievement of an interim target such as the completion of a vocational training program designed to enhance a client's employability. In Australia, the government pays the contracted agency a fee of 80 dollars for placing a recently unemployed person whereas it would pay 1,200 dollars for placing a long-term unemployed person. This will pay for itself if the client stays in the job for, say, 12 months, as the government will save on benefit payments and will receive both income and purchase tax (due to increased purchasing power) from the newly employed worker. Lower costs and higher placements have been recorded in some of the national PES that have pursued this approach.

An inclusive labor policy should aim to increase employment rates for vulnerable groups and women. Young people in general, rural residents, women, and specific vulnerable groups (including Roma, disabled workers, youths leaving institutionalized care, and ex-prisoners) face higher barriers to entering the labor market. These groups can be helped to access the labor market by specific programs and robust anti-discrimination policies in companies and public institutions. Romania already has anti-discrimination legislation in place in all laws in the employment and social assistance fields. Additional efforts are needed to increase the awareness and impact of this legislation.

BOX 7



Successful EU Approaches for Integrating the Low-skilled and Long-term Unemployed into the Labor Market

Taking an individualized approach to helping the long-term unemployed to find work is one of the key recommendations of a recent OECD report. The report evaluated several successful person-centered approaches and found that they had the following common characteristics:

- They provided continuity of support and the right support at the right time.
- They were holistic interventions rather than focusing on only one aspect of employability.
- High-quality personal advisors were available to support an individual's needs. Having the same person act as coach and mentor helps to build client confidence and to establish a positive relationship.
- They made an early assessment of each client's basic skills and devised a plan to enhance them.
- They provided continuity of training even after the client found a job.
- They helped the clients in their job search activities.
- They took a long-term approach and continued to provide their clients with support even after they are employed.

Evidence from other EU countries confirms that the most successful services also provide intensive person-centered counseling to re-motivate the long-term unemployed to resume their job search with frequent sessions with the same counselor. Intensified support brings positive results. These types of integrated approaches require collaboration between or even the integration of different agencies and organizations around a central caseload management and tracking system.

Source: European Commission (2014c: 13-14) and OECD (2013c).

In order to ensure that vulnerable groups are able to access the labor market, the government should aim to: (i) reduce discrimination against vulnerable groups, especially Roma, disabled, and female job seekers; (ii) develop support services to facilitate the employment of vulnerable groups, especially Roma and people with disabilities; (iii) increase access to housing and transportation for the unemployed, especially for those from rural areas; (iv) develop fiscal facilities for entrepreneurs starting businesses in rural areas and creating jobs for disadvantaged groups; (v) create guarantee schemes for disadvantaged people from rural areas as well as for youths; and (vi) support entrepreneurship activities, particularly for young people.⁴¹

2.1.6. Developing the Social Economy to Increase Employment Opportunities for Vulnerable Groups

A recent movement in the Romanian labor system has been the introduction of a social economy sector law in June 2014, which provides for the registration, regulation, and intended expansion of a social and work integration enterprise sector for vulnerable groups. In light of the fact that over 4.1 million people in Romania were “out of work” (unemployed and inactive) in 2012 and suffered from social exclusion and faced multiple labor market barriers, the development of a diverse social economy sector including community-based social service providers could play an important role in promoting the inclusion of these citizens into the productive economy.

Despite the significant amount of budgetary funds that the government has allocated to finance social economy projects, the efficiency of these interventions remains questionable. Between 2007 and 2013, the government allocated over €600 million to social inclusion. Of this, the largest share was assigned to developing new social economy initiatives (over €350 million, of which approximately €150 million was for projects approved up to

2010). Although there has been no evaluation of the impact of EU funds on the social economy, the main EU-funded research project reports have indicated that the results during the 2007 to 2013 programming period were not satisfactory.⁴² For instance, during that period, EU-funded projects related to the social economy created only 274 jobs or 10 percent of their initial target.⁴³ The various entities working in the area of the social economy are insufficiently or inadequately supported, and most of the social economy activities developed with EU funds have been experimental. The main activity funded by the EU was the provision of training regardless of actual development needs. The main problem is that the regulations governing EU funds are not oriented towards addressing the needs of the social economy sector. Current social economy initiatives tend to be concentrated in the most developed areas, while there are very few in the poorest localities.⁴⁴ The complex and changing financing rules that govern EU funds has increased these disparities and make it difficult for less developed and well-financed providers to prepare proposals and to ensure adequate project management. As a result, the allocation of EU funds has followed the expertise of providers rather than needs of the poor and vulnerable in Romania.

Although the legal framework exists to allow NGOs to raise money to finance their social projects, there are some practical problems with putting it into practice. The current legislation allows an NGO to carry out an economic activity without paying any tax on profits if their profit does not exceed €15,000 or 10 percent. This low limit is a considerable obstacle for the development of any economic activity, particularly when the NGO is looking to provide employment for socially vulnerable people, and use their profits to finance their social projects. In effect, NGOs cannot fully exploit the potential of the economic activities in question as a way to raise money to support its project (or to co-finance the project if funding is available from external sources). Therefore, what is needed is for the government to put in place regulations that will enable NGOs to raise their own resources to fund their own social economy activities.

Although sheltered workplaces, in which vulnerable people are employed in a separate defined workplace, are potentially a way to foster the inclusion of vulnerable

⁴¹ These recommended policy measures are in line with the Employment Strategy (GD 1071/2013) and the Ministry of Economy Strategy for the Development of Small and Medium-sized Enterprises and the Business Environment in Romania – 2020 Horizon (GD 859/2014).

⁴² Arpinte et al (2010), ADV (2011), Stănescu, Căce and Alexandrescu (coord., 2011) Constantinescu (2012), Stănescu et al (2013), MLFSPE (2013), and Barna (2014).

⁴³ MLFSPE (2013).

⁴⁴ Constantinescu (2012).

groups,⁴⁵ they are not sufficiently encouraged. The sector has significantly increased since 2006, mainly focused on including disabled people in the labor market. However, although there are approximately 500 protected workshops nationwide, there is scope for much more of this kind of employment. These sheltered workshops need subsidies and preferential credits to retain their market competitiveness as well as specific regulations to support their capacity to employ disabled people.

In order to increase the role played by the social economy sector in providing social assistance, between 2014 and 2020 the government aims to: (i) identify the relevant European financing interventions for all types of social economy entities and provide them with technical assistance to prepare and submit their proposals for European funding; (ii) develop the secondary legislation required for the sustainable development of the social economy; and (iii) encourage NGOs to get more involved in these activities.

⁴⁵ This type of employment is in contrast to "open employment" where people with vulnerabilities enter mainstream, competitive employment alongside people without vulnerabilities.

2

PEOPLE-BASED POLICIES



2.2. Social Transfers

The goal of social protection is to ensure the incomes of those who cannot work (such as the elderly, the disabled, or children deprived of parental care), to guarantee a minimum income floor for the extremely poor population, and to provide cash benefits to the poor in return for them meeting their co-responsibilities. The main co-responsibility for work-able adults is to find a job on their own or with the help of employment services. The key policy initiatives recommended in the area of social protection are: (i) the introduction of a single program for the poor, the Minimum Social Insertion Income program (MSII), which is expected to reach all poor families by 2016, and (ii) an increase in the overall social assistance budget allocated to the poor.



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2.2. Social Transfers

This section covers the key policy initiatives recommended in the area of social transfers for the poor and vulnerable population, particularly increasing the volume of social assistance resources that reaches the income-poor and enhancing the overall progressiveness of social protection spending. It is organized according to the traditional pillars of the social protection systems: (i) non-contributory cash transfers for the poor and vulnerable (social assistance transfers); (ii) cash support for people with disabilities; (iii) cash support to protect the poor against energy shocks; and (iv) cash programs for the older population (consisting of pensions, including social pensions). Social services are covered in the following section.

2.2.1. Improving the Performance of the Social Assistance System

Romania's social assistance policy uses a combination of categorical and means-tested programs to protect the income of poor and vulnerable families. According to their objectives and target groups, these programs fall into four categories: (i) family policy programs; (ii) means-tested programs for low-income households; (iii) programs for people with disabilities; and (iv) other programs, most notably the social pension. Seven programs form the backbone of the social assistance system. All seven are large both in terms of the number of beneficiaries served and of spending levels, and together they account for two-thirds of total social assistance spending. Because of their size and impact on poor beneficiaries, these programs are the focus of this background study:

- The State Child Allowance (SCA) is a monthly cash transfer to all children age 0 to 18 years old (or older if still in school). Benefit levels differ depending on the age and status of the recipients. All children aged 0 to 2 years old receive 200 RON, while those aged 2 to 18 years old receive 42 RON. For children with disabilities, the rates are 200 RON for those aged 0 to 3 years old and 84 RON for those aged 3 to 18 years old. The program uses categorical targeting (age) and covers all children irrespective of the means of their family.
- The Child Raising Benefit (CRB) is a monthly cash transfer paid to parents who stay home to care for children. It is equivalent to 85 percent of the average income earned by the person over the previous 12 months with a minimum of 600 RON and a maximum cap that varies depending on the duration of the benefit. The CRB is granted until the child turns 2 years old or 3 years old if the child is disabled. Parents who opt to benefit for two years receive a monthly allowance up to a maximum of 1,200 RON. Parents who opt to benefit for one year have a maximum cap of 3,400 RON. Parents who opt for the one-year program and return to work before the end of the program are eligible for a back-to-work bonus of 600 RON per month for one year upon returning to work. The CRB is another categorical program, which covers mothers with young children irrespective of the means of the mother or of the family.
- The Guaranteed Minimum Income (GMI) program is a monthly cash transfer that tops up household income to a GMI threshold. Adult household members who are capable of working are subject to a work requirement (they must work on projects that will benefit the community in exchange for their portion of the transfer) and an activation requirement (they are required to actively seek work through the unemployment office). The average per capita benefit is around 80 RON per month. The program is targeted to the poorest 5 percent of the population and is means-tested.
- The Family Support Allowance (FSA) is a monthly cash transfer to families with children in the poorest three deciles. In order to receive the FSA benefits, the school-aged children of the recipient families must attend school. The FSA program pays a benefit of 82 RON for each of the first four children of families with a per capita income of less than 200 RON and 75 RON for each of the first four children of families with a per capita income of between 201 and 530 RON subject to additional asset tests. Benefits are higher for single-parent families in each of these income categories (107 RON and 102 RON).
- The Heating Benefit (HB) is a seasonal cash transfer program targeted through a means test to households

in the poorest half of the population. The program operates during the winter season (November to March). It covers a share of household heating costs, with higher subsidies for households in the lower income brackets. There are four service delivery channels depending on the type of fuel used for heating: (i) for households connected to the central heating grid; (ii) for those heated with natural gas; (iii) for households heated with electricity; and (iv) for those heating their homes with wood, coal, or crude oil fuels. The amount of subsidy varies between 16 RON and 262 RON.

- The Indemnity of Disabled Adults and the Complementary Budget for Disabled Adults are monthly cash payments for people with disabilities based on the severity of their disability (major, severe, and average). The first component provides income support for people with disabilities. The second component pays the cost of a carer for people with major or severe disabilities. The program is categorical.
- The Social Pension (SP) offers a minimum pension to elderly people who have not contributed enough to the pension system to qualify for a contributory old age pension. The benefit amount is 350 RON. The program is income-tested.

Coverage and Targeting Accuracy of the Social Assistance Programs

The social assistance system scores high in terms of its coverage of the poor (64.8 percent of the poorest quintile benefitted from at least one social assistance program in 2013) and of its generosity (in the same year, social assistance programs accounted for 23.2 percent of the income of the poorest quintile) (see Table 18). Five programs account for a large share of the income of the households in the poorest decile - the Child Raising Benefit (CRB), the GMI, the HB, the benefits for people with disabilities, and the social pension. The high coverage of the social assistance system is due mainly to the SCA and the HB programs as all of the others cover less than 10 percent of the population.

The social assistance system has produced mixed results in terms of protecting the poor and vulnerable. Targeting accuracy varies among the social assistance programs as measured by the 2013 Household Budget Survey (HBS).

Means-tested programs for low-income households have very good targeting accuracy, with about two-thirds of targeted benefits accruing to those in the poorest quintile. The targeting accuracy of means-tested programs (the GMI, the FSA, the HA, and the SP) is on a par with the best last-resort programs in the European Union. This share is substantially higher than for categorically targeted programs (for family policy programs or for people with disabilities), which transfer only about one-third of their funds to those in the poorest quintile. Overall, the targeting accuracy of the system (33 percent in 2013) is quite low due to the prevalence of categorically targeted programs.

The Modernization of the Social Assistance System (2010-2014)

The social assistance system in Romania has strong foundations and has undergone a series of gradual improvements over the last four years during the implementation of the government's Social Assistance Reform Strategy which was adopted on March 10, 2011. The main objectives of the strategy, which have largely been achieved, have focused on: (i) improving equity in the social assistance system; (ii) increasing administrative efficiency by reducing the administrative costs of the system and the private costs for applicants; (iii) reducing error and fraud; (iv) developing a performance monitoring system; and (v) improving the training of the staff employed in the social assistance system and the quality of the services that they offer. It is very important to build on the results achieved so far and to continue the activities that are achieving these objectives.

A key objective of the Social Assistance Reform Strategy was to increase the share of social assistance funds reaching the poorest 20 percent of the population (targeting accuracy), while reducing the overall cost of the social assistance system. The targeting accuracy of social assistance spending as a whole has increased from 35.8 percent in 2009 to 37.6 percent in 2012. The government has taken several different steps to achieve this goal. In categorical programs with modest targeting accuracy, the benefit level was kept constant in nominal terms. The duration of the Child Raising Benefit was reduced for those mothers who opted for the high-replacement option, while the back-to-work bonus for parents was increased. The number of irregularities in the largest social assistance programs was significantly reduced thanks to a series of thematic inspections done by the National Agency for

TABLE 18: Targeting Accuracy, Coverage, and Generosity of the Main Social Assistance Programs in Romania, 2013

	Targeting Accuracy	Coverage		Generosity	
	Poorest 20%	Population	Poorest 20%	All beneficiaries	Poorest 20%
All Social Assistance	33.0	55.6	64.8	7.4	23.2
Family Policy Programs					
State Child Allowance (SCA)	25.8	51.5	56.4	3.5	9.9
Child Raising Benefit (CRB)	20.4	2.8	3.3	24.0	42.7
Programs for Low-income Households					
Guaranteed Minimum Income (GMI)	86.7	2.9	12.2	22.7	27.5
Family Support Allowance (FSA)	55.7	3.8	10.5	4.2	6.4
Heating Benefit (HB)	40.7	13.7	34.8	7.1	10.4
Programs for People with Disabilities					
Allowances for the disabled	40.9	4.0	7.9	16.4	26.1
Other Social Assistance Programs					
Social Pension (SP)	61.6	0.4	1.1	6.8	11.4
Scholarships or Money for High School	33.8	0.9	2.0	11.5	17.2
Privileges for War Veterans and the Politically Persecuted	44.1	0.4	0.8	17.6	28.8
Other Social Assistance Benefits	7.5	0.4	0.2	18.5	22.0

Source: World Bank calculations using data from the 2013 HBS. Deciles constructed based on per adult equivalent income net of all social assistance transfers (similar to EU definition).

Notes: Targeting accuracy is the transfer amount received by the group as a percentage of total transfers received by the population. Program coverage is the proportion of population in each group that receives the transfer. Generosity is the ratio of the transfer amount received by all beneficiaries in a group over the total welfare aggregate of the beneficiaries. By beneficiaries we mean all direct and indirect (other household members) beneficiaries of the transfer. The coverage of the HB program refers to the cold season only (estimated based on the first quarter of the year).

Social Payments and Inspection (ANPIS). At the same time, the number of beneficiaries of well-targeted, means-tested programs (the HB, the FSA, and the GMI) has fallen. One reason is the lack of indexation of the thresholds set in the FSA and the GMI program. Another reason is the introduction of an extensive set of asset filters that has excluded a large proportion of the true poor from means-tested programs (as many as one-third of those in the poorest decile and 38 percent of those in the poorest quintile). After the introduction of these filters, the targeting accuracy indicator went down. After evaluating household survey data, the Minister of Labor, Family, Social Protection, and the Elderly (MLFSPE) amended the filters in November 2013 to increase targeting accuracy.

Another objective of Romania's Social Assistance Reform Strategy has been to reduce error and fraud in the social assistance benefit system. Significant progress has been made in this area in recent years, placing Romania at the forefront in Europe in terms of improving program compliance rules. More social assistance programs (the FSA, the CRB, and the GMI) are now being paid through the National Agency for Social Payments and Inspection (ANPIS), thus reducing discretion in eligibility decisions at the local level and extending controls over more of the system. Social Inspection has also been strengthened in terms of numbers, and the inspectors have received training from their counterparts in the United Kingdom's Fraud Investigation Service. Annual thematic inspections have been carried out on five high-value, high-risk social

assistance programs (the abovementioned three plus the Heating Benefit, and the two disability allowances) since 2010. These inspections found levels of irregularity ranging from 2.5 percent to 36 percent. Furthermore, a data cross-checking effort has been undertaken for four large social assistance benefits since 2013, which has meant that suspicious files can be identified in a more cost-effective manner. These high-risk suspicious files have been reviewed by the social inspection team, and remedial actions have been taken.

The MLFSPE has been at the forefront of reforming its social assistance programs, based on sound economic and social analysis. Since 2011, the government has committed itself to dismantling producer subsidies in the energy sector while mitigating the effect of increased tariffs on vulnerable consumers. In 2011, district heating subsidies were eliminated, and the Heating Benefit program was adjusted following ex-ante simulations of the effects of different reform options. These simulations helped the government to make the most efficient and appropriate policy choices. During 2013 and 2014, the MLFSPE worked with international partners on a similar analysis to identify the best policies to protect vulnerable consumers against the gradual increase in electricity and gas prices over the 2013 to 2018 period. Finally, the MLFSPE is preparing legislation for the forthcoming Minimum Social Insertion Income (MSII) program, which will be the country's flagship anti-poverty program, based on sound microeconomic simulations.

The MLFSPE has made strong progress in monitoring the results of the country's social assistance policies. ANPIS produces regular reports on payments to beneficiaries using SAFIR, its management information system. To track the share of social assistance funds going to the poorest 20 percent of the population, the National Statistical Institute has received technical assistance from the World Bank to develop a social assistance bulletin. The MLFSPE has produced an initial estimate of the private costs incurred by beneficiaries in accessing the means-tested programs and has developed a plan to track both the administrative and private costs of providing social assistance programs using an internal monitoring mechanism.

Too Much Spending on Categorical Programs and Too Little on Means-tested Programs

Despite these improvements, the social assistance system is still dominated by universal and categorical programs, which reduces the poverty reduction impact of social assistance spending. In 2011, the budget for means-tested programs shrank disproportionately more than the budget for non-targeted programs (from 21 percent in 2010 to 13 percent in 2011) and has not recovered since (Figure 11). In 2014, it represented only 16 percent of the total budget. This has reduced the efficiency of the social assistance system in reducing poverty, given that means-tested programs channel about 67 percent of their funds to the poorest quintile, while only one-third of the benefits of categorical programs go to those in that quintile.

To increase the extent to which the social assistance budget reduces poverty, the government will need to increase the budget of means-tested programs and their share of the overall social assistance budget. This process started in 2014 with increases in the budgets and benefit levels of the GMI and FSA programs to mitigate the impact of increased energy tariffs on the poor among other reasons, and with a doubling of the FSA benefit level in October 2014.

A Fragmented and Costly Means-tested Subsystem

Not only do means-tested programs receive only a small share of the overall social assistance budget, but they are also fragmented. Romania has three means-tested programs that support the income of the poorest people - the Guaranteed Minimum Income (GMI), the Family Support Allowance (FSA), and the Heating Benefit (HB). All three have small budgets, limited coverage, and low benefit levels. They each have their own separate beneficiary files and payments, which results in waste and unnecessary duplication of administration. The GMI is targeted to the poorest 5 percent of the population, the FSA to families with

FIGURE 11: Total Budget for Social Assistance and the Percentage Allocated to Means-tested Programs



Source: World Bank calculations using data from the GMI, the FA, the Heating Benefit (HB), the SCA, the Child Raising Benefit and incentive, scholarships, and allowances for disabled. For the other benefits, the budget was estimated using data from the HBS.

Note: The budget is expressed in nominal prices.

children in the poorest three deciles, and the HB to families in the poorest 60 percent of the income distribution. Although these programs are all targeted to the low-income population, the eligibility criteria vary from program to program,⁴⁶ increasing the private costs incurred by applicants to access the program, and the administrative costs of the system. Moreover, each program currently maintains separate paper and electronic records related to processing benefit applications, recertification, and payments.

These differences between the three means-tested programs result in unnecessary administrative complexity

that heightens the risk of error and fraud and involve higher than necessary private costs for beneficiaries (related to applications, recertification, and payments) and administrative costs for the system. In 2013 the private costs associated with applying, recertifying, and receiving benefits amounted on average to 18 percent for the GMI, 29 percent for FSA, and about 10 percent for HB. This is equivalent to two GMI payments, four FSA benefits, and one HB benefit lost in private costs. Table 19 presents the estimates of the average monthly costs per beneficiaries per month. Administrative costs amounted to about 10 percent of each program's budget in 2012.⁴⁷

⁴⁶ Before November 2013, each of the three programs used a different means test. However, since November 2013, all three programs use a single methodology to test the means of the households (formal income, imputed informal agricultural income, and asset filters). However, other differences in eligibility criteria remain in terms of the assistance unit (the household or the family), whether or not an equivalence scale is used, the length of the recertification period (three months for the GMI and the FSA and the cold season for the HB), and the payment method (directly to the beneficiary or transferred to the service provider in the case of HB recipients using district heating).

⁴⁷ Tesliuc et al (2014).

TABLE 19: Average Monthly Private Costs of Accessing Means-tested Programs (RON/beneficiary/month)

	GMI	FSA	HB: Wood	HB: Gas	HB: District Heating
Total private costs, of which:	31.5	16.7	9.2	6.5	5.2
Application costs	5.1	4.0	4.8	6.5	5.2
Recertification costs	14.8	11.6			
Unemployment benefit certificate's cost	10.0				
Cost of cashing the benefit	1.6	1.1	4.4		
Total private cost for all programs/beneficiaries			15.5		
Pro memoria:					
Average number of beneficiaries	194,748	254,714	303,995	115,032	107,709
Total cost per program	6,125,220	4,261,179	2,796,841	744,279	560,576
Total cost for all the programs (GMI+FA+HB)			14,488,096		
Number of beneficiaries per month			932,478		

Source: Grigoraş (2014) using data from the Citizen's Score Card Survey carried out by the MLFSPE and World Bank in 2013.

Notes: The FSA costs are estimated for beneficiaries of this program only (not those who also receive the GMI).

The fragmentation of means-tested benefits also reduces the take-up of the programs by the eligible population. Each means-tested program covers only between one-quarter and one-third of the poor, but together they cover 46 percent of the poor population during April to November and 62 percent during the cold season during November to March (Table 20). The reasons for the low coverage are: (i) the high private costs of applying for such benefits relative to their value; (ii) the fact that some of the asset tests introduced to keep high-asset households out of the program still exclude a large number of genuinely poor households; and (iii) a lack of awareness on the part of potentially eligible people about the availability of such benefits.

In response to this low coverage, the government has simplified access to these programs and increased their benefit levels. The new measures included unifying means-testing criteria and streamlining asset filters to reduce inclusion errors in November 2013, increasing the generosity and expanding the coverage of means-tested programs to mitigate energy shocks in June 2014, and in December 2014 doubling the FSA benefit for poor families with children and increasing support for children deprived of parental care. However, these measures have only partly overcome the existing impediments.

To increase the poverty reduction impact of the means-tested programs, the Government of Romania is preparing

TABLE 20: Share of the Population in the Poorest Quintile Benefitting from Means-tested Programs

Coverage of the poorest quintile	Cold season	Rest of the year
Guaranteed Minimum Income	24.7	24.7
Family Support Allowance	30.0	30.0
Heating Benefit	39.2	n.a.
Total	61.9	46.3

Source: World Bank estimations using data from the 2012 HBS, first quarter.

Notes: Coverage statistics have been corrected for under-reporting.

a legislative and regulatory framework to consolidate the three current means-tested programs (the GMI, the FSA, and the HB) into a single program - the Minimum Social Insertion Income (MSII) program. This was announced in the Social Assistance Framework Law (292/Dec 2011). The new consolidated program will become the key anti-poverty program in Romania. Its main features will be: (i) an increase in the budget of the MSII compared to the combined budgets of the current programs to ensure that social assistance funds cover most of the poor and (ii) the introduction of a benefit formula that gives recipients an incentive to find work (by making it a co-responsibility or condition of receiving the benefits). The program is expected to become operational at the beginning of 2016. The program will be crucial for achieving the poverty reduction target assumed by Romania under the Europe 2020 strategy.

After the introduction of the MSII program in 2016, the budget for means-tested programs will be increased from RON 1.2 billion in 2014 to RON 2.2 billion in 2016 (when the MSII will be launched) and then to RON 2.5 billion in 2017 and will be maintained at this level in real terms thereafter. To create fiscal space within the social assistance system, the government will assess the efficiency and effectiveness of the universal and categorical programs in achieving their objectives and then consider a range of parametric reforms, including the possibility of transforming the categorical programs into means-tested benefits during 2015.

Rationale for Introducing the MSII Program

The implementation of the MSII program is expected to bring many benefits for applicants and program administrators compared with the current situation:

- By increasing the budget allocated for this program over the combined budgets of the current programs, the MSII program is likely to cover more of the poor and to offer more generous assistance to its beneficiaries. This will restore the balance of social assistance spending between targeted (means-tested) and categorical programs. An increase in the absolute and relative budget devoted to a single unified means-tested program is expected to have a stronger poverty reduction impact.
- The MSII program will be able to cover a larger fraction of poor beneficiaries (roughly, the poorest 20 to 22 percent of the population) because of economies of scale realized by combining the means-tested programs. The current means-tested programs cover only about 10 percent of the population. With a budget twice as big as the budgets of the current programs combined, the MSII program should be able to cover all households in the poorest quintile. Increasing the coverage of the program will also increase the political acceptability of the reform (because there will be more winners than losers), while reducing poverty.
- The MSII (which will exempt a share of the current labor incomes of the members of beneficiary families) will cover a larger fraction of the in-work poor than its predecessor, the Guaranteed Minimum Income program. It will also give work-able adults who are currently not working and are living on social assistance an incentive to look for work by allowing them to continue to receive social assistance while they work. Technically, the new formula will replace the provisions of the Guaranteed Minimum Income program, which puts a 100 percent marginal tax rate (MTR) on earnings, with a benefit formula that will have an MTR of around 50 percent. According to the relevant literature,⁴⁸ between 7 percent and 17 percent of work-able adults who are NEET could go from receiving assistance to being employed or could get a job while still receiving a lower level of assistance under this benefit formula.
- The adoption of a benefit formula that exempts part of beneficiaries' labor earnings will open the program to a larger number of in-work poor, given that households with working adults will have higher eligibility thresholds than households whose adult members do not work.
- By strengthening the activation and school conditionality elements of the original programs (the GMI, the FSA, and the HB), the MSII program is likely to increase school attendance and improve the school outcomes of the children of the beneficiary families and increase the employment rate of work-able adults.

⁴⁸ Gerard (2013) and Bachas (2013).

- Consolidating three rather small means-tested programs into a single program will reduce the amount of information needed to process applications. This, in turn, will reduce the administrative costs of the system, the private costs incurred by beneficiaries to interact with the program, and the scope for error and fraud.
- By introducing a performance management system for the MSII program, the administrators will be able to track whether the program is achieving the desired development outcomes - reducing the income poverty of the beneficiaries, increasing the school attendance of the children in the program, and increasing the employment and earnings of work-able beneficiaries. They will also be able to tell whether the delivery costs are reasonable (by tracking administrative and private costs), whether the program correctly identifies the poor, and whether the program maintains low rates of error or fraud.
- The MSII will make it possible to use EU structural funds to finance supply-side human capital measures such as the reduction in the implicit MTR on earnings and the introduction of bonuses for occupational and geographical mobility as well as ALMPs and remedial services that will reduce the barriers to employment

for the poorest in Romania. This is an opportunity for Romania to use EU funds to stimulate employment for low-income families.

- From an operational perspective, the MSII will use the EU definition of relative income poverty or AROP to identify the poor, including those in marginalized areas. The government will then be able to use this unique, efficient, and effective mechanism to target other sectoral policies to the poor.

The MSII program will gradually expand its menu of interventions to provide not only cash with co-responsibilities but also services. The various cash benefits and services are all currently delivered separately, which is inefficient and diminishes the positive impact of these interventions. The MSII is designed to take advantage of complementarities between cash benefits and other social services (such as employment, education, health, and housing services). The mechanism used in the MSII program to identify potential beneficiaries is likely to increase the coverage of the poor by increasing the accuracy of targeting (see Table 21). International evidence suggests that the coordination of cash assistance with the provision of social services for the poor improves the living standards of the beneficiaries and helps them to rise more rapidly out of poverty.

TABLE 21: Shifting from Separate to Complementary Provision of Cash Assistance and Social Services in the MSII Program

Link with:	Mechanisms for the Provision of Services
Employment services	The MSII program will have a strong activation component with the following elements: (i) increasing the coverage of the in-work poor by exempting a share of the current labor incomes of members of the beneficiary families, both from agricultural and non-agricultural activities; (ii) allowing local authorities to replace community work with training and lifelong learning courses to increase the employability of the beneficiaries; and (iii) capping the total benefit per family to a ceiling linked to the minimum wage (for example, 75 percent or 80 percent) to maintain work incentives and reduce the stigma associated with the current GMI.
Education and health for children	The MSII program will include a benefit for children from beneficiary families to stimulate the positive behaviors and parental care: (i) participation in the national program of compulsory vaccination for children aged 0 to 1 years old; (ii) 100 percent attendance in kindergarten by children aged 3 to 5 years old with only an official certificate from the family physician being accepted for absences; and (iii) 95 percent attendance rate in school by children aged 6 to 16 years old with only an official certificate from the family physician being accepted for absences. During any months when a conditionality is not met, the benefit will be suspended. However, it will not be suspended for a child in cases where that child's siblings are not in compliance, which differs from the design of the current Family Support Allowance (FSA). The logic of the current FSA program links the school conditionality to parents' obligation to send children to school as stipulated in the Law of Education. In contrast, the logic behind the MSII program is to award positive behavior that is likely to break the intergenerational cycle of poverty and exclusion. This cycle is perpetuated when low educational achievement and poor health severely limit the labor market opportunities that are accessible to the next generation of children. Thus, the MSII program will have a greater chance of breaking the intergenerational cycle of poverty and exclusion through targeted cash transfers that address the multiple drivers of inequality.
Housing services	The MSII program will include a housing benefit for families living in social housing in addition to the heating subsidy targeted to low-income families living in their own dwellings. This housing benefit for beneficiaries living in social housing will cover the cost of their rent and a part of their heating-related costs. In this way, the MSII program will address the excessively high housing cost overburden rate and will prevent homelessness by reducing evictions.
Social services for vulnerable groups	The MSII program will cover a larger proportion of the poor population than its predecessors but will also do a better job of addressing the problems of vulnerable groups. The MSII will exempt some social benefits from its definition of household means such as the allowance for people with disabilities or the allowance for children in foster care.

The implementation of the MSII program and of its performance management system will be an opportunity to coordinate and to reduce the administrative costs of the existing social programs, including those financed from the European funds (see Box 10). For example, all children from a MSII beneficiary family will be able to apply for the national program of school supplies using a simple paper issued by their local Public Social Assistance Service (SPAS) instead of the current system, which often is too complex and costly for

poor parents with little education. In this way, poor children's access to and participation in national programs will no longer depend only on their parents' knowledge and interest.

Given the interrelated components of the MSII program, the implementation of the program will require strong inter-ministerial coordination between the MLFSPE, the Ministry of Education, the Ministry of Health, the Ministry of Regional Development and Public Administration, and the Ministry of European Funds.

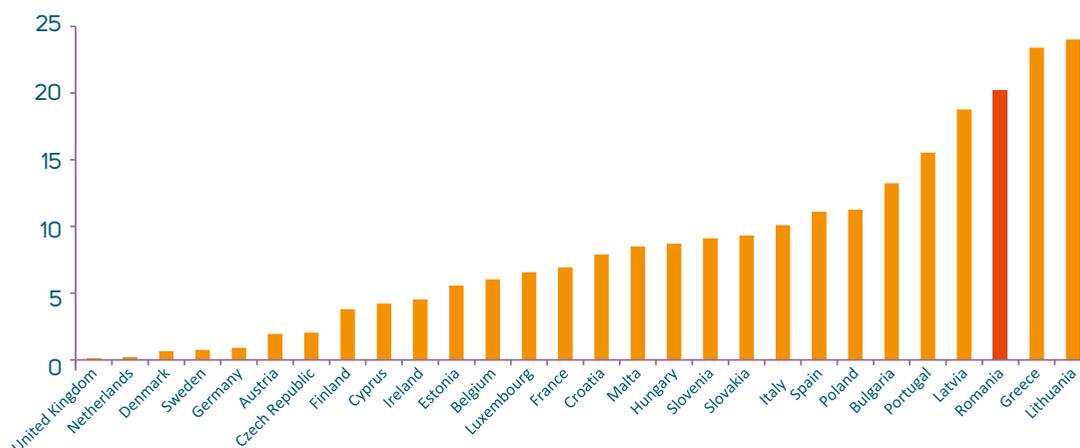
BOX 8

Fund for European Aid to the Most Deprived (FEAD)

The Fund for European Aid to the Most Deprived (FEAD) is part of the 2014-2020 EU programming period and supports actions to provide material assistance (food, clothing, and other essential items for personal use) to the “most deprived.” This term means “natural persons, whether individuals, families, households, or groups composed of such persons, whose need for assistance has been established according to the objective criteria set by the national competent authorities in consultation with relevant stakeholders, while avoiding conflicts of interest, or defined by the partner organizations and which are approved by those national competent authorities and which may include elements that allow the targeting of the most deprived persons in certain geographical areas” as defined by EU Regulation No 223/2014 of the European Parliament and of the Council, Article 2.

The funding complements the financing provided by the European Social Fund (ESF) in the sense that FEAD addresses the basic needs of the most deprived in order to enable them to access training or employment as is also the case with the programs supported by the ESF. The total available resources for FEAD at the EU level come to €3,395,684,880 (at 2011 prices). The minimum allocation per member state is €3,500,000 (for the period 2014 to 2020), and this amount has already been allocated to Cyprus, Denmark, Luxembourg, Malta, the Netherlands, and the United Kingdom. Romania has a total allocation of €391,300,000, which is the third largest allocation at the EU level (in 2011 per capita prices).

The Allocation of FEAD per Member State, 2014–2020 (EUR 2011 prices per capita)



Source: Authors' computations using data from EU Regulation No 223/2014, Annex III and population data (for 2014) from Eurostat database.

In Romania, FEAD is funding the Operational Program for Aid to the Most Deprived, which supports the distribution of food and basic material such as school bags and equipment in order to increase school attendance of children of all ages. The school materials are targeted to children from families in which the net monthly per capita income is less than or equal to 50 percent of the gross national minimum wage. The program targets beneficiaries of the GMI or people whose total income is less than 45 percent of the gross national minimum wage. The detailed categories of beneficiaries of the program's food aid are specified in GD 779/2014 and include beneficiaries of the Family Support Allowance, the unemployed, pensioners with incomes of less than 400 lei a month or beneficiaries of the Social Pension, people with medium or severe disabilities (adults and children), and war veterans.

Implementing the program requires strong inter-ministerial coordination between the Ministry of European Funds, the MLFSPE, and the Ministry of Education (through its school inspectorates). The program shares a management authority with the Human Capital Operational Program. It was approved by the European Commission in November 2014 and began to be implemented in December 2014 (food aid component).

Poverty Reduction Impact of the Increase in the MSII Budget

The proposed increase in the MSII budget is likely to have a significant impact in terms of reducing poverty and will significantly increase the chances that Romania will meet its national poverty target before 2020. This policy initiative will increase both the number of beneficiaries of means-tested programs and the benefit levels that they receive. Compared to 2012, the budget is expected to go up gradually from RON 1.1 billion in 2012 to RON 2.2 billion in 2016 and to RON 2.5 billion in 2017 and to be maintained at this level in real terms afterwards. The new program is expected to be better targeted towards the poorest quintile than the three existing programs (based on international experience, the targeting accuracy of the new program is expected to be around 80 percent). Moreover, given the increase in budget funds, the coverage of households in the poorest quintile can be expected to increase from the current level of 60 percent (according to HBS data from the

National Institute of Statistics as well as administrative data) to about 80 percent, with progressive coverage and larger benefit levels for the poorest.

Simulations have shown that the increase in the program budget compared to the combined budgets of the current programs will have a major impact in reducing poverty under all economic scenarios (Table 22, row A). Assuming moderate economic growth, relative poverty will decrease by about 4.4 percent from 22.8 percent in 2014 to 18.1 percent in 2016. The simulations show the program having a similar impact on absolute poverty (with the poverty line anchored in 2012 and indexed to the inflation rate). Given the additional financing envisaged for 2017 and the economic parameters, the decrease in poverty due to the program is likely to be even higher in 2017 at 5.8 percent (down from 17.2 percent in the absence of the program to 11.4 percent after the introduction of the MSII). This will reduce poverty well beyond the assumed poverty target of 580,000 individuals by 2020.

TABLE 22: Likely Evolution of Relative Poverty after the Implementation of the MSII Program

Implemented policy	2012	2013	2014	2015	2016	2017	2018	2019	2020
Status quo	22.6	23.1	22.8	22.5	22.4	22.6	22.5	22.8	22.8
A. Increase in budget					18.1	17.8	17.9	18.7	18.7
A+B1. Income exemption in MSII causing 7 percent of the NEETD to move into jobs					17.0	16.6	17.1	17.8	17.9
A+B2. Income exemption in MSII causing 17 percent of the NEETD to move into jobs					15.7	15.3	16.1	16.4	16.6

Source: World Bank estimations using data from the 2012 EU-SILC.

Notes: NEETD = Not in employment, education, training, or disabled.

Poverty Reduction Impact of the Introduction of the 50 percent Earnings Disregard in the MSII Program

The MSII will have a benefit formula that will disregard 50 percent of wages and other labor earnings and 25 percent of presumed agricultural profit. This means that for families with a formal income, the more they work, the higher their effective eligibility threshold and benefit levels will be.

Moreover, it will be possible for beneficiaries to continue to receive some social assistance while they work, thus raising their total income. Based on international literature, it is expected that the change in benefit eligibility criteria will result in between 7 to 17 percent of the work-able poor who are currently not in employment, education, training, or disabled (NEETD) becoming employed. Therefore, the simulations in Table 22 assume that the beneficiaries who are activated and enter the labor market get an increment of half of the minimum income per month. They also assume that most of the people who are activated come from the

poorest quintile (70 percent) while the others come from the other quintiles.

We simulated an upper and a lower bound for the proportion of NEETD who benefit from the MSII are activated – 7 and 17 percent (Table 22, rows A+B1, A+B2). The individuals from the first quintile were selected using propensity score matching (those with the highest chances of being employed), while those from the second to fifth quintiles were selected randomly. The simulations show poverty being reduced further in 2016 by an additional 1.1 to 2.4 percentage points.

2.2.2. Providing Adequate Financial Support for the Disabled at Risk of Poverty or Social Exclusion

Romania has a strong system for supporting people with disabilities. There are three main sources of support. First, individuals who lost their ability to work while they were in formal employment receive a disability pension (a cash transfer) and rehabilitation services. These services are financed by social security contributions and are provided by the Pension House, which supports about 700,000 people at an annual cost of about 1 percent of GDP. Second, all individuals with severe, mild, or moderate disabilities receive a cash transfer, free or subsidized provision of equipment to ensure their social inclusion, and rehabilitation services (including caregivers). The provision of these services is decentralized to the local authorities, and they benefit about 800,000 people. The cash transfer payments only amount to 0.4 percent of GDP. These benefits are financed by both national and local government revenues. Third, there is a system of institutionalized care, which supports about 17,000 people. This system is financed by both state and local budgets.

The first priority for the government in this area is to unify the institutional framework for beneficiaries of invalidity pensions and disability allowances, who are often the same individuals. The operation of two separate sources of support for the non-institutionalized disabled presents a number of challenges. The two systems cater to the same beneficiary group, but they treat beneficiaries differently

(different medical and functional criteria apply to pensioners and to beneficiaries of allowances), have different points of entry into the system, and separate staff. The level of duplication is high and increasing. As of 2012, about 30 percent of the disability allowance beneficiaries were also receiving disability pensions, and at the household level, the level of duplication was even greater. More than half of the disability allowance recipients also receive some type of pension.

Overall, the operation of two separate systems to certify an applicant's disability is inefficient for both beneficiaries and taxpayers. Because of different eligibility criteria, applicants face inequitable access to rehabilitation services, and if they need to apply for both kinds of benefit, then they incur double the costs to do so. From the perspective of taxpayers, having two systems results in the inefficient use of scarce administrative resources, higher administrative costs, poor information management (which translates into poor policymaking), and poorer compliance. In addition, it does not provide all disabled people with the same set of rehabilitation services.

The government is already committed to correcting these institutional issues, to simplifying access to the disability support system, and to making the most efficient use of scarce administrative capacity. As part of its Social Assistance Reform Strategy, the government aims to: (i) harmonize the medical criteria in the disability assessments for the invalidity pension and the disability allowance and (ii) unify the institutional framework to create a single delivery channel to serve all people with disabilities. The new system will improve the lives of people with disabilities in a number of other ways as well. It will include individual assessments of both types of beneficiaries (pensioners and recipients of allowances) to find ways to improve how they function in their social environments. It will also improve the system for referring patients to rehabilitation services, making it more equitable and accurate to ensure that only the most deserving individuals will be included, thus increasing the overall efficiency and effectiveness of the system.

The government's second priority is to maintain the purchasing power of the cash allowances for people with disabilities. The majority of people with disabilities live in families that are faced with significant economic and social difficulties. Moreover, in the families of severely disabled people, the usual practice is that one of the parents leaves his or her job and becomes a personal caregiver for the disabled child. A 2010 study related to the quality of life of children and youths with physical disabilities showed

that 89 percent of the personal caregivers for these people are family members.⁴⁹ Among these families, only 20 percent of the respondents said that their level of revenue is sufficient for a decent quality of life. These mono-parental families are numerous, and their risk of poverty is often high, particularly when the families have two or more disabled children. The lack of indexation of the cash benefits for people with disabilities over the last four years has compounded their hardship. To address these issues, the government has passed a law increasing the generosity of disability allowances programs by 15 percent. Over the 2016 to 2020 period, the government intends to index these benefits to inflation.

The government's third priority is to improve the disability assessment and remedial or support services.⁵⁰ The government will work to improve the existing disability assessment system to ensure that it takes account of the real needs of people with disabilities. This will mean designing a holistic system that takes into account both personal and environmental factors and the individual's life habits and choices.

2.2.3. Protecting Elderly People at Risk of Poverty or Social Exclusion

Romania is facing an unprecedented demographic aging of its population brought about by steady increases in life expectancy and declining fertility rates.⁵¹ These

two demographic trends are rapidly changing the age structure of Romanian society. This process is being further accelerated by strong net emigration, particularly among the younger population.

Overview of the Aging of the Population in Romania

Over the next four decades, Romania will experience an unprecedented aging of its population. Falling fertility rates and increasing life expectancy will significantly increase the proportion of elderly people in the population and the share of age-related expenditures in GDP, especially for public pension programs and for health and long-term care services.

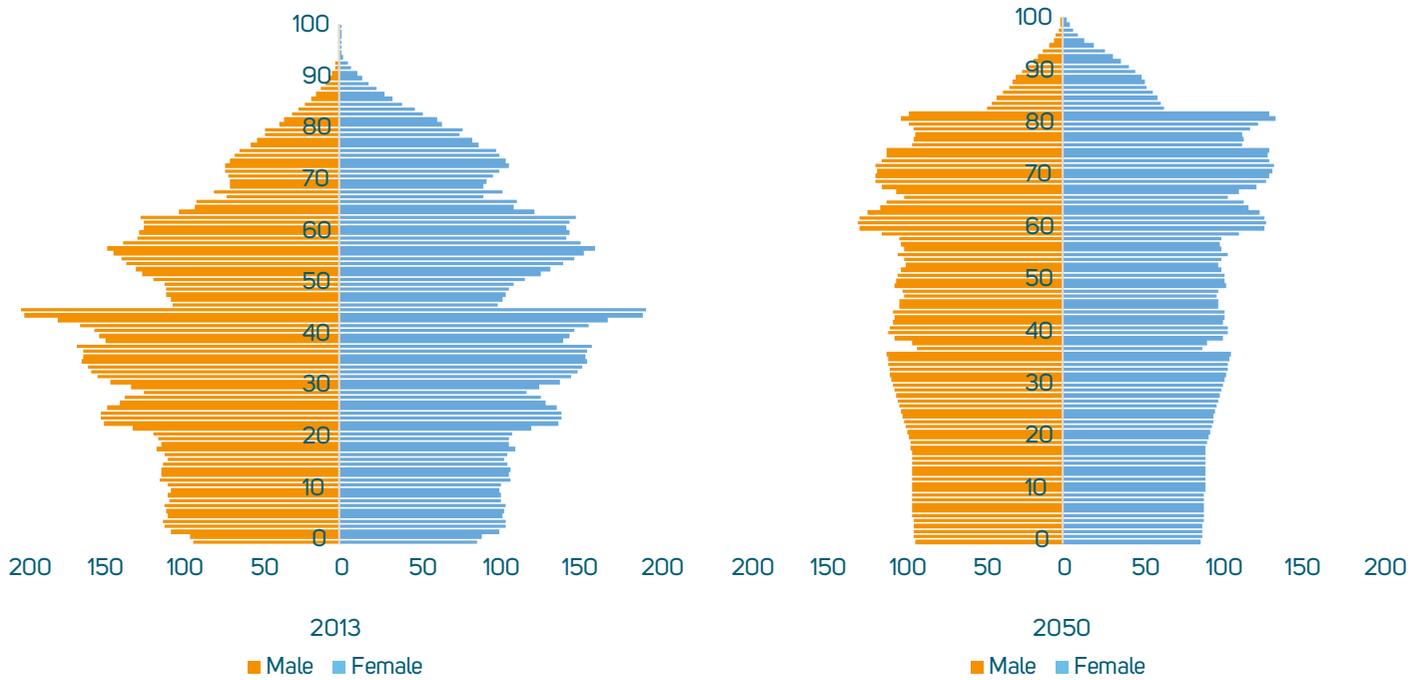
In Romania, average life spans have increased substantially in the last 60 years, with life expectancy at birth rising by about 14 years for females and 10 years for males (Figure 13). At the same time, the total fertility rate dropped from 2.9 children per woman in the late 1960s to 1.3 by the late 2000s (Figure 14). The aging of the population in Romania is being compounded by high rates of emigration, especially over the last decade and particularly among younger age groups. Figure 14 shows the percentage reductions in age cohorts between 2002 and 2011, which underscores the emigration trend among the under-30s. For example, only 82 percent of the population who were aged between 10 and 19 in 2002 reappeared in the 2011 Population and Housing Census.

⁴⁹ ASCHF-Romania (2010).

⁵⁰ This topic is discussed extensively in the social services chapter.

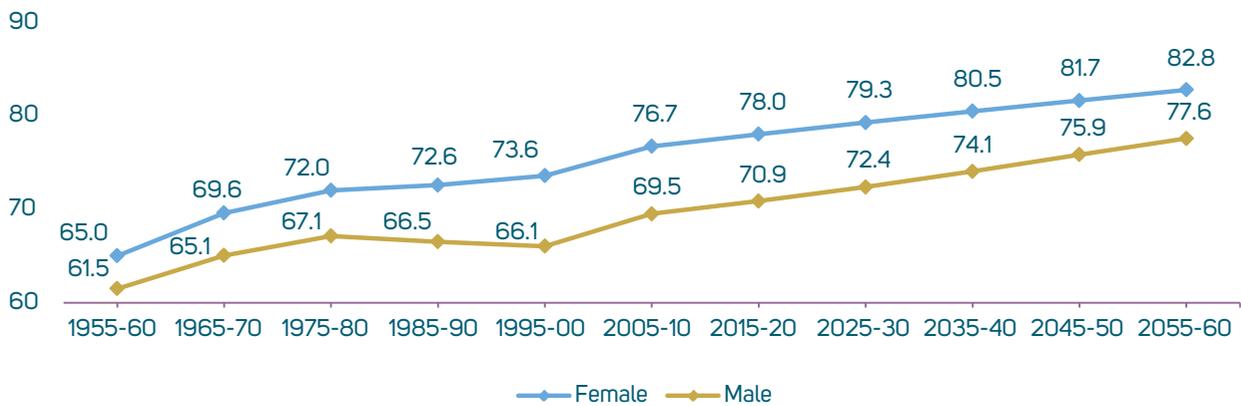
⁵¹ According to Eurostat's population projections, Romania's working age population is projected to decline by 40 percent by the year 2060. Its old age dependency ratio, in other words, the ratio between the number of older people (aged 65 and over) and the number of working age people (aged between 15 and 64), is projected to double over the next four decades.

FIGURE 12: Age Composition of the Romanian Population in 2013 and 2050



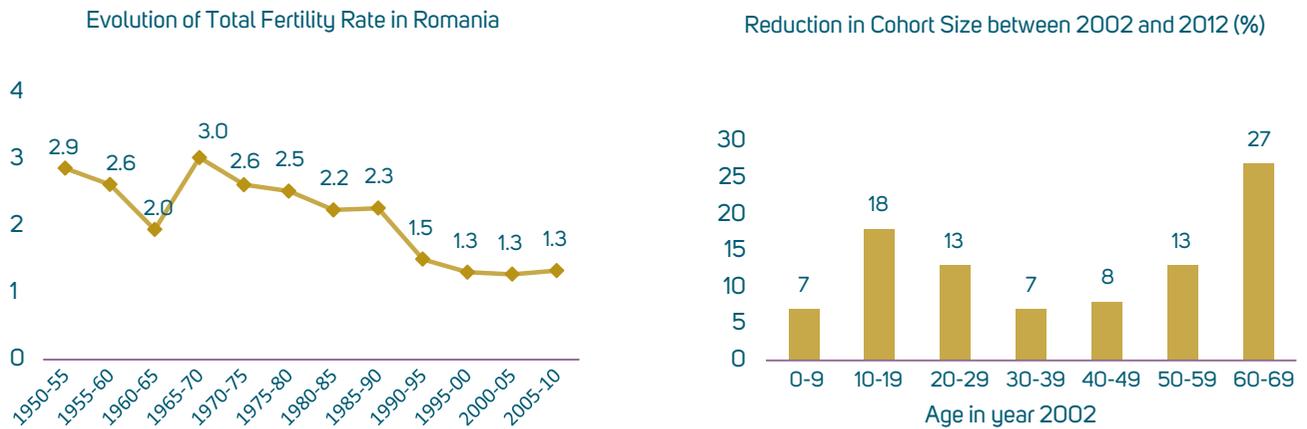
Source: World Bank calculation using PROST, 2013 input data provided by Ministry of Public Finance.

FIGURE 13: Evolution of Life Expectancy in Romania



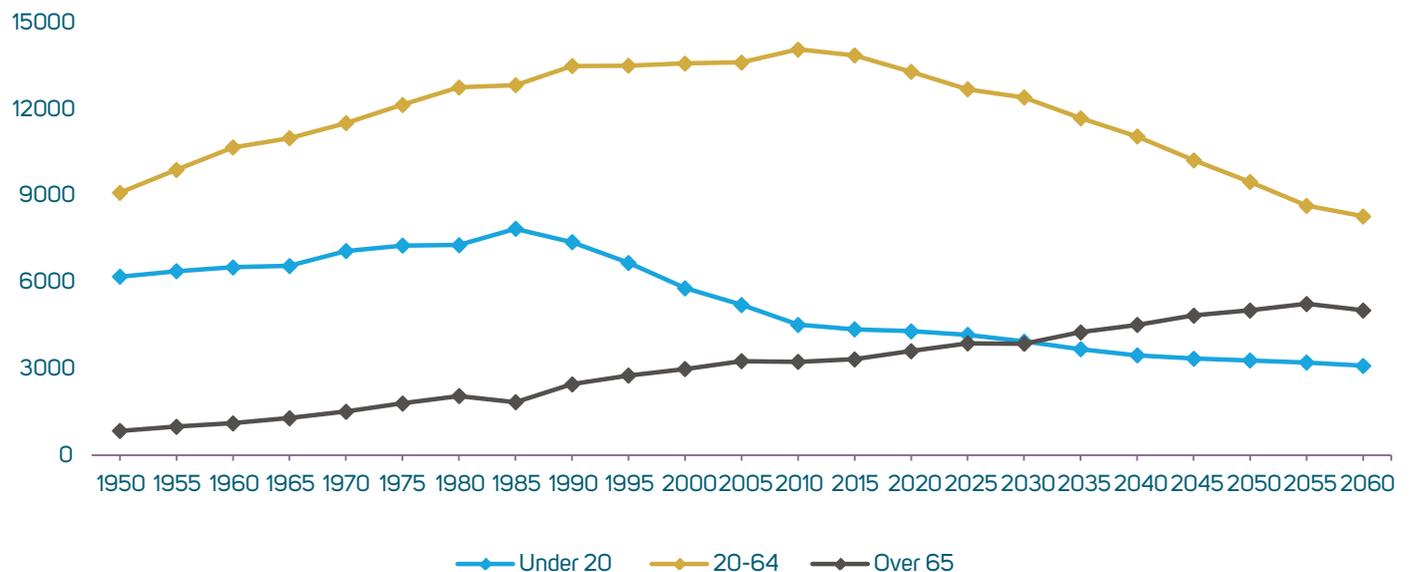
Source: UN Population Prospects data.

FIGURE 14: Evolution of the Total Fertility Rate in Romania and the Reduction Effect on Cohort Sizes between 2002 and 2011



Source: World Bank calculation using UN population data (graph on the left), Eurostat (graph to the right).

FIGURE 15: Number of People in Different Age Brackets from 1960 to 2060 (thousands)



Source: UN Population Statistics; European Union Population Projections for 2014-2050.

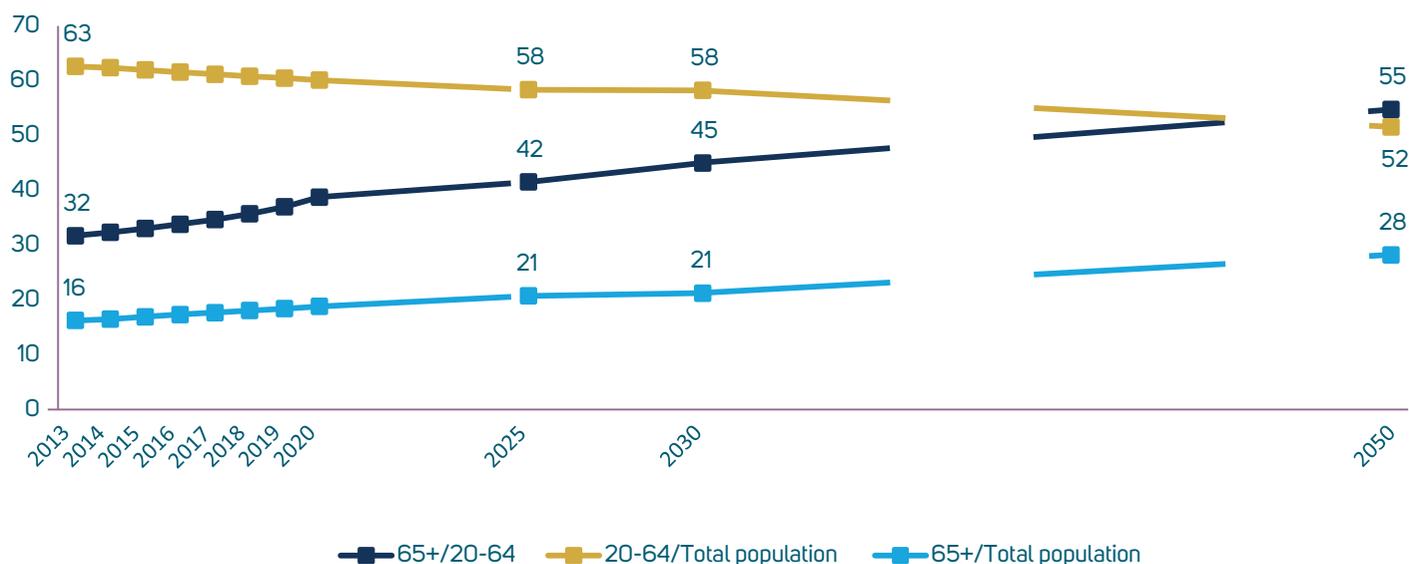
By 2030, it is expected that there will be more people over the age of 65 than people under the age of 20 in Romania (see Figure 15). So far, the rise in population aged 65 and above has been an outcome of increasing life expectancy and larger cohorts of people reaching that age. The declining fertility rate is reflected in the reduced number of children since 1980 and the decline in the size of the working age population since 2010. It is important to note that population projections may not be extremely precise, especially when the projection horizon spans decades. For example, migration has proven particularly difficult to estimate. Fertility rates may also change, although any changes would only start influencing outcomes in a few decades time. The trend of lengthening life expectancy is already well entrenched.

Romania is projected to experience one of the sharpest drops in its working age population in the European Union, a trend that is likely to impose a heavy burden on the economy. The European Union's population projections show that, by 2050, the numbers of people aged over 65 are expected to increase dramatically and will account for close to 30 percent of the total population by 2050.

At the same time, the working age population (those aged between 20 and 64) will decrease by more than 10 percent as a share of the total population (see Figure 16). As a result, Romania's old age dependency rate – defined as the ratio of people older than 65 to the working age population – will more than double over the next four decades, reaching 55 percent by 2050. During the period covered by this background study, the old age dependency rate will increase from about 22 percent in 2014 to 33 percent by 2020. The decline in the share of the population contributing to economic output could result in lower growth in per capita income and might dampen prospects for economic growth.

The population dependency ratio – defined as the ratio of people younger than 20 and older than 65 to the working age population (those aged between 20 and 64) – is set to increase by more than 0.35 by 2050, up from a historically low rate of 0.60 in 2013. This rapid increase in the dependency rate will partly be driven by a sharp increase in the number of people over the age of 65 as a share of the total population, as shown on Table 23.

FIGURE 16: Projected Changes in the Age Composition of Romanian Society (%)



Source: UN Population Statistics; European Union Population Projections for 2014-2050.

The projected demographic transition is likely to increase fiscal pressure on public budgets as the increasing numbers of elderly people will result in increased spending on pensions and health and long-term care services. As growth and income tax revenues decline – a likely outcome of a

shrinking working age population – Romania will need to find low-cost solutions to meeting the growing needs of an expanding older population. In the absence of reform, the demographic aging trend may lead to higher rates of poverty, social exclusion, and dependence among the elderly.

TABLE 23: Trends in Population Dependency Rate and Share of the Population Aged 65 and Over

	2015	2020	2025	2030	2050
Population Dependency Rate	61	66	71	72	94
Share of 65+ in Total Population	17	19	21	21	28

Source: European Union Population Projections for 2014-2050.

Ethnic Dimensions of Population Aging in Romania

In contrast with these national demographic trends, one of the largest ethnic minorities of Romania, the Roma population, is a comparatively young and dynamically growing group.⁵² About 613,000 Romanians, approximately 3.3 percent of the population, declared themselves to be of Roma ethnicity in the 2011 Population and Housing Census, which makes them the second largest ethnic minority in Romania after Hungarians. However, there are concerns that this estimate is inaccurate because of significant under-reporting. Experts estimate that the actual number of Roma is much higher. According to Council of Europe data, the Romanian Roma population in 2010 was between 1.2 million and 2.5 million or 6.5 to 13.5 percent of the total population. Children and youths aged between 0 and 14 years old – the next generation of labor market entrants – make up almost 40 percent of the total Roma population compared to 15 percent among the general population. Therefore, the demographic trend among Roma stands in stark contrast with the fast-aging profile of Romania's general population (Annex Figure 4.1). Life expectancy among the Roma ethnic minority is considerably lower than among the general population in Romania. Some estimates point to a gap of six years, while others have found a 16 year difference in the average age of death of Roma and of the general population in Romania.⁵³

As the working age population in Romania is projected to fall, the share of Romania's Roma minority is expected to grow. Depending on which of the aforementioned estimates of the Roma population is used, between 6 percent and 20 percent of today's youth are Roma. This minority group tends to be excluded from the labor market and if this continues, the employed population will shrink even faster than national demographic projections suggest. Therefore, ensuring the inclusion of the Roma minority is critical for the development of Romania. Increasing employment rates and earnings among Roma has the potential to yield considerable economic benefits ranging from €887 million to €2.9 billion annually as well as additional fiscal benefits ranging from €202 million to €675 million annually.⁵⁴

Regional Dimensions of Population Aging in Romania

The aging of the population in Romania has a pronounced regional dimension as evidenced by the uneven distribution of the older population across the country (see the left side of Annex Figure 4.2).⁵⁵ This uneven pattern of aging does not necessarily translate into an equivalent regional reduction in the number of taxpayers or increased old age related spending. For example, the areas of high "pensioner density" shown in Annex Figure 4.2 (right side) are not always where the share of population aged 65 and over is the highest. While the two maps in Annex Figure 4.2

⁵² This section borrows from the World Bank (2014a).

⁵³ World Bank (2014a).

⁵⁴ World Bank (2014a).

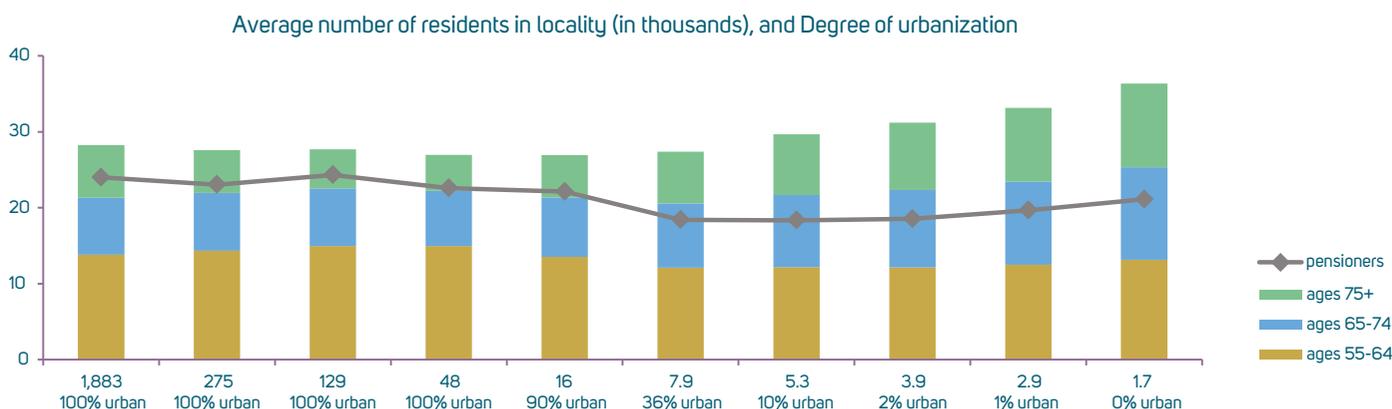
⁵⁵ This section borrows from the World Bank (2014a).

show a concentration of the elderly and pensioners in the Southern provinces, the West and Central Romania have considerably more pensioners than the numbers of elderly residents would suggest, while the reverse is true in the North-East.

Further analysis of the geographical distribution of the older population highlights stark divergences in the age composition of the population by the degree of urbanization. To approximate the degree of urbanization, we grouped the population of Romania into deciles by the size of municipality in which they live (see Figure 17). The far left column represents the population of Bucharest, while the

far right column represents the 10 percent of Romania's population living in the smallest rural municipalities with an average of 1,700 inhabitants. Figure 17 shows that 12 to 15 percent of the urban population is aged over 65, but this proportion is higher (23 percent) in the smallest rural communities. However, close to 25 percent of the urban population are receiving a social insurance pension compared with only 18 to 20 percent in rural areas. While the latter statistic is biased lower due to the exclusion of recipients of the farmer's pension benefit, which has been closed to new beneficiaries since 2000, it represents the future trend of the pension system in the absence of a farmer's scheme.

FIGURE 17: Proportion of Older Population by the Degree of Urbanization in Population Deciles



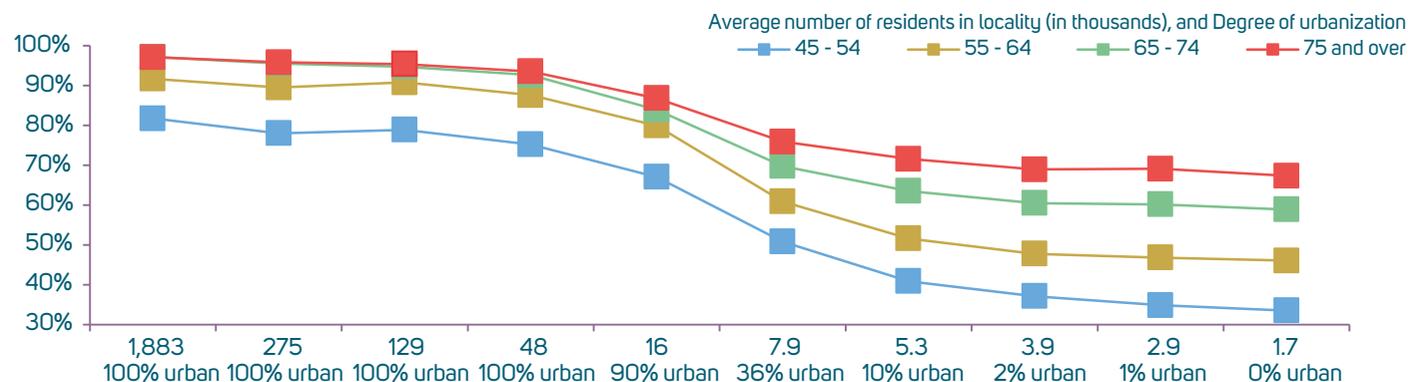
Source: 2011 Population and Housing Census data.

The uneven geographical distribution of the aging population and of social insurance coverage is likely to put many future elderly people in rural areas at an increased risk of old age poverty. As shown in Figure 18, social insurance coverage among the over 65 urban population exceeds 95 percent. On the other hand, pension coverage is declining among the older rural population. While most rural elderly people who are not covered by the general social insurance scheme are eligible for the farmer's pension benefit, this is no longer true for those in younger rural age cohorts since the farmer's scheme was closed to new entrants. Although the rural population can and should participate in the PAYG public pension system along with the entire Romanian population, a large percentage of the rural population is engaged in self-subsistence farming – typically operating outside the cash economy. As a result,

self-employed small-scale farmers often cannot afford to pay pension system contributions, thus losing their right to a contributory pension, which could insure them against the risk of old age poverty.

The magnitude of the challenge of providing medico-social services to the rural older population is even larger when the geographical distribution of the very oldest people is taken into account. Despite the lower life expectancy in poorer rural areas, the highest proportion of the very old – those aged 75 and over – still live in rural regions. Up to 11 percent of the populations of the smallest municipalities are in this age bracket, and more than one-third of them live alone (Annex Figure 4.3). This population is extremely vulnerable to poverty, exclusion, and a lack of access to health services and long-term care.

FIGURE 18: Social Insurance Coverage of the Older Population by Degree of Urbanization in Population Deciles



Source: 2011 Population and Housing Census data.

Note: Recipients of the farmer's pension benefit, which has taken on no new members since 2000 but continues to pay benefits to members who joined prior to 2000, are excluded from this analysis.

The large differences in old age dependency rates between urban and rural communities (Annex Figure 4.4) are mostly caused by migration, a large part of which consists of internal migration resulting from urbanization. It is important for policymakers to realize that migration, especially internal migration to urban areas, is a natural product of development that mostly benefits urban areas. The phenomenon is often encouraged in the name of increased productivity and employment opportunities of the young population and might be beneficial for other reasons. However, high old age dependency rates in rural settings are often a cost of such economic development, the burden of which should be shared between urban and rural communities.

In Romania, the pension system plays the most important role in protecting against old age poverty. The poverty incidence rate among pensioners was relatively high during Romania's transitional period of the 1990s. However, it dropped significantly during the strong economic growth period between 2000 and 2008. The absolute poverty rate, which takes account of the minimum basic needs of a household based on World Bank methodology, has fallen from 35.9 percent in 2000 to around 5 percent in 2008. In 2008, the poverty incidence rate for people aged 65

years and over before the receipt of any transfers stood at 80.7 percent. However, income transfers from the pension system lifted 61.9 percent of the elderly population out of poverty. Other social transfers further reduced the poverty incidence rate by 2.6 percentage points. Similarly, for people aged between 50 and 64, pension transfers reduced the pre-transfer poverty incidence rate of 48.4 percent by 32.8 percentage points, and other social transfers reduced it by 2.1 percentage points. This analysis strongly suggests that substantial reductions in replacement rates and/or declines in pension system coverage could significantly increase the old age poverty incidence rate in Romania.⁵⁶

No significant increase of the PAYG pension system's deficit is expected in the future (Annex Figure 4.5). This is primarily because pension coverage is shrinking, especially in rural areas where the farmer's pension scheme has been closed to new entrants, and because of declining replacement rates. The average pension from Pillar I and Pillar II combined as a percentage of average wages is projected to decrease by more than 15 percentage points, settling at around 35 percent of the average wage by the end of the simulation horizon. The decline is due to a less generous pension indexation as foreseen in the law starting from 2021 when the pension point value is to be increased annually by

⁵⁶ International Labour Organization (2010) and World Bank (2015b).

100 percent of the inflation rate plus 45 percent of the real wage growth of the average gross earnings in the previous year. Over the next nine years, the percentage of real wage growth taken into account in the calculation of pension values will be gradually reduced by 5 percent per year until 2030 when the pension point value will be increased only in line with any increases in the inflation rate.

The projected decline in pension coverage (see Table 24) will mean that fewer elderly people in the future will have access to a contributory old age pension, especially in rural parts of the country. As discussed above, the pension system has had the single largest effect on reducing old age

poverty in Romania. As a result, any decline in coverage could seriously jeopardize Romania's chances of reaching its EU 2020 target of lifting 580,000 people out of poverty. The developing situation in rural areas also raises the question of how the risk of old age poverty will be addressed by policymakers in the medium to long run. The changes will especially affect women, 32 percent of whom currently depend on the farmer's pension after reaching the age of 65 (only 13 percent of men in this age group are currently receiving the farmer's pension). Universal old age pensions, re-established farmer's pensions, or greatly expanded social assistance programs for rural areas seem to be the only viable options.

TABLE 24: Projected Pension Coverage and Projected Replacement Rate, Pillars I and II (%)

		2015	2020	2025	2030	2040	2050	2060	2070	2080
Projected coverage of pension system	Age 65 female			85	82	78	73	68	67	67
	Age 65 male	86	85	83	81	77	73	68	67	67
Total projected replacement rate (Pillars I and II)		49	44	41	37	34	33	33	33	34

Source: World Bank calculation using PROST, 2013 input data provided by Ministry of Public Finance.

In the future, average real pension income is expected to continue rising but will slowly decline in relation to wages. The pension reform of 2000 has strengthened the link between the contributions paid and pensions received, which has provided workers with some incentives to work longer. However, the reform also aimed to address projected fiscal imbalances that were developing along with the rapidly rising population dependency rates. Policymakers should be credited for realizing early that demographic developments require the accrual of fewer pension rights. This, of course, means that replacement rates will decline unless contribution periods are significantly prolonged. Even with the projected gradual increase in retirement ages, the replacement rates are still expected to decrease over time, as shown in Table 24. It is likely that the people affected by this change will prefer to work longer in order to soften the relative decline in their pension incomes.

This demographic change will put increased fiscal pressure on the public pension system, on healthcare services, and on long-term care at the same time as labor tax revenues will be increasing. The number of elderly people is projected to increase both in absolute numbers and as a proportion of the total population, resulting in an increased demand for health and long-term care services. This raises difficult

questions about how to meet the growing needs of the elderly. At the same time, the projected decline in the proportion of the population contributing to economic output could result in lower growth in per capita income and could dampen overall economic growth. In the absence of reform, the demographic aging of the population may therefore lead to higher rates of poverty, social exclusion, and dependence among the elderly.

To mitigate the risks triggered by the aging of the population, we recommend that the government implement policies to:

- **Ensure longer, healthy life spans and careers for the vulnerable working age population.** Fiscal pressures are likely to lead to a low internal rate of return on pension contributions in the future, requiring even longer contribution periods and higher contribution levels in order to achieve adequate pensions. This may put a significant proportion of future pensioners at risk of poverty. Women are especially vulnerable because they usually spend fewer years in paid employment and earn lower wages (thus accumulating smaller pension entitlements). Also, they often outlive their partners and end up living

alone and face higher living costs as a result and thus are at a higher risk of poverty and social exclusion. In order to address this problem, we suggest that the government ensures that an adequate level of pension income is provided to those elderly people with short formal careers and low wage incomes as well as for elderly people living alone. In addition, it is vital to find ways to increase the length of working careers in the formal sector and to increase the employment and/or earning capacity of vulnerable groups.

- **Review social pension policy.** Low coverage of the working age population by the pension system, especially in rural areas, will eventually lead to a large segment of elderly people who are not eligible for contributory pensions and are thus at risk of poverty. This will, in turn, put strong pressure on social assistance programs. Therefore, there is a need to expand the coverage of the pension system and to ensure an adequate level of income for elderly people who have no rights to a contributory pension. To prepare for this risk, the government should consider reviewing its policies regarding social pensions for the elderly and identify financing sources for non-contributory pension liabilities, which can be expected to quickly grow in the future.
- **Review legislation regarding anticipated pensions and the future pension age.** The problems involved in reducing the number of anticipated retirees and raising the pension age are being further explored and properly documented at the national level. The preconditions for these measures need to be carefully put in place, and programs need to be developed and adapted to prepare for this transition.

2.2.4. Protecting Poor and Vulnerable Consumers against Energy Shocks

Vulnerable consumers are those living in income poverty as well as select groups (such as single people and the elderly) from the lower-middle-income part of the distribution. The government has gradually increased electricity and gas tariffs to align them with EU tariffs. This is increasing the energy burden on consumers, especially poorer households.

Poor and lower-middle-income consumers will continue to receive social assistance benefits that will compensate them for a proportion of their heating costs during the cold season. These current mitigation measures include top-ups in means-tested programs (the Guaranteed Minimum Income program and the Family Support Allowance) plus seasonal support via the Heating Benefit program. The latter program was recently reformed to cover consumers whose only option is to heat their houses with electricity in addition to the existing coverage of users of wood, gas, and district heating. This program will be continued under the auspices of the forthcoming MSII program.

In addition to the heating subsidy targeted to low-income families living in their own dwellings, the new consolidated means-tested MSII program will include a housing component for families living in social housing. This housing benefit for beneficiaries living in social housing will cover the cost of their rent and a part of their heating-related costs, in order to prevent homelessness by reducing evictions.



PEOPLE-BASED POLICIES



2.3. Social Services

“Our goal is to ensure the development of a national network of social services of good quality, adequately distributed in the territory and accessible to all potential beneficiaries at national level.” Government of Romania: The Strategy for Social Services 2006-2013, HG 1826/2005.



Main Objectives

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2.3. Social Services

Social services, according to Law 292/2011 on social assistance (Article 27/1), represent the activity or group of activities carried out in response to social needs as well as to special, individual, family, or group needs aimed at overcoming difficult situations, preventing and fighting social exclusion, enhancing social inclusion, and raising the quality of life.⁵⁷ In this section, the focus is on social services within the social assistance system, given that the other types of services (such as employment, education, health, justice, and housing) are discussed in other chapters.

The development of social services has been a strategic goal of the Government of Romania since 2006 and will continue as such until 2020. Since 1990, the state, local authorities, NGOs, and commercial businesses have developed a wide spectrum of social services for all vulnerable groups throughout Romania, which nevertheless need to be further strengthened and enhanced. At present, the national social assistance system is a structured system that completed the following key phases:

- Adoption of legislation mandating local public authorities to organize, grant, and finance social services as local public interest services.⁵⁸
- Adoption of legislation providing for a diverse set of funding instruments including public funds through a direct but also competing (directed to the private organizations) financing.⁵⁹
- A shift in 1998 in the kind of programs funded by the MLFSPE from those setting-up or re-organizing day care and residential services to those supporting their running costs (in parallel with the setting up of new centers), especially salaries and the training of specialists.
- Adoption of a regulation setting up a quality assurance mechanism for social services.⁶⁰
- Adoption of regulation governing specific professions in the field (such as social workers and psychologists in 2004).
- Ratification of the European Social Charter (1998), which stipulates the individual's right to social services provided by qualified social workers.
- Adoption of legislation governing the social work system (in 2001, 2006, and 2011), which provides strategic planning of social assistance measures as a rapid response to economic, demographic, and social changes.

An extensive, coordinated, and integrated network of services is needed to address most of the most persistent social problems in Romania, such as children's precarious nutritional status, the neglect and abuse of children, early school leaving, and weak early childhood educational programs. These problems also include youth unemployment, insufficient primary and preventive health services, underdeveloped social housing, and a lack of support services for a wide range of needs (such as disabilities, drug addiction and alcoholism, domestic violence, homelessness, and ex-prisoners). Monetary poverty further deepens the various vulnerabilities, but cash transfers alone cannot solve existing social problems. Social benefits (both cash and in-kind) must provide recipients with a secure income, and therefore any reforms of the system will need to consolidate and optimize these kinds of support. While income support (cash transfers) are crucial given the high level of poverty and material deprivation in Romania and the fact that families with young people and children are most at risk, most vulnerable groups require social services developed to cover their specific needs. Therefore, support packages for most vulnerable groups should be developed that integrate cash benefits with social services with the aim of promoting their full inclusion into society.

⁵⁷ This definition of social services is compatible with the most widely used definition in the EU, that of "personal social services" (Munday, 2007: 10). In Romania, social services are services of general interest and are organized in various forms/structures, according to the activities carried out and to the particular needs of each category of beneficiaries (Law 292/2011, Art. 27/2). These services are provided in a variety of locations and settings, such as individuals' homes, day centers, and residential establishments, and they are staffed by personnel that include social assistants, social workers, care managers, home-helpers, therapists, and crèche staff.

⁵⁸ Including a separate budgetary section for social services (1996) and child protection services (1998) in the local budgets; the first Local Budgets Law (after 1989); the setting up of social services as local public interest services (1996, 2001, through the Local Public Administration Law); the setting up of child protection services at the county council level as an optional (GD 1159/1996) and mandatory (GD 205/1997) responsibility. Recognition of social service providers as local public interest providers (2001). Increased accountability of local public authorities for setting up, organizing, and financing social services (2001, 2003).

⁵⁹ The subsidy (1998), grant financing (2005), concession, procurement (2001, 2006, 2012) program.

⁶⁰ Quality standards (2001, 2004, 2005, etc.), accreditation of service providers (2004), social inspection of service providers (2006).

In the medium term, the demand for social services will most likely continue to grow, given the main demographic evolutions. Eurostat data based on the 2011 Census show that Romania is among the top five European states experiencing demographic decline caused both by negative natural population growth and migration. Although almost half of the population lives in rural areas,⁶¹ only 24 percent of the social services are located in rural areas, and only 6 percent of the subsidies from the state budget for associations and foundations (Law no 34/1998) goes to centers located in rural localities. The aging of the population in rural areas together with the optional pension for farmers (2010), as well as youth and adult migration for labor abroad, are expected to result into an increase in demand for social services from elderly people and children left at home. In Romania, the tradition of families being responsible for providing care is still strongly evident, although the massive numbers of the working age population migrating overseas for work has already left an increasing number of children and older people without family support. Over the next few years, outmigration (particularly of women) is likely to have an even greater impact on the need for and supply of social care service.

In the shorter term, a paradigm shift in the development of social protection is envisaged. The government's current emphasis on cash transfers has been criticized for creating dependency and for not being appropriate or developmental. Most community development practices currently being used in Romania have been criticized for not being focused on empowerment or human development. Many social services have been criticized for not responding to the real needs of their beneficiaries or for not being person-centered (with the client often being seen as merely a passive recipient). Therefore, there is a need to shift to an approach that focuses on improving families' living conditions, ensuring that families are involved in the decisions about their own cases, and engaging communities in supporting families.

The new approach that needs to be fostered in the coming years is family- and person-centered, as well as sustainable and based on a holistic vision of development. The aim of this approach is to encourage beneficiaries to use creatively

and innovatively the knowledge of the individuals in their communities and of the resources available in their environment to meet their socioeconomic needs. This approach aims to maximize human potential and to foster self-reliance and participation in decision-making. It also stresses services and support that are person-centered and family-centered and, at the same time, community-based and integrated. In other words, the approach focuses on the safety and needs of children, youth, adults and elderly in vulnerable situations within the context of their families and communities, and it builds on the strengths of families in order to achieve optimal outcomes. In accordance with this approach, the current volume emphasizes the need for appropriate services for all, particularly the poor, the vulnerable and those with special needs, it promotes integrated and community-based services to ensure the sustainability of interventions, and it recognizes that social workers, among other professions, play a key role in enhancing the capacity of people to address the causes and consequences of their poverty and vulnerability.

The development of social services must be framed within a coherent policy based on an inclusive approach designed to support individuals within families and communities, especially in the context of regionalization and financial and administrative decentralization.⁶² To this end, the background study has identified six main objectives: (1) increasing co-decision and participation of beneficiaries in the social services provision; (2) improving needs assessments and information management system and ensuring their alignment with local decision-making policies and practices; (3) improving financing for social services; (4) strengthening and enhancing social assistance at the community level; (5) developing integrated intervention community teams, particularly in poor and marginalized communities; and (6) developing services for vulnerable groups, including children and people with disabilities (mental health problems included), elderly people, and other vulnerable groups. These objectives are treated in the next sections.

⁶¹ According to the new NUTS classification (common classification of territorial units for statistics), Romania has two counties that are predominantly urban (with rural populations of less than 20 percent), 18 intermediary counties (with rural populations of between 20 percent and 50 percent), and 27 counties that are predominantly rural (with rural populations of more than 50 percent).

⁶² Social services are set up in a decentralized system (2003) and, therefore are not subject to decentralization process (2006). Thus an amendment to the Law no. 195/2006 on decentralization is needed. Strengthening government capacity to ensure access to quality public services is a general objective of the government's Strategy for Public Administration 2014-2020 (General objective IV, Annex 1: 83-85, www.mdrap.ro/userfiles/consultari_publice/30_06_14/anexa1.doc). The Strategy recommends the development of quality and cost standards for all public services to make them more efficient and to improve their quality. It also proposes the creation of a minimum package of basic public services that each territorial-administrative unit will be mandated to provide as well as an optional package of services to be delivered by the more developed localities. The government is currently considering the budget allocations that will be necessary to achieve this objective.

2.3.1. Fostering the Participation of Beneficiaries in the Planning and Provision of Social Services

The participatory involvement of beneficiaries is critical to the success and sustainability of social services provided within a community. It is also necessary to ensure that social assistance interventions have a positive impact and produce solid results. Romania does not yet have any clear guidelines for involving beneficiaries in the decision-making process for social services. Therefore, the government should develop specific measures in line with other forms of consumer rights protection to ensure that beneficiaries can have a say in decisions related to the planning, development, management, and evaluation of all types of social services. Social responsibility also involves the responsibilities and liabilities of social service providers towards their beneficiaries as well as the need to implement mechanisms for handling and addressing complaints and petitions.

The role played by private providers and NGOs in delivering and developing of social services needs to be increased at both the national and local levels. The existing public-private partnerships have evolved positively over the years in terms of both the number and size of their activities. The government aims to provide greater support to NGOs that are delivering social services as well as to develop adequate contracting procedures, with the objective of increasing the number and improving the quality of social services available to communities as well as to a significant number of vulnerable and excluded people.

Moreover, in drawing up the secondary legislation for Law no. 292/2011, the MLFSPE is:

- Drafting the special regulations under which for-profit providers are entitled to deliver social services (differentiating among them by type of contract rather than by type of enterprise).

- Ensuring its compliance with the Directive on services in the internal market (2006) and the obligation to have a unique contact point (GEO 49/2009).
- Taking into account analysis on different types of public-private partnerships in the field of social services, in line with the Directive on public procurement and the law on public-private partnerships (for instance, analysis of how the Romanian Social Development Fund chooses which groups from poor rural communities can initiate income-generating activities or small infrastructure projects).
- Simplifying accreditation procedures for social service providers (online registration with subsequent confirmation); organizing the registry by region so that the future regional authorities could take it over when they will undertake the responsibilities from the central government.
- Improving the Nomenclature of Social Services (specified at NACE level 4, including a short description of responsibilities, specifying the type of provider that is allowed to provide the services in question).
- Including the obligation of recording the funding contract in the land registration with the procedure applied for investments in daycare and residential centers, to ensure the sustainability of the investments.
- Abolishing the need for foreign non-profit entities to obtain prior consent from the government to operate in Romania and formally recognizing the public utility of private social services providers (supplied by local and county councils or through intercommunity/ regional partnerships).

2.3.2. Improving Needs Assessments and the Management Information Systems and Ensuring They Align Local Decision-making Policies and Practices

Needs assessments and information management systems in the social services sector are still deficient and are rarely used to inform local decision-making policy and practice.⁶³ One of the main obstacles to the development and monitoring of social services is the dearth of data on local social problems, particularly on the needs of poor and vulnerable groups, on what services are available, and on referral patterns. The existing services are not regularly evaluated, and as a result, there is no information to guide policymakers or program managers in making any necessary adjustments. Social services are not provided in accordance with a transparent plan geared to local and regional needs. There is no national methodology for carrying out community needs assessments and local strategic planning of social services, and local authorities do not have enough knowledge or capacity for these tasks, especially in rural and small urban areas. As a consequence, over the past decade, social services (including prevention services) have mostly been managed by the county authorities (through the County Directorates of Social Assistance and Child Protection or DGASPCs) instead of by the local communities themselves.

Consequently, the monitoring and evaluation (M&E) of social services needs to be improved in order to make the social service system more accountable, relevant, and efficient. The current database (national register) of service providers is limited and is not yet fully operational for a range of functions that would support data collection and the documentation of public policies.

Investing in a complex e-social assistance system will be essential to ensure the effective planning, monitoring, and evaluation of social protection benefits and services. This kind of e-system would make it possible to make automatic cross-checks of social assistance data across all relevant databases. The e-social assistance system would include: (i) a public finances electronic database; (ii) an electronic agricultural registry; (iii) an employment and pensions' electronic registry; (iv) a civil electronic registry; and (v) a national registry of providers of social services. Implementing such a system at the local authority level would help beneficiaries to access information, benefits, and services, simplify procedures, avoid overlapping schemes, reduce administrative and beneficiary costs, and reduce or even prevent error, fraud, and corruption, while at the same time respecting the client's right to data protection and privacy.⁶⁴

The e-social assistance system would also meet beneficiaries' needs more effectively by facilitating coordination between the social benefits and social services systems. These two components of the social assistance system need to become more complementary and coordinated in order to ensure the wellbeing and inclusion of all beneficiaries. By providing a clear picture of each recipient and all of the cash benefits that he or she receives, it would also enable social workers to develop a comprehensive planning system for support services, to make informed referrals to specialized services (when needed), and to observe and evaluate the impact of any support measures.

⁶³ Law no 292/2011 sets out the responsibilities of local public authorities to plan the contracting out of social services based on community needs, to conduct an inventory of existing social services and of their efficiency, to collaborate with public and private service providers in developing the criteria for providing evidence about the types of social services to be contracted out, to include the contracting program in their annual action plans on social services, and to include the necessary funding in the local budgets.

⁶⁴ Ministry of European Funds (2014).

TABLE 25: Current Status of Necessary Development Actions, 2014

Development need	Current status
Gate-keeping mechanisms – macro level	
Local needs assessments	Available only in isolated cases despite being legally mandated (in the Law on social assistance 292/2011)
Mapping of needs	Available only in isolated cases. No methodology in place but this is a legislated obligation of local authorities.
Mapping of existing services	Available only in isolated cases. No methodology in place but this is a legislated obligation of local authorities.
Integrated information system at the national level	Still deficient. A single database of accredited service providers is available. World Bank loan is in effect for the development of e-assistance.
Gate-keeping mechanisms – micro level	
Individual needs assessments	For people with disabilities that are very “medicalized.” The evaluation methodology is under revision with the support of a World Bank/ Japanese government grant. For other vulnerable groups, these are poorly developed.
Case management approach	Poorly developed, especially in smaller communities. Better organized for children in public care but needs development. Almost absent for adults with disabilities. This is a legislated obligation of local authorities.
Referral to services	Referral systems for the most vulnerable groups are poorly developed or completely missing. SPAS social workers do not know what specialized services exist at the county level so cannot make informed referrals. The referral system for people with disabilities is outdated. With no mapping of existing services, the referral commissions do not know what network of services is available at the local level. In addition, people with disabilities enter into a specific referral process in Romania once their disability has been certified. Generally, the commission members are not properly trained and receive no ongoing training.
Licensing/accreditation procedures	
Licensing/accreditation procedures	The licensing and accreditation process was changed in 2013. It is now in the process of being reformed again.
Quality standards	Outdated. Strong need for revision and modernization, especially for services for adults.
Contracting and funding procedures for service providers	
Contracting (with national or local authorities)	Not yet included clearly in the legislation. Strong advocacy effort ongoing at the national level for this procedure.
Funding procedures (all types of funding mechanisms included)	A limited range of options, small budgets at the local and national levels, and no unit costs in place for the budgeting and development of new (and existing) services. The few existing unit costs are obsolete and in need of revision, especially for services for adults.
Monitoring and evaluation	
Monitoring	No professionals in place for this process, despite a legal obligation to provide monitoring.
Evaluation procedures	No professionals in place for this process, despite a legal obligation to provide regular evaluation of services.

2.3.3. Improving the Financing of Social Services

This section is based on an analysis of the data available in the European System of Integrated Social Protection Statistics (abbreviated as ESSPROS).⁶⁵

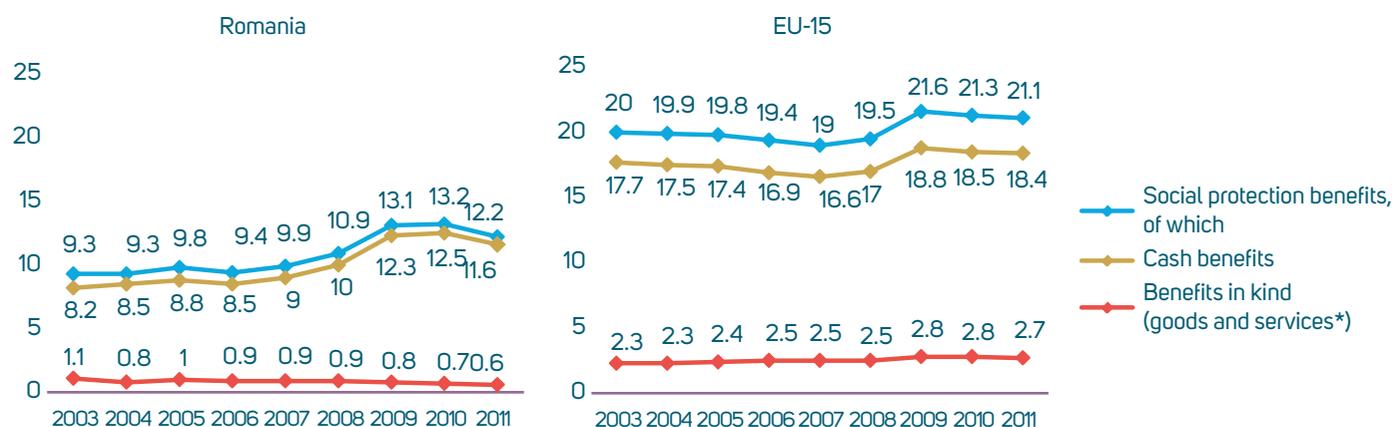
Romania's social protection efforts are still the weakest in the European Union despite the increasing availability of funds. Social protection spending⁶⁶ as a percentage of GDP is considerably lower in Romania than in developed European countries on both cash and in-kind benefits (goods and services) (see Figure 19). Expenditure on cash benefits in Romania has followed the European trend in terms of increasing during the global financial crisis,

whereas in-kind services have constantly received about 4 to 5 percent of Romania's GDP compared with the EU-28 average of 8 to 10 percent (more than 10 percent in the EU-15 with an increasing trend after 2008).⁶⁷

The total allocation for social services (from all funding sources) has always been low. In absolute terms, the total budget allocation for social services (in-kind benefits) increased from about 300 PPS⁶⁸ to 573 PPS per inhabitant between 2003 and 2011. Even so, this allotment is starkly low compared with the EU-28 average of almost 2,500 PPS per inhabitant or over 2,800 PPS per inhabitant in the EU-15 countries.

Over 85 percent of total expenditure on in-kind benefits in Romania relates to medical care (goods and services used in prevention, cure, or rehabilitation).⁶⁹ Thus, in 2011, only about 0.6 percent of GDP was actually spent on social services other than medical care, including services

FIGURE 19: Social Protection Spending by Type, 2000–2011



Source: World Bank calculation using data from Eurostat, ESSPROS, extracted on August 29, 2014.

Note: *Benefits in kind (goods and services) other than for medical care.

⁶⁵ Data extracted on August 29, 2014. ESSPROS contains national administrative national data on social protection spending, both on cash transfers and in-kind benefits (goods and services) that are collected using a methodology that makes it possible to make coherent comparisons between European countries.

⁶⁶ Social protection encompasses all interventions by public or private bodies intended to relieve households and individuals of the burden of a defined set of eight risks or needs, provided that there is neither a simultaneous reciprocal nor individual arrangement involved. The set of eight risks (or needs) include: (1) sickness, medical care; (2) disability; (3) old age; (4) loss of a family member; (5) children and families; (6) unemployment; (7) housing; and (8) social exclusion not classified in other categories, such as the rehabilitation of substance addicts. Cash benefits include cash payments to protected people and reimbursements of expenditure made by protected people. In-kind benefits refer to goods and services directly provided to protected people. (Eurostat, ESSPROS Manual, 2011: 9).

⁶⁷ In-kind services are increasingly a favored tool of governments across the OECD. Over the past 20 years, total spending on social services has been steadily increasing, whereas spending on cash transfers has been stable. In the OECD countries, spending on social services is likely to continue to grow in the context of the ongoing global recession as the uptake of front-line social services increases. (Richardson and Patana, 2012: 3).

⁶⁸ Purchasing power standard.

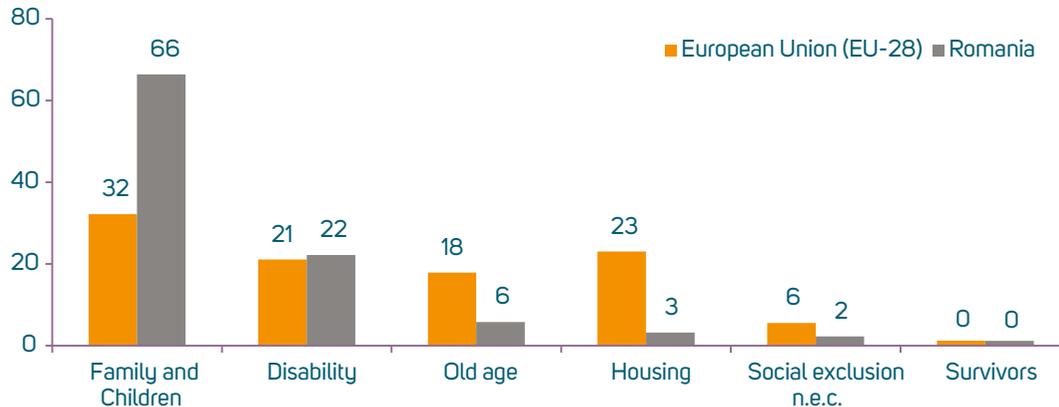
⁶⁹ For comparison, the percentage of the sickness/healthcare function in total expenditure on in-kind benefits was 73 percent among EU-28 countries in 2011. Furthermore, between 2005 and 2011, this proportion increased in Romania from 77.3 percent to 86.7 percent, whereas in developed European countries (the EU-15) it has stayed constant at 73 to 74 percent.

intended to protect the population against risks or needs related to old age, children and families, housing, the loss of a family member, disability, unemployment, or social exclusion (for example, the rehabilitation of alcohol and drug abusers). In Romania, social services other than medical care receive a total allocation from all financing sources of around 84 PPS per inhabitant (compared with an EU-28 average of 664 PPS per inhabitant and an EU-15 average of over 764 PPS per inhabitant in 2011).

The highest spending on social services (other than medical care) is oriented towards protecting the population against

risks or needs of children and families and of persons with disabilities. All other risks have constantly been severely underfinanced. Figure 20 shows that, in Romania, the low expenditures on in-kind benefits have resulted in a limited spectrum of services. Considering the major demographic trends that Romania will face in the coming years, the government needs to pay more attention and allocate higher budgets to risks and needs related to old age. In addition, social housing services receive disproportionately small budgets in Romania in comparison with other European countries.⁷⁰

FIGURE 20: Structure of Spending on Personal Social Services other than Medical Care, 2011 (%)



Source: Eurostat, ESSPROS, Extracted on August 29, 2014

Note: Data refer to in-kind benefits in all schemes including residential care, home help, rehabilitation, child daycare, funeral expenses, social housing, and other in-kind benefits. Social exclusion n.e.c. (not elsewhere classified) includes services not categorized under the other functions.

The financing for disability-related services (and goods) has declined in recent years, both as a proportion of GDP and in terms of PPS per inhabitant. This has been particularly the case for assistance in carrying out daily tasks (home help).⁷¹ This trend is particularly worrying considering the national goal to deinstitutionalize people with disabilities and to transition to a system of family-type care.

In conclusion, despite the government's efforts to finance social protection at satisfactory levels, the crowding-out effect of the cash transfers budget has resulted in the

severe curtailment and neglect of services. This has been exacerbated by the global crisis. Social service practitioners have been forced to adopt a "make do" approach, mainly dictated by resource limitations rather than by need or priority. Furthermore, while specialized social protection services have remained underfinanced but mostly functional, preventive social assistance services at the community level have continued to lag behind in terms of institutional development, capacity, and use.

At the moment, local authorities, DGASPCs and NGO

⁷⁰ In 2011, social housing services were given a budget allocation of 2.66 PPS per inhabitant in Romania compared with an EU-28 average of over 145 PPS per inhabitant.

⁷¹ Between 2003 and 2011, the allocation for disability-related home help declined from 0.2 percent to 0.1 percent of GDP and from 15.3 PPS to less than 7 PPS per inhabitant. In contrast, spending on residential care for people with disabilities slightly increased from 5.8 to 8.6 PPS per inhabitant.

providers do not receive sufficient funds from the state budget for the development of social services. As a result, local budgets tend to have to support the development of social services at the local level, but these budgets have been severely curtailed by the decrease in tax receipts during the recent period of austerity and fiscal consolidation. For example, the level of tax collection in rural areas in 2012 was only 30 percent of the usual level (according to the Association of Communes in Romania). For this reason, local authorities need additional support from the central budget for developing social services.

The DGASPCs, which are financed by the state budget and county councils,⁷² constitute the main providers of specialized social services and, at the same time, the main purchasers of social services. In some counties, the DGASPCs face financial difficulties, especially providing services for the disabled and the elderly, given the decline in extra-budgetary funding (such as donations and sponsorships).⁷³ The non-government providers of social services are also facing significant challenges as the available funding for this category of providers is declining, non-sustainable, and unpredictable. The key funding mechanisms available to NGOs are subsidies (from the central budget) and grants from local authority budgets.

BOX 9

Access of social services providers to public funds



Most key stakeholders in Romania feel that private non-profit providers of social services (non-government organizations and religious entities) are not given sufficient access to public funds to help them to develop these services. They also feel that this access is not properly regulated at the national level. Because of the general underfunding of the social services system and of the lack of any clear regulation ensuring the consistent enforcement of GEO 34/2005 on public procurement in the social field, social services cannot be developed at the pace necessary to meet citizens' needs.

Currently, in Romania, non-profit service providers have access to a limited range of public funds:

- Subsidies from the national budget for certain types of expenditures incurred while providing an existing social service in line with Law no 34/1998, as subsequently amended.
- Non-reimbursable funds from the county or local councils in line with Law 350/2005.
- Public funds used for the concession or development of some of the services provided by public authorities in line with GEO 68/2003 on social services.⁷⁴

Public authorities can contract with non-profit private providers through the procurement procedure regulated by GEO 34/2006 (updated). However, most public authorities claim that terms of reference can only be produced for those services for which minimum cost standards have been set at the national level. These are usually services related to child protection, social assistance, and adoption and some services for people with disabilities for which quality and cost standards were developed between 2004 and 2014.

Nevertheless, if the local need for services is pressing, county and local authorities may decide to procure additional services from private non-profit providers even without these minimum cost standards. In these situations, the procedures used to draft the terms of reference and then to monitor the expenditure differ significantly from one county to another, as there are no specific norms for the enforcement of the ordinance related to social services.

Local authorities still highlight the need to have clear norms for the procurement of local services from private non-profit providers under GEO 34/2006, especially for those services for which there are still no national cost standards.

Currently, only a very small number of counties have procured services in this way (for example Alba and Arad), although the MLFSPE believes that this method should be used extensively. The

⁷² According to the law, DGASPC are financed 75 percent from the state budget and 25 percent from the county and local budgets (through the County Councils). In practice, the proportion of funds from the county budget varies widely among counties.

⁷³ MLFSPE and SERA Romania (2012).

⁷⁴ As the methodological norms for Law no 292/2011 (on social assistance) have yet to be developed this ordinance is still in force.

BOX 9 (continued)

main difficulties that county authorities tend to experience when procuring services in this way are: (i) Preparing the terms of reference for the social services in question, especially if the services to be procured have no national cost standards; (ii) Developing cost-quality assessment criteria to efficiently compare the bids received from various private providers; and (iii) Launching the procurement process in counties or areas where the number of providers is limited so the legal conditions for an open competition cannot be met.

Most counties or municipalities are still reluctant to use this ordinance, especially because of the different interpretations issued by the Court of Accounts on the contracts for the procurement of social services.

As a result, various social services for which there are as yet no minimum cost standards at the national level (and often no unitary quality standards) cannot be procured from public funds under GEO 34/2006, although they are very much in demand and needed at the local level.

Romania's obligation to comply with the new EU Directive on Public Procurement, from February 26th 2014 (2014/24/EU) is an opportunity to adopt a single consistent nationwide regulation on public procurement in the social services. The Directive has a distinct section on social services (Articles 74-77), and member states are expected to enshrine these Articles in their national legislation by 2016. At the end of 2014 and the beginning of 2015, several large national non-profit provider networks in Romania (including Dizabnet, SenoriNet, Federation of Children NGOs, and Federation of Social Services NGOs) asked to take part in discussions with representatives of the Ministry of Finance and the National Authority for the Regulation and Monitoring of Public Procurement (ANRMAPP) with a view to developing these provisions for the social services sector.

Source: Opinions presented at the Social Services Forum in Brasov (February 10-12th 2015), organized by Caritas Romania, Fundatia pentru Voi Timisoara, and Alaturi de Voi Iasi as part of the project Stronger NGOs Together.

The financing framework also needs to be improved to ensure the sustainability of financing for social services. The financing framework has a critical role to play in regulating the supply of and demand for social services and is one of the key public policy tools for ensuring the availability, cost-effectiveness, and quality of social services. The qualitative research conducted for this report showed that local and county authorities are reluctant to develop social services even when funding is available, specifically because of the lack of a proper financing framework to protect them against potential charges of fraud in connection with any inspections by the Romanian Court of Accounts. The procurement (and contracting out) of social services is not yet properly regulated at the national level, nor are there any effective monitoring and evaluation mechanisms. For this reason, the fiscal authorities often apply different legal interpretations to the contracting out of social services to not-for-profit providers. In many counties, as a result, local authorities have become reluctant to contract these services out to private providers, despite their own limited capacity to provide all the services needed.

The financing framework should ensure that the limited amount of available financing for social services is spent where there is most need. It is necessary to prioritize among many demands to ensure that public funds are allocated to those groups with the greatest need and to those services that produce the best outcomes. This prioritization (or rationing) requires staff with the technical knowledge and training to perform needs assessments and service matching, as well as the assistance of social workers at the community level to identify potential beneficiaries and services. The framework should also set out service standards to ensure that all providers – whether public, private, or NGO - supply services efficiently and of an adequate quality.

In order to achieve an improved financing framework, developments in several areas are still needed:

- **Funding mechanisms and procedures** need to be fully developed, especially in the context of the decentralization. The main objective should be to direct more resources to community-based services targeted to families at risk and family-type care alternatives. At the same time, the existing procedures for collecting and using donations from and sponsorship by public institutions are rather unwieldy and need to be simplified.

- **Coordination and harmonization between financing mechanisms in different sectors** (such as healthcare, education, housing, and employment) need to be increased in order to encourage and support the development of integrated services.
- **Improvement, increased transparency and dissemination of the procedures for contracting out social services** to non-government and private providers are highly needed. For those social services with a series of agreed performance indicators, policymakers may wish to consider adopting an output-oriented contracting model with staged payments. The procedures for contracting out social services should take into account the results of local needs assessments and prioritization of social services.
- **Improvement of the costing methodology and procedures for social services** is required. The Ministry of Labor, Family, Social Protection, and the Elderly (MLFSPE), has developed standard costs for social services (GD 23/2010). However, a 2012 study showed that, while 94 percent of the DGASPCs apply these standard costs, 93 percent of them believe that they need to be revised and modified.⁷⁵ Social service providers (especially NGOs, but not only) consider that the current standard costs are not accurate and realistic because they are determined as average costs that are highly influenced by the costs of large residential centers, with no direct reference to care standards. For this reason, the development of a methodology and improved procedures for determining standard costs for social services is still very much needed, especially for adults and the elderly.

To ensure the full development of the sector, it will be vital to secure adequate government funding in parallel with the funding received from various European bodies.⁷⁶

BOX 10



Harghita county – partial funding of private non-profit providers from non-reimbursable local funds allocated and used in line with Law 350/2005

The County Council in Harghita has found a solution to this problem in terms of developing home care services, a type of service for which, until now, there have been no national quality and cost standards. They have chosen to support these services from non-reimbursable funds from the county council in line with Law 350/2005. Initially, the County Council in Harghita used non-reimbursable funds: (i) to develop preventive services related to child protection and (ii) to fund innovative activities in the county. For the past two years, the County Council has decided that all social programs funded from this mechanism should be transferred to and managed by the Harghita DGASPC. Currently, there are five programs in Harghita county funded from non-reimbursable funds:

- The Community Assistance Program that was created after the DGASPC noticed that there are many communities where people have no access to basic services such as healthcare and transport. The program has built a network of community workers to help people with their day-to-day tasks. The community workers have vans that they use to travel from one settlement to another. They do shopping for their clients, help them to pay bills and solve administrative issues, and sometimes transport people with limited mobility.
- The Home Care Program is a program targeted to people with more complex caretaking needs. This program from Harghita is the only program in Romania that allows home care services to be developed in all settlements. The program grew out of the collaboration between the Caritas NGO and the County Council but was also as the result of the County Council convincing all

⁷⁵ MLFSPE and SERA Romania (2012).

⁷⁶ In 2011, Social Services Europe, a consortium of European non-profit providers of social services, recommended that the European Commission should prevent its member states from replacing their existing, sustainable financing of core services by funds from the European Social Fund (ESF), in order to ensure the continuity of service delivery and of the core activities of beneficiaries.

BOX 10 (continued)

local councils to participate. Now in Harghita most of the necessary funds for the program are provided by the local councils, with an additional contribution from the County Council.

- A program for people with disabilities funds and organizes cultural and sports events and services for people with disabilities.
- A similar program for deprived elderly people is also funded from non-reimbursable funds.
- A program preventing children from entering the child protection system is run by the county DGASPC together with NGOs involved in the protection and promotion of children's rights.

In Harghita the funds for all of these programs are approved by the County Council after it approves the county budget. This funding is then subject to a public debate for 30 calendar days, meaning that these funds only become available to the non-profit providers in the middle of the year (no earlier than June 1st). The methodology for submitting bids and evaluating the projects that use these funds is transparent, with notices published in the Official Gazette. Competitive bidding for all social services projects funded from non-reimbursable funds is open to all non-profit providers. The County Council President appoints a committee to evaluate the bids and then signs specific contracts with every non-profit organization that wins the bidding process. The county funds supplement those provided by the local councils, as well as the service providers' own funds and those from the state budget (subsidies). The main benefit of funding services from non-reimbursable funds is that it is possible to support innovative services or services that have been requested directly by local citizens or their representative organizations.

This funding mechanism also has some limitations:

- The eligibility of some types of expenditures is decided by the County Council. For instance, in Harghita the Council does not cover staff costs (not even as own contributions, which

should be at least 10 percent), even though, for social service providers, staff costs represent the highest share of the budget for that service, usually 60 to 70 percent.

- The funding does not become fully available until the middle of the year, meaning that it covers only six to seven months of the provider's operating costs. As a result, the providers are required to make a significant financial commitment of their own.

Under these circumstances, it is most efficient to use non-reimbursable funds as an additional funding source to other public and private funds. Although these funds cannot fully cover the operational costs of social services, they are an important local mechanism for expanding services.

Source: Interview with representatives of DGASPC Harghita.

2.3.4. Strengthening and Enhancing Social Assistance at the Community Level

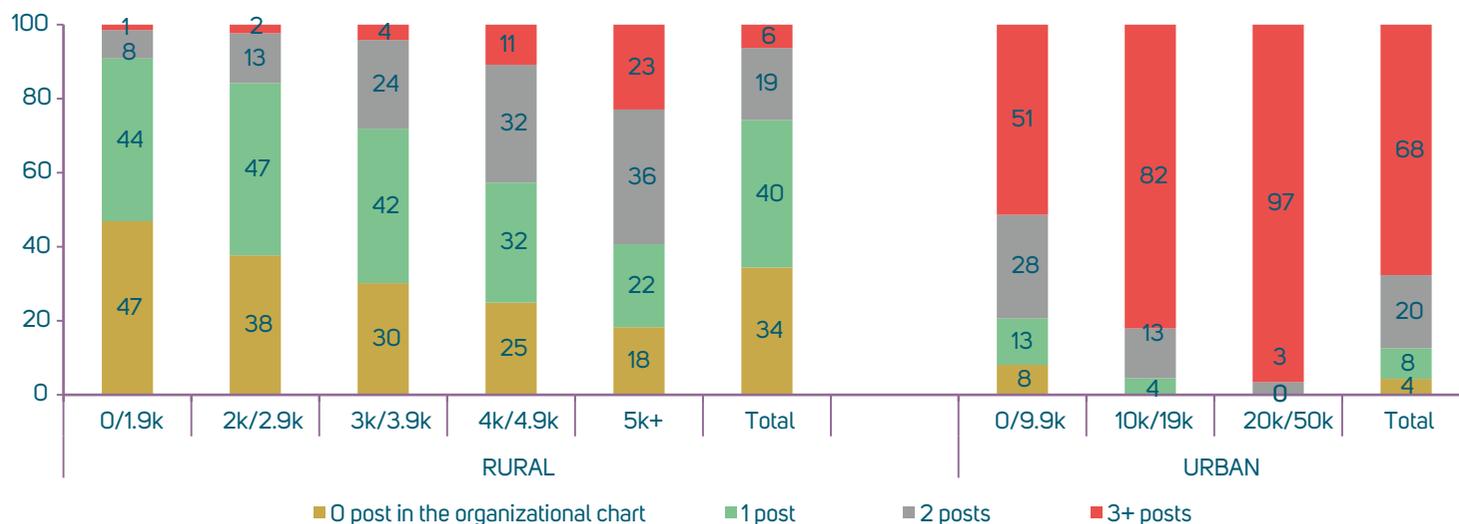
The World Bank carried out a survey of Public Social Assistance Services (SPAS) in all cities and rural communities in Romania, in May 2014, as an input to the National Strategy on Social Inclusion and Poverty Reduction 2015-2020. The aim of the survey was to account for all local authority staff with social work responsibilities. The questionnaire was filled in by 3,014 localities out of 3,180, a completion rate of 95 percent (see also Annex 5 Section II).⁷⁷

Local authorities are required by law (292/2011) to establish departments of Public Social Assistance Services, which are responsible for putting social assistance policies and strategies into operation and for delivering services at the community level. The SPAS identify community needs, provide appropriate services to vulnerable groups, and develop prevention and information services to enhance

⁷⁷ Bucharest was not included. Due to partial non-responses, the (40) cities with 50,000 or more inhabitants were also excluded from the analysis. Thus, the analysis presented in this section covers 279 cities with fewer than 50,000 inhabitants and 2,861 communes, a total of 3,140 local authorities.



FIGURE 21: Social Assistance Duties Listed in the Organizational Charts of Rural and Urban Localities by Population Size and Number of Posts



Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

Notes: k = thousand inhabitants. See also Annex Table 5.1.

public awareness about risks and social problems. The social workers from SPAS, in cooperation with the professionals from the DGASPC, are expected to play the role of gatekeeper for all children and adults in poverty or vulnerable situations in their communities. However, there is at present no methodology that governs the collaboration between the SPAS and the DGASPC, though one is currently being prepared by the government.

Many local authorities have yet to comply with the legal requirement to establish SPAS, especially those in smaller rural municipalities. Although some progress has been made in recent years,⁷⁸ in 2014 over one-third (34 percent) of local public administrations in rural areas and 8 percent in very small cities (those with fewer than 10,000 inhabitants) had not set up an SPAS but instead had added these responsibilities to the job descriptions of existing staff (Figure 21).⁷⁹ This overall proportion varies widely from 47 percent of small communes (those with fewer than 2,000 inhabitants)

to 18 percent of the large communes (those with 5,000 inhabitants or more). Virtually all local authorities in cities with more than 10,000 inhabitants have established a SPAS.

The development of primary social services as mandated by law has been hindered by a lack of financial resources at the local level, by the hiring freeze and wage cut-off in the public sector (as part of the austerity policies implemented in 2008 to 2010), by the limited use of flexible forms of employment (such as part-time working) in the public sector, and by a lack of effective training for staff. As a result, local authorities have limited capacity to employ specialized staff in social assistance, especially in rural areas.

An additional constraint for local authorities in retaining and recruiting a specialized workforce in social assistance is given by the very low wages of social workers. The average monthly net wage in the health and social assistance sector is only 87 percent of the average wage across the economy

⁷⁸ Previous research showed that, in 2011, almost 45 percent of local public administrations in rural areas had not set up the relevant services. Furthermore, among SPAS, only 30 percent were accredited as social service providers, with 70 percent falling short of the standards needed for accreditation (MLFSPE and SERA Romania, 2012).

⁷⁹ Actually, due to vacancies, the proportion of local authorities with no SPAS increases to 38 percent in rural areas (varying between 52 percent of small communes and 21 percent of large ones) and to 9 percent in very small cities.

TABLE 26: Net Wage Earnings in the Health and Social Assistance Sectors in Romania

	2008	2009	2010	2011	2012
Monthly net average wage earnings at national level (nominal, RON)	1,309	1,361	1,391	1,444	1,507
Health and social assistance					
nominal, RON	1,266	1,342	1,226	1,210	1,315
% monthly average wage at national level	97	99	88	84	87

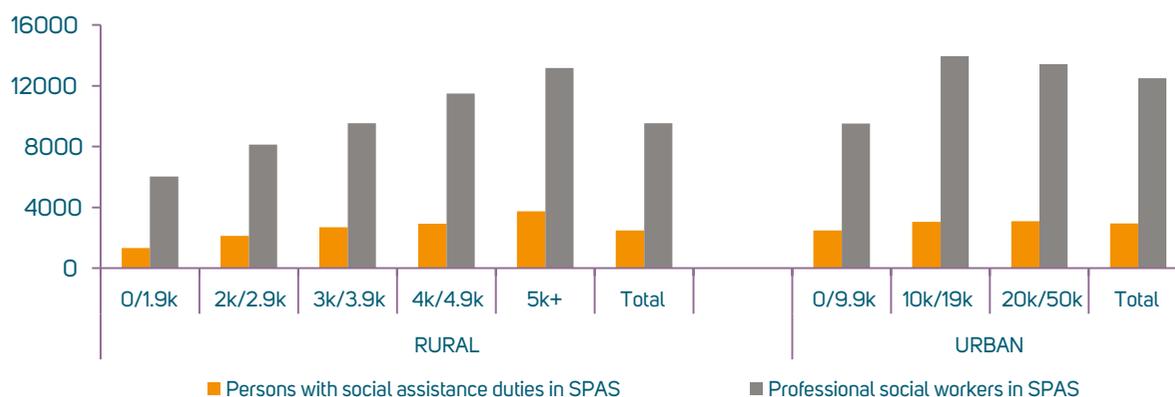
Source: Tempo-Online, National Institute of Statistics.

Note: Statistical research on labor costs in economic and social establishments from data collected in enterprises with three or more employees.

(Table 26). Considering that wages in the health sector are almost double those in social assistance, social workers' wages are very low.

The ratio of inhabitants per social worker is very high in Romania, especially the ratio of inhabitants to each professionally trained social worker. There are nearly 6,000 active social workers in Romania (almost 4,125 of whom are registered with the National College of Social Workers)⁸⁰ and a total population of 20.1 million people, which yields a ratio of 3,350 inhabitants per single social worker, much higher than the ratio in other European countries such as

Sweden (1 per 300), the United Kingdom (1 per 600), or Italy (1 per 1,600).⁸¹ The ratio of inhabitants to each social worker is even higher when only the social workers of the Public Social Assistance Services (SPAS) are taken into account (Figure 22). The World Bank's census of SPAS showed that this ratio varies between about 6,000 and over 13,000 inhabitants per professional in rural and small urban SPAS. When all personnel with social assistance duties are taken into account, the average ratio declines to almost 2,500 in rural areas and approximately 3,000 inhabitants in small urban towns.

FIGURE 22: Ratio of Inhabitants per Social Worker

Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

Notes: k = thousand inhabitants.

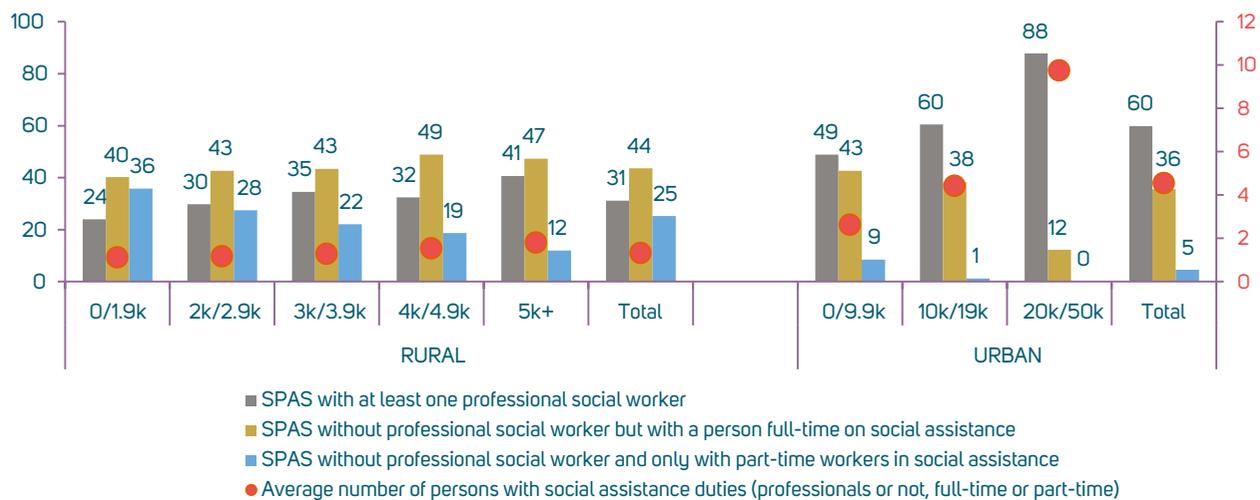
⁸⁰ <http://www.cnasr.ro/?modul=stiri&CID=14&pg=42&key=>

⁸¹ Campanini et al (2010) in Preda (2013).

Public social assistance services are severely understaffed in rural and small urban areas. Figure 23 shows that, in most rural communities, there are only one or two staff members with social assistance duties (and very few professional social workers) to respond to the needs of a population who are usually spread over several (between 2 and 40) villages, often located many kilometers away from each other.⁸² In small urban areas (those with fewer than 20,000 inhabitants), the SPAS usually includes one professional social worker and an additional two to three people with social assistance duties. In larger cities, the SPAS tend to have more staff. In urban areas, including large cities with over 50,000 inhabitants, the average

number of employees increases to 25 per SPAS. In fact, in all large cities, the SPAS also include a spectrum of social services, such as social canteens, daycare centers, shelters for homeless people, and social housing. For example, out of 149 social canteens reported by the MLFSPE in December 2013, 137 belonged to urban SPAS, nearly all in medium or large cities (those with over 20,000 inhabitants). Rural and small urban areas lack the staff, resources, and capacity necessary to develop and implement social assistance activities. Therefore, despite the many people who have graduated with social work degrees from Romania universities over the last 24 years, few are employed in rural and small urban areas.

FIGURE 23: Social Assistance Staff at the SPAS Level



Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

Notes: k = thousand inhabitants. See also Annex Figure 5.1.

The World Bank's census of SPAS indicates that the deficit of human resources at the SPAS level in rural and small urban localities is estimated to be between 2,300 and 3,600 people.⁸³ In Figure 24 the minimal scenario assumes that at least one person is employed full-time on social assistance in every local SPAS, irrespective of whether he or she is a professional social worker, in this scenario, at least 1,600 new employees are needed

in rural communities (of whom more than half are needed in small communes) and another 700 in cities with fewer than 50,000 inhabitants, thus a total of 2,300 people. The maximal scenario assumes a more favorable situation in which every local SPAS has at least one professional social worker. In this scenario, almost 3,600 personnel, mostly professional social workers, would have to be employed, of whom almost half would be in communes with fewer than

⁸² The 2,861 communes include over 13,000 villages. Most communes comprise two to eight villages.

⁸³ In May 2014, the total number of SPAS staff dealing with social assistance in these localities was around 4,800.

3,000 inhabitants. Given the poor transport connections that many of these communes have with urban areas as well as their poor living conditions, this scenario is much less probable in practice as only a small number of professional workers is likely to accept a low-paid job in a remote, poor community.

At present, most staff with social assistance duties in SPAS do not have clearly defined responsibilities and are often expected to take on additional duties other than social work. The World Bank census of SPAS reconfirmed this finding from previous studies.⁸⁴ Of all staff with social assistance duties, 35 percent in rural areas (from 46 percent in small

communes with under 2,000 inhabitants to 23 percent in larger communes with populations of over 5,000) and 10 percent in urban areas with fewer than 50,000 people hold several different responsibilities at the same time, such as agricultural registrar, archivist, registration clerk, human resources specialist, librarian, tax consultant, and emergency manager.

The insufficient professional training of social assistance staff at the local level constitutes another major problem. About 4,800 personnel cover social assistance activities in 3,140 rural and urban localities with fewer than 50,000 inhabitants. Around three-quarters of these are women

FIGURE 24: Estimated Number of Staff Needed at the SPAS Level in Rural and Small Urban Localities, in Two Scenarios



- Minimal scenario: Vacancies in SPAS with at least one professional social worker (PSW) or in SPAS without PSW but with at least a person full-time on social assistance PLUS One person full-time on social assistance in all other SPAS
- Maximal scenario: Vacancies in SPAS with at least one PSW PLUS One PSW in all SPAS without such an employee

Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

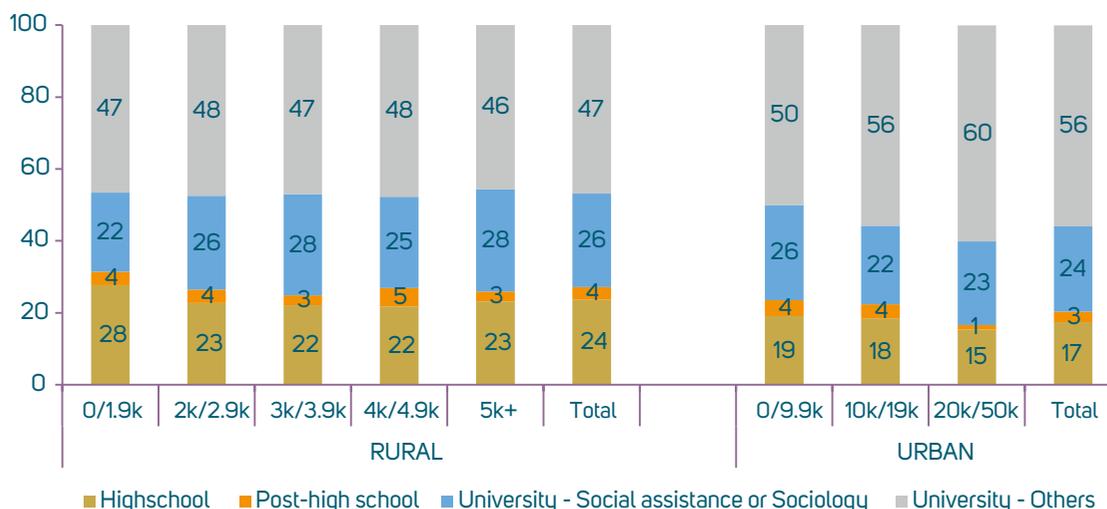
Notes: k = thousand inhabitants.

aged between 35 and 54 years old (73 percent).⁸⁵ Most have a university degree, but only one in every four is a professional social worker (Figure 25). Therefore,

developing ongoing training and supervision programs for SPAS personnel will be absolutely necessary to enhance the effectiveness of primary service at the community level.

⁸⁴ IRECSON (2011), MLFSPE and SERA Romania (2012), and Preda (2013).

⁸⁵ The distribution by age groups is shown in Annex Table 5.2.

FIGURE 25: Distribution by Education of Social Assistance Staff at the SPAS Level (%)

Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

Notes: k = thousand inhabitants.

At the local level, social work is almost exclusively concerned with the processing of paperwork related to the management of cash benefits (such as the Guaranteed Minimum Income, the Winter Fuel Allowance, the Child Allowance, and family benefits).⁸⁶ Various qualitative studies carried out by UNICEF have indicated that in rural communities about 85 percent of the work of social assistance staff is office-based and bureaucratic. Often, any social work is limited to granting cash benefits, including making and checking files, handling monthly payment records, and making house calls (especially in large and very large communities – those with a population of over 3,000) rather than carrying out prevention and counseling activities for people at social risk. For example, of all child beneficiaries of SPAS in 2010, only 24 percent benefited from services while the remainder received only cash benefits, although 21 percent of the recipients of cash benefits were children at risk of being abandoned by their parents.⁸⁷

Case management⁸⁸ is the main instrument in social assistance in Romania as in the rest of Europe, but it is

rarely used, especially in rural and small urban areas. Local prevention, information, and counseling services have very little effect, mostly due to the shortage of social workers and the insufficient professional training of existing ones. There are no methodologies for evaluating or monitoring the circumstances of different vulnerable groups in each locality, nor are there any methodologies for the early detection of at-risk cases. Social assistance is provided not on the basis of clear plans and objectives but only when cases turn up. Social workers rarely attempt any outreach because they are overwhelmed with paperwork related to the provision of social benefits. Referral systems for most vulnerable groups are either poorly developed or completely non-existent. SPAS social workers do not know what specialized services exist at the county level and cannot thus make informed referrals. In general, they refer children and families to services without ensuring that such services exist in the county. Prevailing social attitudes and practices that foster discrimination and tolerance of negative behavior add more obstacles to the identification and referral of at-risk children and adults. Under these

⁸⁶ Magheru (2009), HHC Romania (2011), and UNICEF (2011).

⁸⁷ FONPC (2012).

⁸⁸ Case management is widely used in European countries. It focuses on the needs of individuals and their families and aims to mobilize all available resources to meet those needs, including those of the family as well as the community and wider society.

conditions, it is even more important to ensure that staff receives professional training to improve the quality of services and increase the chances of them having a positive impact.

In line with the current legislation and taking into consideration these deficiencies, this background study recommends the development of a minimum intervention package⁸⁹ to be mandatorily delivered in every rural and urban community. This minimum intervention package is aligned with the minimum package of social services set out in Law no. 292/2011 on social assistance and with the minimum package of public services delivered by local public administrations (GD 1/2013 and Strategy on strengthening public administration 2014-2020, 2014). This minimum intervention package should consist of:

- Outreach activities, which are crucial for identifying potential beneficiaries and for early intervention services.
- Needs assessments for communities, households, and vulnerable people or those at social risk as well as the planning of needed services based on a family- and person-centered approach.
- Information and counseling services targeted to vulnerable groups or those at social risk, individuals who have experienced domestic violence or neglect, problematic drug users/ex-prisoner members, and single-parent low-income families as well as youth at risk (such as young offenders, school dropouts, and children in low-income households).
- Administrative support (such as helping clients to fill in forms to apply for all kinds of benefits), as well as social, medical, and legal assistance.
- Referrals to specialized services.
- Monitoring of and home visits to all people in vulnerable situations within the community.

Various other services (such as the provision of social canteens and daycare centers) will preferably be added to this minimum intervention package depending on specific community needs and resources. For the effective implementation of this minimum intervention package, it

would be useful if professionals (especially universities, service providers and the National College of Social Workers in Romania) would develop family- and person-centered tools and methodologies regarding the intake, assessment, planning, design, implementation, and M&E of services. These tools and methodologies should be taught in the continuous training program for the personnel with social assistance responsibilities at the local level.

BOX 11

The Package of Key Primary Services Currently Being Piloted by UNICEF

The Helping the Invisible Children project (HIC), which is being implemented between June 2011 and September 2015, is part of UNICEF's Community-based Services Program in Romania. The aim of this program is to develop a preventive approach within the social protection system, particularly in rural areas. The ultimate objective of HIC has been to increase the impact of social protection policies for poor and socially excluded ("invisible") children aged from 0 to 17 years old and their families. The main specific objectives of HIC are to: (i) strengthen the effectiveness and efficiency of the national strategy for prevention services; (ii) increase the national capacity for delivering basic services with an emphasis on identifying children and families at risk and on strengthening monitoring and assessment mechanisms; and (iii) in the long run, extend access to essential services to 30,000 poor, excluded, and vulnerable children.

In 2011, there were social workers employed in 96 communes in eight counties (Bacău, Botoșani, Buzău, Iași, Neamț, Suceava, Vaslui, and Vrancea). After a short period of training, these social workers identified the "invisible" children within their communities and mobilized community consultative structures (CCSs) under the supervision of the DGASPC as specified by Romanian legislation. The members of these consultative structures included such local decision-makers as the mayor/vice-mayor, the secretary of the mayoralty, social

⁸⁹ Since 2011, UNICEF has developed and piloted a similar package of primary services as part of its First Priority: No Invisible Children project.

BOX 11 (continued)

workers, doctors, policeman, school representatives, and priests. Cojocar (2008) showed that CCSs were not properly functioning in most localities in the country at the start of the project.

In 2012, the project covered only 64 communes. A basic package of community preventive social assistance services was piloted. The social workers conducted outreach activities including needs assessments, monitoring, information dissemination and counseling, social, medical and legal support, and referral to specialized services. They have also delivered appropriate social assistance services to the worst-off children and families. In parallel with these services being implemented at the community level, another initiative was launched to increase access to community-based medical care and refine the legal and regulatory frameworks for community nursing. In 2013, these two initiatives merged and the modeling project aimed at the development of basic social services at community level was given a new name: "First Priority: No More Invisible Children!"

Two formative evaluations of the project have been carried out, the first in 2012 and the second in 2013. A third evaluation is planned for 2015, and an impact evaluation is scheduled for 2017.

The second evaluation (2013) showed that the project has been largely successful, and its general recommendation was to continue the intervention and to enhance advocacy efforts to encourage the adoption of the model of community service piloted within HIC more widely at the national and county levels. The project is very relevant and highly efficient but still needs to address some problems related to its effectiveness and sustainability. In order to address these challenges, UNICEF has developed an online application (AURORA) to provide guidance and support to the DGASPC supervisors and social workers (many of whom are not professionally trained). AURORA incorporates a methodology for making a complete diagnostic of children's vulnerabilities based on a grid of indicators to be applied unitary for all children/ households and across all communities, as well as a methodology for developing an individual plan of intervention based on this diagnostic. Also, AURORA allows its users to monitor both the vulnerable

children and the field activities of social workers in real time. In addition, it makes possible to aggregate data at various levels (such as the community, county, or project levels) at any time, which supports evidence-based adjustments in the project in a timely manner.

In 2014, UNICEF built on the work of HIC by supporting two parallel projects in Romania focused on developing the quality standards and costing standards required for the basic package of community social assistance services.

The development and strengthening of local capacity to provide social assistance services is essential for the entire social welfare system and would cover a wide range of needs. Given the serious budgetary and human resource constraints faced by local public authorities in rural and small urban areas, our background study recommends a national program aimed at strengthening social assistance services at the community level at least for the period of 2015-2020, including the following actions:

- Earmarking a budget from the state budget for social assistance services at the community level and developing mechanisms for monitoring the efficient use of this budget. This budget would support the salary of a full-time employee in the field of social assistance (preferably a trained professional) in each eligible/ selected locality, as well as the costs related to the national monitoring system. Thus, communities with a low level of development would benefit from a specialized professional capable of and financially motivated to implement and develop social services at the local level.
- Ensuring that local authorities should include in their organizational charts at least one full-time social assistance employee and that they publicly advertise for this position in order to improve the recruitment of social workers, especially trained professionals.
- Including consistent outreach tasks in the job description of this full-time social assistance employee (preferably a professional social worker) and ensuring that he or she works one-to-one with people in vulnerable situations and their families, according to a clear schedule. Cash benefits (and the

corresponding files) should be administered by local authority staff, thus leaving social workers free to perform their duties.

- Mandating the professional training of existing and newly hired social assistance staff and drafting methodologies, guidelines, and tools to strengthen the implementation of case management in SPAS, especially in rural and small urban areas.

By investing in social assistance services at the community level and more generally in community-based services now, Romania can make long-term savings in other policy areas. For example, quality services in the community will lead to better health and education outcomes for individuals and to fewer children being separated from their families, which in turn will reduce the use of specialized services and the burden on the social protection and healthcare budgets. Using EU funds to support the development of alternatives to institutional care and to make mainstream services more accessible will give more people the chance to be included in society and to contribute to its social and economic growth. Moreover, investing in family-based care and community-based services as well as mainstream services will not only improve the quality of life of those who use them but will also create more and better jobs in the social, education and health sectors. This will help Romania to achieve the Europe 2020 objectives on the sectors of social inclusion, education, and employment.

2.3.5. Developing the Integrated Intervention Community Teams

Romania still faces significant challenges in fighting extreme poverty and social exclusion. Despite the significant progress that has been made in reducing poverty and improving human development indicators since 2000, extreme poverty has persisted. Extremely poor families face multiple constraints in addition to monetary poverty, including long-term adult unemployment or joblessness, poor child nutrition, a high risk of child neglect and/or abuse

(associated with parent alcohol abuse), poor parenting practices, young or single parenthood, unstable marriages, poor health or disability, low school attendance or dropout, poor or no housing, domestic violence, petty crime, and discrimination. There are also problems of low aspirations, low self-esteem, and learned helplessness. Therefore, families in extreme poverty represent a particular challenge, not just in terms of skills and physical capital but also in terms of psychological issues. Research has documented very well the extreme poverty in Romania since the 1990s, and more recent studies have confirmed time and again that children, young people and Roma continue to face the highest risks (see also Section 1.1).⁹⁰ Furthermore, extreme poverty in Romania is not only an individual or family phenomenon but is geographical in that it tends to be concentrated in marginalized areas, both urban and rural, within which extreme poverty is transmitted from a generation to another (see Section 3.2. Integrating Marginalized Communities).

An integrated approach on social service delivery on the supply side and social intermediation⁹¹ and facilitation programs on the demand side are needed to effectively reduce extreme poverty and social exclusion. Families in extreme poverty face multiple complex problems besides the need for financial support. Thus, the provision of cash benefits - although necessary - is not in itself sufficient to alleviate extreme poverty. A variety of social services in education, employment, healthcare, social protection, and other public services need to be provided in addition to cash benefits to help those poor to more effectively manage their lives and provide adequate care to their children. However, families in extreme poverty face multiple obstacles in using such services, starting with their lack of knowledge of their existence, their inability to access the available welfare services, and discrimination. These constraints are even greater when the supply of services is insufficient and/or social service delivery is fragmented and complicated, with multiple unconnected systems and different rules and regulations that require a variety of documents and certificates from applicants. Consequently, the system is difficult for poor families to navigate. On the institutional side, integrating the delivery of social protection, employment, education, healthcare, and other public services - with real horizontal and vertical coordination

⁹⁰ On "extreme poverty" and "poor zones" or "marginalized areas": Chelcea (2000), Stănculescu and Berevoescu (coord., 2004), Constantinescu et al (2005), Berescu et al (2007), Preda (coord., 2009), Stănculescu et al (2010), Berescu (2010), Stănculescu and Marin (2012), Stănculescu et al (2012), Stănculescu et al (2013), and World Bank (Swinkels et al, 2014a). On Roma and Roma communities: Zamfir and Zamfir (coord., 1993), Rughiniș (2000), Zamfir and Preda (coord., 2002), Duminiță and Preda (2003), Sandu (2005), Berescu et al (2006), Bădescu et al (2007), Fleck and Rughiniș (ed., 2008), Preoteasa et al (2009), ICCV (2010), Bottonogu (2011), Daragiu and Daragiu (2012), Giurcă (coord., 2012), Tarnovschi (ed., 2012), FRA et al (2012), and World Bank (Anan et al, 2014).

⁹¹ Camacho et al (2014).

between agencies - is vital for providing appropriate support to families and children in extreme poverty. At the same time, social mediation or facilitation programs are needed to help extremely poor families, especially those in marginalized areas, to access welfare services in both rural and urban areas.

In the medium term, the government should commit to establishing multi-disciplinary teams of community workers at the local level and multi-agency cross-sectoral cooperation at all levels as a first step towards the full integration of service delivery in the long term. Research has shown that integrating social services has several advantages over the silo approach,⁹² for addressing the diverse and complex problems related to social exclusion, for facilitating better access to services, for helping to ensure the continuity and sustainability of service delivery, for increasing the efficiency and effectiveness of service provision, for reducing overlap between different services, and for avoiding unnecessary expenditure.⁹³

The full integration of services would mean abandoning the silo approach and the fragmented administration of national and local services in favor of multi-agency teams at the national, regional and local level. These teams would work under an integrated management structure, with shared budgets, programs, and objectives and a single key worker (or case manager) with responsibility for coordinating the various interventions from the different agencies and professionals involved. Given the current regulatory framework in Romania as well as the deficit of human and financial resources in the social sectors, the full integration of services is likely to have to remain a long-term objective. Nevertheless, in the short and medium term, is feasible for policymakers to move Romania up the integration ladder (Scheme 4) by adopting multi-disciplinary teams of professionals at the community level (Box 12) and by initiating cooperation and coordination among the different sectoral agencies. Therefore, in the foreseeable future, the government's aim is to integrated social work management at the community level while simultaneously setting up the framework for the full integration of social services after 2020. This integration of interventions at the community level should go hand in hand with the introduction of the Minimum Social Insertion Income (MSII) in order to ensure that the program is able to meet the specific needs of vulnerable groups.

BOX 12



UNICEF Pilot of Multi-disciplinary Teams Integrating Social and Medical Services at the Community Level

The concept of having multi-disciplinary teams of professionals at the community level is the first stage towards the formal integration of the integrated provision of social and medical services. In this stage, staff from different professions work as a team at the community level (for example, social workers, community nurses, Roma mediators, and policemen). These teams are formed as a result of local initiatives rather than as part of a national program. Cooperation is based on personal relationships rather than on common methodologies or formal procedures. Such initiatives have already been developed in some communities.

Since 2014, a more formal model of multi-disciplinary teams including a social worker and community health nurse is being piloted by UNICEF in 32 rural communities in the North-East region. The "First Priority: No More 'Invisible' Children!" project aims to identify families at risk through outreach activities, implement coherent needs assessment plans, implement a minimum package of primary services effectively and efficiently, and enhance access to integrated social and medical services for the most vulnerable groups in the community, with an emphasis on children and their families. The local teams do not necessarily include qualified social workers but are coordinated and monitored by professionals from the DGASPCs and the County Directorates for Public Health (DSPs). Cooperation at the community level is based on harmonized methodologies for needs assessments and for personalized intervention plans that are incorporated in an online application (AURORA), which provides guidance and support to teams in the communities and makes it possible for any key stakeholder to monitor their activity in the field in real time as well as to aggregate data at various levels (the community, county, or project levels) at any given time. The impact evaluation of this project and this model will only become available in 2017.

⁹² Each agency works solely within their confined area of responsibility.

⁹³ European Committee for Social Cohesion (2006).

The ladder progresses upwards from almost no attempt at integration at the bottom through various levels of coordination, cooperation, and collaboration to integration at the top. The levels are not mutually exclusive as each level includes one or more of the components of the other levels.

Currently, ad hoc integration prevails in the social sectors in Romania. It emerges mostly out of necessity and external pressures. Cooperation between services tends to be informal and based on personal contacts and relationships. Only in isolated cases do individuals or groups of professionals from public services or NGOs take the initiative and cooperate in the interests of their clients.

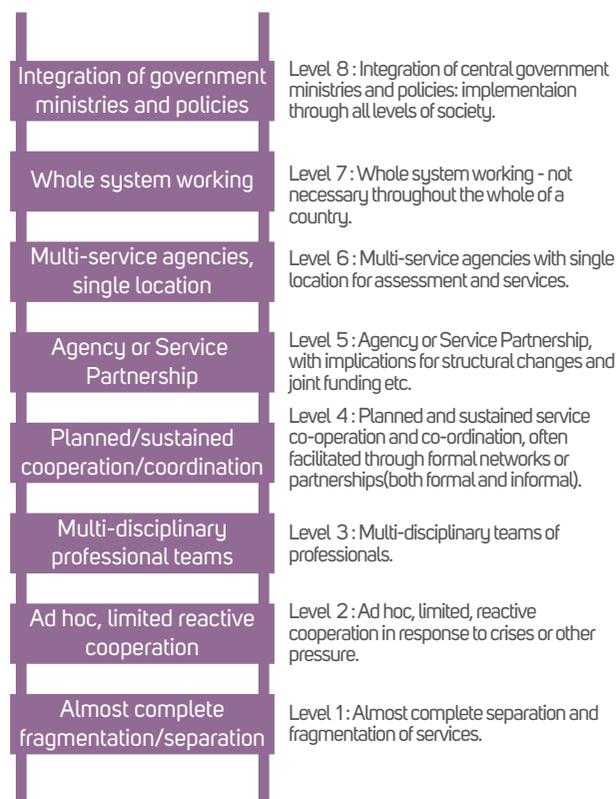
Strengthening the Capacity of the Local Public Social Assistance Services

Integrated intervention community teams⁹⁴ will be staffed by local social workers, including social workers with full-time activities in social assistance, community health mediators, Roma health mediators, school mediators, school counselors, and Roma experts. Depending on the community's needs and resources, the team might also include a health assistant, a family doctor, school teachers, or the local policeman. If the community has few resources of its own, then local authorities could build integrated community intervention teams to cover several neighboring communes or towns, within the intercommunity development associations or local action groups (LAGs).

Strengthening the local SPAS is a key objective, given that they will be the main promoter of integrated services by implementing social intermediation and outreach to individuals and families in extreme poverty as well as in marginalized areas. Therefore, the national program for strengthening social assistance services at the community level will be essential for the development of the integrated intervention community teams (see the previous section 2.3.4).

Investing in more and better-trained staff in the social sectors is absolutely necessary for developing integrated, multi-disciplinary primary services at the community level. As shown in the previous subsections, the deficit of

SCHEME 4: The "Integration Ladder"



Source: Taylor (2014) based on Munday (2007).

staff, in terms both of numbers and of their professional training, is an important issue in all social sectors. There is also a dearth of all types of community workers (such as community nurses, Roma healthcare mediators, and school mediators), particularly in rural and small urban areas (see also Section 2.5.3 on Developing the Emerging National Network of Community-based Healthcare Workers).

The main focus of the government's 2014-2020 social policy agenda will be the transfer of public financing to the community level and the creation of integrated community services, in which local stakeholders will play a decisive role. Thus, the introduction of the Minimum Social Insertion Income Program should go hand in hand

⁹⁴ NGOs and some pro-active local authorities have piloted the integrated services approach in various localities in Romania. On a larger scale, UNICEF has developed and piloted the integration of social and medical services at the community level in several poor communes in the North-East region (in its First Priority: No Invisible Children project). In the future, the World Bank's Social Inclusion and Integrated Basic Services Project will be implemented in selected marginalized communities in urban and rural areas across Romania between 2016 and 2020 under the auspices of the Ministry of Labor, Family, Social Protection, and the Elderly with the involvement of the Ministries of Health, Education, and Regional Development and the Romania Social Development Fund (RSDF).

with the development of integrated support services at the community level in order to ensure a tailored response to the specific needs of vulnerable groups. Also, the EU's strategic healthcare directions for the forthcoming period imply a shift away from institutional care to community-based care. In this general framework, Romania has an opportunity to reshape its healthcare and social assistance systems with support from some of the forthcoming European funds with a view to increasing access to affordable, sustainable, and high-quality social services, reducing inequalities between regions, and giving disadvantaged groups and marginalized communities better access to proper care.

Increasing Horizontal and Vertical Coordination and Moving towards the Integration of the Social Services

A new regulatory framework and a harmonization of financing mechanisms will be needed to enable agencies in different social sectors to work together effectively. In Romania, each locality provides decentralized primary and secondary education, primary healthcare, and social assistance services and benefits as well as of other public services and social programs, generally with a wide degree of coverage. However, there will have to be better use of existing resources at the local level in order to address the root causes of extreme poverty and exclusion. At present, the existing services operate in organizational silos as follows:

- The Ministry of Education, along with its County School Inspectorates (ISJ), is solely concerned with providing education. County Resources and Educational Assistance Centers (CJRAEs) are in charge of supporting the education of children with special needs and the school mediators. School mediators are hired by schools, are financed by the state budget from resources provided by the Ministry of Education, and have no formal reporting relationship with the local administration. There is no system for monitoring school mediators at the national level.
- The Ministry of Health, together with its County Directorates for Public Health (DSPs), is solely concerned with the healthcare system. At the local level, community nurses and Roma healthcare mediators are hired either by the local authorities or by local general practitioners (since 2012), are financed from the state budget from resources provided by the Ministry of Health, and have no formal reporting relationship with the local administration. They are coordinated and monitored by the DSPs. There is no system for monitoring community nurses at the national level.
- The Ministry of Labor, Family, Social Protection, and the Elderly (MLFSPE), along with the DGASPCs at the county level, are concerned with social assistance programs. Social workers as well as Roma mediators and Roma experts are hired and financed by the local authorities to work in their Public Service of Social Assistance (SPAS). The relation between the DGASPCs and SPAS is not yet regulated. The capacity of SPAS, particularly those in rural and small urban areas, tends to be limited. There is no system for monitoring SPAS social workers at the national level.
- The Ministry of Regional Development and Public Administration regulates and finances social housing. However, local authorities decide on what buildings are used as social housing, determine the eligibility criteria for obtaining a social dwelling, and are responsible for managing the existing social housing stock. There is no system for monitoring social housing at the national level.

The development of integrated services such as socio-medical services, complex rehabilitation services, or vocational and apprenticeship centers is hampered by these organizational silos. The rigid and fragmented regulation of services in different sectors, especially related to funding, costing of services,⁹⁵ staff allocation, internal procedures and practice norms, and functioning standards, is preventing the creation of multi-disciplinary or mobile teams (for example, to help isolated children with disabilities or the elderly with complex dependency needs, particularly in rural communities). Thus, improving horizontal coordination within and between ministries and the vertical coordination of social service delivery, between the central,

⁹⁵ Some services, if provided within the healthcare sector, cost twice as much as the same service delivered by a social assistance agency.

county, and local levels is a must for promoting the effective development of any type of integrated services.

Some services, if provided within the healthcare sector, cost

twice as much as the same service delivered by a social assistance agency (see section on services for people with disabilities).

BOX 13

Coordination in the Delivery of Social Services based on Trust and Equality

As a way to integrate social service delivery, coordination “represents a planned and deliberate harmonization of the activities of the separate agencies in a more systematic way. Coordination implies the surrendering of a significant degree of autonomy by each of the agencies involved, with plans being fixed according to a protocol, or decision making being vested in a third party (for example a case manager) with responsibility for coordination.” (Kuzminskyj, 2013: 8)

True formal coordination, facilitated through formal networks or partnerships, requires a level of mutual trust and cannot really function where there is competition for influence and resources. This requires the partnership to be based on a balance of power and requires formal

and informal mechanisms that are based on a common interest and understanding. Partnerships are doomed to fail if partners are forced to cooperate. In Europe, this kind of cooperation is often seen where integrated service partnerships come together as a precondition for accessing funding. The need for trust and balance of power does not mean that there is no role for a leader or coordinator who takes responsibility for the overall process and the overall objectives of the partnership. Partnerships do not need to be institutions in their own right, nor are major efforts needed to set them up or to run them. They just need to be able to find flexible and cooperative ways to ensure that the needs of the clients are met.

Source: Taylor (2014: 24-25).



Estimating Accurate Costing Needs and Allocating an Adequate Budget

It will be essential to estimate the accurate costs of setting up and running the integrated intervention community teams and then to allocate an adequate budget to cover these costs. The government needs to develop a comprehensive financial strategy for integrating social work (including an earmarked budget), including all relevant budget lines from other sectors as well as resources from European funds and any other types of external funding. However, as Leutz (1999) has shown, “integration costs before it pays” both in human and financial terms. Leutz has

identified three kinds of costs that are likely to be incurred in the integration process: (i) the costs of staff and support systems; (ii) the ongoing costs of delivering services; and (iii) start-up costs. Costs will be noticeably higher in the initial stages of implementation, but they will decrease with time. International experiences show that a return on investment is not usually seen in the short to medium term. Given the constraints on public expenditure in Romania, the model of integration proposed in this book focuses on the community level. However, sufficient funding will be needed to procure a sufficient number of adequately trained staff and IT resources. For the time being, there are no solid estimations of the real direct and indirect costs of establishing such services, including the costs of the human, financial, and IT resources that will be needed.

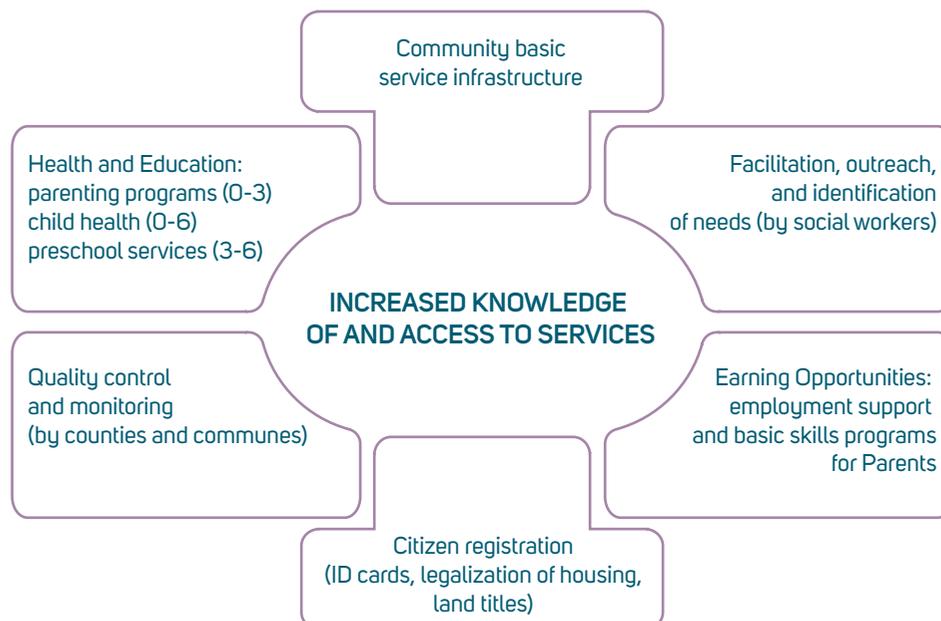
BOX 14**Putting a Model of Integrated Basic Services into Practice**

A model of integrated basic services will be piloted by the World Bank in Romania in 2016 to 2020. The Social Inclusion and Integrated Basic Services Project will aim to break the intergenerational cycle of poverty and exclusion by increasing the ability of the social protection system to reach out to poor communities and households and connect them to services. The project will: (i) strengthen the links between communities/households and services, and (ii) implement an integrated package of simultaneous interventions for tackling a multitude of problems faced by the poor and marginalized in Romania.

It will aim to use different implementation methodologies suitable for different geographical areas (with a particular focus on localities with low human development indicators, high unemployment, and low levels of service access or use) and human development contexts and needs. It will build on the successful experiences of programs such as A Good Start (Roma Education Fund), the Priority Intervention Program (Romania Social Development Fund), A Place for Everyone (UNDP),

Helping the Invisible Children (UNICEF), and others in the region and elsewhere, particularly the successful experiences of the Chile Solidario and Colombia Red Unidos programs. It will be based on the concept of the social mediator or social worker being the key figure in helping individuals and families to overcome social exclusion and will have strong social intermediation and family-counseling components. The project will also take a community-led development approach by encouraging community members to identify problems, develop solutions, and participate in the project's implementation and monitoring as facilitated by the local authorities.

The program will be implemented in select marginalized communities in urban and rural areas across Romania between 2016 and 2020, under the auspices of the Ministry of Labor, Family, Social Protection, and the Elderly and with the involvement of the Ministries of Health, Education, and Regional Development and the Romania Social Development Fund (RSDF). The aim is to develop a model that will strengthen the social protection system as well as an integrated social inclusion intervention with the potential to be scaled up with

**An Integrated Approach with Interventions on the Demand and Supply Sides**

BOX 14 (continued)

financing from the EU Structural Funds after 2020.

The proposed integrated service approach will put social workers at the center of the approach and empower them to develop solutions jointly with households and families in need. The focus of their work will shift to accurately identifying the needs of a poor or vulnerable household as a unit and meeting these needs mainly using locally generated and locally implemented solutions. The backbone of the approach will be intensive local facilitation and outreach via community workers (or social mediators). This intensive facilitation approach will be complemented by the provision of an integrated package of services that will contain the following elements:

- **Basic Health and Education** – investments in expanding and improving inclusive early childhood development (such as parenting programs), education (kindergartens), and basic health services (such as public health information and promotion for children and mothers and recreational activities).
- **Earning Opportunities** – programs to increase the employment prospects of parents (such as literacy programs and labor market counseling).
- **Community Infrastructure** – investments in increasing the availability of basic services and improving their quality.

Developing Clear Methodologies, Protocols, and Work Procedures

The main role of social workers and other community workers working together as a multi-disciplinary team will be to mobilize demand and to help extremely poor families and those in marginalized areas to access available welfare services, in both rural and urban areas. In other words, they will ensure the delivery of the minimum intervention package of key basic services as described in Section 2.3.4 and in doing so will be focused on the client rather than on the structural integration of the agencies that will actually deliver the various services.

To support this outcome, policymakers should consider taking the following actions: (i) provide appropriate training in the use of case management to all community workers, including social workers, community nurses, Roma healthcare mediators, school mediators, and Roma experts; (ii) clearly define the target groups and eligibility criteria underpinned by laws or instructions from appropriate government bodies; (iii) develop methodologies and tools for conducting a comprehensive needs assessment to offer constant guidance and support to community workers, especially as many community workers will not be qualified in case management at the outset; (iv) develop protocols to guiding teams of community workers in various sectors, including clear outlines of responsibilities and rules for reporting, transferring information, and documenting activities); (v) establish functional relationships between teams of community workers and higher levels of management to ensure professional coordination, supervision, and training/retraining; (vi) define functional relationships between teams of community workers and other service providers (such as GPs, GPs' nurses, and NGOs); (vii) define protocols for joint case planning with other service providers based the equality of all participants; (viii) develop procedures for referrals and protocols for interagency cooperation; (ix) develop procedures for participation of beneficiaries in the social services provision; and (x) in the larger marginalized areas, develop multi-functional community centers to provide integrated primary and preventive services primarily (though not exclusively) to families in extreme poverty, including Roma.

A national integrated evaluation system needs to be developed to measure the effectiveness and efficiency of the multi-disciplinary teams of community workers (integrated intervention community teams) and the outcomes for - and the satisfaction of - beneficiaries. The development of the e-social assistance system will be helpful in this respect but not, in itself, sufficient. Assessing the performance of the integrated intervention community teams will require a framework that will make it possible to measure outcomes for both children and adults on several fronts, such as education, health, skills, employment, income, and housing. Evaluating the satisfaction of beneficiaries will require a separate component. In addition, the performance of staff in using the case management approach will also need to be assessed. An evaluation should be built into every stage of service provided by them as a way of gauging the effectiveness of all processes. Ideally, an online system for inputting and monitoring data in real time should be developed.

BOX 15**Building on the Successful Experience of Chile Solidario**

In response to constraints that were hampering the effectiveness of social programs, Latin American countries have been developing social intermediation programs that take a holistic, systemic, and family-based approach to supporting the poor. Social intermediation programs do not provide families with cash or in-kind benefits, but they help families to access other programs and thus improve their chances of graduating out of extreme poverty by addressing their specific needs. Therefore, to be successful, they must be well integrated into the social assistance system.

Sistema Chile Solidario was the first such program in the region. **Chile Solidario** is not a distinct program or social benefit but a management model based on the creation of institutional and local networks for providing social protection to the poorest families. **Chile Solidario** provides individuals and families living in extreme poverty and vulnerability (such as the homeless, elderly people living alone, and children of detainees) with guaranteed social protection coverage for five years, with the objective of leading individuals and families to autonomously access and effectively use the social services network.

The Family Support component and the preparation of a family-specific development plan are the backbone of **Chile Solidario**. The target group for the program is the poorest 5 percent of families in Chile. Participation in the system is voluntary but the participants commit themselves to working towards the achievement of measurable goals. Common and measurable objectives for both the institutions and beneficiaries involved are structured around 53 “minimum quality of life” conditions, organized in seven categories: identification, health, education, family dynamics, housing, work, and income.

The entry point to the system is a Psychosocial Support Service (**Programa Puente**) in which a family counselor works with a family for two years through family visits, information dissemination, guidance, and referrals to social services and benefit programs. The Psychosocial Support Service is complemented by a monthly family cash transfer (a fixed amount per family), preferably delivered to a female family member, which is intended to help to cover the costs incurred by

families when they use services. The value of the transfer decreases every six months. All families who conclude the psychosocial support stage automatically enter a phase in which the **Programa Puente** monitors and tracks their life conditions. Throughout this three-year period, families keep their guaranteed benefits and preferential access to social programs, and the family cash transfer is replaced by an exit cash transfer for 36 months as a “prize” for completing the first stage.

The Psychosocial Support Service is delivered by professionally trained family counselors. After families have signed the required participation agreement, the family counselor visits them regularly in their home, and also refers them to local social services. One family counselor works with between 60 and 100 families simultaneously, some of them in the initial intensive phase (weekly or biweekly) and others in the monitoring and follow-up phase (monthly, bimonthly, or quarterly visits). **Chile Solidario** provides family counselors with regular training. Twice a year, these counselors go through a binding performance evaluation process, and only those who have achieved satisfactory scores can continue in the role. The performance evaluation assesses the counselors on three criteria: (i) personal ability; (ii) their ability to manage the supply of services; and (iii) productivity (coverage of beneficiaries, the number of families graduating, and the social empowerment of families). Ninety-five percent of these family counselors are university graduates.

Chile Solidario began operating in 2002. By 2012, the effective cumulative coverage of the program amounted to 482,558 families (or around 2 million people). Effective coverage includes those families who completed both phases of the program and excludes those who refused to participate (only 2.2 percent of those invited) and those who did not complete the two phases (5.6 percent of those who signed the participation agreement). All these families entered **Chile Solidario** through the **Programa Puente**. Since 2006, additional vulnerable target groups have been incorporated into the system, such as homeless individuals, the elderly living alone, and dependent children of adults in prison. In all three cases, the program’s support component was adapted to the specific needs of these populations.



BOX 15 (continued)

The range of programs and social services sponsored and coordinated by **Chile Solidario** has been restructured over time. A few new programs were also created to meet the needs of **Chile Solidario** beneficiaries, such as a subsidy to pay for the issuing of ID cards, a school retention subsidy paid directly to schools, an extra school meal per day, family dynamics workshops, a housing program, and support for self-production. The Chilean government increased the overall program budget significantly from US\$3.6 million in 2002 to US\$182 million in 2012. Of this, around 14 percent financed the psychosocial support component, 24 percent consisted of cash transfers, and 62 percent was transferred to other social programs in order to fill gaps in coverage. Administrative costs seem to be relatively low. In 2009 (the latest year for which information is available), they represented around 3 percent of the total budget.

Analysts differ with regard to their assessment of the impact of **Chile Solidario** depending on the evaluation methodology and data used. All analysts agree that social intermediation programs can be powerful and cost-effective tools for supporting poor and marginalized families. The innovative and intensive **Chile Solidario** has been able to help the poor to access to cash benefits, to enhance their knowledge of the existence of social programs, to improve their socio-emotional wellbeing, and to generate positive outcomes in the health and education (school attendance, literacy and job training) of the beneficiaries. Nevertheless, the program's power to transform the lives of the poorest families in terms of key long-term welfare outcomes - employment and housing - remains the subject of some controversy.

Sources: Camacho et al (2014) and Carneiro et al (2014).

2.3.6. Developing Social Services for Vulnerable Groups

Social services aim to maintain, restore, or develop the capacity of individuals and families to function in society. The County Directorates of Social Assistance and Child Protection (DGASPCs), financed by the state budget and county councils, are both the main provider and, at the same time, the main purchaser of specialized social services.

In the coming years all efforts will focus on reducing the fragmentation and lack of coordination in the specialized services sector. In 2011, the government passed a comprehensive law on social assistance (292/2011), but secondary legislation has yet to be developed. Combined with an insufficient budget allocation (at both the national and local levels), this has led to fragmentation and a lack of coordination in the specialized services sector, especially in rural areas and in the area of services for adults.

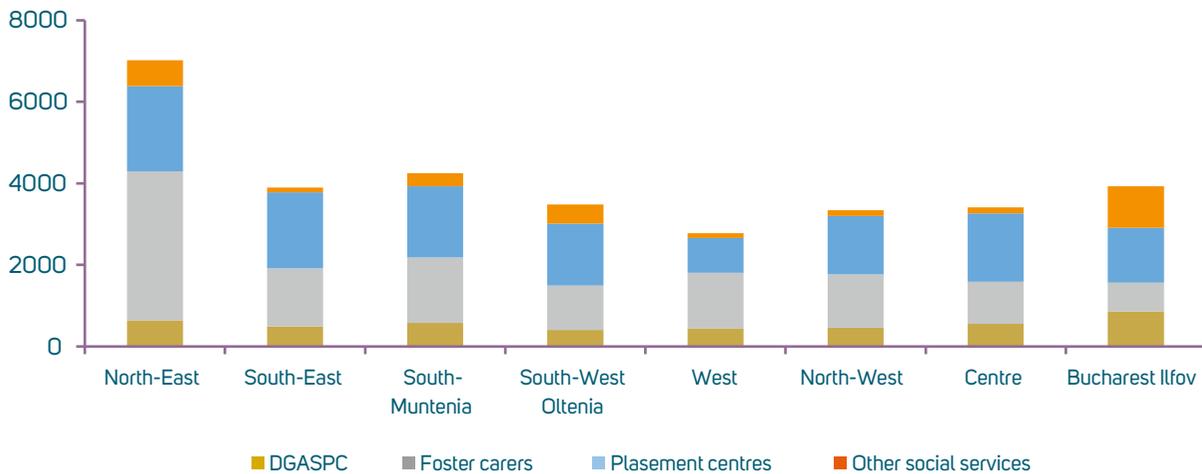
To achieve the objectives of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, it will be necessary to strengthen the role played by the DGASPCs in strategic planning, methodological coordination, and supporting SPAS at the community level, as well as in monitoring and evaluating service providers within the county. At the same time, its role as the main provider of social services should gradually come to an end. Consequently, the DGASPCs in most counties will need to be fundamentally reorganized and strengthened, by contracting out existing services to NGO or private providers and by increasing the number of their professionals in strategic planning, monitoring and evaluation, as well as case management. At present, only 60 percent of Directorates have drawn up strategies, plans, procedures, and methodologies, only 53 percent use the case management method or have developed case management procedures, and only 61 percent report having case managers. On average, one case manager oversees 74 cases, while a department for preventing social marginalization has been set up in just 61 percent of the Directorates and a quality management department for social services has been set up in only 65 percent. Finally, only 29 percent of DGASPCs have a department for coordinating and supporting SPAS.⁹⁶

⁹⁶ HHC Romania (2011), MLFSPE and SERA Romania (2012), and FONPC (2012).

The DGASPCs are going to need adequate sustainable financial and human resources in order to develop a national network of social services. The DGASPCs are large employers of specialized staff,⁹⁷ but they face serious difficulties in acquiring adequate staffing and skills to deliver their services. The lack of performance indicators makes it impossible to evaluate the professional performance of DGASPC employees. The investment in the ongoing training of specialized staff⁹⁸ is small and its added value remains unmeasured. At the same time, the existing staff

of DGASPC specialized services have to bear excessive caseloads because of the shortage of professionals, especially since the budget cuts of 2009. Cuts were made in both the DGASPCs' own staff and foster carers (from 15,023 in 2008 to 12,201 in 2013) and placement center staff (from 16,534 in 2008 to 12,513 in 2013). At the end of 2012, research indicated a deficit of 11,000 social workers across the whole system of primary (SPAS) and specialized (DGASPC) services.

FIGURE 26: Distribution of DGASPC Staff by Type of Child Protection Service and Region, end December 2013



Source: National Agency for Protection of Children's Rights and Adoption.

The government needs to develop an initial and a continuous training system for professionals working in social services, including professionals dealing with the social services regulatory system. There is still no dedicated mechanism for evaluating social services or for training of evaluators of social services. The inspectors who currently evaluate social services are also in charge of controls and sanctions in the sector, which often creates confusion and conflicts of interest. The capacity of Social Inspection to evaluate and control social services also needs to be strengthened.

With regard to the initial and a continuous training system for professionals working in social services, policymakers should consider taking the following actions: (i) establishing coordinated inter-ministerial bodies (for example, from the Ministries of Education, Health, Labor and Social Protection, and Youth and Sports) to manage the training of professionals involved in specialized services; (ii) managing the accreditation of curricula and training for trainers; (iii) developing a comprehensive program of training at the national level (including blended learning and distance

⁹⁷ As of December 31st, 2013, DGASPC staff consisted of over 32,000 people, of whom 77 percent were working either in placement centers or as foster carers and 9 percent were employed in other services according to the National Agency for Protection of Children's Rights and Adoption (NAPCRA).

⁹⁸ Only some 20 percent of DGASPC staff in 45 counties attended professional training courses in 2010 (HHC Romania, 2011).

learning); (iv) developing an accreditation system for professional social workers; (v) developing a system of continuous evaluation and re-calibration or re-training of professional social workers; and (vi) developing specialized training for social services evaluators.

Deinstitutionalization and the development of family-type alternatives will continue to be among the government's main objectives both for the child protection system and for services for adults with disabilities. Worldwide experience indicates that institutionalized care is more expensive and less beneficial per client than more inclusive approaches designed to support individuals within their families. In fact, the unnecessary institutionalization of some of the most vulnerable and/or marginalized groups (whether children, people with disabilities and mental health problems, or dependent older people), in addition to violating their human rights, also puts an excessive burden on social and healthcare systems.

The access of some vulnerable groups to specialized services needs to be increased while certain types of

service should be further developed. Certain groups at risk of exclusion should have greater access to quality social services in Romania, such as children deprived of parental care or mistreated by their family, lone elderly, individuals with disabilities and complex dependency needs, people suffering from addictions and chronic illness, people with rare medical conditions or victims of abuse, and homeless people. Specific types of services should be developed to meet their specific needs, including early intervention, long-term care, home or ambulatory care, social housing, a wide range of support services for inclusion/participation (in various areas such as education, employment, justice, and healthcare), and integrated social and medical services. What is also needed are services that help people to transition between different age cycles (from school to employment, from institutions to independent living, and from employment to retirement, for example) and multi-disciplinary mobile teams.

TABLE 27: The Main Development Needs in Human Resources in Social Services, 2014

Profession	Current situation
Formal training	
Social workers	Mainly at the county level and in the urban SPAS. Not enough.
Psychologists	Mainly at the county level and in the urban SPAS. Not enough in the disability sector.
Sociologists	Rare in the disability sector
Educators	Not trained for inclusive education.
Special educators	Reduced number at the national level. Training curriculum is relatively old and is not adapted to the current needs of children and families.
Special teachers	Few at the national level. Training curriculum is relatively old and is not adapted to the current needs of children and families. Reduced number of special schools from 2008 on.
Educators-rehabilitators	The very few current professionals are trained by NGOs or international cooperation programs so they are not trained in the context of the Romanian system.
Medical doctors	Not familiar with disability in general with the exception of professionals in rehabilitation medicine and psychiatry. Strong need for overall training of family doctors and pediatricians. Hardly any outreach activities by GPs.
Nurses	Not familiar with disability in general with the exception of professionals in rehabilitation medicine and psychiatry. Strong need for overall training.
Speech therapists	Exist only at the county level and in large cities.
Occupational therapists	Rare in Romania. No official training for this profession. Strongly needed.
Physiotherapists	Better coverage in urban areas, very scarce number in rural areas. Great need for practitioners located as close as possible to people with disabilities.

TABLE 27 (continued)

Orthoprosthesists	Better coverage in urban areas, very scarce in rural areas. Great need for practitioners located as close as possible to people with disabilities.
P&O technicians	Better coverage in urban areas, very scarce number in rural areas. Great need for practitioners located as close as possible to people with disabilities.
Art therapists	Rare in Romania. No official training for this profession. Increasing demand.
Personal assistants	Crucial people within the support services system. The current low salaries do not encourage professionally trained assistants to enter the system, which leads to the hiring of family members for this position. Huge need for more professionally trained assistants at the local level and for more formal training (of around 40 hours).
Foster parents	Not trained in disability-related issues. Hard to place children with disabilities in foster care or with adoptive families
Informal training	
Personal assistants	According to the law, personal assistants for people with disabilities must have a mandatory number of training hours (40), but only the DGASPCs currently provide this type of training, which in practice is very rare.
Coach, mediator for the labor market	Training provided only by NGOs or private training agencies.
Home carers	Training provided only by NGOs or private training agencies.
Sign language interpreters	Training provided only by NGOs or private training agencies, plus one Masters degree program at Cluj University.
Instructors for guide dogs	Training provided only by one specialized NGO (Light into Europe).
CBR workers (community-based rehabilitation)	These do not exist in Romania. They would be very useful in remote, rural, or isolated areas.

The following are the main development objectives and actions related to specialized social services organized by vulnerable groups:

- Developing and funding services for children deprived of parental care in order to: (i) reducing the rate of child abandonment in medical units, mainly by developing and strengthening the key preventive mechanisms at the community level; (ii) reducing the number of children within the special protection⁹⁹ system, particularly by reconsidering the ways and means (including cash benefits) of providing family support in order to prevent child-family separation and by revising the existing child protection services to enhance the quality of care provided while reducing the length of stays to the minimum necessary; (iii) reducing (and eventually eliminating) child homelessness, mainly by assessing and mapping the real situation of street children at the national level and by developing preventive and specialized

services according to identified needs; (iv) identifying the categories of children with parents working abroad who are at social risk and developing support services for them and for the adults caring for them.

- Developing and financing services for people with disabilities, which according to the National Strategy for People with Disabilities 2015-2020 should focus on: (i) establishing a functional and coherent set of evaluation methodologies related to disability and invalidity; (ii) expanding the spectrum of services for the disabled and making them better and more affordable; (iii) providing funding for and ensuring the continuous development of support services for youths with disabilities living within communities; (iv) speeding up and increasing the effectiveness of the transition from residential care to community-based services for adults with disabilities; (v) drastically reforming long-term care and rehabilitation services for people with mental health problems, based

⁹⁹ According to the National Strategy for Protecting and Promoting Children's Rights 2014-2020 (GD 1113/2014), younger children are a priority group for the next phase of the reform of the child protection system.

on a plan to be agreed and developed jointly by the MLFSPE and the Ministry of Health; and (vi) continuing the national plan to increase access to public spaces and the environment.

- Developing and financing a spectrum of tailored services to meet the specific needs of the elderly with complex needs, with a special focus on in-home care services in accordance with the National Strategy on Elderly People and Active Aging.
- Regulating, developing, and financing tailored social services for other vulnerable groups, including teenage mothers; adults deprived of liberty or on probation; drug, alcohol, or substance addicts; victims of human trafficking; and victims of violence. These services should be developed jointly by the MLFSPE with the MRDPA (which will prepare a draft National Housing Strategy), the National Prisons Administration (responsible for the National Strategy for the Social Integration of People Deprived of Liberty 2015-2019); the National Anti-Drug Agency (responsible for the National Anti-Drug Strategy 2013-2020, GD 784/2013), the National Agency against Domestic Violence (responsible for the National Strategy for the Prevention of and Fight Against Domestic Violence 2013-2017, GD 1156/2012), and the National Agency Against Trafficking in Human Beings (responsible for the National Strategy Against Trafficking in Human Beings 2012-2016, GD 1142/2012).

The next sections discuss in detail the needs of each vulnerable group for social services.

Services for Children Deprived of Parental Care

Support for children and family welfare is one of the cornerstones of Romania's social protection strategy, grounded in a concern for both human rights and cost-effectiveness. To this end, it is crucial to develop and harmonize cash benefits and social services for children and families in a range of different circumstances. Once a child is separated from his or her family, the childcare system provides protection based on an individual plan developed by a case manager within the DGASPC. Because of the

often limited available information about the history and antecedents of children and their families and also because of the lack of capacity within the DGASPCs, most individual protection plans are incomplete and are structured around the availability of services rather than the specific needs of the child.

A. Children Abandoned in Medical Units

More children are being abandoned in hospital wards. While the number of children abandoned in medical units decreased by two-thirds during the last 10 years (from 4,614 in 2004 to 1,449 in 2014), the figures recorded a 12 percent increase between 2010 and 2012. During the last three years, they constantly remained at over 1,400, with a peak of 1,474 abandoned children recorded in 2013. The majority of these children were abandoned in maternity wards (56.94 percent in 2010 and 65.78 percent in 2011), with the next largest number being abandoned in pediatric wards (31.86 percent in 2010 and 27.30 percent in 2011).

Poverty and a lack of identity papers are among the underlying causes of child abandonment in medical wards. Research in Romania has shown that a common reason given by mothers for leaving their healthy children in medical institutions is their lack of identity papers. This prevents the child's birth from being officially registered and thereby affects his or her right to acquire a name and citizenship.¹⁰⁰ Poverty is associated with single parenting, teenage pregnancy, out-of-wedlock pregnancies, child disability, and the lack of access to adequate healthcare/monitoring and social-support services, all of which are among the main causes of child abandonment in medical care units.

Most new babies and very young children entering the child protection system have been abandoned in medical units. While it is encouraging to see that the number of children returned to their biological and extended families has been constantly increasing during the last four years, it is still worrisome that the majority of children released from hospital units were moved into the child protection system (around 60 percent). Most of these went into foster care (around 45 percent between 2010 and 2012, with a 3 percent drop in 2013) and some to residential care services (placement centers and emergency reception centers), where the highest number was recorded in 2013 (79

¹⁰⁰ Stativă et al (2005).

children or 6.2 percent of the total number of abandoned children entering the child protection system).

Because of faults in the system, there are still children who spend months in hospital units that are not adapted to their development needs. It is also worrying that, of the total number of children abandoned in hospital units, a number remained in those units every year (236 in 2010, 248 in 2011, 234 in 2012, and 175 in 2013). This means that children were kept in an institutional environment that was not geared to their development needs, which may have severely affected their physical, cognitive, and emotional development (depending on the age of the children and the length of their stay) given that young children are severely affected by institutionalization. This is due mainly to the lack of clear referral procedures between the healthcare and social protection institutions and to a lack of identity papers on the part of the parents, and also because of the lack of available foster care families prepared to care for children aged between 0 and 2 years old.

Reducing the rate of child abandonment in medical units will require the development and/or strengthening of key preventive mechanisms at the community level. Some of these measures relate to the entire field of social welfare, such as providing identity papers to all, strengthening social assistance services at the community level, and providing equal access to social benefits. Others will be aimed at reducing the numbers of specific vulnerable groups - such as single mothers and adolescent/teenage parents through the provision of sex education and family planning services. These two kinds of measures will need to be coordinated and harmonized. For example, improving the health monitoring of all pregnancies clearly falls under the responsibility of the healthcare services. However, this will need to include measures to enable the early identification of pregnancies with a high risk of child abandonment and to ensure their immediate referral to social services so that counseling and support services may be provided as early as possible. In this way, by the time of birth, a long-term plan will already have been developed, if it should such be required. Also on the preventive side, when mothers (or parents) arrive at medical units with no identity papers, they should be considered without exception as being high-risk for abandoning their baby. For these situations, policymakers need to develop procedures to enable medical personnel to alert social services (child protection services) and the police (for identification purposes).

Reducing the length of time spent by abandoned babies in maternity wards will require the development of special response services such as foster families who can take babies even in emergency situations. Adequate case management and planning should reduce the length of time that children spend in the child protection system either by reintegrating them into their biological or extended family or by finding adoptive families for them.

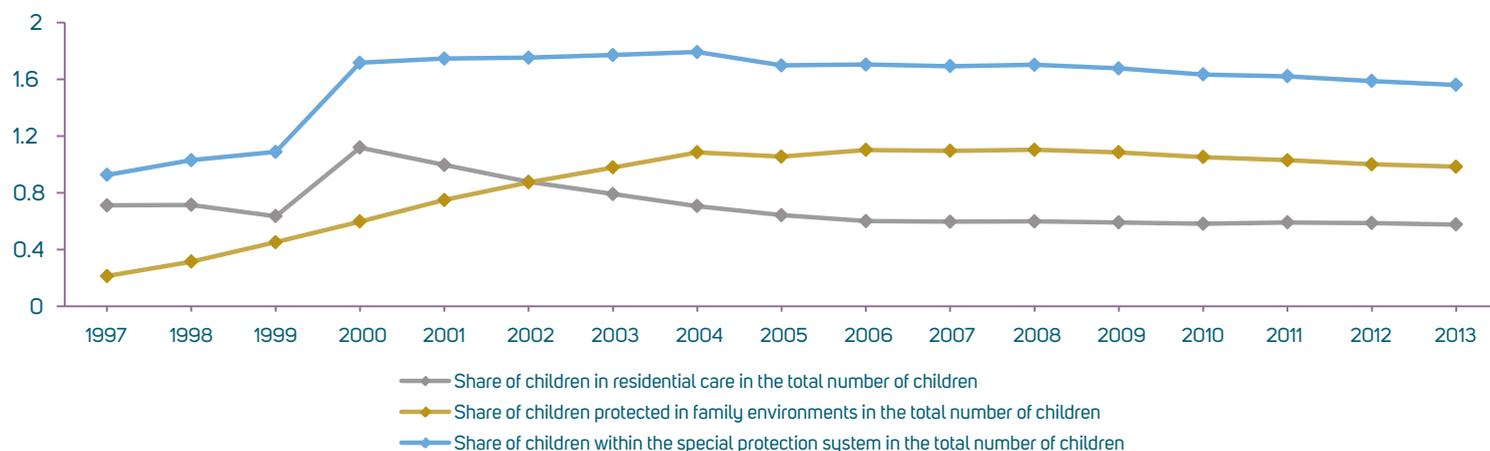
B. Children Living in Residential Care or Alternative Family Care

Reducing the number of children within the child protection system remains a priority for the coming years. The government has made significant progress over the last 15 years in reducing the number of children in institutional care and by developing family-based alternatives. The number of children in residential care (public and private placement centers, including small group homes) has dropped from a peak of 57,181 in December 2000 to 21,365 as of June 30, 2014. Nevertheless, during 2011, for the first time in 15 years, the number of institutionalized children increased¹⁰¹ as a consequence of an impoverished population and the limited budget for family-based services. However, the rate has begun to decline once again over the last three years. The total number of children placed in public care (in either residential care or in family environments) dropped significantly from around 98,000 children in 1997 to about 62,000 at the end of 2013 (and to almost 59,000 as of the end of June 2014). However, the total child population of the country also declined and, for that reason, the rates of children placed in public care have in fact been at a plateau (1,776 in 2000 and 1,641 in 2011), which is indicative of the failure of the system to reduce the number of children entering the protection system (Figure 27).

Research has shown that children entering public care have multiple and complex vulnerabilities at the household level. As mentioned earlier, many of the children entering the child protection system were abandoned in hospitals. According to data collected by the National Agency for the Protection of Children's Rights, the three main causes for children being separated from their family and entering into public care are poverty (42 percent), abuse and neglect (25 percent), and disability (10 percent). However, policymakers should ensure that poverty is never the only justification for removing a child from parental care,¹⁰² and, in fact, evidence

¹⁰¹ MLFSPE, DGPC (2011: 1). The number of institutionalized children was 23,240 in 2011 compared with 23,103 in 2010.

¹⁰² United Nations (2009) and European Commission (2013b).

FIGURE 27: Share of children within the special protection system (1997-2013)

Source: World Bank estimations using data on number of children in the special protection system from MLFSPE and TransMonEE database for the total number of children (aged 0-17 years old).

suggests that separation is determined by multiple and complex vulnerabilities.¹⁰³ In most cases, these complex vulnerabilities consist of a varying mixture of extreme poverty, parental unemployment, poor quality housing or homelessness, poor school attendance or dropout, poor parenting, domestic violence, a high risk of neglect and abuse of the child (associated with parental alcohol abuse), young or single parenthood, unstable marriages, low expectation and/or self-esteem, and learned helplessness.

Reducing the number of children placed in care will require the development of community-based prevention and support services. Children often end up in the child protection system because of a lack of services for identifying children at risk and of early intervention services and referral systems at the community level. According to official statistics, children at risk of separation from their families account for nearly 1.4 percent of children aged between 0 and 17 years old. However, a 2012 UNICEF study estimated that the percentage would be higher – almost 2 percent of children aged between 0 and 17 years old – if “invisible” children are taken into account.¹⁰⁴ These

are children who have not been identified by and registered with local authorities. Community Consultative Structures (CCSs) are legally constituted entities at the community level with members drawn from among local stakeholders (local authorities, social workers, doctors, police, and teachers). This UNICEF study found that the number of “invisible” children is considerably smaller in those communes where Community Consultative Structures are functional, but as yet they have been set up in very few places across Romania. The system continues to be in stasis, and local authorities do not seem to have taken over the responsibility for implementing services aimed at preventing the separation of children from their families.

Policymakers should review the current arrangements for placing children in family-based care with the aim of reducing total number of children considered to be in protective care. Currently, over 60,000 children are deprived of parental care in Romania.¹⁰⁵ Out of those, 61.4 percent are in family-based care alternatives, with 30.8 percent in professional foster care and 30.6 percent having been placed with their own extended family (kinship care)

¹⁰³ Stănculescu et al (2013).

¹⁰⁴ Stănculescu and Marin (2012). “Invisible” children refer to children “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).

¹⁰⁵ 61,749 according to NAPCRA data for December 2013.

or with other families. The proportion of children placed in family-based care alternatives has dropped from 65.3 percent in 2007 to 61.4 percent in 2013. This has been mainly due to budget cuts, which have led to a serious decrease in the number of professional foster carers,¹⁰⁶ but also to a 25 percent drop in the number of children placed in kinship care. While the number of placements with extended families or other families is quite impressive, the kinship care placement is often simply a way for children to remain with their families and is not in fact truly a protective care arrangement. Yet because social workers must continue to manage these cases, this puts unnecessary additional pressure on the already limited staff of the child protection system. Therefore, policymakers should review the current kinship care placements and reclassify them as preventive rather than as protective measures, while making monitoring of these placements the responsibility of the local authorities under the direct supervision of DGASPC staff. This would reduce the workload of DGSACP case managers (which in turn should enhance the quality of case management) and, while reducing costs, would improve kinship care monitoring by devolving it to the community level.

A matter for concern is that kinship care/family placements are not regulated in a similar way to foster care. On the one hand, there are no criteria nor is any training of the family required prior to placing a child with their extended family or any other family, a situation that may be risky for the children in question. Therefore, it is important to establish minimum quality standards for family-based care and to develop selection criteria and training requirements for placement families. However, a placement family receives a monthly allowance of only RON 97 (about €22) and a

food allowance of less than €2 per day per child, whereas a specialized foster parent receives a wage accompanied by a package of in-kind benefits covering equipment, bedding, toys, hygiene materials, school supplies, and living expenses for the placed child. This year, NAPCRA has drafted new regulations aimed at encouraging and supporting family placement by extending the coverage of these in-kind benefits to extended or other placement families.¹⁰⁷

Speeding up the closure of all the old residential care institutions for children must remain a priority, especially for those with over ten residents.¹⁰⁸ The government has already recognized that institutionalized care is more expensive and less beneficial than family-type alternatives. As of June 30, 2014, of the total number of children deprived of parental care, 21,365 (36.3 percent) were in residential care. Most of these were in small group homes, but 9,937 were still in institutions (both classic and restructured/modulated). Of these, 8,679 were in public institutions and 1,258 were in institutions operated by NGOs or private service providers. After 2007, the process of closing these institutions began but at a very slow pace. Currently, 248 institutions are still functioning, of which 110 are classic institutions (25 of which are run by private service providers), and 138 are restructured/modulated institutions (23 of which are run by private service providers). As Map 1 shows, the classic institutions that should be closed down are unevenly distributed throughout the country. Out of the 41 counties in the country, 14 have finished closing their classic institutions,¹⁰⁹ whereas three counties are still operating eight to ten large residential units for children (namely Prahova, Sibiu, and Valcea).

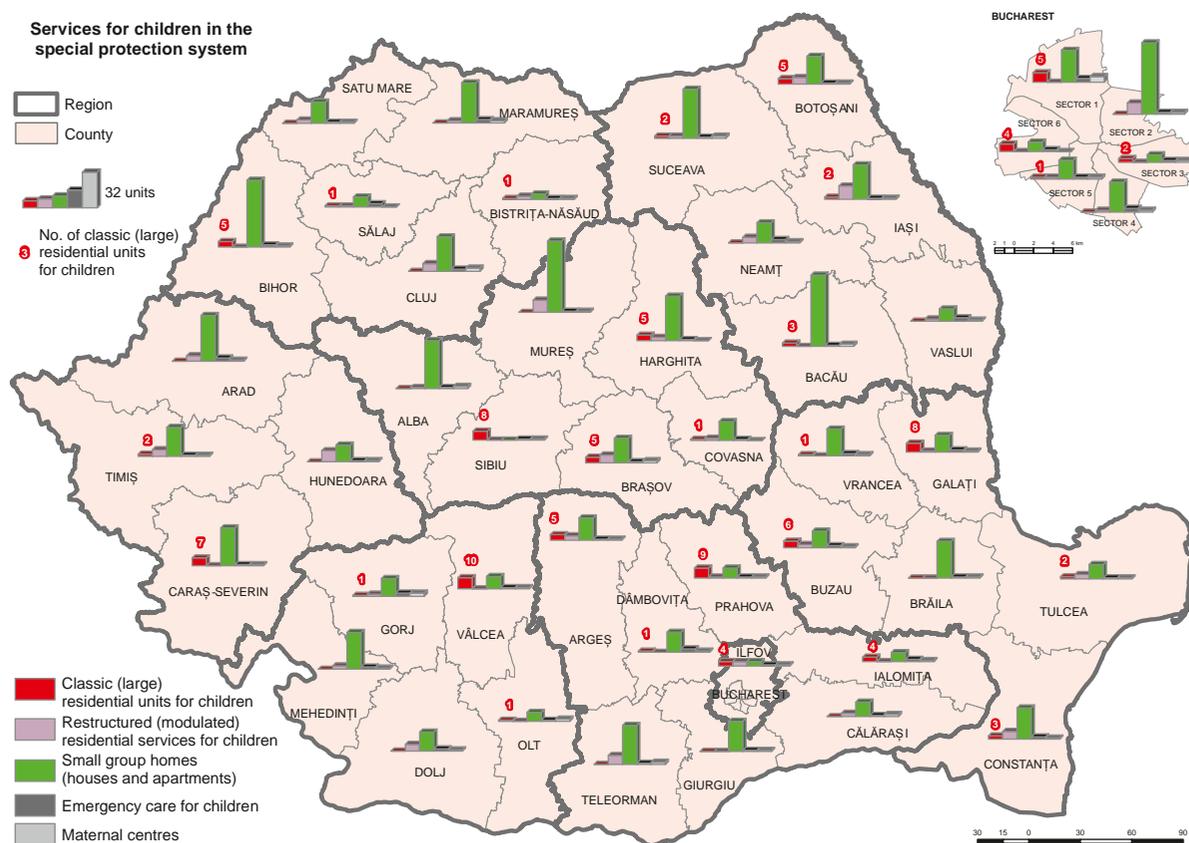
¹⁰⁶ From 16,534 in 2008 to 12,513 in 2013.

¹⁰⁷ As part of the same regulation, the food allowance will be doubled (to almost €4 per child per day) for all children in either residential care or family-type alternatives. Overall, the allowance per child placed with a family or in foster care will be increased to almost RON 600 (about €130) per month.

¹⁰⁸ Even if the closing or restructuring of the classic residential units for children is the most urgent activity, efforts still need to be made to restructure some of the modulated residential services that contain large numbers of children.

¹⁰⁹ These counties are: Alba, Arad, Braila, Calarasi, Dolj, Giurgiu, Hunedoara, Maramures, Mehedinti, Mures, Neamt, Satu Mare, Teleorman, and Vaslui. Of the six sectors of Bucharest, two sectors (2 and 4) have finalized the process.

MAP 1: Residential Care Services for Children by County



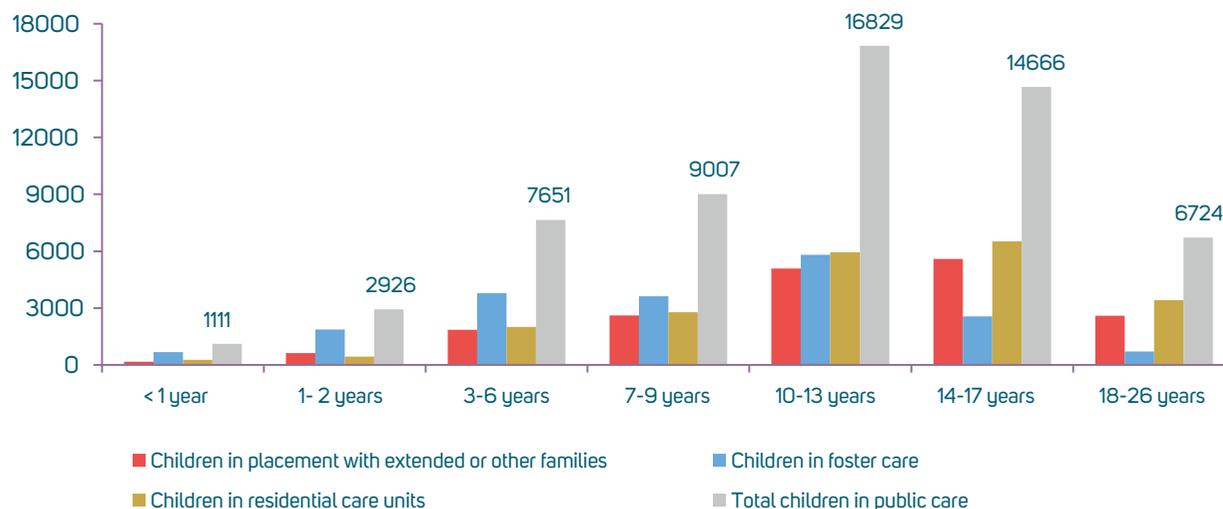
Source: National Agency for Protection of Children's Rights and Adoption.

Note: Residential care units including public and private placement centers, small group houses, and apartments.

Very young children should be the priority group for the next stages of the reform of the child protection system. Although efforts have been made to avoid institutionalizing children under the age of 3 years old (and there are laws against placing children under 2 years old in residential care),¹¹⁰ over 700 children under the age of 3 years old were still in residential care as of the end of June 2014. The Child Protection Strategy aims to integrate these children either into their natural families or into foster families. However,

out of all children placed in public care services, most are aged between 10 and 13 years old (29 percent), followed by those aged 14 to 17 years old (25 percent). Together, these two age groups make up more than half of the children placed in residential care, and their total number and proportion have been constantly increasing over the last four years, (from 12,379, or 53.6 percent, in 2010 to almost 12,500 children, or over 58 percent, at the end of June 2014).

¹¹⁰ An extension of the ban on placing all children aged 0 to 3 years old in care is currently being legislated.

FIGURE 28: Distribution of Children in Protection Services by Age Group and Type of Service, June 2014

Source: National Agency for Protection of Children's Rights and Adoption.

Note: Residential care units including public and private placement centers, small group houses, and apartments.

Enhancing the quality of care while also reducing the length of time spent in care to the minimum necessary, is critical. Due to the economic crisis, the public care system is confronted with a chronic lack of staff. Since 2007, the total number of staff employed by the child protection system has decreased by 27 percent. The staff of residential care services has decreased by 18 percent over the same period. With each case manager overseeing an average of 74 active cases, each child's case is reviewed only every six months instead of every three months as legally required, and the monitoring of placements is also generally suffering. Quality control mechanisms are poor, with only one compulsory site visit by social inspection required every five years when the institution's license is due for renewal, and a lack of child-appropriate complaint mechanisms. This situation raises important concerns about the quality of care provided to children in protective care, which may be leaving children exposed to potential abuse, neglect, and exploitation. Because of this lack of capacity within the child protection system, even though care within the public system is meant to be temporary, the average stay for children in care is around seven years.

Policymakers need consider taking the following steps to strengthen case management in the child protection system: (i) provide children entering the child protection system with adequate services tailored to their specific needs and reduce the length of their stay in the system

to the necessary minimum by adequate planning, implementation, and review; (ii) revise and enforce case management standards to improve cross-sectoral and multidisciplinary communication and collaboration; and (iii) invest in the continuous training of all DGASPC staff (including foster parents).

They also need to consider taking the following actions to improve quality control mechanisms in the child protection system: (i) review existing legal requirements to increase the frequency of quality controls and the enforcement of the minimum quality standards; (ii) introduce a regular performance evaluation mechanism for staff working in the child protection system and a specific set of performance indicators to assess the professional performance of DGASPC employees; (iii) introduce regular (annual) assessment mechanisms on the quality of services provided by the DGASPCs, including assessments provided by the end beneficiaries (both children and parents); and (iv) introduce accessible and child-appropriate complaints mechanisms (developed with the direct contribution of children themselves) to improve quality control and reduce risk of abuse, neglect, and exploitation.

C. Youths Leaving Residential Care

Young people over 18 years old may remain in the child protection system up to the age of 26 if they are attending a form of education. Therefore, as of as June 30, 2014, more than 11 percent of all children in public care are aged between 18 and 26 years old.

The main priority for the coming years is to increase the number of children and young people exiting child protection services to sustainable living situations. Between July 1, 2013 and June 30, 2014, more than 8,500 children left Romania's child protection system. Leaving care means one of the following: reintegration into the child's biological or extended family (40 percent), social integration/independent living (40 percent), adoptions (11 percent), and other situations including transfer to the care system for adults (9 percent). Young people (those over 18 years old) represent 43 percent of all of these exits, most of them being integrated into society (39 percent of all exits) with fewer than 4 percent being reintegrated into their families. For younger children, the main exit route is reintegration into their biological or extended families (especially for those aged 7 to 17 years old) or adoption (especially for those aged 1 to 6 years old).

Helping children in protective care to developing the abilities needed to live independently is of vital importance for ensuring their full and sustainable inclusion in society. At the moment, social and professional integration services and independent life-skill development services are underdeveloped in Romania, although specific quality standards and guidelines were adopted some years ago. For this very reason, young people leaving childcare at the age of 18 are a vulnerable group at risk of social exclusion. Therefore, what is needed is for the government to mandate the compulsory development and provision of life skills training throughout the child protection system in accordance with quality standards requirements and guidelines. While the main priority should be those aged between 14 and 17, children aged 10 to 13 years old should also be included, and ways should be found of including children regardless of age because life skills are a lifelong

learning process.

Policymakers should prepare now for the next contingents of children leaving institutional care by strengthening social integration support services. Currently youths leaving care lack both family support and social and professional integration skills. With an increasing number of youths leaving care each year (approximately 4,000 young people as of 2014), this is reinforcing the need for services to help them to establish an independent life, find a job, and obtain adequate housing. Although this problem has been a government priority since the creation of the National Strategy for the Social Inclusion of Young People Leaving Childcare 2006-2008 in 2006, the situation of the has not improved. In order to facilitate the social integration of young people leaving the care system, policymakers should consider providing them with support during their transition from the care system to independent living, including sheltered or social housing, counseling, and help to find employment.

D. Children and Youths Living on the Streets

Child homelessness should be addressed as top priority, with the aim of eradicating this phenomenon completely. In order to achieve this objective, policymakers will need to tackle the root causes that lead to children living on the streets and to develop specialized services targeted to existing street children.

The most urgent priority must be to conduct a thorough nationwide analysis of the issue of homeless children living on the streets. The DGASPCs reported that a total of 954 children were living on the streets at the end of 2013.¹¹¹ Due to the weak monitoring mechanisms and the questionable reliability of the available data, little is known about the real situation of children and youths living on the streets.¹¹² However, previous research showed that street children and youths are denied most of their rights and are profoundly excluded from society. Living on the streets is associated with serious health problems, chronic malnutrition, school dropout and illiteracy (about 50 percent), physical abuse

¹¹¹ These street children and youths were split into the following categories: (i) 383 who live on the streets separated from their families for long periods of time; (ii) 339 who live with their families but go onto the street or are taken onto the street every day to beg, to clean car windshields, and carry out other similar activities; and (iii) 232 children who live on the streets with their families.

¹¹² Save the Children ran an estimate in 2009 in three major cities – Bucharest, Braşov, and Constanţa. The number of children thus identified was nearly 1,400 (the lowest number being 800 and 1,700 being the highest). Most of them live in the capital city (about 1,150). In the seaside city of Constanţa, their number depends strongly on the season. More than half are children (aged between 0 and 17), the others being young people aged between 18 and 35 years old. Children living in the streets typically have a low level of education (most have no more than a completed primary school education), and their main source of income is begging, followed by daily occasional work and washing cars/ windshields. They generally have little if any access to services. While in Bucharest the situation is slightly better, with more than half of the subjects (55.9 percent) receiving services at some point, in Braşov and Constanţa very few have benefited from such services (Grigoras, 2009).

(sometimes even from the police),¹¹³ (usually started at home and continued on the street), stigmatization and discrimination, limited access to social services (education, healthcare and social assistance), the use of drugs or solvents (including common glue or paint thinners), and even prostitution.

What is urgently needed is a system to monitor street children as well as services designed to meet their needs and foster their inclusion into society and to prevent this problem in the future. Although there are national policies to address the phenomenon of homelessness, both in relation to children and adults, the current state initiatives are limited to providing social support, access to emergency healthcare, and emergency and temporary housing. NGOs, on the other hand, are providing medical care, education, psychosocial support and, sometimes, housing and use outreach techniques and implement homelessness awareness campaigns. However, their efforts are limited in terms of coverage and are highly dependent on the availability of funding, especially from international donors. To address this issue, policymakers should consider taking the following essential actions: (i) revising the quality standards for street children's services in order to provide an integrated response (including psychosocial support, education, healthcare, and legal support); (ii) outsourcing or contracting out services to NGOs or other private service providers; (iii) designing and implementing some tailored prevention mechanisms to address the root causes of this problem as identified by research; and (iv) introducing early identification, referral and response (multidisciplinary/cross-sector) mechanisms for children in risky situations.

E. Children Whose Parents Migrate Abroad for Work

A permanent and reliable system to monitor children with migrant parents should be created. Official figures (which have been collected by the DGASPCs since 2006) indicate that 80,036 children had migrant parents as of December 2013.¹¹⁴ However, this number seems to have decreased since December 2010.¹¹⁵ However, the official statistics are likely to underestimate the number of children who are in this situation as they only take account of those emigrants who intend to formally change their address

of residence.¹¹⁶ In reality, migrant parents very rarely (7 percent) inform local authorities about their intention to leave to work abroad. Other data sources¹¹⁷ also suggest that there are more children with migrant parents than is reflected in the official DGASPC statistics. Furthermore, at the community level, more institutions collect data on these children including the SPAS (which report to the DGASPCs), schools, and, sometimes, local authorities. However, there is no unified methodology for collecting and sharing these data between institutions, which means that they are rarely analyzed or used to inform policy decisions at either the national or local level.

Children with parents working abroad are a special challenge for the social protection services, because their development needs are primarily emotional rather than financial. Children with migrant parents are generally financially well-off. UNICEF research¹¹⁸ has shown that the migration of parents results in some gains for the family in the short term, such as the improvement of living standards, but it seems likely that children of migrant parents are vulnerable to monetary poverty shocks due to their strong dependence on remittances. While their access to healthcare does not seem to be significantly different from that of children who live in complete families, the main consequences for these children are emotional and psychological suffering as reported by both parents and children.¹¹⁹ Regarding the profile of children left behind, half of the children with both parents having migrated are younger than 10 years old, and more than half of those children are between 2 and 6 years old. In terms of time spent without their parents, 16 percent of children with both parents abroad have spent more than one year without seeing their parents, and 3 percent spend more than four years apart from their parents.

Despite the lack of accurate quantitative data, it can be estimated that a significant proportion of children with migrant parents do not appear to be in need of support services. The most at-risk categories of children left behind are those with both parents abroad, thus leaving those children at risk of the psychological effects resulting from the long-term separation from their parents. For the majority of children counted in the DGASPC records,¹²⁰ the person taking care of those children (the present parent or

¹¹³ Alexandrescu (2002).

¹¹⁴ Of these, 22,329 had both parents abroad, 47,394 had one migrant parent, and 10,313 were living in families where the parent as a sole provider was working abroad.

¹¹⁵ In December 2010, 84,084 children with migrant parents were registered.

¹¹⁶ Toth et al (2008).

¹¹⁷ Toth et al (2007) showed that some 170,000 5th to 8th graders had at least one parent working abroad, yet only 82,464 children were officially reported as such at the time. Another sociological study carried out in 2008 identified 350,000 Romanian children with migrant parents (Toth et al, 2008).

BOX 16

Children with Migrant Parents in the 2011 Population and Housing Census Data

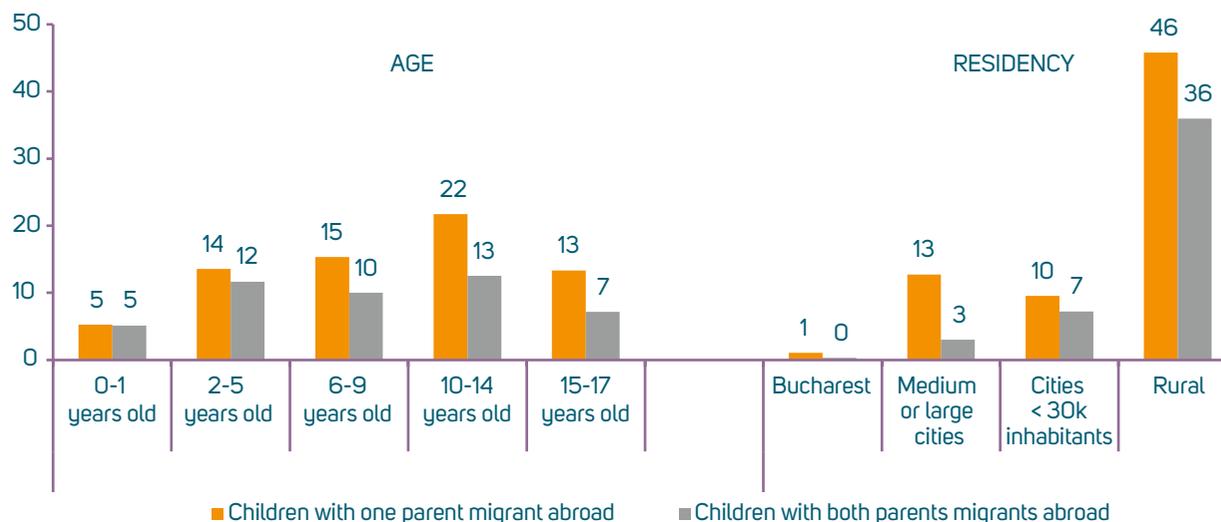
The total number of children in Romania aged between 0 and 17 years old recorded in the 2011 Census was over 3.83 million. About 3 percent of all children (or over 116,000 children) have experienced one (1.8 percent) or both (1.2 percent) parents migrating to work abroad. More children are left behind by one or both parents migrating abroad in rural areas than in urban areas (4.1 percent as opposed to 1.8 percent), and this gap increases with the child's age - from 2.6 percent of toddlers under 1 year old to 3 percent of 2 to 9 year olds, to 3.2 percent of children aged 10 to 14 year olds, and 3.1 percent of adolescents aged 15 to 17 years old.

The Census data indicate that the predominant pattern is that the mother stays at home and cares for the children, while the father migrates for work abroad (and probably sends remittances home to provide for the family). Of all children with migrant parents, 43 percent live with their mother and 16 percent with their father, while the other 41 percent lack both parents.

The parents left to care for children are most often employees (35 percent), self-employed in agriculture (22 percent), or home carers (26 percent). The other parents, up to 100 percent, hold various other activity statuses such as employer (0.4 percent), self-employed in non-agricultural activities (2 percent), unemployed (5.2 percent), or students (1.2 percent). In comparison, in families with both parents at home, 56 percent of parents are employees, 13 percent are self-employed in agriculture, and another 13 percent are home carers. Therefore, the welfare of families with children where one parent is living at home while the other is working abroad depends heavily on remittances. As for education (Annex Table 5.2), the 2011 Census data show that children with both parents having left for work (either abroad or within the country) are most at risk of not attending school. A lack of parental care is a source of great vulnerability for a child, while the presence of a parent at home gives a child a sense of stability and helps the child's development.



Children with One or Both Parents Having Migrated to Work Abroad (thousands)



Source: World Bank calculations using 2011 Population and Housing Census data.

Note: Migrants abroad to work or to study who are absent from the household for less than 12 months.

a relative) has not received any specialized support. Of the 80,036 children with migrant parents officially registered in 2013, around 3,700 required special protection measures,¹²¹ but this number has dropped since 2010. At present, local authorities lack the human and material resources needed to address the phenomenon. Developing the capacity of local institutions in order to address the phenomenon is crucial as there are no signs that labor migration abroad will diminish any time soon and these migrants come home only rarely if at all.

The government's main objective must be to provide adequate support services to at-risk categories of children with parents working abroad and to the adults caring for them. With this objective in mind, policymakers should consider taking the following steps: (i) strengthening social assistance services at the community level, which is essential for the entire social welfare system and would cover a wide range of needs; (ii) improving and strengthening monitoring and reporting mechanisms at the local (SPAS) level to enable the early identification of children who need support; (iii) equipping schools with the capacity to compensate for the absence of the parents by providing counseling; and (iv) developing after-school social-educational services.

This development of support services for at-risk children with parents working abroad and for the adults caring for them could be geographically targeted to those areas with the highest incidence of such children. The 2011 Census data indicate that 71 percent of all children with one or both parents as migrants abroad come from rural areas and that over 40 percent live in seven counties, namely Maramures, Satu Mare, Suceava, Botosani, Iasi, Dambovită, and Bacău.¹²² Furthermore, 45 percent of all children with both parents abroad come from the same seven counties.

F. Services for Children Deprived of Liberty

The number of children deprived of liberty in Romania is declining. In the third quarter of 2013, 2,400 children committed criminal activities but were not imprisoned, and other 1,700 children in detention were counted in the statistics of the National Administration of Penitentiaries.¹²³ The official juvenile crime rate¹²⁴ has remained fairly stable since 2003, with figures close to the 1,400 per 100,000 children level of 2011, and a slight decrease to 1,211 in 2012.

The situation has improved in recent years on all indicators.¹²⁵ Boys account for 95 percent of arrested children, 91 percent of convicted children, and 95 percent of detained children.¹²⁶

There has been an even more spectacular decrease in the number of children in detention (in other words, the total number of children in a closed facility by reason of their actual or suspected participation in criminal activity). This indicator dropped from 1,955 cases in 2000 to 444 in 2012 according to the latest available data.¹²⁷ It is difficult to make international comparisons as there are significant differences between the juvenile systems that exist in the countries of Europe (Map 2).

No public data are available about re-offending or new crime rates among children and young people released from detention, but experts estimate¹²⁸ that almost 8 in 10 children and young people leaving prison end up in detention again. A comprehensive analysis is needed of the socio-demographic profile of children deprived of liberty in Romania to inform future policy measures.

Having an adequate policy response to juvenile delinquency is particularly relevant at both the national

¹¹⁸ Stănculescu et al (2012).

¹¹⁹ Toth (2008).

¹²⁰ As of December 2013, 95 percent of children with one or both parents abroad and 88 percent of children with one parent working abroad.

¹²¹ More than half (53 percent) were in kinship placement, 14 percent were entrusted to foster parents, 8 percent were placed with other families, and 25 percent were placed in residential care units.

¹²² The number of children left behind by migrant parents as a percentage of the total number of children in the county was 8.4 percent in Maramures, 7.1 percent in Satu Mare, 6.1 percent in Suceava, 5.3 percent in Botosani, 5 percent in Iasi, 4.6 percent in Dambovită, and 4.5 percent in Bacău.

¹²³ ANP (2014a) According to the National Administration of Penitentiaries, in Romania, there are four prisons for juveniles (Bacău, Craiova, Tichilesti, and Targu Mures) and three rehabilitation centers (Buzias, Gălesti, and Targu Ocna).

¹²⁴ The TransMonEE data only cover crimes committed by juvenile offenders between 14 and 17 years of age and do not take account of any other crimes in which juveniles were involved. All reported offences perpetrated by juveniles are included, irrespective of the year in which they were reported.

¹²⁵ In absolute figures, the number of crimes committed by, or with the participation of children between 14 and 17 years old, declined by more than two times in 2012 (10,713) in comparison with 2000 (25,470). The number of arrested children declined from 790 in 2004 to 450 in 2011 but increased to 887 in 2012. The number of children charged with a crime also dropped from 16,510 in 2001 (0.32 percent of the 0 to 17 population) to 10,482 in 2012 (0.240 percent of the 0 to 17 population). In 2012, 444 children were arrested and imprisoned in closed institutions, less than one-fourth of the level in the 2000 to 2002 period. The number of juveniles convicted during the year 2012 was 3,026, once again around half of the 2000 to 2006 level (TransMonEE 2014 database).

¹²⁶ TransMonEE 2014 database.

¹²⁷ The rate (as a share of the total population of children) dropped from 0.03 percent to 0.01 percent. The child sentencing rate (per 100,000 average population aged 14 to 17) also decreased from 518 to 342 (TransMonEE 2014 Database).

¹²⁸ These estimates are based on consultations in 2010 and 2011 by Save the Children experts with children and young people serving custodial educational sentences and measures, and with prison experts. These consultations were carried out under the auspices of the project JUST-Juvenile Justice.

and the EU levels as it addresses a vulnerable group that is likely to be at high risk of social exclusion. In addition to this, it develops activities to prevent “the adult crime of tomorrow.”¹²⁹ The European Council for Juvenile Justice has selected three principles that will underlie its interventions in the period of 2015-2017: (i) facilitating access to justice and procedural rights, which can be difficult to implement when children are involved in the justice system; (ii) promoting restorative justice, which it defines as “a system of justice that refuses a punitive approach in favor of a more participative role of victim, offender, and community, towards an educational aim,” and (iii) ensuring that “unaccompanied minors, children on the move, and victims of human trafficking” are not subjected to “exploitation, discrimination, abuse, and violence.”¹³⁰ However, the problem of juvenile delinquency has not been addressed in the most recent relevant programming documents in Romania – the Draft Strategy for the Judicial System for 2015-2020 or the recently adopted National Strategy for Protecting and Promoting Children’s Rights for 2014-2016. Also, little about juvenile delinquency is mentioned in the National Strategy for the Social Integration of People Deprived of Liberty 2014-2018 produced by the National Administration of Penitentiaries.

The Government of Romania has already taken some steps towards creating a legal framework for restorative justice measures, but little has been done in terms of implementation. In the last two years, the majority of “minor” detainees (including those aged 18 to 21 years old) were released from prisons as a result of the government’s adoption of a new Penal Code. The National Probation Directorate has reported that, out of the 7,700 detainees evaluated for probation in 2013, more than 5,000 were minors (under 21 years old). In the same time, 20,446 ex-prisoners who had been released in 2013 and in previous years were kept under surveillance of which 18,710 were minors. The new provisions of the Penal Code require that non-custodial sentences should be given to children who have committed a penal offence. These sentences can include a civic training program, recording (consemnare) at the end of the week, and daily assistance. However, other than the Court for Minors and Family in Brasov, there are hardly any designated courts for hearing cases involving children, and members of the judiciary and court officials

have not been given any special training that would ensure an adequate, coordinated practice in the field of juvenile justice.¹³¹

The legislation requires penitentiary institutions, rehabilitation centers, and detention centers to organize and provide educational, cultural, therapeutic, psychological, and social assistance activities during detention to facilitate the social reintegration of inmates. Within projects developed in partnership with the MLFSPE or other partners, the National Administration of Penitentiaries provides professional training courses, vocational guidance and counseling, and job placement assistance to juveniles in detention to help them to reintegrate into society after their release.¹³²

The law also requires that psychosocial assistance must be provided for children involved in criminal acts, including imprisoned children. Members of this group have often been exposed to violent acts and antisocial influences in their social environment and, during their detention in rehabilitation centers or penitentiary facilities, they are likely to deviate even further from normal development pathways. However, in Romania, the extent to which there is any collaboration between magistrates and specialists working in psychosocial support services varies from one county to another, and there is a chronic lack of support services for child victims and children in conflict with the law.¹³³

The prevention side of juvenile delinquency should be developed at the community level with the education and social assistance sectors being involved. In addition to this, a restorative justice system will not be able to work unless cooperation between members of the judiciary and those working for the DGASPCs and SPAS is strengthened. Studies have blamed the lack of available services for children deprived of liberty as the main reason for the weak cross-sectoral collaboration.¹³⁴

While rehabilitative activities are provided in detention facilities, when children and young people leave detention, they are confronted with many obstacles that increase the risk of recidivism on their part. The most common are a lack of support from and/or rejection by their family (resulting in a lack of housing for the young person after leaving detention), difficulties in finding a job (because

¹²⁹ International Juvenile Justice Observatory (2010).

¹³⁰ European Council for Juvenile Justice, Roadmap 2015-2017.

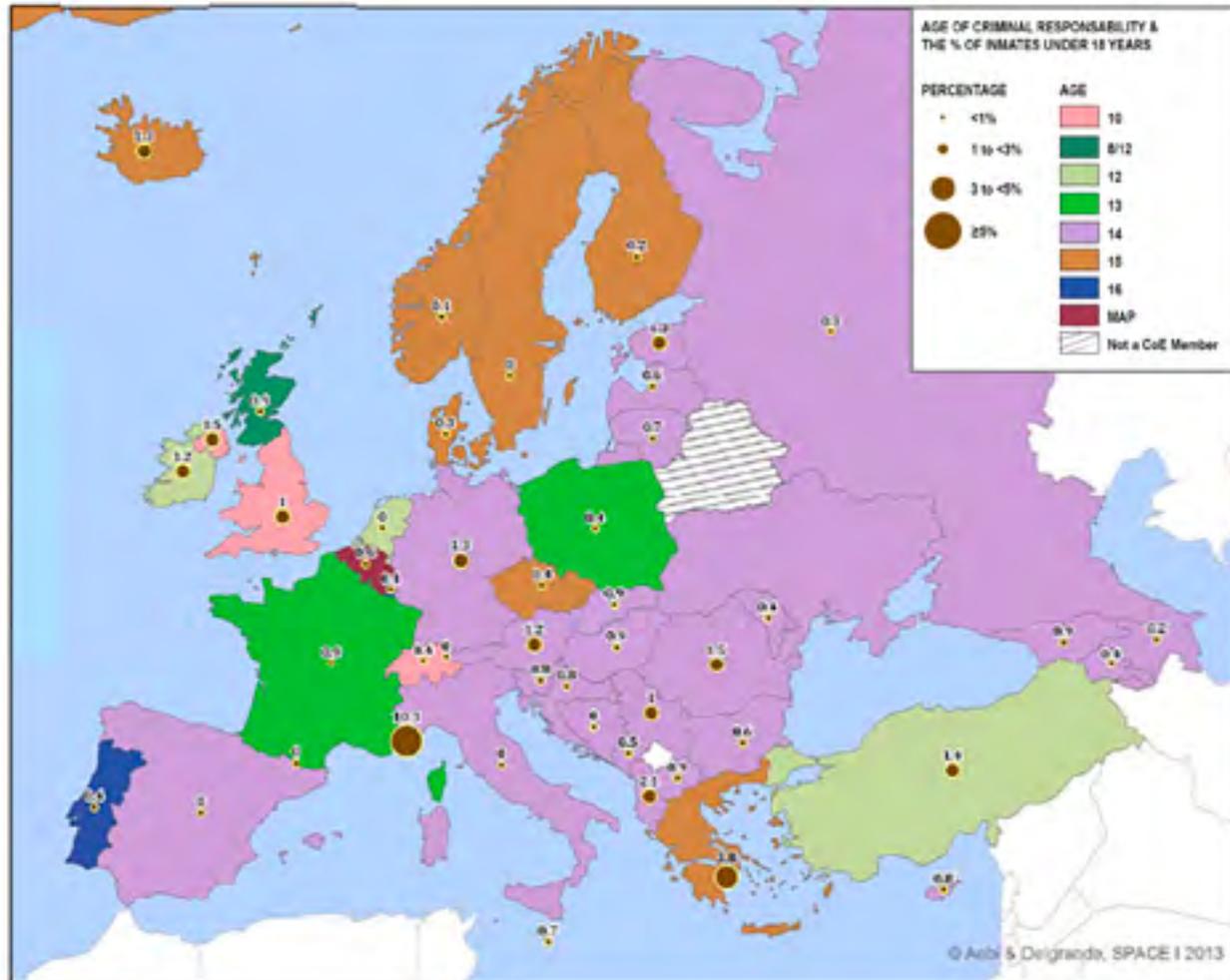
¹³¹ Alternative Sociale (2010).

¹³² According to the legislation, young people aged 16 or over with a minimum of eight years of education can access a range of training courses.

¹³³ Alternative Sociale (2010).

¹³⁴ Alternative Sociale (2010).

MAP 2: Breakdown of the Age of Criminal Responsibility and Percentages of Prisoners Less Than 18 Years in European Countries, in 2013



Source: Aebi and Delgrande (2014: 83).

Note: This map should be used cautiously. Many figures presented in this map are partial, and cannot be compared among countries. Several countries did not provide the general data for the whole prison populations. Therefore, sometimes we used the available data (for example, only on sentenced prisoners). Moreover, some of the countries included in the map (for example, Italy) do not count young people held in institutions as juvenile offenders in their prison population. As a consequence, their percentage of inmates aged under 18 years old is close to zero.

of inadequate professional training paired with a lack of required job-searching skills and knowledge), low educational attainment, and a lack of minimum skills and abilities for coping with life outside prison, such as self-sufficiency, social interaction, and using public transport.

The government's main objectives for this category of children must be to ensure their successful reintegration into their families and society and to prevent recidivism. The following actions should be considered in order to achieve these objectives: (i) developing a network of services targeted to children in conflict with the law; (ii) improving the quality of custodial services for juveniles and young; (iii) improving the mechanisms for monitoring custodial services for juveniles and the young; (iii) consolidating and strengthening capacity within SPAS at the local level to provide support services; and (iv) improving and strengthening the specific monitoring and reporting mechanisms at the SPAS level to ensure the early identification of juveniles who need support and the application of effective interventions.

Services for Teenage Mothers

Live births among teenage mothers under the age of 15 have been increasing to a worrying extent in recent years. According to NIS data, in 2011 2,898 live births were recorded among mothers under the age of 20, representing 10.6 percent of the total number of live births recorded in that year. While the rate of live births among all teenage women has been declining (from 13.2 percent in 2006), it is worrying to note that in 2011 there were 748 mothers who were younger than 15 years old (3.6 percent of the total number of live births recorded among teenage women) up from 551 births and 1.9 percent in 2006.

Preventive services, mainly those related to the education and health sectors, are essential for reducing teenage pregnancies. For example, policymakers might consider: (i) introducing educational policies (such as information campaigns) to prevent risky sexual behavior¹³⁵ among teenagers; (ii) improving the health monitoring of teenage women with the aim of identifying pregnancies early; and (iii) increasing the access of teenagers to health counseling and family planning services.

From the social services point of view, counseling for at-risk groups will be necessary to reduce and prevent teenage risky sexual behavior and teenage pregnancies. Policymakers need to develop clear protocols for immediate referral of all pregnant teenagers to social services so that they can receive counseling and support services as early as possible. These services will aim to keep the child with the family (where possible) or to find it a permanent home as well as to help mothers to continue their education or to find a job as appropriate. Services for teenage mothers and their children need to be developed across the whole country but particularly in rural areas. According to the 2011 Census, 73 percent of children with teenage mothers and 72 percent of teenage mothers are located in rural areas, with the majority of these being located in 10 counties - Mures, Dolj, Bihor, Iasi, Dambovita, Brasov, Bacau, Arges, Galati, and Constanta.

Services for People with Disabilities

People with disabilities and invalidity represent almost 7 percent of the Romanian population, and this percentage has been steadily increasing since 2006. People with disabilities are estimated to constitute 3.5 percent of the population, nearly all of whom live with their family or independently (over 98 percent of the total).

The single system for assessing a person's functional limitations is currently being developed. In Romania, over 1.4 million people have various degrees of functional limitations, either due to the loss of working capacity (partial or total) for people of working age (called "invalidity") or to a birth condition or disability. According to current Romanian legislation, individuals' functional limitations are evaluated by two separate commissions, one for work accidents and the other for non-work disabilities. Currently, a World Bank project is helping the government to merge the assessment criteria and instruments using in these two assessment systems.

The unification of the system for assessing functional limitations is particularly necessary given that the invalidity pension is far more generous than the disability allowance. This differential creates an incentive for potential

¹³⁵ Risky sexual behavior among teenagers is directly linked to teenage pregnancy and motherhood. A recent study showed that, in Romania, 25 percent of teenagers over 14 years old and 1 percent of those under 14 years are sexually active (CURS, ISE, and UNICEF, 2013). On average, teenagers begin their sexual activity at the age of 15½ years old. At the time of the research, sexually active adolescents had an average of 2.3 partners, and 68 percent had a stable partner. Fewer than half (47 percent) of sexually active adolescents consistently used means of protection, mainly for preventing pregnancy and not for protecting themselves against sexually transmitted diseases. The survey from which these data came had a sample of 607 adolescents (aged 10 to 17 years old), with a margin of error of plus or minus 3.9 percent and a confidence level of 95 percent.



BOX 17

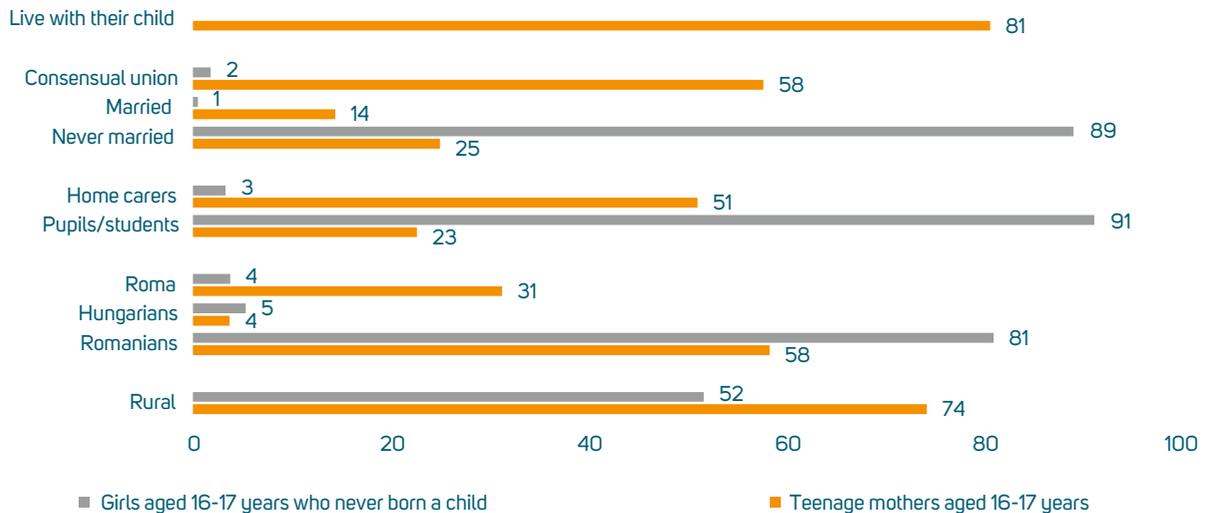
Teenage Mothers in 2011 Population and Housing Census Data

In 2011 Population and Housing Census data, 8,605 cases of teenage mothers aged between 11 and 17 years old were recorded across the country (with 8,422 children in their households). Of these, 7,175 were aged 16 or 17 years old (with 7,246 children), meaning that the rate of teenage motherhood in this age group was 3.3 percent. This rate is significantly higher in rural areas than in urban areas (4.7 percent versus 1.8 percent), and it is extremely high for Roma girls (22.1 percent).

Most Romanian girls aged 16 to 17 years old are unmarried, living with their parents and family, and attending fulltime education. By contrast, teenage mothers aged 16 to 17 years old tend to in rural areas, are in consensual unions or are married, and are living – along with their partner and child - within an extended family, and 77 percent have dropped out of school, mostly becoming home carers.

Also, the Census data indicate that vulnerabilities linked to teenage motherhood are perpetuated later in life. Thus, young women aged 18 to 24 years old who were teenage mothers are at a disadvantage compared with those who had their first child after the age of 18 and even more so compared with young women with no children (Annex Figure 5.3).

Comparison between Teenage Mothers and Other 16 to 17 Year Old Girls (%)



Source: World Bank calculations using 2011 Population and Housing Census data.

beneficiaries to try to become eligible for the invalidity pension, especially given that the current legislation allows people to receive both benefits. As of 2010, about 50 percent of disability allowance beneficiaries were also receiving a pension, and 20 percent were in receipt of an invalidity pension.¹³⁶ However, this is mainly the result of the limited opportunities that disabled people have of entering the labor market during their working life because of the structural barriers discussed in the Employment Chapter. In addition, finding a job is often considered by the evaluation commission as grounds for cancelling or reducing a beneficiary's eligibility for the disability allowance. This creates a disincentive for them to enter the formal labor market and an incentive for them to attempt to become eligible for the invalidity pension.

The specific requirements in terms of access to services for people with disabilities or invalidity are being addressed in two important policy documents, currently being drafted by the MLFSPE. The first is the National Strategy for the Social Inclusion of People with Disabilities 2015-2020, and the

second is the new unified methodology for assessing the situation and needs of people with disabilities and suffering from invalidity, in accordance with the International Classification of Functioning, Disability and Health. The recommendations put forward in this volume have also taken into account the opinions of families, professionals, and people with disabilities in recent years as expressed to various disability NGOs or during the consultations related to the preparation of the National Strategy for Social Inclusion of Persons with Disabilities (2015-2020).¹³⁷

People with disabilities and those suffering from invalidity have both common and separate needs for various social services. Those in both categories need accessibility measures as well as (re)habilitation and medical services,¹³⁸ adapted transportation, respite care, daycare, long-term care or homecare, home adaptations, and lifelong learning.¹³⁹ However, early diagnosis and intervention, education, and early stages of vocational training are specific to those with disabilities since in most cases their disabilities manifest before they reach working age.

TABLE 28: Evolution of the Number of People with Disabilities or Invalidity (in thousands)

	Dec 2011	Dec 2012	Dec 2013
Total number of people with disabilities in Romania (children + adults), of whom:	690	697	692
Children (total)	60	61	61
Adults (total)	629	636	631
Children with severe disabilities	30	31	32
Adults with severe disabilities	202	203	203
Children in residential institutions for adults with disabilities	0.026	0.015	0.012
Children in residential institutions for children with disabilities (public and private residential services together)	9	9	8
Adults in residential institutions	17	17	17
Total number of people receiving an invalidity pension	805	748	715

Source: MLFSPE (2013 Quarterly Statistic Bulletin).

¹³⁶ World Bank (2014a).

¹³⁷ Specific recommendations related to the consultations on the future strategy are available from the NGO Secretariat coordinated by the foundation, Fundatie Alpha Transilvania, Targu Mures, www.alphatransilvania.ro

¹³⁸ The key priorities for improving the access of persons with disabilities to healthcare, which are presented in the next sections, are aligned to those recommended by UNICEF (e.g. Stanciu, 2013; UNICEF, 2013) and Handicap International (Chiriacescu, 2008).

¹³⁹ In the context of the UN Convention on the Rights of Persons with Disabilities, habilitation and rehabilitation services include a wide range of activities aimed at enabling people with disabilities to achieve their maximum level of independence and participation in socioeconomic life. While habilitation refers mainly to those measures that enable people to achieve a functional level that they have never reached before (due usually to impairment from birth or from very early age), rehabilitation services focus on restoring (or compensating for) those abilities that have been lost due to an impairment or injury. The differentiation in terminology is due to the fact that these two situations often require different types of service and intervention. Here, the term "(re)habilitation services" is used when referring to both measures.



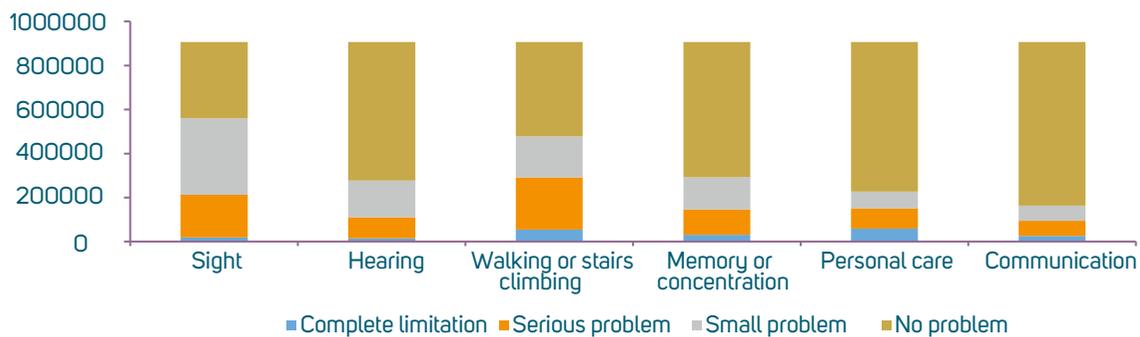
BOX 18

People with Complete Functional Limitations in the 2011 Population and Housing Census Data

The 2011 Census included a set of questions about the existence of a medical condition that prevents individuals from carrying out their daily activities. About 906,000 people reported being limited in their daily activities because of one or more health problems related to vision, hearing, walking or stair climbing, memory or concentration, personal care, or communication. The most frequent reports were of minor limitations related to sight problems. Complete limitation because of health problems was reported by 115,000 people (or 0.6 percent of the total population).

These people were women and men spread across the country, in rural areas, small urban areas, and large urban areas and in all counties. Most were aged 55 years old or over, 5 percent were children, 28 percent were aged between 18 and 54 years old, 13 percent were 55 to 64 years old, 17 percent were aged between 65 and 74 years old, and 37 percent were 75 or older. Most lived in households, and (61 percent) had help and support from family members or other people. Nonetheless, 30 percent of people with complete limitations because of health problems face serious difficulties because they receive no help from other people, even some of those who live with their family.

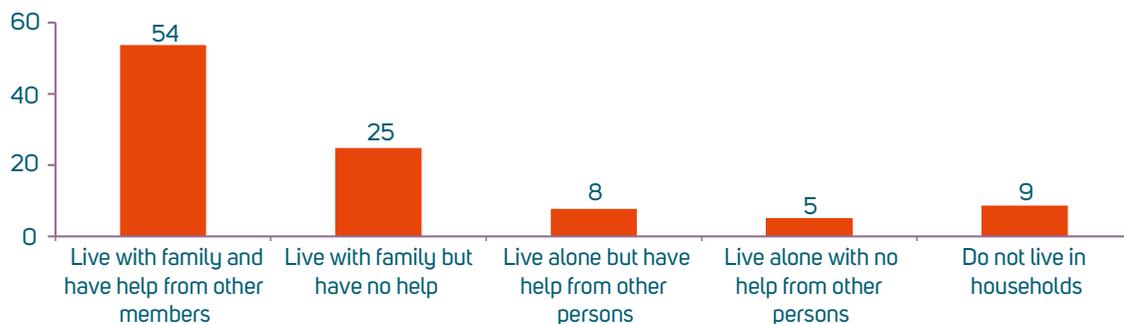
Number of People with Limitations on Their Daily Activities by Health Problem



Source: World Bank calculations using 2011 Population and Housing Census data.

Note: N=906,500 people.

Family Support for People with Complete Limitations because of Health Problems



Source: World Bank calculations using 2011 Population and Housing Census data.

Early Detection and Early Intervention Services

A greater range of early detection and early intervention services is critical for ensuring that children with disabilities receive proper care.¹⁴⁰ Early diagnosis and intervention are of major importance for children with disabilities. Depending on the medical condition of the child, an impairment or functional limitation can be successfully detected immediately after birth (for example, various types of agenesis or cerebral palsy) or in the first six months to three years of life. This early detection increases the chances of the child developing the skills that he or she needs to live as independently as possible. In this respect, this background study recommends that:

- Each pediatric hospital should have an early detection unit staffed by professionals who are trained to deal with the entire spectrum of conditions that can lead to a potential disability.¹⁴¹
- Each maternity ward and pediatric hospital should have a counseling unit to support families after a diagnosis of a current or potential disability. This family counseling should aim to offer guidance, concrete support, practical solutions, and information during the early stages of the (re)habilitation process.
- Each city should have at least one early intervention unit or specific services for people with various types of functional limitations (physical, sensorial, intellectual, and behavioral).

The network of early detection and early intervention services should cover the entire range of disabilities and the entire country. Currently, in Romania, early detection of medical conditions that can lead to disability is done by family doctors or by specialist doctors in pediatric, neuropsychiatric, or child neuropsychiatric units. However, there are several types of disorders - such as autism spectrum disorder (ASD), behavioral disorders, attention

deficit hyperactivity disorder (ADHD), and some rare genetic diseases - that often go undiagnosed, even by specialized medical departments. While the medical diagnosis of motor-neuron and sensorial conditions is relatively frequent, especially in pediatric hospitals or in the physical rehabilitation units of general hospitals, the diagnosis of developmental and learning difficulties and intellectual disabilities is less frequent as the early detection and intervention of these conditions have only been emphasized since 2001 or 2002. In addition, early intervention services are usually located in the main city of a county, which means they tend to be inaccessible to many families living in smaller towns or rural areas as appropriate transportation is often scarce or unaffordable.

The quality of Romania's existing early detection and early intervention services could be enhanced by following proven best practices.

- The number of professionals specializing in early diagnostics is still very low, and most existing practitioners were trained in - or acquired additional relevant qualifications in - Western European programs (such as pediatricians, neuropsychiatrists, neurologists, speech therapists, psychologists, and physiotherapists). However, a program for training professionals in the early detection of impairment and in early intervention is currently offered by Cluj University, in the Faculty of Special Psychopedagogy. The Ministry of Education approved the curriculum in 2013.¹⁴²
- The way in which families are notified of their child's disability in Romania is inappropriate. According to various NGOs,¹⁴³ parents have reported that medical professionals have often described their children's disability as an irreversible condition and as a burden that will harm the life of the family. Despite some rare positive examples and initiatives, the overall practice is rather humiliating and disturbing for families. Therefore, medical professionals need to receive training for addressing this problem.

¹⁴⁰ Early detection is a screening and diagnostic process, designed to identify potential risks of impairments, developmental delays or functional limitation in infants and toddlers. Early intervention is a set of comprehensive and inter-disciplinary services that enhance the development of infants and toddlers with disabilities (0-3 years old) and minimize the risks of physical, developmental or psychological delays.

¹⁴¹ For example, Autism Spectrum Disorder (ASD), Down's syndrome, fragile X chromosome syndrome, cerebral palsy, various types of agenesis, Prader Willi syndrome, Coffins Siris syndrome, other rare genetic diseases, ADHD, learning difficulties, and speech-related delays.

¹⁴² <http://www.monitoruljuridic.ro/act/anexa-din-18-ianuarie-2013-privind-continutul-educativ-pentru-interventie-timpurie-anteprescolara-destinat-copilor-cu-deficiente-senzoriale-multiple-surdocecitate-emitent-ministerul-educatiei-147553.html>

¹⁴³ Autism Romania, the European Center for Children's Rights, and the Parents Association of Physically Disabled Children.

- In the last five years, significant progress has been made in the diagnosis of ASD, but families in small cities and rural areas rarely have access to medical professionals capable of assessing and diagnosing such cases. Between 2010 and 2013, the MLFSPE, in partnership with the Romanian Angel Appeal Foundation and the Romanian Association for Cognitive-Behavioral Therapies, created 40 counseling and support centers for the families of individuals with ASD.¹⁴⁴ Similar support services are very much needed across the country, especially in smaller cities.
- In the last decade, several NGOs¹⁴⁵ have started to develop early intervention and support services for children at risk and their families in cooperation with local authorities and/or existing public services (hospitals, kindergartens, and counseling services). Maternity wards and pediatric hospitals in the pilot municipalities have progressively incorporated a program of early screening for children at risk.

TABLE 29: Early Diagnosis and Intervention Services in Romania

	Mainstream services*	Specific services	Support services
Typology	A. Family medicine B. Maternity wards C. Pediatric services D. Neuropediatric units E. Neuropsychiatric units	A. Medical services Complex screening and diagnostic services for children with the potential for impairment or functional limitation. These are mainly available in pediatric hospitals, as well as in neuropsychiatric units for autism spectrum disorder (ASD). B. Multidisciplinary services Early intervention services are available in some of the major cities, focusing mainly on physiotherapy, speech therapy, behavioral and learning therapies (including specific therapies for ASD), sensorial stimulation (hearing and sight), and art therapy. These services are provided in medical rehabilitation units or by NGOs. C. Early education - described in the Education chapter	A. Counseling for families, drafting of individual habilitation plans for children, home adaptations, and psychological support for parents and extended families B. Self-support groups for families D. Information and awareness, both for families and professionals
Professionals who currently provide these services	Family doctors Neonatologists Pediatricians Neuropediatricians Orthopedists Neuropsychiatrists	Neuropediatricians Orthopedists Child neuropsychiatrists Psychologists Educators Psycho-pedagogy professionals Speech therapists Physiotherapists Occupational therapists	Psychologists Speech therapists Physiotherapists Psycho-pedagogy professionals Social workers

Note: * These services are intended to provide the family with a warning of a potential impairment or functional limitation.

¹⁴⁴ A map of these services is presented at <http://autism.raa.ro/servicii/centre-de-consiliere-si-asistenta>.

¹⁴⁵ Some examples include Alpha Transilvana in Targu Mures (for children with motor-neuron disabilities); Speranta in Timisoara (for children with developmental problems); The Center for Motoric Rehabilitation in Cluj; Thysia and Albin in Oradea; Sense International in Bucharest and Oradea, Timisoara, and Iasi (for deaf blind children); World Vision in Cluj, Craiova, and Bucharest; Help Autism in Bucharest; the Iulia Pantazi Center in Bucharest; and the Inocenti Foundation in Bistrita.

Rehabilitation Services

The development of mobile multidisciplinary teams for early intervention is very much needed, especially for children with high dependency needs and complex medical conditions and those in rural or isolated areas. The number and composition of these teams should be adapted to local (county) needs. However, best practice examples tend to involve an average of three to four teams per county, each of which includes a physiotherapist, a psychologist, a speech therapist, a nurse, a social worker, and a psycho-pedagogue or educator. Currently, the use of this kind of mobile multidisciplinary team for early intervention is rare in Romania. In 2011, the MLFSPE developed 20 mobile teams to support the families of children with disabilities based at home in 18 counties and two sectors in Bucharest.¹⁴⁶

More (re)habilitation centers and services are needed in small communities, including mobile teams that are able to provide integrated services in rural and remote areas and to people with mobility difficulties. Habilitation/rehabilitation is obviously not limited to medical care. It relates to a much wider range of activities including physical, psychosocial, and occupational therapy, as well as a variety of support services for community living and daily life activities.

Although in the past medical rehabilitation was mostly provided in institutional settings, these services are increasingly being provided at the community level managed by local authorities or accredited NGOs (Annex 5, Section III). The Ministry of Health is supporting this positive trend for the foreseeable future. However, policymakers need to encourage the development of more medical rehabilitation services for adults, which lag behind those for children, especially in terms of accessibility and affordability. Similarly, during the qualitative research, NGOs mentioned the need for more free or subsidized medical equipment, medical consumables, and medicines for those with disabilities. Also, service providers drew attention to the need for incentives to attract and retain staff working with individuals with complex disabilities or high dependency needs given the high levels of outmigration among this category of professionals, who are in high demand in Western Europe.

Services for People with Mental Health Problems

According to WHO, mental health is a state of wellbeing in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively, and make a contribution to the community. Mental disorders comprise a broad range of problems that have different symptoms. However, they are generally characterized by some combination of disturbed thoughts, emotions, behavior, and relationships with others. Some examples of mental health conditions are depression, anxiety, behavior disorders in children, bipolar disorder, and schizophrenia. The key factors that prevent sufferers from accessing quality services are discrimination and marginalization, stigmatization, and a lack of coordination between sectors, which translates into poor collaboration between institutions at the central and local levels.

People with mental health problems are at high risk of poverty and social exclusion. Mental health problems and poverty usually create a negative cycle. People living in poverty are more likely to develop mental health problems that are more severe, last longer, and have worse outcomes than average.¹⁴⁷ Conversely, with no targeted social and financial protection or assistance, people with mental problems are very likely to fall into poverty or not be able to rise out of it.¹⁴⁸ In order to break the cycle of poverty and discrimination, it will be necessary to introduce more income-generating and community empowerment programs for people with mental health problems.

Stigmatization is a significant constraint to accessing proper care for people with mental health problems. Many people fear being “labeled” with a mental health problem, which is why they delay or avoid seeking treatment. This self-stigmatization combined with previous negative experiences with the health care system (for example, discriminatory behavior from medical personnel, high costs, and a lack of health literacy skills on the part of the patient) often cause the person with mental issues to postpone seeking professional help.¹⁴⁹ In this context, many mental problems remain under-diagnosed and untreated. It is important for medical and social specialists working with

¹⁴⁶ Arad, Argeş, Bihor, Bistriţa Năsăud, Brăila, Braşov, Dâmboviţa, Dolj, Galaţi, Giurgiu, Gorj, Mehedinţi, Mureş, Neamţ, Olt, Sălaj, Satu Mare, Vaslui, and Bucharest (Sectors 4 and 6). Each mobile team consisted of a speech therapist, physiotherapist, psychologist, social worker, pediatrician, occupational therapist, and a special educator. <http://www.mmuncii.ro/j33/index.php/ro/transparenta/comunicare/comunicate-de-presa/2009-rezultatele-implementarii-proiectului-cresterea-capacitatii-autoritatilor-publice-locale-din-romania-in-vederea-sprajinirii-copilor-cu-dizabilitati-in-cadrul-propriilor-familii>.

¹⁴⁷ Lunda et al (2010).

¹⁴⁸ WHO (2012a).

¹⁴⁹ Wahlbeck and Huber (2009).

people with mental health problems to provide accessible information on symptoms and treatments and to ensure that patients understand their rights. Educational and advocacy programs are needed to promote mental health and to challenge the myths surrounding mental problems among both the general population and medical specialists.

In 2002, the Government of Romania passed the Law on Mental Health Promotion and Protection of Persons with Psychiatric Disorders. This became operational only in 2006 when the National Strategy for Mental Health was launched. Since 2007 the Romanian Ministry of Health has had a National Program for Mental Health in place, which aims to ensure the accessibility, continuity, and quality of services for people with mental health problems. In 2009 the government created the National Center for Mental Health and the Fight against Drugs and began the process of reforming the mental health care system. The National Health Strategy 2014-2020 - Health for Prosperity reinforces the need to improve the mental health status of the population by assuring equal access to adequate and efficient medical services. The rights of children with mental problems to treatment, dignity, and active community participation are specified in the National Strategy for Mental Health for Children and Teenagers, which has recently been approved despite having been under discussion since 2007.

There is a strong need for both horizontal and vertical collaboration between institutions in order to provide appropriate medical and social services for people with mental problems. Theoretically, a chronic patient may be hospitalized for maximum 44 days (114 days for long-term chronic patients) in a mental health hospital and then should be referred to a residential specialized institution such as the Neuropsychiatric Recovery and Rehabilitation Centers (NRRC), which in principle are supposed to offer residential, specialized, recovery, rehabilitation care and, when possible, social and professional reintegration for people with mental health problems. However, in practice, this varies across the country as there are no clear referral mechanisms or collaboration protocols between institutions. There are at least two ministries that need to coordinate their policies and strategies - the Ministry of Health and the Ministry of Labor, Family, Social Protection, and the Elderly (MLFSPE) - and two local structures - the mental health hospitals and the NRRCs, which may or may not be directly run by the MLFSPE. NRRCs receive financing from the MLFSPE and the county councils, at the national level they are overseen by the National Authority for People with Disabilities, and at the county level they are a subordinate structure of the General Directorates of Social Assistance

and Child Protection (DGASPCs) and the county councils.

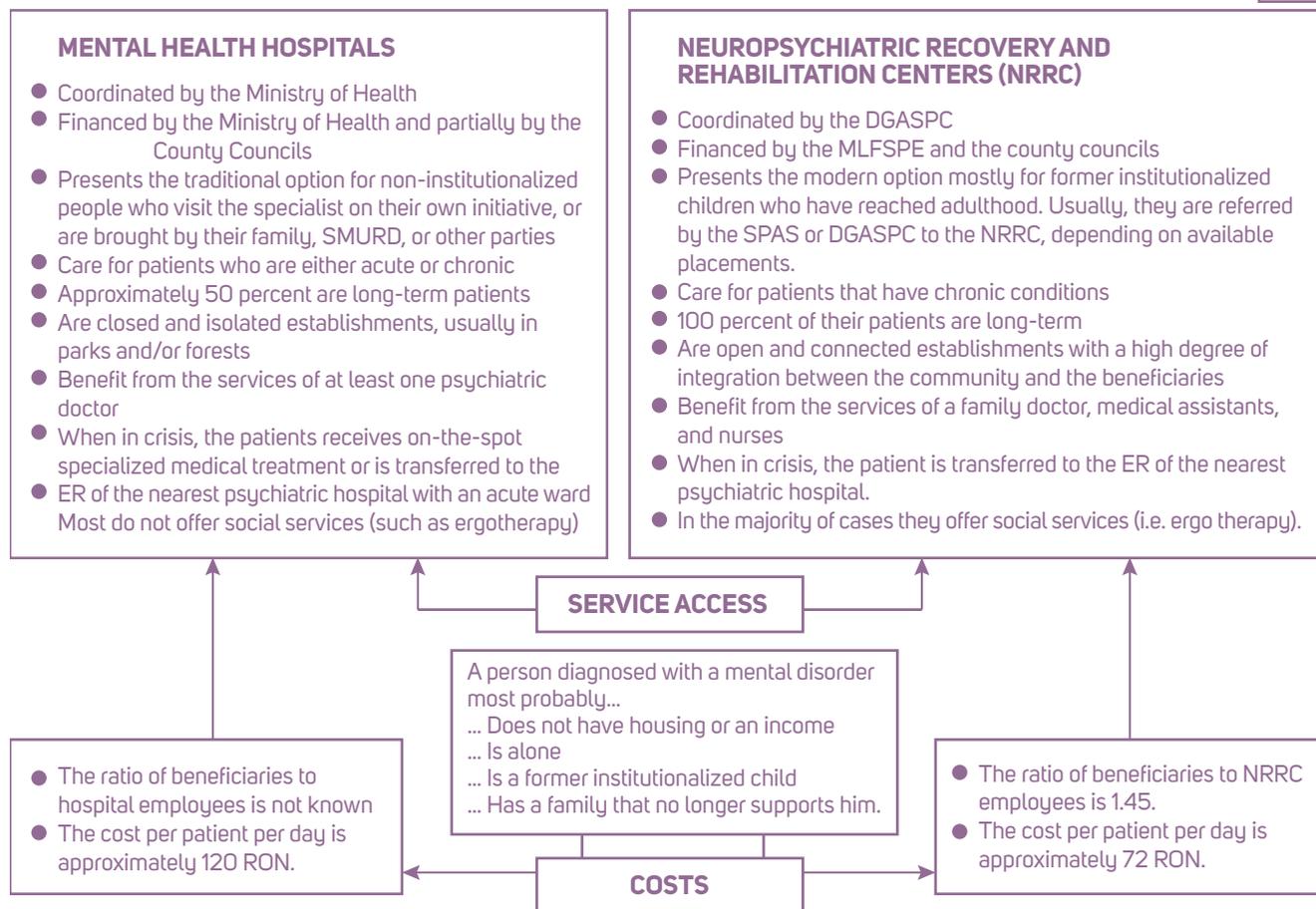
Therefore, for the benefit of the patient, there needs to be more collaboration between institutions and sectors. At the moment, some services provided by mental health hospitals and the psychiatric departments of general hospitals overlap with the services provided by the NRRCs. Although mental health hospitals and NRRCs should be providing complementary services for mental health patients, in practice they often offer similar services but with different specialists, different funding sources, and different standard per capita costs (Box 19). The institutional gaps have allowed the creation of informal functional mechanisms. In many mental health hospitals, even in the psychiatric departments of general hospitals, most patients are residents for years, in some cases more than 15 years. This situation is the result of a vicious cycle in which few institutions are available to accommodate mental health patients who have been released from hospital (mostly a small number of NRRCs) and families and/or local authorities do not have the capacity to provide them with the necessary specialized care. In most cases, the mental health hospitals and the psychiatric departments cover the institutional gap by providing these patients with residential and specialized medical treatment as a response to a social problem (see interview excerpt in Box 19).

These factors increase the pressure felt by the families of people with mental health problems. To address this, policymakers should consider funding psychosocial counseling and support for families and other caregivers of people with mental health issues.

The NRRCs were designed to be a viable alternative to mental health hospitals for patients with chronic mental health problems. They were intended to be institutions where people with neuropsychiatric disabilities live in a family-type environment and where their individual needs are met through activities focused on ensuring their recovery, rehabilitation, and reintegration into society. However, few have been established as yet. According to MLFSPE reports, as of March 31, 2014, only 53 NRRC had been authorized and were functioning in Romania serving 5,310 beneficiaries. The process of restructuring or closing down large residential institutions that do not meet minimum quality standards started in 2002 and was reinforced in 2006 in the National Strategy. The aim was to reduce the size of the institutions caring for people with neuropsychiatric disabilities, with the optimum number of beneficiaries expected to be no more than 60 people. However, 16 of the NRRCs that have been approved so far have over 100 places and an additional 17 are already home to more than 100 beneficiaries each. Thus,

BOX 19

A Comparison between Mental Health Hospitals and the Neuropsychiatric Recovery and Rehabilitation Centers



Opinions of an Administrator of a Mental Health Hospital

"In our hospital, the majority of patients, more than 70 percent, are social cases. Theoretically, the hospitalization period for chronic cases is 44 days. Normally, after 44 days we should discharge them from the hospital, but we cannot do so because we do not have anywhere to send them. We discuss these cases with the municipalities... [but] the municipalities cannot receive them, although every mayoralty should have special or protected homes for people like that. But we know that this involves high costs. [...] Those who have families should be reintegrated with their families. But you know, families also need to be educated. They say "Can you just keep him or her hospitalized a little bit

longer?" And it is normal, because the entire responsibility for treatment falls into their hands once the patient arrives at home. Many do not understand this... so they don't pay attention to the treatment and the patient's condition worsens... Here... everybody is happy, everybody feels well. If you discuss with the patients, you will see, many of them do not want to go home, do not want to return to their families. What would you make of this? What kind of treatment is a mental health patient likely to receive from his family? I tell you, they are at the margins of the society."

Source: World Bank qualitative study carried out in July-August 2014 for preparing this background study.

in 2014, 33 out of the 53 existing NRRCs are significantly overpopulated. With respect to the availability of places in the 53 NRRCs, 13 are at full capacity, 13 have between one and ten available places, 16 have more than 10 available places, eight have exceeded their capacity by between one and ten people, and three have exceeded their capacity by more than 10 people. At the national level, in the 53 NRRCs, there are more than 400 available places yet 97 beneficiaries are living in NRRCs that have exceeded their approved capacity.

NRRC places are reserved for people who have been diagnosed with a mental, psychological, or associated disorder or handicap. In 2014, about 80 percent of the beneficiaries had mental or psychological problems. Among the remaining 20 percent, 9 percent have associated disorders and 11 percent have other types of handicap, and these people could be defined as social cases rather than neuropsychiatric patients.

Although the NRRCs are meant to be a step towards reintegrating patients into the community, most patients consider them to be long-term, even lifelong, institutions. As a result, many chronic patients prefer hospitals because they expect to be released at the end of a finite stay. As a NRRC director in Arad County explained, “[They] probably have in mind that coming here is like forever, a decision for life. And in this context they rather not take a definitive position... at least theoretically, when you take the patients to the hospital, at some point you have to take them back home.”¹⁵⁰

An ANPIS 2013 Evaluation Report¹⁵¹ revealed that many NRRC patients do not benefit from any recovery therapy or social inclusion programs because no such programs are available (because of the lack of personnel, adequate number of places, or materials), because they are inappropriate for the needs of the beneficiaries, or patients are not encouraged to participate. However, compared to psychiatric hospitals, the NRRCs are more connected to the community, in that the beneficiaries can go outside the center, work in the community, and participate in social events (such as community days and church events).

Although the NRRCs were designed to accommodate chronic mental health patients released from hospitals and to reintegrate them into the community, most of their current residents are formerly institutionalized children. The NRRCs are being used to solve the problem of what to do with institutionalized children once they reach the age of 18.

The long-term success of mental health service will depend on coordination between the health services and the services provided by other sectors, in particular the social sector. The challenges faced by the mental health sector are related to the paradigm shift in the treatment of mentally ill people. In the past, the policy was to segregate them from society whereas the aim is now to reintegrate them into society wherever possible.

This has involved the evolution of a hospital-based model of care into a community-based integrated model of care.¹⁵² In order for this approach to succeed, it will be necessary to provide multi-disciplinary support services at the community level to ensure that people with mental health problems are accepted by their communities and to protect their right to live an independent life.

Psycho-social and Psychiatric Habilitation and Rehabilitation Services

The number of psycho-social and psychiatric habilitation and rehabilitation services should also be increased and their geographical distribution should reflect the distribution of need across the country. Currently, this type of (re) habilitation is provided in the following ways: (i) general services are provided for children in a small number of mainstream schools and kindergartens, public and private after-school programs; and public and private (re) habilitation centers and (ii) specific services for people with disabilities are provided in residential settings for children and adults with disabilities, public and private daycare centers for people with disabilities, and public and private rehabilitation centers specifically for people with disabilities or people with mental health conditions. Psycho-social and psychiatric (re)habilitation is governed by quality standards set jointly by the MLFSPE, the Ministry of Health, and the Ministry of Education and is provided by psychologists, special educators, psychiatrists, and occupational therapists. It is very probable that, once occupational therapy becomes sufficiently developed in Romania, psycho-social rehabilitation and occupational therapy will merge. It will be critical to develop system for the constant training of professionals at both the county and national levels since these professionals often work alone with no

¹⁵⁰ World Bank qualitative study carried out for this background study.

¹⁵¹ ANPIS (2013) - National Authority for Payments and Social Inspection.

¹⁵² Caldas de Almeida (2011).

BOX 20

Best Practices - Community Involvement Increases the Chances of Rehabilitating People with Mental Health Problems

The success of interventions to help a person suffering from mental health problems is often due to close collaboration between the community and social workers. This collaboration proved to be very effective in the case of a schizophrenic woman from Arad who received help after the social assistance services (SPAS) had been alerted by the owners' association in the apartment block where she lived. The woman lived alone with limited financial resources (some money that she received after her mother died) with no health insurance or diagnosis. The Owners' Association proactively assumed responsibility for their neighbor's recovery by providing her with the necessary support (especially with regard to the costs of housing and utilities). The challenge for the SPAS was to diagnose her and to give her access to treatment without incurring enormous costs for her. This was possible only due to the

generosity of the medical personnel involved who volunteered their services free of charge. At the same time, the patient was included in a local social assistance program that provided her with meals at a social canteen and that helped her to apply for and receive an invalidity pension and heating benefits. She receives weekly visits from the community medical nurse who checks her status. This is an example of how an integrated intervention provided jointly by the community, social workers, and medical specialists can provide effective, timely support to people with mental health issues in a non-institutionalized setting. The most important conclusion is that the intervention was triggered by the community

Source: Interview with a representative of the Department of Development and Community Assistance Arad, World Bank qualitative study carried out in July-August 2014 for preparing this background study.



professional network or peer support. Additionally, training could be provided for psychiatrists on the different kinds of disability and on the provisions of the UN Convention on the Rights of Disabled Persons.

Occupational Therapy Services

The government needs to develop comprehensive regulations for occupational therapy.¹⁵³ These regulations should cover funding and evaluation methodologies and the inclusion of newly trained professionals in all public and private services that deal with people with disabilities. The development of occupational therapy in Romania is in the very early stages. It represents a new departure for (re)habilitation-related practice. As a first step in the

development of the service, a mobile team of occupational therapists could be developed per county, as was done in the program managed by the MLFSPE in 2011.¹⁵⁴ In the long term, each rehabilitation unit (in the areas of medical, social, or mental health) should employ at least one occupational therapist. Professionals in the field are currently trained in Bacau (a bachelor's degree course at Vasile Alecsandri University), Timisoara (West University), and Oradea,¹⁵⁵ in cooperation with a European professional network of occupational therapists (ENOTHE). The funding for the occupational therapy service could come jointly from the Ministry of Health and the MLFSPE.

¹⁵³ Occupational therapy is the use of treatment to develop, recover, or maintain the daily living and work skills of people with a physical, mental, or developmental condition. Occupational therapy focuses on adapting the environment, modifying the task, teaching the skill, and educating the people with disabilities (and/or their families) in order to increase their participation in and performance of their daily activities, particularly those that are meaningful to the person in question. Occupational therapy often involves physical therapies related to preventing diseases, improving the daily quality of life, and improving physical functionality. However, it also includes: (i) activities aimed at building skills of children and youths to enable them to participate in meaningful occupations and addressing their psychosocial needs to enable them to participate in meaningful life events; (ii) mental health services such as routine building, coping skills, medication management, employment, education, community access and participation, social skills development, leisure pursuits, money management, and childcare; (iii) services for the elderly disabled to help them to maintain their independence and daily routines and to adapt their homes accordingly; and (iv) training in the use of assistive devices.

¹⁵⁴ <http://www.mmuncii.ro/j33/index.php/ro/transparenta/comunicare/comunicate-de-presa/2009-rezultatele-implementarii-proiectului-cresterea-capacitatii-autoritatilor-publice-locale-din-romania-in-vederea-sprrijinirii-copilor-cu-dizabilitati-in-cadrul-proprilor-familii>

¹⁵⁵ These faculties prepare professionals for the following services: (i) health services – general hospitals, rehabilitation centers, spas, plastic surgery, neurology units, pediatric departments, internal medicine, cardiology units, and respiratory units; (ii) Centers for Assistance and Care (CIA) - residential rehabilitation centers for disabled people and centers for occupational therapy (CITO) under the coordination of the DGASPC; (iii) both public and private placement centers for children; (iv) both public and private services for the elderly; and (v) probation services.

Support Services within Communities

Support services for people with disabilities to help them to benefit from independent or supported living are crucial for their full inclusion in society. This is the area in which support services play the most important role (see Annex 5, Section IV). Most people with disabilities in Romania live with their families and are not able to access affordable housing or support services for independent living. Adapting houses to take account of a person's disability is expensive since state subsidies cover only the interest on a bank loan for such purposes. Many families of those with disabilities do not have high enough incomes to qualify for a bank loan, which makes the subsidized interest irrelevant. Furthermore, the qualitative research indicated that local authorities do not always give priority to families of people suffering from disabilities for social housing, as is stipulated in Law 448/2006. Various group homes and supported living arrangements are emerging, mostly for children and adults with intellectual disabilities. In-home support, legal assistance, and accessible leisure, culture, and sports programs are all very limited at the national level but are gradually increasing. To accelerate this process, policymakers could consider:

- Developing a national program of independent and supported living for people with disabilities that covers the total or partial cost of home adaptations
- Revising the regulation system and the cost and quality standards for housing services to take account of the needs of people with disabilities.¹⁵⁶
- Increasing the number of respite centers for children and adults with disabilities. These centers offer a break for families who are providing 24/7 care for people with complex dependency needs and by doing so they make it possible for people with complex dependency needs to remain with their families. Respite centers are not yet fully regulated at the national level, for example, in terms of quality standards and unit costs.
- Testing a personalized budget for independent living, a mechanism that would allow people with disabilities

to afford the basic costs of community living (such as the rent for an apartment and the costs of utilities and transport) after a long period of institutionalization. This should be considered in the context of a reform that increases the efficiency of the entire set of cash benefits for the disabled.

- Strengthening and developing social assistance services at the community level to provide professional and peer support to families and carers of people with disabilities, including counseling, self-support groups, and help with administrative procedures and with applying for relevant benefits or services. Of particular importance is helping carers to obtain a disability certificate for children in need as a first step towards accessing a series of entitlements (cash benefits and services). In practice, families in rural areas or deprived communities are often not keen to require a disability certificate. According to UNICEF and several NGOs,¹⁵⁷ there is a significant number of undeclared disabled children in these areas for three main reasons: (i) a lack of information about the application procedure; (ii) the stigma that is often attached to disability in these communities; and (iii) the costs involved, including the transportation costs from the person's city of residence to the county commission or the DGASPC office.
- Increasing control over the implementation of legislation, mainly because numerous families of people with disabilities have drawn attention to abuse and irregularities. An example is provided in Box 21.

There is a particular need for support services for young adults with disabilities living in their communities. The needs of adults with disabilities have often been treated the same as those of elderly people. However, while some support services might serve both categories (such as in-home support for people with complex dependency needs and help with daily home activities and personal care), there is a wide range of needs specific to younger adults with disabilities that do not usually apply to the elderly. These include: (i) the need to find and keep accessible housing, live independently, and, in some cases, manage financial and personal assets; (ii) the need for habilitation and rehabilitation services adapted to the specific needs of adults with disabilities and provided in the context of

¹⁵⁶ For example, a person who was institutionalized for many years might need stronger support in the first year after deinstitutionalization, but this need for support will progressively decrease over the years.

¹⁵⁷ Salvati Copiii, World Vision, and Alpha Transilvana.

BOX 21**Remuneration of the Personal Assistants of People with Severe Disabilities**

Between 2009 and 2013, people with severe disabilities reported numerous abuses and delays in the remuneration of their personal assistants (usually family members). In some cases, the personal assistant's salary was paid a smaller indemnity for carers. These two different types of benefits works as follows.

Law 448/2006, for the protection and promotion of the rights of people with disabilities, refers to the personal assistant as follows: "Art. 42 para 4: The parents or the legal representatives of children with severe disabilities, or adults with severe disabilities or their legal representatives, excepting the ones with severe visual disability, can choose between a personal assistant and a monthly indemnity." The monthly indemnity is lower than the personal assistant's salary and is equivalent to the net salary of an entry-level social worker with a secondary degree in the public system.

In September 2010, the government issued Ordinance no. 84/2010, which allowed local authorities to ignore the choices of parents or people with disabilities and to automatically swap the salary of the personal assistant for a "carer indemnity" (indemnizatia de insotitor) paid directly to the disabled person. This switch was justified by the inability of local authorities to afford to cover the salaries of personal assistants, as well as by the freezing of public positions in the public system. As a result of this regulation, a large majority of personal assistants did not receive their salaries for more than six months in 2010

and 2011 or were made redundant (collectively) by the local City Halls, with their salaries being replaced automatically by carer indemnities. Personal assistants lost their working contracts and therefore their health and social coverage. The number of court actions initiated by personal assistants against local public authorities increased significantly in 2011 and 2012.

The legislation has been amended to revert to the 2006 situation, but local authorities maintain the practice. Many families currently report strong pressure from town halls, especially in rural areas, to accept an indemnity instead of a personal assistant's salary (and thus a working contract for this assistant).

Many family members in Romania have no choice other than to become personal assistants for their severely disabled children. The lack of support services and the low income of these assistants do not give these families many options. Under these circumstances, removing this option of being a remunerated (and contracted/insured) personal assistant within the family means that many of these families risk becoming impoverished and threatens the wellbeing of this vulnerable group.

Sources: <http://legeaz.net/legea-448-2006/art-42-asistentul-personal-servicii-si-prestatii-sociale>; http://www.dscllex.ro/legislatie/2010/septembrie2010/mo2010_654.htm#oug84; <http://www.mmuncii.ro/pub/imagemanager/images/file/Legislatie/LEGI/L%20136-2012.pdf>



independent living; (iii) the need for vocational preparation, training, job coaching, and employment support (tailored for people at various ages and at various stages of the employment cycle); (iv) the need to access to other community services (such as healthcare, legal services, outdoor activities, cultural activities, and leisure facilities); and (v) the need for a balanced family life (requiring, for example, family counseling and sex education). For these reasons, services for independent living are a very specific and important category that needs to be developed over the coming years.

The continuation of the national plan to make public spaces more accessible should be an important priority for the disability sector. This plan was initiated in 2006 and aimed to make services such as transportation and the built environment more accessible to people with disabilities. The implementation status of this plan needs to be evaluated as do any plans for it to be continued. Renewing and extending this plan is especially relevant to Romania given that compliance with Article 9 of the UN Convention on the Rights of Persons with Disabilities (Accessibility) is a general ex-ante condition for receiving financing from the European Structural and Investment Funds (ESI).¹⁵⁸

Transition from Residential Care to Community-Based Services

The transition from residential care to community-based services for adults with disabilities remains a priority and is included in the National Strategy for Social Inclusion of People with Disabilities (2015-2020). Deinstitutionalizing adults with disabilities has been a very slow process. During the communist regime, (re)habilitation and care services for people with disabilities in Romania were provided in very large residential and segregated institutions. The unacceptable living conditions for disabled people in these institutions have been widely publicized by numerous international organizations, disability activists, and the media. Over the last decade, there has been a growing number of calls for action the government to close these institutions and rapidly develop community-based services instead. Although the old large-scale residential institutions have mostly been transformed into rehabilitation centers¹⁵⁹ and have to some extent modernized, overall

care practices have not improved significantly, and the percentage of real and effective (re)habilitation services has remained very low in these institutions. Recent reports by the Center for Juridical Resources have raised serious concerns about the quality of services in large-scale (re)habilitation centers and in neuropsychiatric units.

The speed and effectiveness of the deinstitutionalization process for adults with disabilities need to be increased. To this end, policymakers should consider the following actions: (i) developing and implementing a national plan for the progressive transfer of adults with disabilities from residential centers to small group homes for up to 50 residents (either houses or apartments that are rented in the community or small-scale residential units for people with high dependency needs or with medical conditions that require permanent medical or rehabilitation care services); (ii) developing a permanent monitoring mechanism for all forms of abuse and neglect of individuals with disabilities in residential services; (iii) ceasing all new investments in the infrastructure of the current residential centers, except where the safety and/or lives of the current beneficiaries are endangered by the lack of such investment; and (iv) strengthening social assistance services at the community level accompanied by investment in community-based services such as daycare and other support services for independent or supported living (such as transportation, personal assistants, assistive devices, and interpreters).

Services for the Elderly

The elderly population as a proportion of the entire population is set to grow considerably and, consequently, the demand for healthcare and long-term care services will constantly increase. According to the 2011 census, 16.1 percent of the population of Romania was then 65 or older (about 3.24 million people). According to the EU, this percentage is projected to grow rapidly in the near future and to reach almost 30 percent by 2050. As of 2011, more than 1.45 million people were aged 75 or over (7.2 percent of the Romanian population). This particular age group requires particular attention from social policymakers because of the higher need for long-term care services among the elderly population. Elderly people with no family support face a higher risk of poverty and social inclusion. As previously shown, elderly people in Romania have a relatively low risk of poverty compared with other age

¹⁵⁸ European Commission (2014a: 349).

¹⁵⁹ Methodological coordination is currently provided by the Department for the Protection of Persons with Disability (in the MLFSPE), while administratively and financially they depend on the DGASPCs.

groups, particularly children and young people, but the risks that they do face relate to the low value of pensions (pensions from agriculture, health-related pensions, or survivor's pensions) and to their higher incidence of health problems.¹⁶⁰ The elderly with no family support face a considerably higher risk of poverty, especially elderly women (see the poverty profiles in the Poor and Vulnerable Groups chapter). The number of elderly with no family support is expected to grow in the future, especially given the mass overseas migration of the working age population.

The government took a first step towards systematically defining the social and healthcare needs of older people in 2000 by introducing the National Grid for Needs Assessment of Older People. This includes all items necessary to assess an older person's social and economic status, his/her health conditions, and related care needs in order to determine three levels of care needs as well as the types of social and healthcare services required. The grid takes into account the preferences of the beneficiary and of his/her informal caregiver and also the availability of local services. Currently, legal reforms are being prepared to unify the assessment procedures used for disabled people and for elderly people.

Regulating, developing, and financing a spectrum of services tailored to meet the specific needs of the elderly is becoming increasingly important. More and better services for the elderly must be made available within rural and urban communities, especially for those without family support and/or with complex dependency needs. At present in Romania, the range of care services (including homecare and long-term care) is insufficient, as is the number of staff for these services. There is a need for more of every kind of care service, including nursing homes, respite centers, daycare centers, and home-based social services for dependent people.

A network of integrated social, medical and homecare services must be developed jointly by the MLFSPE and the Ministry of Health. As 2011 Census data indicate, about 6 to 7 percent of the elderly population in Romania need homecare services, but only 0.23 percent benefit from these services at present. The number of requests for long-term care, either at home or in residential centers, is constantly increasing, and 81 percent of Romanian service providers report a constant increase in requests for services coming from the elderly.¹⁶¹ In many households, older

people find it face difficult to afford the cost of medicines, food, and utilities. For this reason, many elderly people would prefer to receive long-term care in a residential institution. However, the number of these services remains completely inadequate. Only 393 residential centers currently exist in Romania, of which 67 are not accredited, and their overall capacity does not exceed 17,000 places.¹⁶² The priorities of policymakers must be to develop a wide network of affordable and person-centered homecare services in both urban and rural areas, to enhance the ICT infrastructure and new technologies that could support the needs of elderly people at home, and to diversify the provision of care to include nursing care, tele-assistance, day centers, integrated services, and more. In the long term, these actions would significantly reduce the pressure on institutional care.

Services for People in Other Vulnerable Situations

Besides the large vulnerable groups of children, people with disabilities, and the elderly, the government should also aim to regulate, develop, and finance social services tailored to the needs of other vulnerable groups, including adults deprived of liberty or on probation; drug, alcohol, or substance addicts; victims of human trafficking; and victims of violence. These services should be developed jointly by the MLFSPE and the National Administration of Penitentiaries (which is responsible for the National Strategy for the Social Integration of People Deprived of Liberty 2015-2019, GD 389/2015), the National Anti-Drug Agency (which is responsible for the National Anti-Drug Strategy 2013-2020, GD 784/2013), the National Agency against Domestic Violence (which is responsible for the National Strategy for the Prevention of and Fight Against Domestic Violence 2013-2017, GD 1156/2012), and the National Agency against Trafficking in Human Beings (which is responsible for the National Strategy Against Trafficking in Human Beings 2012-2016, GD 1142/2012).

A. Services for Adults Deprived of Liberty and on Probation

There is no effective system for supporting the social inclusion of detainees after their release. Inappropriate reintegration policies can negatively affect the employment prospects of these people as well as their access to housing,

¹⁶⁰ See also CNPV (2013) - National Council of Elderly People.

¹⁶¹ According to the SeniorNet project of the Caritas Confederation - <http://www.seniornet.ro/>

¹⁶² <http://www.seniornet.ro/>

BOX 22



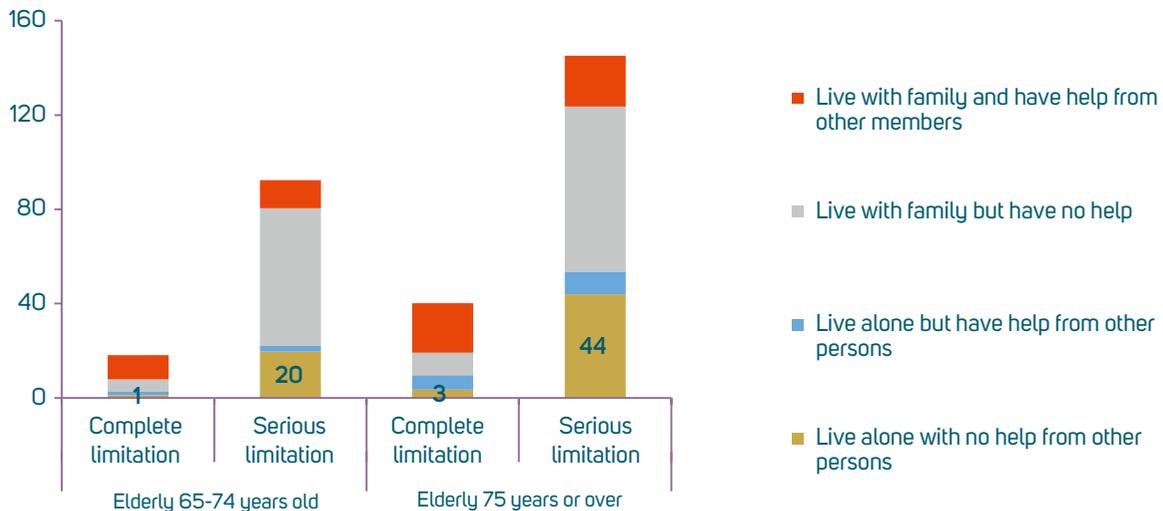
Elderly People in Vulnerable Situations in the 2011 Population and Housing Census Data

Of all Romanians aged 65 years and over, fewer than 1 percent live in institutions while the majority live in households. More than 26 percent live alone, 28 percent live in households with other elderly people (most of these households consist of pensioner couples), and 45 percent live in extended families. People aged 65 to 74 years represent 55 percent of the elderly, and women represent almost 60 percent. Most elderly people are located in rural areas (55 percent).

In the 2011 Census, 14 percent of these elderly people reported being limited in their daily activities due to one or more health problems related to

vision, hearing, walking or stair-climbing, memory or concentration, personal care, or communication. Over 242,000 elderly people reported having serious limitations, of whom about 5,000 lived in residential facilities and 237,000 lived in households. In addition, more than 62,000 elderly people reported having complete limitations due to health problems, of whom about 4,000 live in institutions and 58,000 in households. Nearly 212,000 elderly (or 6.5 percent of all people aged 65 or older) have serious or complete limitations but do not receive any help within the family and so need support for carrying out daily activities. Of these people, 68,200 live alone, 127,000 are aged 75 years or over, and 47,300 are 75 years old or over and living alone.

Family Support for Elderly People with Complete or Serious Limitations due to Health Problems by Age Category



Source: World Bank calculations using 2011 Population and Housing Census data.

Note: Complete or serious limitations in any of the following medical categories: vision, hearing, walking or stair climbing, memory or concentration, personal care, and communication.

identity documents, social benefits, and mental health services. As a result, the risk of social exclusion for former detainees is high, and, as a perceived necessity, many of them revert to criminal activities. The National Administration of Penitentiaries estimates that 60 to 80 percent of all current prisoners in Romania will end up back in prison. The actual level of repeated offences is already high, with 45% of prisoners being repeated offenders, in 2013.

During 2010-2013,¹⁶³ the prison and probation system faced great pressure in the context of an increasing number of prisoners and individuals on probation. The inmate population increased from 28,244 (2010) to 33,434 individuals (2013). Out of them, over 10,000 were released on probation in 2013 (compared to about 8,000 in 2010) and 659 were released on parole. As in most EU-27 states, prisons are overpopulated, exceeding 100 percent occupancy.¹⁶⁴

A series of factors expose the inmate population to a high risk of social exclusion.¹⁶⁵ Most prisoners are male (over 90 percent) with a low level of education. A significant part of them have only primary education, while only about a quarter are graduates of vocational education. Before imprisonment, half of them were unemployed or were working on the black market. Nevertheless, most inmates tend to have a positive attitude toward labor and vocational training. Although efforts were made to increase integration chances on the labor market of prisoners after release, they continue to face a lack of viable job opportunities both during imprisonment and after release, all the more so since the onset of the economic crisis.

A general low level of education and training is one of the main factors for the social exclusion of prisoners. European statistics show that maximum 25 percent of the adult population in prisons in EU Member States (Romania included) accesses any type of education during imprisonment.¹⁶⁶

According to European estimates, 3-5 percent of the inmate population has the required level of education to attend higher education.¹⁶⁷ Furthermore, prisoners have negative perceptions on education as a result of negative school experiences and do not see long-term usefulness of social-educational programmes.¹⁶⁸ For certain subgroups of prisoners, access to education during imprisonment is even more difficult than for the majority. Minors, women and foreign citizens in prisons require special attention.

The prison and the probation system face a lack of social-educational and psychosocial personnel that helps to prepare the social reinsertion of prisoners and reduce the re-offending risk. According to European standards, it is recommended that a psychologist/social worker cover 200 prisoners and an educator about 100 prisoners. However, in 2013, according to ANP data,¹⁶⁹ prisons had 659 social-educational specialists for over 33,000 prisoners. Moreover, social workers - staff that can play an important role in supporting the social rehabilitation of prisoners - are not allowed (as per internal rules) to visit the home of the inmate to see his/her living conditions. In 2013, the probation system had less than 400 positions for approximately 10,000 individuals on probation.¹⁷⁰ In addition, there is no annual continuous specific training provided to each personnel category in the prison or probation system.¹⁷¹ In the same time, there are no adequate spaces and sufficient materials to effectively organize educational and psychosocial activities.

Providing prisoners' access to universal medical services and to specialized services (e.g. methadone substitute treatment programs for drug users, testing for HIV, hepatitis B or hepatitis C) as well as the availability of medical services within the community have not proven sufficient to ensure adequate physical and mental health conditions among prisoners, both during imprisonment and after

¹⁶³ ANP (2013) - National Administration of Penitentiaries.

¹⁶⁴ In Romania, there are 36 prisons (out of which four for minors and young people, one for women and six departments for women in co-ed prisons), six hospital prisons and two correctional centers. Of the prisons, 16 are open and half-open and 17 are closed and with maximum security.

¹⁶⁵ IRECSO (2012). Survey on the inmate population (5,000 respondents), representative at the national level.

¹⁶⁶ GHK Consulting (2013).

¹⁶⁷ According to the Romanian legislation in force, prisoners of all ages have the right to general education during imprisonment, vocational training, as well as non-formal education. Starting with 2011, a credit system was implemented through which inmates attending and completing education programmes or other activities (e.g. labour) receive points. Cumulating these points would bring inmates additional benefits, such as more family visits, parole etc. In certain circumstances, completing general education programmes or qualification programmes could also reduce the sentence by a certain number of days. Inmates attending university education or qualification courses may also receive, during education, a monthly stipend in the amount of the minimum guaranteed income.

¹⁶⁸ Dămboeanu (2011).

¹⁶⁹ ANP (2013) - National Administration of Penitentiaries.

¹⁷⁰ The probation system is coordinated by the National Directorate of Probation, under the Ministry of Justice. There are probation services in each county seat and in Bucharest, as a result of the restructuring of probation services attached to tribunals. The maximum number of positions for territorial offices has been: 370 in 2013, 663 positions in 2014, 945 positions in 2015 and 1,177 positions in 2016. The probation office personnel consists of a head of office and probation officers, people with higher education, licensed in social assistance, psychology, pedagogy, law, and sociology.

¹⁷¹ ANP 2013 data show that over 3,000 ANP employees attended continuous training for acquiring prevention and control measures in prisons, but there was no training for the social-educational personnel.

release.¹⁷² First of all, the imprisonment culture fosters the persistence of conditions and practices that jeopardize the physical and mental health of the prisoners (poor hygiene conditions, overcrowding, tattoos, drug use, mostly injection drugs, alcohol abuse, violence and psychological abuse among prisoners etc.). Secondly, upon returning to the community, prisoners may face situations that limit access to medical and recovery services, especially to major specialized interventions (such as surgery, anti-TB treatment, psychiatric treatment), including: stigmatization, lack of medical insurance, lack of identity documents or of a stable residence, lack of financial resources to purchase medical care.

Regulating, developing, and financing of post-detention support services at the community level are essential to ensuring the effective inclusion of ex-prisoners. Once they leave prison, ex-prisoners tend to become socially marginalized because of the lack of essential post-detention services at a time when they have little social and economic capital and they are often stigmatized by the community.¹⁷³ The National Strategy for the Social Integration of Persons Deprived of Liberty 2015-2019 envisions the reintegration process as a continuum, starting in prison and continuing after release. Existing data suggest that there is a need to target work integration measures to prisoners both while in detention and after their release. Because post-detention services are currently very scarce, many prisoners who received support while in detention are deprived of this support once they are released. There is still no relevant legislation for organizing post-detention support services. Existing services need to be scaled-up and integrated (for example, those aimed at harm reduction and social rehabilitation) on a continuum that links the life of the prisoner in detention with his or her subsequent life in the community. These measures should focus on reducing the risk of re-offending, on increasing the integration of ex-prisoners into the labor market, and reducing the social and institutional stigma associated with the prisoner's status.

The probation system is responsible for managing the social reintegration of convicted people with a non-custodial sentence by serving as a liaison between the judicial system (while the sentence is being served) and the community.¹⁷⁴

Between 2007 and 2011, the number of people serving non-custodial sentences ordered by the court being handled by the probation services gradually increased from 7,673 to 12,857 cases. By the time the new criminal code becomes effective in 2014, it is estimated that the number of cases handled by the probation services will have reached 34,000 and will jump to 48,400 in the following year. As national figures rise and alternatives to detention are being encouraged by the European Union, the efficient management of the probation process for each registered offender is going to require substantial resources.¹⁷⁵ Currently, there is no public sectoral strategy for the probation system.

In this context, partnerships between the probation services, local and/or central governments, and civil society at large can become a part of the solution. In many European countries, EU structural funds are continually used for the social reintegration of offenders. For now, the cooperation between prisons and the probation system, on the one hand, and community institutions, on the other hand, is rather weak. For example, according to the legislation in force (Law 275/2006 on enforcement of sentences), prisoners may attend primary, lower secondary or upper secondary education levels during imprisonment. However, the system most often meets the demand for primary education, but for the lower secondary level, it often stumbles over the refusal of teachers in the community to teach in prisons or over the arguments provided by the school inspectorates in the lack of resources to organize these courses. A study¹⁷⁶ from 2011 shows that there are local cooperation problems between prisons and a series of institutions: probation services (with insufficient human resources to provide individualized assistance for each inmate released on probation), Directorates of Social Assistance and Child Protection (that are often reticent to take children to visit their parents in prisons), Pension Agencies and even with NGOs (whose mission may not overlap with the social insertion needs of the prisoners). Therefore, strengthening the cooperation between prisons, probation offices and local and central institutions which can play a part in the social reintegration of prisoners is critical for achieving the targets on social inclusion in Romania.

¹⁷² ANP (2014b). According to the Social Assistance Law (2011), prisoners could receive, during imprisonment, free educational, social and psychological counseling services and medical care within prisons. These services should be provided in an integrated system with educational, psychological, social assistance, school training and vocational training services, which are delivered the Ministry of Education, the Ministry of Health, the Ministry of Labor, Family and Social Protection or NGOs in partnership with the National Administration of Penitentiaries. During imprisonment, prisoners may also receive counseling on social services available in the community where they will reside after release. The same type of counseling is also available within probation services. In addition, prisons provide harm reduction services (health education sessions, testing for HIV, hepatitis B, hepatitis C, methadone substitute treatment for prisoners with drug addictions), as well as specific measures for social reintegration of prisoners recovering from drug addictions (three therapy communities in Jilava, Rahova and Targor Prisons).

¹⁷³ ANP (2014b) - National Administration of Penitentiaries.

¹⁷⁴ The probation system operates as part of the judicial system, but it is strongly connected with public, private, and non-profit institutions and organizations that provide social services. The probation system is funded by public sources, but its institutional development has been greatly supported by projects funded from external sources.

¹⁷⁵ Probation services provide the following services for individuals on probation: psychological counseling, assistance and mediation employment, further education, access to healthcare and other community support services.

¹⁷⁶ Dămboeanu (2011).

BOX 23**Labor Market Integration Services for Former Detainees in Arad County**

The qualitative research carried out for this background study confirmed the finding of existing reports and documents that few services exist to support former detainees, either in terms of training and labor market integration services or services aimed at promoting their social inclusion. However, local initiatives in Arad County do exist that aim to meet the needs of this vulnerable social category.

Two main public entities are involved in promoting labor market services for former detainees in Arad - the Probation Service (Serviciul de Probațiune), which is primarily responsible for the social inclusion of indicted people who are not currently in custody, and the County Directorate for Social Assistance and Child Protection (DGASPC) through a project financed by the Sectoral Operational Program Human Resources Development 2007-2013 (SOP HRD). In addition, the interviews with the Probation Service representatives carried out as part of this background study qualitative research effort indicated that the Arad penitentiary occasionally provides informal limited education and psychosocial support to some former detainees. The County Employment Agency (AJOFM) does not specifically deal with this group, and its role is confined to providing lists with vacant jobs to the Probation Service or the DGASPC.

The Probation Service in Arad was set up as a pilot project by the central government in 1997. According to the 2014 legislation, the Probation Service deals with several types of adult clients: (i) indicted people for whom the judge has requested an evaluation report; (ii) adults whose sentence was suspended; (iii) adults whose sentence was postponed; (iv) adults who were sentenced to educational measures with no custodial sentence; (v) adults who were released from prison on parole; (vi) detainees or ex-detainees who request support from the Probation Service; and (vii) victims of violent offenses. The type of interventions and the frequency of the service's interaction with the beneficiaries vary according to the category of the sentence and execution regime.

One of the main challenges for probation specialists is the limited time that have available to work directly with each beneficiary, which is considered essential to any

attempt at social reintegration. This is the result of understaffing. Only six probation specialists are available in Arad to work with 500 beneficiaries in various categories, with different ranges of interventions being involved for each client. The number of beneficiaries has increased lately and is expected to get even higher as a result of the wider range of categories that are now subject to probation according with the new Penal Code and the new Penal Procedure code. The concomitant administrative reform (Law 252 /2013) shifted the financing of the system from the local court houses to the National Probation Directorate within the Ministry of Justice, which led to an additional burden being put on existing staff. Now probation staff members are expected to handle procedures like budgetary planning, accounting, or public procurement with no proper training.

Nonetheless, the Probation Service in Arad attempts to use a personalized, case-by-case, approach with former detainees in promoting their employment prospects. The Probation Service has entered into a partnership with the County School Inspectorate whereby beneficiaries with an incomplete education can access to schools that deliver Second Chance education programs. Under this arrangement, the Inspectorate monitors their school attendance and results. Occasional support in the form of clothes, hygiene articles, and subsidies for transportation costs is also awarded as a result of a partnership with a local NGO. A similar relationship with the AJOFM ensures that probationers can access weekly updated job listings. If a probationer is interested in a particular job, his or her probation officer contacts the employer and arranges an interview. The Probation Service also helps beneficiaries to write their CVs and gives them guidance on how to be interviewed for a job.

Ex-prisoners face several substantial obstacles to finding employment. There are not enough adequate training courses for ex-prisoners. This is exacerbated by the overwhelming stigma associated with ex-detainees, which means that few employers are prepared to consider them as potential employees. Several successful cases were mentioned during the qualitative interviews, but these were considered to be exceptions rather than the rule as most beneficiaries do not succeed in finding a job.



BOX 23 (continued)

The DGASPC in Arad has a specialized department for promoting the employment of those from vulnerable groups. This department was set up within the SOP HRD project “Equal Opportunity on the Labor Market” (Șanse egale pe piața muncii), which aims to increase employment opportunities for individuals with disabilities. The financing ended in 2012, but the project has a three-year sustainability period. During this phase, the project has opened up eligibility to all socially vulnerable groups, including ex-detainees. The representatives of the DGASPC reported facing difficulties similar to those encountered by the Probation Service in terms of trying to find real employment opportunities for ex-prisoners.

Source: World Bank qualitative study carried out in July-August 2014 for preparing this background study.

B. Services for People with Alcohol Problems

There is no national system of data collection and analysis that would make it possible to make periodic estimates of the number of individuals who abuse alcohol (including those who are dependent). The only available estimations of alcohol abuse in Romania come from the World Health Organization.¹⁷⁷ According to the most recent available data, 3.8 percent of men aged 15 years and older and 1.1 percent of women in the same age group abuse alcohol,¹⁷⁸ while

alcohol dependence affects 2 percent of the men and 0.6 percent of the women.¹⁷⁹ There are no other recent survey data documenting the needs and profile of groups prone to alcohol abuse. Also, there is no national system of data gathering and analysis that to allow a periodical estimate of the number of individuals that abuse alcohol (including dependence). Therefore, it is crucial to find ways to identify these individuals so that preventive measures can be designed and effectively targeted to those most at risk.

At the community level, the prevention actions that currently exist tend to be passive, while activities among the school population mostly consist of active interventions. The main measures at the community level are: imposing a minimum legal age for alcohol consumption (18 years); zero tolerance of drunk driving; requiring the media to add warnings about the risks associated to excessive alcohol consumption after alcohol advertisements; and banning advertising for alcoholic beverages near schools and in the media between 6am and 10pm.¹⁸⁰ The interventions that are conducted in schools are optional health education courses for those in grades 1 to 12 and the national competition on anti-drug projects “Together” that for more than 10 years has been supporting students in the 9th and 10th grades to implement their own ideas for drug prevention in high schools.¹⁸¹

Besides the insufficient supply of services, access to existing services is hindered by a variety of factors including a lack of specialized human resources, lack of information, and stigma. Over 80 percent of individuals with alcohol problems did not use the services that are currently available because they did not know that they existed. Those who use these services are usually in an advanced state of alcohol abuse, and most of them are dependent.¹⁸²

¹⁷⁷ WHO (2014a).

¹⁷⁸ Alcohol abuse refers to a chronic use that is having medical-psychological-social effects on the individual, as well as to alcohol addiction (WHO, 2014a: 232).

¹⁷⁹ In addition, Romania is one of the European countries with the highest number of deaths caused by liver cirrhosis or cancer caused by alcohol consumption (70 to 102 deaths per 100,000 inhabitants in 2013). In 2012, the total amount of fees reimbursed by the National Health Insurance House for patients hospitalized due to health problems related to the harmful use of alcohol was RON 107,487,375.50 – about €25 million. The same year, 1,396 road traffic accidents were reported in which one of the drivers was under the influence of alcohol (WHO, 2013b).

¹⁸⁰ In addition, information, assessment, and referral services are also provided by: (i) the Drug Prevention, Assessment, and Counseling Centers (CPECA) of the National Anti-Drug Agency in each county; (ii) the four Infocenters opened by ALIAT in Bucharest, Campulung Moldovenesc, Miercurea Ciuc, and Craiova in partnership with local hospitals; and (iii) the only online health platform for preventing and treating alcohol abuse (www.alcohep.ro) also administered by ALIAT. Between 2010 and 2013, ALIAT implemented its only active prevention measure – Alcoohelp Caravan, a mobile campaign that organizes events in urban and rural communities known for their high alcohol consumption levels.

¹⁸¹ Other than the initiatives of the Ministry of Health, several other public institutions (such as the Drug Prevention, Assessment, and Counseling Centers of the National Anti-Drug Agency) and NGOs implement annual prevention actions aimed at students (such as information sessions in school, competitions, camps, sport events, and cultural events).

¹⁸² General physicians usually are not able to make early diagnoses of disorders related to alcohol consumption but only when the disease is quite advanced. Thus, 55 percent of the patients with alcohol-related problems received information on alcohol abuse from their general physician and 44 percent were referred to a specialized service compared with only 2 percent and 3 percent of non-patients (ALIAT, 2011).

However, the main barrier to accessing these services is the stigma associated with being identified as having an alcohol problem. 70 percent of specialist doctors, over 50 percent of the beneficiaries of treatment, and 80 percent of the individuals with alcohol consumption problems who did not use specialized services identified stigma as the main barrier to accessing the services.¹⁸³

No assessment has been conducted of the efficiency and impact of Romania's prevention, recovery, and social reintegration measures related to alcohol consumption and abuse. For the school population, the only tool that is gathering data on the impact of prevention measures is the European School Survey Project on Alcohol and other Drugs (ESPAD), to which Romania has contributed since 2004.¹⁸⁴ However, there are no studies that have measured the impact of passive or active measures to prevent alcohol consumption and abuse among adults.¹⁸⁵

Currently there is no national strategic document for the prevention, recovery, and social reintegration of individuals with alcohol abuse problems. In principle, reducing demand for alcohol is one of the goals of the National Anti-Drug Strategy, and it has also been, over time, a component of various national programs implemented by the Ministry of Health (including a health promotion program and a mental health program). Nevertheless, there is no institution that effectively coordinates all actions related to prevention, treatment, and care in this sector. Furthermore, except for the documents developed by the National Anti-Drug Agency (the National Anti-Drug Strategy 2013-2020 and the National Standards for the Medical, Psychological, and Social Assistance of Drug Users), there are no guidelines or protocols governing the integrated treatment of alcohol abuse. The survey performed by the Alliance to Fight Against Alcoholism and Drug Addiction (ALIAT), in 2011 indicated that, of all psychiatrists in dependence treatment units, only half had attended training on alcohol dependence in the previous three years, and about one-third had never attended any such training. The percentage is even higher among general practitioners and those with other medical specialties who can play an important role in referring individuals with alcohol abuse problems to the specialized services, with 65 percent never having had any training on this topic. Up until now, training for specialists

in the early identification of alcohol abuse and behavioral change therapies has been provided mainly by NGOs.¹⁸⁶

Intervention is very necessary since, according to the WHO, for every person who has problems with alcohol, seven other people are affected (family, relatives, and friends)

BOX 24

Best Practice - Treatment and Social Reintegration Centers for Alcohol



Two treatment and social reintegration centers were established in 2011 in Bucharest and Targoviste under the coordination of ALIAT, an NGO, with co-financing from the European Social Fund. These centers provide case selection and assessment services (psychiatric evaluations, assessments of the patients' level of consumption, and personalized intervention plans), personalized treatment (psychological counseling for patients to increase motivation and to prevent relapses and for families and children affected by alcohol abuse), and social assistance (legal counseling, vocational counseling, assessment of professional competences, access to vocational training, and mediation for employment). The centers are included in a cross-cutting service provision mechanism that involves psychiatrists, psychologists, psychotherapists, social workers, educational psychologists, legal advisers, vocational counselors, and professional training providers. During 2011 to 2014, the two centers helped 1,220 alcohol dependents (of whom 400 also received professional training) and 440 family members, including children. ALIAT also wants to train 750 general physicians in Bucharest-Ilfov and South-Muntenia to recognize the early signs of alcohol dependence and to apply short-term interventions that could reduce the patient's level of dependence.

¹⁸³ ALIAT (2011).

¹⁸⁴ Hibell et al (2012).

¹⁸⁵ Although the implementation of the National Anti-Drug Strategy 2005-2012 (ANA, 2005a) had a final assessment in 2012, it focused on assessing measures to reduce demand for and supply of illegal drugs and did not include alcohol.

¹⁸⁶ For example, in 2013, ALIAT implemented two training programs for specialists in the medical and psychosocial areas working with individuals with alcohol abuse. Over 130 general practitioners participated in a residential training session on the early identification of and short interventions in disorders related to excessive alcohol consumption, and 24 specialists were trained in the use of art therapy and cognitive-behavioral therapy techniques (ALIAT, 2013).

on average. Furthermore, recent UNICEF studies¹⁸⁷ have shown that child nutrition, child neglect and/or abuse, and child separation from the family are strongly associated with parents' alcohol abuse.

This background study recommends that the government draft a multi-sectoral integrated strategy for the prevention and counteraction of alcohol abuse both among adults and minors. This national plan should be accompanied by a clear methodology for monitoring and assessing the outputs and outcomes of prevention, assistance and recovery measures for people with alcohol abuse issues.

C. Services for Drug Users

While there are data on the prevalence of lifetime illegal drug use in the general population, there is no clear evidence to indicate how many high-risk drug users (or problem users) there are at the national level. According to the latest available data for 2010 provided by the National Anti-Drug Agency,¹⁸⁸ show that 4.3 percent of the Romanian population aged 15 to 64 years report having used illegal drugs at least once (including psychoactive substances sold under the label of "ethnobotanical plants," which were legal at the time of the survey) and about another 4 percent reported having used medication without a doctor's recommendation (tranquilizers, sedatives, and antidepressants). The most commonly used drugs were "ethnobotanicals" and cannabis, followed by ecstasy, heroin, and cocaine - in decreasing order of frequency.¹⁸⁹

Problem drug users or high-risk drug users are the main targets of government policies designed to reduce drug-related vulnerabilities. High-risk drug use was defined by the European Monitoring Center for Drugs and Drug Abuse in 2012 as "recurrent drug use that is causing actual harms (negative consequences) to the person (including addiction, but also other psychological or health problems) or is placing the person at a high probability/risk of suffering such harms."¹⁹⁰ According to the Romanian legislation (Law 143/2000 as revised), high-risk controlled substances include opiates, cocaine, fentanyl, derivatives, and "ethnobotanicals." Substances such as cannabis and barbiturates are in a different category - "risk substances."

Among high-risk drug users, injection drug users (IDU) are highly vulnerable from a social point of view.¹⁹¹ Injection drug use makes individuals prone to blood-borne infections (such as HIV, hepatitis B, and hepatitis C), to tuberculosis, to living in poor conditions, and to unemployment. The available data indicate that there was an increase in 2012 of the prevalence of hepatitis B, hepatitis C, and HIV among IDUs, with the last two exceeding the European averages.¹⁹²

BOX 25

Profile of Injection Drug Users



In 2012, the average heroin user had the following characteristics: male, aged between 30 and 39 years old, with a low level of education. Most had asked for help on their own initiative. Most had a stable home, living with their parents or family and, in general, had no income as they were unemployed. Most started using drugs between 15 and 19 years of age and had been using for a long time (at least six years) and had previously requested treatment for psychoactive substance use. They tended to inject heroin daily (with most having injected in the 30 days prior to their admission to treatment), and most only used heroin (in other words, there was no polydrug or secondary drug use).

The average new psychoactive substances (NPS) user has the following characteristics: male, aged under 40 years old, with a low level of education, user of emergency medical care, lives with the parents/ family in stable homes, most probably without an income or a pupil/student. About one out of every three NPS users started using before reaching the age of 19. Most of them have been using NPS for a maximum of two years, most often by injection, and have experimented with polydrug use (also using alcohol, opiates, or cannabis).

Source: ANA and EMCDDA (2013).

¹⁸⁷ Such as Klingemann (2001), Stănculescu et al (2012).

¹⁸⁸ ANA and EMCDDA (2013). The latest survey to gather data on prevalence was carried out by the National Anti-Drug Agency in 2014, but these data are not yet available.

¹⁸⁹ Drugs are associated with different social-demographic profiles. For example, medication without a prescription and solvents are most often used by adult women between 45 and 64 years old. Heroin and cocaine are most common in the Bucharest-Ifov, West, and Center regions, while solvents/inhalants are mostly used in the West, South-West, Bucharest, North-East, and North-West. There are also drugs that are used in almost all regions – ethnobotanicals, cannabis, and ecstasy.

¹⁹⁰ EMCDDA (2012).

¹⁹¹ Iliescu and Georgescu (2013).

¹⁹² Abel-Ollo et al (2014).

Measures for the social reintegration of high-risk drug users have a two-fold aim: (i) to reduce the physical and mental health harm associated with injection drug use (including HIV, hepatitis B or hepatitis C infections, overdoses, abscesses on injection sites, and neuro-cognitive harm) and (ii) to support and encourage users to give up drugs and recover their lives. Most of these initiatives in Romania have been projects implemented by NGOs and/or state organizations.¹⁹³ The number of these services decreased significantly in 2010 when the programs financed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria and by the United Nations Office on Drugs and Crime (UNODC) ended. Specialists estimate that this reduction in services is among the main factors leading to the HIV outbreak among users during 2010 to 2013.¹⁹⁴

In order to provide a coherent policy response, there is a need to further develop integrated addiction care services (medical, psychological, and social assistance) at the national level.¹⁹⁵ At present, only Bucharest and Ilfov have a wide range of services, including harm reduction measures available both within the community and during imprisonment.¹⁹⁶ Although service providers and academics active in the field have drawn the government's attention to the need for specialized harm reduction and social reintegration services for minors with drug use problems, no measures have been taken so far in this regard.

To ensure the social integration of problem drug users (PDUs), the health services should be integrated with or strongly linked to social rehabilitation services.¹⁹⁷ Psychological counseling/ psychotherapy and social support should be provided to PDUs before and after they undergo specific drug treatments, especially to those PDUs with neuro-cognitive impairment caused by chronic drug use. Currently, there are not enough services available to PDUs living in the community or for those in prison.

Preventive services, mainly in the education and health sectors, are vital for reducing the use of drugs as well as the harmful consumption of tobacco and alcohol among teenagers. Policymakers should consider: (i) introducing adequate educational policies aimed at preventing risky behavior among teenagers and (ii) increasing the provision of health counseling and family planning services to teenagers.

BOX 26



Integrated Care for Addiction

As of 2013, the following addiction care services were available in Bucharest and Ilfov:

- Five medical units of the Ministry of Health, of which three provide rehab services and medical and psychological care and two provide outpatient care including medical, psychological, and social assistance and substitute treatment with methadone, suboxone, or naltrexone for opiate addiction
- Three centers of the National Anti-Drug Agency providing medical, psychological, and social care for outpatients and integrated care for addictions, including substitute treatment with methadone, suboxone, and naltrexone for opiate addiction
- Three centers/private practices in Bucharest (run by the National Association for Drug Addiction Intervention, PSYMOTION, and D&C Medical) providing integrated care for addictions including substitute treatment for opiate addiction for outpatients
- Two centers in Bucharest called Arena and Titan managed by ARAS, an NGO, and providing integrated care for addictions (including substitute treatment for opiate addiction) for outpatients
- Two centers of the National Administration of Penitentiaries located in Jilava and Rahova prisons providing integrated care for addicted prisoners (including substitute treatment for opiate addiction).

¹⁹³ For example, during 2010–2013, ARAS (Romanian Association against Aids), an NGO, implemented a project that helped ex-injection drug users to be reintegrated into the labor market by means of qualification training, professional counseling and guidance, and mediation for employment. However, these activities came to an end once the project closed.

¹⁹⁴ Institutul Național de Boli Infecțioase “Prof. dr. Matei Balș” (2013), ANA and EMCDDA (2014), and Andrus et al (2014).

¹⁹⁵ The principles underlying the organization and provision of services for drug users in Romania are presented in Annex 5, Section V.

¹⁹⁶ ANA and EMCDDA (2014) and Andrus et al (2014).

¹⁹⁷ EMCDDA (2003), ECDC and EMCDDA (2011), EMCDDA (2012).

D. Services to Reduce the Risk of Becoming a Victim of Human Trafficking

Available evidence suggests that women and individuals with a low social and economic status are highly vulnerable to the phenomenon of human trafficking in Romania.¹⁹⁸ The highest numbers of cases are registered in counties in the North-West, South-West, West, and Center regions.

The 2014 report¹⁹⁹ of the National Agency against Trafficking in Human Beings (ANITP) showed that there was a general decrease in the number of victims of trafficking in human beings in 2013 compared to previous years, as well as a decrease in the ratio of victims from rural areas. As in previous years, in 2013 women were more likely to be

trafficked (77 percent), as were individuals with low levels of education (47 percent with a lower secondary education at most), and minors (48 percent).²⁰⁰ However, there is insufficient systematic information on the characteristics of trafficking in human beings. Except for statistics gathered and provided by the public authorities, there have been few recent studies (in the past five years) that describe the profile and needs of the groups most vulnerable to trafficking or of the individuals who become victims. The recent statistical analysis of the identified victims of human trafficking during the period January 1 to June 30, 2014 issued by ANITP²⁰¹ confirms that the social and demographic trends presented above were continuing in 2014.

TABLE 30: Number of the Identified Victims of Human Trafficking

	Identified victims* (number)	Trend (previous year)	Traffic victims (number)	Trend (previous year)
2013	896	-14%	419	-24%
2012	1,041	-1%	554	-9%
2011	1,048	-9%	606	-3%
2010	1,154	+32.5%	626	+94.5%
2009	780	-37%	322	+0.4%
2008	1,240	-30%	321	

Source: ANITP (2014a).

Note: *Victims identified in 2013 = victims of traffic and identified in 2013 + victims of traffic of previous years, but identified in 2013.

Romania's system for dealing with victims of human trafficking should be built around the inter-institutional National Identification and Referral Mechanism, which is a cross-cutting and inter-institutional tool for keeping track of

exploited children, those facing labor exploitation risks, child victims of human trafficking, migrant Romanian children, and victims of other types of violence in the territory of other states.²⁰² The National Agency against Trafficking in Human

¹⁹⁸ Trafficking in human beings (Article 165 in the Romanian Criminal Code) refers to recruiting, transporting, transferring, sheltering, or receiving an individual for commercial or non-commercial sexual exploitation, through forced labor or services, in slavery or slavery-related circumstances, for using them in armed conflicts or in criminal activities, for using organs or tissue for transplants, perpetrated by means of: threats of using physical or psychological violence not dangerous for the life or health of the individual, including kidnapping, confiscation of documents or servitude, with the purpose of paying a debt of an unreasonable amount; deceit; abuse of vulnerability or abuse of power, giving or receiving payments or benefits to obtain the consent of an individual holding control over another individual, using dangerous violence for the life, physical or mental health of the individual; by using torture, inhuman or degrading treatment in order to subdue the individual or by rape, physical dependence, weapons, threats of disclosing confidential information to the victim's family or to other individuals, as well as by other means.

¹⁹⁹ ANITP (2014a).

²⁰⁰ The highest number of victims of human trafficking was found in Mures county (with over 40 victims) and in Iasi, Dolj, Olt, Brasov, Bihor, and Timiș counties (with between 21 and 40 victims). At the other extreme, no cases were reported in 2013 in Maramures, Harghita, and Vrancea counties. For more details, see Map3. In general, women victims of trafficking in human beings are subject to sexual exploitation and men become victims of forced labor in agriculture and construction. The available data do not include the number of foreign citizens identified as victims of human trafficking in the Romanian territory.

²⁰¹ ANITP (2014b).

²⁰² Described in GD 49/2011.

Beings (ANITP) within the Ministry of Internal Affairs²⁰³ is the central institution that coordinates, monitors, and assesses policies on human trafficking.²⁰⁴ Currently this system functions poorly in terms both of identifying victims and of referring them to protection and assistance services. Therefore, a review is necessary to determine to what extent the decrease in the number of identified victims is due to an actual decline of the phenomenon or to shortcomings in the functioning of the National Identification and Referral Mechanism.

The available services designed to prevent and counteract human trafficking and to protect and socially reintegrate victims have very little capacity to carry out their mandates.²⁰⁵ The various prevention efforts developed by the public authorities and NGOs are not coordinated or long-term and do not have national coverage. The only permanent intervention is the Helpline set up by ANITP, a free number where anyone can call to ask for information about the rights of victims of human trafficking and about what services are available in the country. A 2012 report by the Ministry of Internal Affairs²⁰⁶ showed that the capacity to monitor and evaluate prevention measures in human trafficking and the support given to victims is quite low. This finding points up the lack of up-to-date and complete data to enable analysts to come to an accurate estimate of the phenomenon and of the need for services for victims as well as the lack of any impartial assessments of the impact of national policies in this field. Currently, the main report assessing the results of national policies in this field is the one drafted annually by the US Embassy in Romania.

The US Embassy's latest report for 2014 shows that the number of psychologists working in existing services is low compared to the need, even though psychological assistance is one of the main ways of supporting victims of human trafficking. There are only six transit centers for unaccompanied minors or victims of human trafficking in the country, although children account for almost a half (48 percent) of the victims. None of these transit centers for minors are in Bucharest, even though a large share of the victims are repatriated by plane and arrive at Bucharest international airport. When not referred to one of the six transit

centers, minor victims are sent to general child care services (within the DGASPC), which are not qualified to provide specialized assistance to victims of human trafficking.²⁰⁷

On the demand side, the existing services are accessed by a very low number of victims, partly also because some services for victims limit their rights. The US Embassy's 2014 report pointed out that, although there are assistance centers and protection services in each county, only one in every three registered victims in 2013 (291 people) benefitted from specialized protection, assistance, and reintegration services. According to the legislation, victims are accepted in residential reception centers at their own request. Nevertheless, victims complain that their freedom of movement is restricted while they are being accommodated in these centers. In addition, there are cases when, although beneficiaries are entitled to free medical care, their access to specialized medical care is restricted if they do not have any insurance or identity documents.

To sum up, reducing the risk of becoming a victim of human trafficking requires integrated and multi-sector initiatives since the risk is dependent on a variety of factors – gender, age, the family environment, living conditions, personal values, and the level of economic development in the area where the victim lives.²⁰⁸ Because of limited available resources and institutional capacity, the initiatives that are currently being implemented in the country are not sufficiently integrated, lack continuity, and have only limited coverage. Efforts to increase public awareness of the risks and forms of human trafficking need to be continued. Human trafficking prevention initiatives must be scaled up and further developed at both the national and local levels through awareness campaigns, hotlines, school programs, and the distribution of modern and interactive information materials.

E. Services for Reducing the Risk of Becoming a Victim of Violence

There is a strong need to gather more evidence on the size and characteristics of domestic violence²⁰⁹ in Romania. As is the case in other countries, the official statistics on this phenomenon are contradictory between institutions with

²⁰³ In 2012, this ministry was the Ministry of Administration and Interior.

²⁰⁴ ANITP has 15 regional centers in counties with Courts of Appeal: Oradea, Cluj, Suceava, Iasi, Bacau, Mures, Alba, Timiș, Craiova, Arges, Brasov, Galati, Prahova (Ploiesti), Constanta, and Bucharest. The main responsibilities of the regional centers are to diagnose and monitor the phenomenon (including gathering data on each identified victim), to refer the victims to protection, assistance, and social reintegration services, and to coordinate the activities of public and non-governmental actors active in this field in the region. Victims who ask that their identity be protected or who refuse support are registered as anonymous cases for statistical purposes.

²⁰⁵ The organization and types of services for victims of human trafficking in Romania are presented in Annex 5 Section VI.

²⁰⁶ Ministry of Internal Affairs (2012).

²⁰⁷ United States Embassy in Romania (2014).

²⁰⁸ Preda (coord., 2009).

²⁰⁹ According to the Romanian legislation (Law No. 271/2003), domestic violence offences cover a broad spectrum from family abandonment, deprivation of freedom, threat to commit serious injuries, murder, and attempted murder.

different roles (prevention, assistance, and regulatory).²¹⁰ A comprehensive methodology for registering the number of individuals (victims and attackers) to compare with the number of offences or number of cases brought to court by victims still needs to be developed. Currently, the main available statistics are those on the number of victims of domestic violence who access social services (managed by the MLFSPE)²¹¹ and those on the number of offences involving domestic violence (under the responsibility of the General Inspectorate of the Romanian Police). Moreover, there are also data belonging to the Ministry of Justice on the number of files related to incidents of domestic violence, including files in which victims filed for a restraining order against the attacker. Nevertheless, due to the high tolerance toward domestic violence among both the general population and the authorities, there are also numerous “invisible” cases that are not reported or included in statistics.²¹²

There are no national continuous measures to prevent²¹³ domestic violence (including emotional abuse and child abandonment) and to reduce risk factors, such as addiction, disability, mental health problems, and economic dependence. According to the European network Women Against Violence (WAVE),²¹⁴ Romania is one of the nine member states within the EU-28 that do not have a national Helpline for identifying cases of domestic violence against women and referring the victims to specialized services. International experience has shown the efficiency of enacting integrated initiatives combining the prevention of domestic violence with measures to reduce it. Thus, this document recommends that the government consider implementing the following measures between 2014 and 2020: (i) developing psychotherapeutic and behavioral change interventions for families affected by alcohol or substance abuse; (ii) creating more initiatives like “School for the Parents” (which informs and trains parents on topics regarding raising, caring for, and educating children focusing on adopting positive practices); (iii) developing psychotherapeutic and behavioral change measures for

victims of domestic violence and attackers; (iv) developing psychotherapeutic and behavioral change measures for children with behavioral disorders (involving violence, school dropout, and delinquency); (v) training teachers, medical personnel, and social staff on the procedures for identifying and referring cases of domestic violence to specialized services; and (vi) carrying out public awareness campaigns to publicize the prevalence and effects of domestic violence along with campaigns to change attitudes and behavior based on the changing social norms in Romania with respect to domestic violence.

Few NGOs and public-private partnerships are providing services aimed at preventing and counteracting domestic violence. Of all available social services²¹⁵ for victims of domestic violence and attackers most are organized by public institutions (65 percent), about one-third by private actors (such as NGOs or for-profit organizations), and only 3 percent are public-private partnerships according to MLFSPE data for 2012.

The capacity of social services for victims of domestic violence is low compared to the EU standards, both in terms of service availability and specialized personnel. EU standards recommend that there should be one place in a specialized shelter per every 10,000 inhabitants. Given the current size of the population of Romania, this would mean there is a need for 2,000 shelter places. However, the total number of available shelter places is much lower, with 14 out of the 41 counties of the country having no residential services specialized in victim protection. In 2012, only 689 women and 1,136 children were offered a place in a shelter, which amounted to only about one-quarter of the potential demand (the 7,530 women, children, and men who are on the records of specialized services).²¹⁶ Furthermore, only some of the victims who were placed in residential units in 2012 were offered any services such as: psychological and legal counseling (595 people), assistance in and counseling for finding a job (478 people), counseling and assistance for increasing their personal safety after leaving the center (445 people), or support at court hearings (82 people).

²¹⁰ In 2013, 4,619 domestic offences were registered in the criminal files. Most offences (2,900 cases) consisted of family abandonment, but it is just as worrisome that almost one in every five offences fell under “beating or other types of violence” (864 cases) and injuries (57 cases), while 4.7 percent of total offences consisted of murder (115 cases), death inflicted by beating or injuries (20 cases), and attempted murder (73 cases). These statistics do not show, however, the number of individuals involved (victims and attackers) as the same file may involve one victim and several attackers, several victims and one attacker, one victim, or one attacker and several offences (General Inspectorate of the Romanian Police, 2014). The number and profile of victims and attackers also are not recorded in the data on the number of cases brought to court by victims in order to receive a restraining order (2,453 files in approximately 14 months during 2012 and 2013). MLFSPE (2012) and Transcena (2013b).

²¹¹ According to MLFSPE data, in 2012, the number of victims of domestic violence registered with social services was 7,000 individuals, of whom 2,575 were women, 4,955 were children, and 898 were men.

²¹² For example, Stănculescu and Marin (2012).

²¹³ We define this as measures that prevent violence or generate circumstances that reduce the possibility that an individual will become a victim or an attacker.

²¹⁴ Lesur et al. (2014).

²¹⁵ The organization and types of services for victims of domestic violence in Romania are presented in Annex 5, Section VII.

²¹⁶ The shelter deficit is also mentioned in the WAVE 2013 report (Lesur et al, 2014), which estimates that 2,012 shelter places were needed for women victims in Romania in 2013 but only 590 were available.

Not only are there few services available, but victims of domestic violence face an additional hurdle in trying to access them. Romanian law requires that victims need to have a forensic medical certificate both to obtain a restraining order against their attackers and to qualify for a place in a residential shelter.²¹⁷ This certificate costs around 40 lei and thus is unaffordable for many victims. There have been a few initiatives aimed at making it easier for victims to obtain a forensic medical certificate, but these initiatives have been local and short-term and have covered only a limited number of cases.²¹⁸ Thus, the measures recommended by this book for 2014 to 2020 include: (i) ensuring that all victims of domestic violence can access specific services, including those designed to support addicts, people with disabilities, and people with contagious illnesses or behavioral disorders, either by adapting existing services to meet the needs of these groups or by developing new services; (ii) ensuring that all victims of domestic violence have access to a forensic medical examination by providing them with information on and covering the costs of the examination; and (iii) conducting studies of the factors that influence victims' access to specialized services.

In terms of specialized personnel, services provided to victims of violence rely heavily on volunteers. A recent study²¹⁹ by an NGO showed that about a quarter of individuals working in services for victims of violence are volunteers, most of whom are working as administrative staff, social workers, and psychologists.²²⁰ As a result, there are significant differences between similar services in terms of the number and qualifications of their available staff. There are residential centers that have only two employees (a psychologist and a social worker), while others have 11 employees.²²¹ Participation of staff in continuous training is also low.²²² In addition, there is no professional supervision system for staff working with victims of domestic violence. Staff members need feedback on the quality of their interventions as well as support to help them overcome the

psychological fatigue that is naturally involved with working with victims of violence.

On the policy side, there is much room for improvement in terms of turning the restraining order into an efficient and effective tool for protecting victims of domestic violence. The key problems relate to: (i) access to information; (ii) the timeframe for issuing a restraining order; and (iii) the type of restrictions included in the restraining order. Victims often do not have sufficient information on how to obtain a restraining order or its consequences.²²³ Moreover, the restraining orders take too long to be issued (on average between 20 and 60 days).²²⁴ Furthermore, even if a restraining order is issued, it may be insufficient (for example, requiring the attacker to stay only 1.5 meters – or about 5 feet – away from the victim) or may include contradictory restrictions (for example, requiring the attacker to stay 50 meters or 160 feet away from the victim but not requiring either the attacker or the victim to move out of their joint home). This suggests a lack of a coherent understanding by the courts of the role that should be played by this tool in preventing and counteracting domestic violence. The current way in which courts are applying the legislation regarding the issuing restraining orders is having a negative impact on the efforts to prevent and counteract domestic violence.²²⁵ Making the restraining order a more effective tool for protecting victims of domestic violence, our background study recommends the following priority actions: (i) developing nationwide interventions (such as awareness campaigns and information services) aimed at providing victims of domestic violence with information on their rights and way of using and applying restraining orders; (ii) increasing the competences of using it of the staff members who have a role in issuing it, by training, by amending/improving methodological guidelines for implementing Law 25/2012 on amending and by completing Law no. 217/2003 on preventing and counteracting domestic violence; and (iii)

²¹⁷ Law 25/2012 requires a forensic medical certificate to be issued before a victim of domestic abuse can file for a restraining order against her or his attacker.

²¹⁸ For example, based on a cooperation protocol between an NGO and the Institute for Forensic Medicine in Bucharest, about 100 women victims received free forensic medical examinations during 2012 and 2013. Also, certain public services cover the costs incurred by victims of obtaining these certificates from their own budgets.

²¹⁹ Transcena (2013a).

²²⁰ The fewest numbers of volunteers are social workers, counselors, and doctors. These services are also staffed by nurses, teachers, and legal advisors (Transcena, 2013a).

²²¹ Most residential centers have between four and eight employees (Transcena, 2013a).

²²² Participation in continuous training is most frequent among counselors (64 percent of them attended training in 2011 to 2013) and psychologists (about a half of them attended training in 2012) both in residential and non-residential services. Furthermore, only 11 percent of the employees of residential centers attended training between 2011 and 2013 (Transcena, 2013a).

²²³ A recent study shows that about a half of the requests submitted by victims are accepted by judges, the rest being either rejected (predominantly) or withdrawn. The main reason that judges give for rejecting a restraining order is that the request has been inaccurately or only partially filled in (Transcena, 2013b).

²²⁴ The victim must first be medically examined by an emergency unit, then she must get a forensic medical certificate attesting that the physical aggression occurred, and then she must file the request in court. Apart from the forensic medical certificate, the victim must also gather other types of evidence, such as evidence of a complaint filed previously. For non-urgent cases, restraining orders can even take more than 60 days to be issued (Transcena, 2013b).

²²⁵ For example, the same Transcena studies (2013a and 2013b) showed that victims may withdraw their request for protection or may refuse to access specialized services because they fear their attacker or do not want to be stigmatized as a victim. The staff in services that assist victims of domestic violence feel at risk of being themselves subject to the violence of the attackers against whom they have no protection. In addition, the police often find it difficult and sometimes impossible to enforce a restraining order with contradictory provisions.

reducing the social stigma that often becomes attached to victims of domestic violence by introducing information and awareness campaigns and education programs in schools.

The government's monitoring and evaluation capacity at the central level needs to be enhanced. The key policy measures aimed at preventing and counteracting domestic violence in Romania are included in the National Strategy for the Prevention of and Fight Against Domestic Violence 2013-2017, GD 1156/2012.²²⁶ This strategy is designed as a cross-cutting effort under the coordination of the MLFSPE in partnership with the Ministry of the Internal Affairs, the Ministry of Health, and the Ministry of Justice. However, there are no studies that assess the results and impact of the measures that are being implemented as part of the strategy. There is no mechanism for assessing the impact and outcomes of services and campaigns aimed at preventing and counteracting domestic violence. Specifically, the government has no feedback to inform its future programming on such important topics as the impact of prevention campaigns on target groups, whether and

how services in shelters or in recovery centers contribute to improving the quality of life of the beneficiaries, or the cost-effectiveness of services for women, children, and attackers.

Law 292/2011 requires that social services for victims of domestic violence should be delivered in an integrated system that takes into account all aspects of the issue: medical, psychological, social, and legal. An integrated approach should also be taken in developing cost standards for these services, but this is not currently the case. For example, the costing for residential centers does not include the costs of acquiring forensic medical certificates or of providing hygiene and health products for beneficiaries.²²⁷ Also, similar services can have different standard costs. For example, recovery centers have higher costs per beneficiary than emergency reception centers, although both types of units provide similar services.²²⁸ Thus, the standard costing of services for victims of domestic violence needs to be revised in order to improve the quality and increase the affordability of services as well as their efficiency.

²²⁶ MLFSPE (2012). This Strategy has the following priorities: (i) providing a coherent and functional legal framework; (ii) promoting harmonized work practices among social services provided to victims of violence; (iii) developing services by increasing their coverage and the number and qualification of their specialists; and (iv) promoting a non-violent culture.

²²⁷ Transcena (2013a).

²²⁸ MLFSPE and SERA Romania (2012).



2.4. Education

The government should focus on ensuring equality of opportunity to quality education for all children. Special attention should be paid to the quality of education and training and to their relevance to the needs of both the labor market and of individuals.



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2.4. Education

The discussion in this chapter is organized by education level with a special focus on increasing the access of children in vulnerable situations to high quality education. The contents of this chapter are in line with a 2012 OECD report²²⁹ on Equity and Quality in Education and with the World Bank's Draft Strategic Framework to Reduce Early School Leaving (ESL) in Romania.²³⁰ (The Draft Strategic Framework to Reduce Early School Leaving (ESL) in Romania will be referred to hereafter in this chapter as the

ESL Strategic Framework.) The OECD report presented worldwide evidence that supporting disadvantaged students and schools strengthens the capacity of both individuals and society to respond to recession and contributes to economic growth and social wellbeing. The World Bank's ESL Strategic Framework set out the main strategic directions for achieving the European Union's Europe 2020 target of reducing the rate of early school leaving²³¹ from 17.3 percent in 2013 to 11.3 percent by 2020.

BOX 27

Improving Equity and Quality in Education

In 2012, the OECD produced a report titled *Equity and Quality in Education*, which demonstrated that improving equity and reducing school failure rates can pay dividends because education is an engine of economic growth. One of the most efficient educational strategies available to governments is to invest in all levels of education from pre-school to upper secondary to ensure that all students have access to quality education throughout the cycle, that they stay in the system until at least the end of upper secondary education, and that they acquire the skills and knowledge needed to participate in society and in the labor market. Governments can prevent school failure and reduce dropouts by taking two parallel approaches: eliminating system-level practices that hinder equity and targeting support to low-performing disadvantaged schools. Students from poor families are perhaps the most disadvantaged. PISA 2012 results in both reading and mathematics showed about a 100-point difference in scores between the top and bottom 20 percent of 15 year olds based on their socioeconomic status, which is equivalent to an academic gap of about 2.5 years.



The OECD report made five recommendations for preventing failure and promoting completion of upper secondary education: (1) eliminate grade repetition; (2) avoid early tracking and defer student selection until the upper secondary level; (3) manage school choice to avoid segregation and increased inequities; (4) make funding strategies responsive to students' and schools' needs related to inclusiveness; and (5) design alternative and equivalent education pathways at the upper secondary level to ensure completion.

The report made an additional five recommendations related to helping disadvantaged schools (those with higher proportions of disadvantaged students) to improve. These were to: (6) strengthen and support school leadership; (7) stimulate a supportive school climate and environment for learning; (8) attract, support, and retain high quality teachers; (9) ensure the use of effective classroom learning strategies; and (10) link schools with parents and local communities.

In addition, education policies need to be aligned with other government policies, such as those on housing or welfare, to ensure student success.

Source: OECD (2012a: 9-12).

²²⁹ OECD (2012a).

²³⁰ World Bank (2014b).

²³¹ Early school leaving (ESL) is defined in Romania as the percentage of 18 to 24 year olds who have completed at most lower secondary education (equivalent to grade 8) and are no longer in education/training. Those who have completed compulsory education, which is equivalent to completing grade 10 according to Romanian law, are not included in the ESL definition even though they have not completed upper secondary education (grade 12).

The key issues concerning the education sector²³² in Romania are related to the quality of education and training and their relevance to the needs of both the labor market and of individuals. The challenges that need to be addressed relate to: (i) school enrollment and attendance in early education; (ii) participation in tertiary education; and (iii) participation in lifelong learning.²³³ Policymakers in the education and training sector should aim for smart and inclusive growth in order to prevent and reduce early school-leaving and to ensure greater participation in the tertiary sector and in lifelong learning. The ESL Strategic Framework emphasizes the need to prioritize support for those groups at risk of leaving school early. In the absence of this support, the primary objective of the ESL Strategic Framework is likely to fail or at least to be compromised. The Framework defines the following groups in Romania as being at risk of leaving school early and, thus, as the intended targets of the proposed interventions:

- Children and young people aged between 11 and 17 years old.
- Children and young people from families with low socioeconomic status.
- Children and young people from rural areas.
- Roma and other marginalized and under-represented groups.

The ESL Strategic Framework proposes four pillars and six flagship programs aimed at reducing early school leaving in Romania during the 2014-2020 period as seen in Table 31.

TABLE 31: Summary of Pillars, Flagship Programs, and Thematic Areas within the ESL Strategic Framework

	Thematic Area
Pillar 1: Ensure That All Children Go To School And Receive A Quality Education	
Flagship Program 1.1: Increase Access To Early Childhood Education And Care	P
Flagship Program 1.2: Provide Access To Quality Primary And Lower Secondary Education For All	P I
Pillar 2: Ensure That All Children Complete Compulsory Education	
Flagship Program 2.1: Develop Early Warning Systems And Consolidate Remedial And Support Programs For Students At Risk In Compulsory Education	P I
Flagship Program 2.2: Increase The Attractiveness, Inclusiveness, Quality, And Relevance Of Vocational Education And Training (Vet)	I
Pillar 3: Bring Early School Leavers Back To School	
Flagship Program 3.1: Provide An Adequate Supply Of Quality Second-Chance Education Programs	C
Pillar 4: Developing Appropriate Institutional Support	
Flagship Program 4.1: Strengthen The Capacity Of The Government To Implement And Monitor And Evaluate The Early School Leaving Reduction Strategy	P

Source: World Bank (2014B: 9).

Note: *P = Prevention, I = Intervention, C = Compensation.

²³² Education in Romania is compulsory for 11 years, starting at primary education, and covering lower secondary education and the first two years of upper secondary education (grades 9-10). The Romanian pre-university education system covers: (i) early childhood education (0-6 years); (ii) primary education (grades 0-4); (iii) lower secondary education/gymnasium (grades 5-8); and (iv) upper secondary education (grades 9-12 or 9-14, depending on the stream: theoretical, vocational, and technological). The entire upper secondary education cycle (provided in high schools) is expected to become compulsory by 2020. Tertiary education includes university and non-university education. The student assessment and evaluation system includes two milestones that determine transitions into upper levels: a national grade 8 exit exam, and the Baccalaureate at the completion of upper secondary education/gymnasium, which is mandatory for entrance into universities, but not mandatory for graduation from upper secondary education or entrance into non-university tertiary education.

²³³ Ministry of European Funds (2013). Each of the three challenges was supposed to be developed and programmed within several separate strategies: the Strategy for the Reduction of Early School Dropouts, the Strategy for Tertiary Education, the Strategy for Lifelong Learning, and the Strategy for the Development of Educational Infrastructure.

In line with this approach focusing on the groups of children and youths most at risk and on disadvantaged schools, this chapter provides additional information that will be useful in designing effective policies to ensure that each child will remain in education and training until at least 16 years of age and will complete at least grade 10.²³⁴ The chapter is organized by education levels with a special focus on increasing access to quality education for children in vulnerable situations.

2.4.1. Improving the Early Childhood Education and Care System

Early childhood education helps children to reach their full potential and is a key factor in determining their later performance in school and in the labor market. It has become commonplace in educational literature to emphasize the importance of good quality early childhood education and care (ECEC) for a child's ability to adjust to the school environment, to acquire skills, and to perform well in rewarding occupational positions. Evidence also shows that access to good quality ECEC increases educational achievement and reduces the risk of early school leaving. According to the latest PISA survey, "Across OECD countries, students who reported that they had attended pre-primary school for more than one year scored 53 points higher in mathematics – the equivalent of more than one year of schooling – than students who had not attended pre-primary education."²³⁵ According to a recent study,²³⁶ increasing participation in pre-primary schooling from 0 to 100 percent could result in a 6.6 percent increase in GDP.

After a steep positive trend in early childhood education rates up to 2008 in Romania, participation rates started to decline. There has been an expansion of early childhood education and care provision for children between the ages of 4 and 6 in the last decade, with the gross enrollment rate significantly increasing from 2001-2002 to 2008,

and slightly decreasing to 85.5 percent in 2012.²³⁷ Discrepancies between rural and urban areas have continued, though they have decreased every year.²³⁸ Romania has been performing better than some of its southern and eastern neighbors, but its enrollment rates are still lower than the EU-28 average and they have little prospect of achieving the EU target of 95 percent. In designing policies to increase equitable access to ECEC, policymakers will need to take into account two key facts: address (i) the 15 percent of preschool-aged children (4-6 years old) deprived of early childhood education, and (ii) the inequalities in the quality of early childhood education for those who have access to it.

On the supply side, the reduction in the number of kindergartens, as part of the government's cost-rationalization of the education sector, has affected children in rural and urban settlements unequally. As smaller kindergartens were moved to the centers of communes in order to reduce costs, smaller villages and hamlets with fewer preschool-aged children were left without any preschool establishments. This situation has prevented many children living in these settlements from attending early childhood education not only because of the costs involved but also because of the long travel distances involved. The ESL Strategic Framework emphasizes the importance of increasing access to ECEC services. The measures proposed in that report aimed to consolidate the steps taken by the Government of Romania in two key areas: (i) expanding the institutional framework to cover children between 0 and 6 years of age and (ii) training teachers and inspectors to execute the new curriculum and inclusive teaching methodologies in ECEC. Moreover, the ESL Strategic Framework proposes the creation of a flagship program to introduce a mix of mobility schemes and financial incentives to encourage new teachers to volunteer for preschool posts in remote, rural, and disadvantaged areas.

On the demand side, actual attendance rates in kindergartens in disadvantaged areas seem to be lower than those given by the official records. Although Romania's participation rate in early childhood education is encouraging in comparison with those of other EU countries, anecdotal evidence from interviews with experts

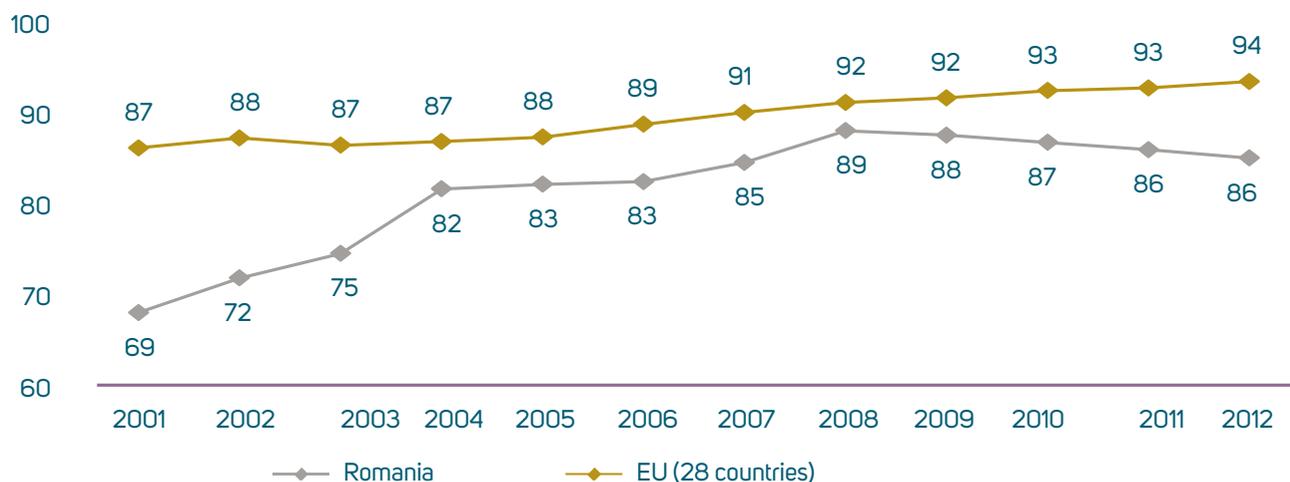
²³⁴ In Romania, completing compulsory education is defined as the completion of Grade 10.

²³⁵ OECD (2013b: 14).

²³⁶ Checchi et al (2014).

²³⁷ At the same time, center-based care for children between the ages of 0 and 3 years old is relatively rare, with only 2 percent of such children being enrolled in nurseries. Increasing the availability of safe and reliable day care centers would increase the extent to which many children would benefit from ECEC, especially those with working mothers who have no family members to serve as caregivers.

²³⁸ Arnhold et al (2013).

FIGURE 29: Percentage of the Age Group between 4 Years Old and the Starting Age of Compulsory Education

Source: Eurostat.

in the field²³⁹ indicates that the actual attendance rate in kindergartens, especially in rural and marginalized areas, is significantly lower than is shown in the official records. This means that children from the most vulnerable categories – rural, Roma, disabled, and those from marginalized communities – are less prepared for and able to adjust to the requirements involved in attending primary school. Parents in low-income and marginalized households usually have little education themselves so cannot give their children any effective help with their homework. They may not even consider education as a relevant asset in life, and thus may pay little attention to their children’s participation in educational activities. This is in addition to the fact that they have little money to invest in their children’s education. One other measure proposed in the ESL Strategic Framework will support the current efforts of the Government of Romania by: (i) developing support schemes for parents in vulnerable groups and disadvantaged communities; (ii) implementing awareness campaigns on the importance of early childhood education; (iii) enriching and expanding parental education (through mentoring and the provision of learning material) for vulnerable groups including Roma, and (iv) providing

financial support to parents in vulnerable groups in the form of nursery tickets as well as existing social protection programs such as complementary family allowance, guaranteed minimum income benefits for poor families, free croissants and milk in schools, and free supplies for vulnerable students. Kindergartens have incentives to enroll these children, but they do not have any way to enforce their attendance.

Although public kindergartens should be free by virtue of being fully subsidized, access to early childhood education at the preschool level is hindered by the fees that such institutions charge parents in order to function. These fees are often a burden that prevents poor and vulnerable families from enrolling their children in early childhood education. This, in turn, constrains the ability of those children to adjust to the requirements of primary education and sets them up for an increased risk of educational failure in the future.

The practice of some kindergartens to select the “best children” is another cause of inequality of access to early childhood education. Although a systematic analysis of this phenomenon has not been carried out so far,

²³⁹ The interviews with representatives of the Ministry of Education and with school directors and teachers from Botoșani and Arad counties were conducted in April–August 2014, under this background study.

anecdotal evidence indicates that some kindergartens managers refuse admission to children from poor and vulnerable families by charging additional fees or by arbitrarily manipulating the number of available places. This phenomenon seems to occur most often in large urban settlements where there is an apparent shortage of places in kindergartens every year. This combination of restricted options for parents and selection by the institution is prone to producing socially segregated kindergartens.

Several projects have been implemented in Romania in the area of inclusive early education, efforts which need to be strengthened and continued. Two highly visible examples are as follows:

Since 2007, the Ministry of Education has been implementing the Inclusive Early Education program²⁴⁰ financed by the World Bank (€6.1 million) and the Romanian Government (€1.7 million) under the Social Inclusion Program I. This program has targeted children aged 3 to 6 years old from Roma and other disadvantaged groups. In 2013, the program covered 5,000 children with an allocation of RON 4 million.

The project Inclusive Kindergartens was implemented by the Association RENINCO Romania (The National Network for Information and Cooperation to Support Community Integration) with UNICEF's support during 2009 and 2011, mainly targeting children with disabilities.²⁴¹

The priorities for education policymakers in the foreseeable future are improving the quality of the ECEC system and developing an equality-focused approach to achieving universal participation. To achieve these objectives, they might consider taking the following actions:

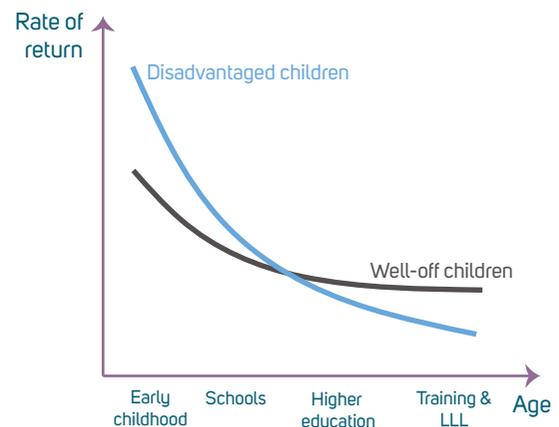
- Introducing means-tested vouchers for disadvantaged families. Each voucher should cover the average fee of kindergarten on a monthly or yearly basis. These vouchers should be nominal and non-transferable. Recipients should be children living in families that are recipients of the Minimum Income Allowance. The use of the vouchers should be strictly conditional on the children actually attending preschool.
- Finding ways to accurately assess the attendance rate in kindergartens and devising measures to increase the number of days/hours spent by children in these institutions.

- Systematically training teachers and care providers in providing ECEC to children from poor and vulnerable families and implementing strong anti-discriminatory policies at the preschool level.
- Extending the operation of school minibuses (or the value of the transport allowance) to cover the transportation of preschool children to kindergartens.

BOX 28

The Efficiency and Equity of Investing Early in Education

This figure shows the different rates of return to a constant investment through all of the different educational levels. Investing in early childhood education and care yields high returns, particularly in the case of disadvantaged children, while investing in training and lifelong learning yields positive but lower returns than for the previous educational stages. Disadvantaged students benefit more from early educational investments, while well-off children benefit more from later investments.



Sources: OECD (2012a: 27) based on Cunha and Heckman (2007 and 2008) for the U.S. and on Woessmann (2008) for Europe.

²⁴⁰ <http://proiecte.pmu.ro/web/guest/peti>

²⁴¹ Vrășmaș and Vrășmaș (coord., 2012).

BOX 29

Using Food Coupons to Encourage Disadvantaged Children to Attend Kindergarten

The Every Child in Preschool program (Fiecare Copil în Grădiniță), managed by the OvidiuRo Association (OvidiuRo), provides food coupons to disadvantaged children in selected rural localities conditional on their regular kindergarten attendance. This program is financed by a combination of major private investors and the European Economic Area Grants scheme (2009-2014), while the local authorities in the targeted localities are required to provide a modest amount to fund clothes and footwear for pupils. Local authorities may apply to the program either for the entire commune or for one or more of the component villages. To qualify for support, the local authority must: (i) quantify the number of disadvantaged children who are not attending kindergarten; (ii) prove that the local capacity and willingness to implement the program exist (the key stakeholders are considered to be the mayor and the school principal, but the presence of supportive school mediators, social workers, professors, health mediators, and County School Inspectors is considered relevant as well), and (iii) commit to conducting a thorough door-to-door recruitment process. The final decision to select a locality to benefit from the program is taken after the OvidiuRo team has performed a site visit. A local action group or taskforce is then formed in the selected commune or village to implement the program, and the school mediator and the social worker carry out an initial census of households to determine the true extent of local needs and to establish a tentative list of beneficiaries. The OvidiuRo team then carries out a second site visit to establish the final list of beneficiaries.

Children and families qualify for the program based on: (i) the level of household income per family member (to qualify this must be below RON 150 or approximately €35); (ii) sub-standard housing conditions (as defined by the provisions of the Social Assistance Law with reference to Housing Law 114/1996); and (iii) the parents' low education level. According to OvidiuRo representatives, the overwhelming majority of beneficiaries live in situations characterized by extreme intergenerational poverty, inadequate housing conditions, and overcrowded extended households. They lack access to clean water or toilet facilities and live in houses with improvised heating, often situated on the outskirts of the

locality, with a high risk of tuberculosis and of under-5 mortality. The incentive is a RON 50 (approx €11) monthly social coupon awarded to the family of every participating child. The main condition attached to the benefit is the requirement for the child to maintain an almost 100 percent kindergarten attendance rate, with only an official certificate from the family physician being accepted for any absences. During any months when this condition is not fulfilled, the family's benefit is suspended. The benefit is awarded on an individual basis, which means that children do not lose their benefit if their siblings lose theirs for not attending kindergarten. In this respect, this program differs from the design of public conditional cash transfers such as the Family Support Allowance). The program also requires that parents participate in the Parents' Day (a monthly special activity with children and parents) and in regular kindergarten activities as a teacher's assistant five times per year.

Besides social coupons, the program awards other types of financial support every year. OvidiuRo allocates €15 per child for school materials, while the local council is required to allocate €35 for every child in the form of clothes and footwear. A series of connected activities facilitates the implementation of the program. Training is provided onsite for the implementation teams and for teachers, and summer-school programs are organized for the targeted children and also for primary and lower-secondary students.

As of 2012, a healthcare component has been built into the program, comprising preventive activities such as vaccinations, complex medical tests, healthy food (fruit) and vitamin-intake support, hygiene lessons and aid, and help with accessing health services (for example, covering the costs of medication, transportation to healthcare facilities, and even treatment for sick children).

The FGC program has expanded significantly during recent years. In 2014, it covered four times as many villages as it did in 2010 (84 villages in 43 localities). Around 2,400 children in 89 kindergartens are being covered by the program in 2014/2015. Furthermore, the retention rate has improved. While six out of the 21 target villages dropped out of the program after the first year of implementation, in 2014 only one village dropped out. The adjustments in the program's design are constantly aimed at achieving better outcomes.



BOX 29 (continued)

The social coupon system is quite widespread nowadays in the Romanian commercial environment. OvidiuRo representatives report that there are usually several shops within their locality where beneficiaries can spend their coupons. The program's managers recall only one single occasion throughout the history of the program's implementation when beneficiaries from one village had to travel to the neighboring locality in order to use their allowance. Even small commercial entrepreneurs who did not join the system are reported to accept the coupons because they can use them to acquire supplies from the major wholesale providers. However, there is an implementation issue that is affecting the sustainability of the program related to the lack of any current legislation to regulate the entitlement of public authorities to use coupons. The local public ownership of the program varies from one county to another. For example, in Cluj, the county council agreed to take over the management of the program, and social coupons are currently used, whereas other local public authorities use them for

different types of social programs (such as food aid for the poor and help for the elderly).

The supervision of the program by the local and central OvidiuRo appears to be essential to the successful functioning of the program. If the program is ever to be scaled up, tighter, more standardized rules might need to be developed and external onsite quality supervision might be needed.

An impact evaluation of a very similar intervention is currently being carried on in Bulgaria with the participation of OvidiuRo, the World Bank, the Bulgarian Ministry of Education, the Trust for Social Achievement Bulgaria, and various academic institutions. This evaluation is investigating the impact of incentives and conditions associated with kindergarten attendance on the efficient development of early education skills. The randomized control group will include approximately 200 rural communities and 2,000 children, and the findings of the evaluation are expected to become available in 2016.

2.4.2. Increasing Participation and Improving Outcomes in Primary and Secondary Education for All Children

The rates of participation in primary and lower secondary education have remained low in Romania compared with the European average despite the improvements achieved in recent years. In 2012, the primary and lower secondary participation rate fell to 90.6 percent from a high of over 100 percent²⁴² in 2005-2006, with a persistent disparity in enrollment rates between rural and urban areas. After a short period during which dropout rates were falling,

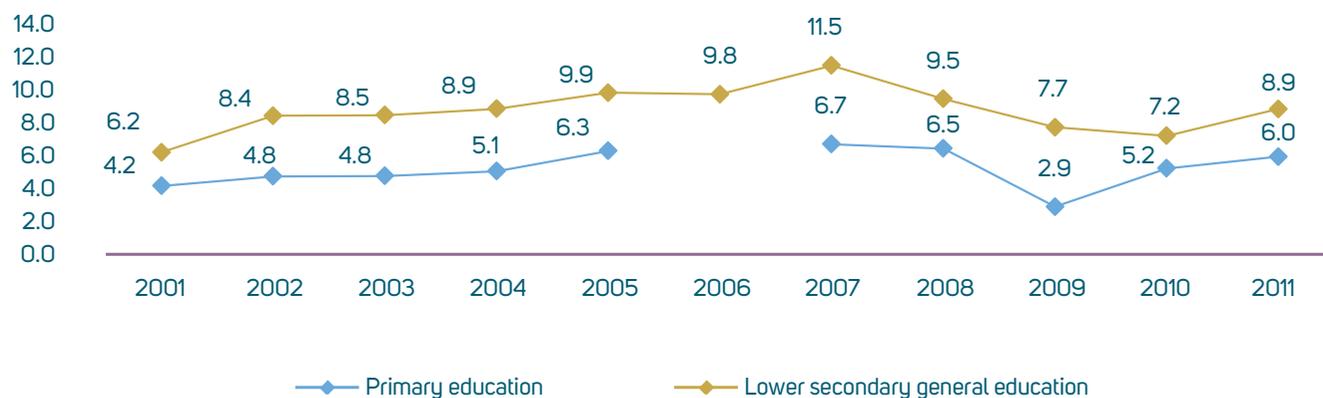
the economic crisis turned the tide, and in 2010 and 2011, dropout rates rose once again to 6 percent at the primary level and 8.9 percent at the secondary level.

Nearly 69,800 children aged 7 to 14 years were recorded as being out of school in the 2011 Census, of whom 48,400 were illiterate (defined as having had no formal education). Almost 99 percent of these lived within families, while only 1 percent lived either in institutions or on the street. However, the rate of out-of-school children of primary school age (7 to 9 years) was 6 percent for children in families and over 16 percent for children in placement or living on the street.²⁴³ The equivalent rates of out-of-school adolescents of lower secondary school age (10 to 14 years) were 3 percent and 11 percent.²⁴⁴ For children living within families, the out-of-school rate was slightly higher in rural areas (4.3 percent) than in urban areas (3.7 percent), whereas for children living without their families, the risk of being out of school is almost five times higher in urban areas than in rural areas, particularly in medium and large cities.

²⁴² "In the 2003/ 2004 school year, gross school enrollment rate in primary and middle education has increased considerably, at above 100%, due to application of the provisions where is stipulated the start of school at six years (thus was determined concomitant entry of 6 and 7 years children, in first grade, in this school year). Subsequently this indicator decreased gradually from year to year." (Ministry of Education, 2014: 49).

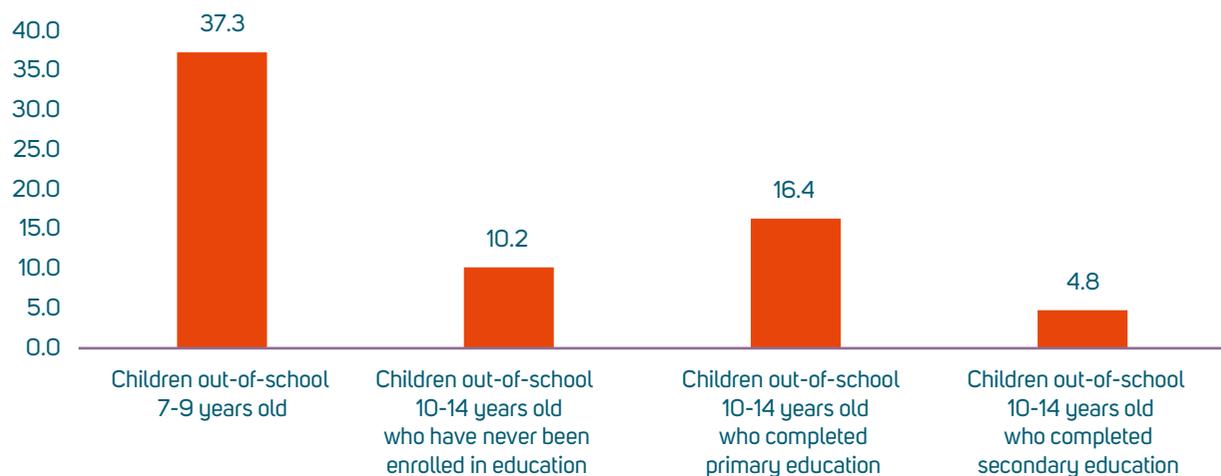
²⁴³ The UNESCO Institute of Statistics reported that 6.3 percent of children of primary school age (7 to 10 years old) were out of school in 2009 (<http://data.uis.unesco.org>).

²⁴⁴ The UNESCO Institute of Statistics reported that 6.9 percent of children of lower secondary school age (11 to 14 years) were out of school in 2009 (<http://data.uis.unesco.org>).

FIGURE 30: Cumulative Dropout Rate to the Highest Grade of Primary and Secondary Education (%)

Source: UNESCO Institute of Statistics, <http://data.uis.unesco.org>.

Note: Definition = proportion of pupils from a cohort enrolled in a given grade at a given school year who are no longer enrolled in the following school year.

FIGURE 31: Number of Out-of-school Children aged 7 to 14 Years Old Living in Families (thousands)

Source: World Bank calculations using data from 2011 Population and Housing Census.

Note: Definition = children in the official primary school age ranged who are not enrolled in either primary or secondary schools.

Among children aged between 7 and 14 years old who are living with families, those with disabilities, Roma children, and poor children face a disproportionately high risk of being out of school. The categories of children most at risk of not participating in or not completing compulsory education are:²⁴⁵

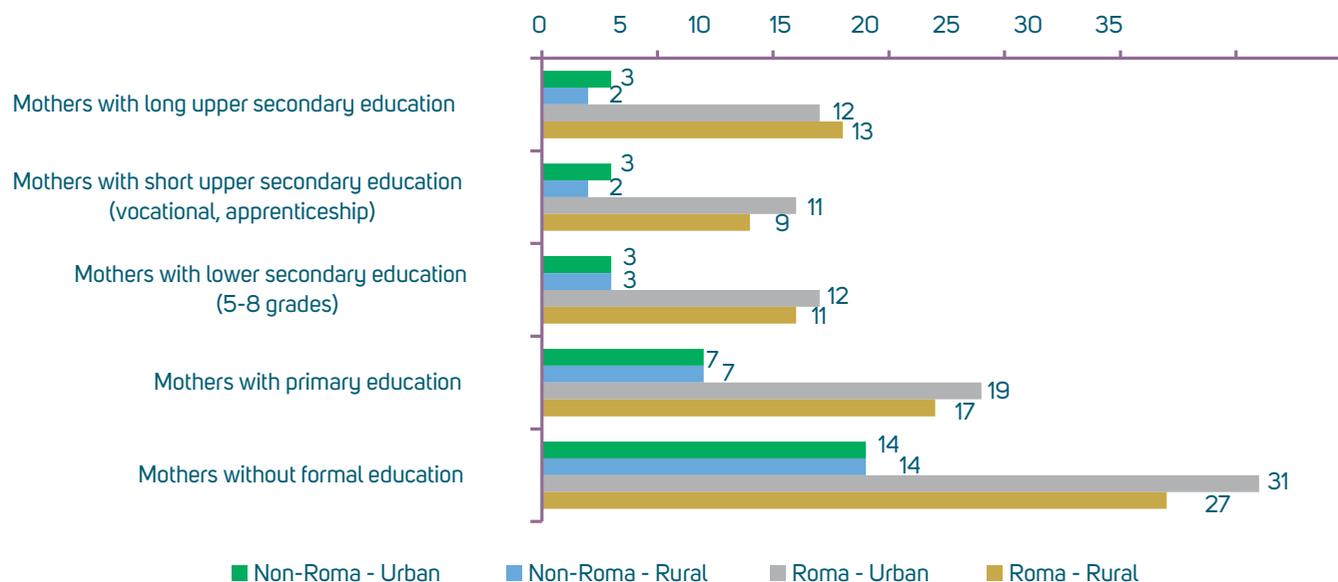
- Children with at least one totally disabling incapacity (55.4 percent) and those with at least one significant incapacity (20.4 percent).
- Children with mothers with no formal education (22.7 percent) or who completed only primary education (10.6 percent).
- Roma children (18.7 percent). Although the mother's level of education is a relevant predictor for school participation, the difference between Roma and non-Roma is large even if the mothers' level of education

is held constant. The gap between Roma and non-Roma children is significant even if the level of education of the parents is the same and they come from the same geographical area.

- Children with numerous siblings in households with three or more children (6.8 percent).
- Children deprived of parental care, in other words, with no parent at home (5.4 percent).

School dropouts and out-of-school children tend to be concentrated in particular areas, especially rural areas or urban marginalized communities that sometimes include a large proportion of Roma. Not only does early school leaving or a lack of schooling disproportionately affect disadvantaged groups in terms of the lifelong opportunities available to them, but, because of segregation, early school leaving, or a lack of schooling, they tend to be concentrated

FIGURE 32: Rates of Out-of-school Roma and Non-Roma Children aged 7 to 14 by Area of Residence and Mother's Level of Education



Source: World Bank calculations using data from 2011 Population and Housing Census.

Note: Only children living within families are considered.

²⁴⁵ The overall rate of out-of-school children aged 7 to 14 years living with their families was 4 percent.

in specific areas and consequently in specific schools, often in rural areas with a high concentration of Roma. In Bihor and Caras Severin counties, 50 percent of all dropouts from the gymnasium (grades 1 to 8) have been recorded in just 5 percent of schools.²⁴⁶

A recent study carried out in several schools²⁴⁷ with a high concentration of disadvantaged students found a very high incidence of academic failure and dropout at the primary level (more than 25 percent), and an even higher incidence at the lower secondary level (almost 50 percent).²⁴⁸

Based on an analysis of school records, the same study

showed that 10 percent of primary school students and 37 percent of lower secondary students qualify as dropouts. Statistically, this means that only about 50 percent of students enrolled in Grade 1 in those schools with a large proportion of disadvantaged children actually complete eight grades. A similar worrying situation was signaled by the Atlas of Urban Marginalized Areas in Romania²⁴⁹ (see more in Section 3.2). In urban marginalized areas, the proportion of children enrolled in education is lower than in other areas, particularly for those who are 14 or older and for Roma (Table 32).

TABLE 32: School Enrollment of Children in Marginalized Urban Areas in Romania (%)

	Age group	Urban Romania		Urban Marginalized Areas	
		Total	Roma	Total	Roma
Population (% total population/Roma)	0-5 years	6	13.2	11.1	15.4
	6-10 years	4.6	10.8	8.9	12.5
	11-14 years	3.7	7.9	6.8	8.9
	15-19 years	4.8	8.5	7.2	8.7
Enrolled in education (% age group)	6-10 years	78.1	68.9	75.9	69.2
	11-14 years	97.7	77.3	90.8	77.4
	15-19 years	86.7	46.3	67.1	43.3

Source: World Bank (Swinkels et al, 2014a: 18) using data from the 2011 Population and Housing Census.

Free compulsory education for all children is provided by law, but law enforcement mechanisms are ineffective in terms of enforcing either aspect. Despite the existing legal provisions, various research on children has shown that free compulsory education has hidden costs, including fees such as school and classroom funds, which are sanctioned by law.²⁵⁰ Most households with children allocate a monthly average amount of €30²⁵¹ per child for school-related expenses, including school supplies, books/notebooks, uniform and sports equipment, school fund/classroom funds, organized events, transport to/from school, home tutoring, and other contributions paid to the school. It is

worth noting that significantly less money is spent on education by households with unemployed people, informal workers, Roma informal workers, and/or two or more children. They also spend less per child. For instance, the monthly average amount allocated by the households of Roma informal workers is less than €3 per child. At the opposite extreme, households of formal workers pay, on average, €56 per month per child. Precisely because of the high costs related to education, parents in poor and vulnerable households often report facing major difficulties in ensuring the enrollment, continuation, and/or completion of their children's education.

²⁴⁶ Hatos, 2011. The concentration is more likely to be observed at locality or at a lower level (villages or small marginalized areas) than at county level. According to the 2011 Population and Housing Census data, out-of-school children aged 7 to 14 years old are spread across all counties, with rates varying from a minimum of 1 percent in Giurgiu and a maximum of 7.1 percent in Mures (and a national average of 4 percent). In seven counties, the rates of out-of-school children aged 7-14 years exceed 5 percent, namely Arad, Bihor, Brasov, Cluj, Ialomita, Mures and Timis. However, these seven counties account for only 27 percent of all out-of-school children aged 7 to 14 years old overall, which means that the concentration of the phenomenon within certain counties is limited.

²⁴⁷ The so-called Educational Priority Areas, identified within the framework of a project implemented by UNICEF and the Institute for Educational Sciences.

²⁴⁸ Jigău et al (2012).

²⁴⁹ World Bank (Swinkels et al, 2014a).

²⁵⁰ Gradinaru et al (2010) and Stănculescu and Marin (2011).

²⁵¹ This is about 125 lei per month, which makes an annual average amount of 1,500 lei.

Consequently, although education is compulsory, the problem of out-of-school children has remained persistent. Nevertheless, it has not yet been addressed by any program or institution. The qualitative research carried out for our background study has highlighted that, even when some teaching staff and/or community workers take the initiative and identify out-of-school children of school age within the community, they have no way of forcing them to enroll or attend school. For the effective implementation of a child's right to education as set forth in the Convention on the Rights of the Child (Article 28), a national program focused on out-of-school children of compulsory education age needs to be designed and implemented for the benefit of all children in Romania.

The quality of education at both the primary and the secondary level in Romania needs to be improved in order to promote social inclusion. Education of a high enough quality to produce a skilled workforce benefits both individuals and society as a whole. Recent evidence on the measurement of competencies in Romania has yielded inconsistent results. Romania's PISA scores have shown definite improvements during the last three rounds of measurements, but Romania remains among the worst performers in the EU. In 2012, 41 percent of Romanian students were found to be functionally innumerate and 37 percent were functionally illiterate. Meanwhile, the TIMSS and PIRLS scores in mathematics for 8th-graders have shown a negative trend. The scores of Romanian students in science during five rounds of measurements stayed largely unchanged as did their scores in reading during three rounds of measurements.²⁵² Variations in the socioeconomic status of the students can explain part of the differences in the test results.²⁵³ Segregated school systems – particularly the more exclusive ones, in which students of similar socioeconomic backgrounds are gathered in the same schools or classrooms – perform poorly compared with the more inclusive ones.

Consequently, national education policymakers need to

reduce the influence of background socioeconomic factors as much as possible to reduce inequality and minimize the risk of failure and exclusion. Any streaming based on ability should not be introduced until late in the education cycle (in other words, until students enter higher education) and a strong emphasis should be put on ensuring the availability of extensive and well-developed vocational education at the upper secondary and post-secondary levels.

In Romania, compulsory education is defined as the completion of grade 10. However, upper-secondary education covers grades 9 to 12²⁵⁴ and used to comprise four streams. Three of these are regarded as "high school": (i) theoretical (which subdivides further into humanities and science); (ii) vocational (education, arts, sports, military, and theology); and (iii) technological (agriculture and services). The fourth stream was vocational education and training (VET) in the Schools of Arts and Trades. In 2009 when the government closed the Schools of Arts and Trades, the children who may have entered the VET (*școli profesionale*) system became part of the technological track. Consequently, while the gross enrollment rate in high school rose from 72 percent in 2008-2009 to 92.7 percent in 2012-2013, gross enrollment rates in VET decreased sharply from 25.3 percent to 3 percent over the same period (Figure 33). The distribution of students by gender is balanced at all levels, except in VET, which is much more popular among boys who made up 76 percent of all VET students in 2012-2013.²⁵⁵

The evidence shows that there is a sharp decline in school participation between the end of lower secondary school and the beginning of upper secondary school (in other words, between grades 8 and 9), especially for those in the poorest decile. There is an even more significant decline in participation in upper secondary once school attendance is no longer compulsory (in other words, between grades 10 and 11) among those from the poorest four deciles (Figure 34).²⁵⁶

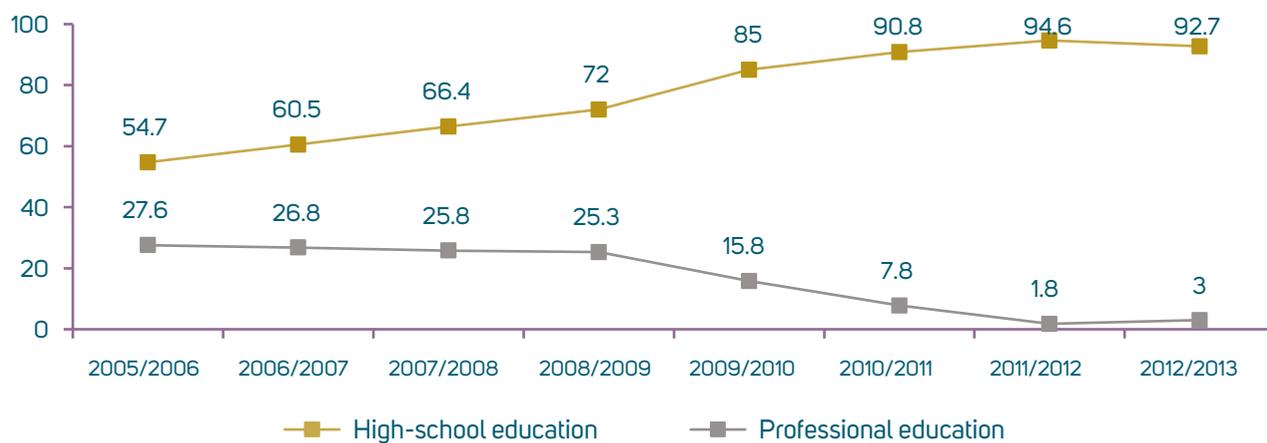
²⁵² All TIMSS and PIRLS data retrieved from <http://timssandpirls.bc.edu/> on August 26, 2014.

²⁵³ For example, 19.3 percent of the variance among Romanian students in their mathematics performance in the PISA test is explained by the socioeconomic status of the student, which is more than the OECD average of 14.8 percent but still not a significant degree.

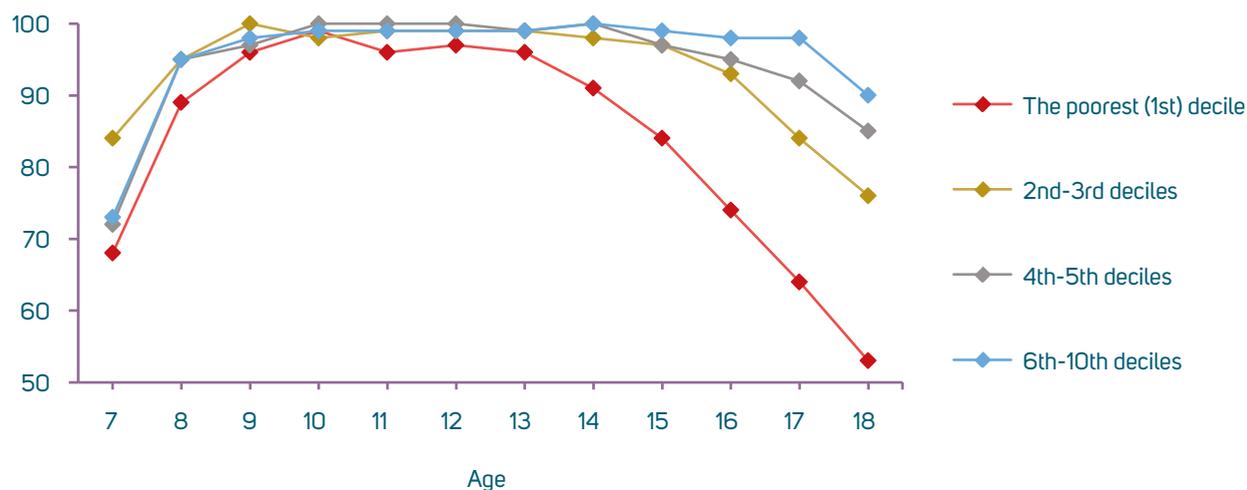
²⁵⁴ After 12th grade, students take a baccalaureate examination that can be repeated if necessary.

²⁵⁵ NIS (2013a).

²⁵⁶ The average dropout rate in Romanian high schools increased from 2.2 percent to 3.8 percent between 2009 and 2011, with even higher rates prevailing in technological high schools (5.3 percent in 2011) as well as in high schools located in rural areas (around 7 percent in grade 11 in 2012).

FIGURE 33: Gross Enrollment Rates in High School and VET (%)

Source: World Bank (2014b).

FIGURE 34: School Enrollment Rates for Children from the Poorest Four Deciles in Romania

Source: World Bank calculations using data from the 2012-2013 HBS.

Note: Quintiles of total income per adult equivalent (using the modified OECD equivalence scale).

There are various reasons²⁵⁷ why Romanian students drop out of high school, but the lack of financial resources is particularly important, particularly for children in rural areas. The reasons for dropping out of high school fall into three broad categories: (i) pedagogical, (ii) financial, and (iii) personal. Pedagogical reasons relate to the low quality of education provided by high schools because of which they are not teaching students satisfactorily, thus leading them to fail and to drop out of school. Some other pedagogical reasons are parents' low expectations regarding the returns from education and the higher opportunity costs of participation. Financial causes refer to the high non-fee costs of participation, including the cost of books, supplies, and transportation. A 2014 study²⁵⁸ has shown that 47.3 percent of parents of students who live in rural areas cited the lack of financial resources as the most important reason why their children do not continue into upper secondary education. This finding is consistent with a 2011 study on access and equality in higher education,²⁵⁹ which found that 38.3 percent of students who had dropped out of school stated that financial constraints on attending high schools were their main reason for dropping out. Personal reasons include a lack of motivation among students to continue studying, real life events such as the migration of their parents, early pregnancy, or marriage, bullying or prejudice within the school environment, and/or students' myopic preferences (for example, preferring to enjoy leisure or consumption now rather than deferring them till later in order to acquire more skills).

The nationwide proportion of teenagers aged 15 to 18 years not enrolled in school or training reached 11 percent for the period 2009-2012, with a substantial gap between urban (6 percent) and rural areas (17 percent). Besides area of residence, factors such as income and the mother's education have a significant influence on the rate of early school leaving (Figure 35). For example, for adolescent girls in rural areas with mothers who have received a primary education at most, the rate of leaving school early is 57 percent for those from the poorest households, more than twice as high as those in households with above average incomes (25 percent). On the other hand, if students' financial status is held constant, then the mother's education has a stark impact on the child's risk of early school leaving. Students with mothers with at most four

grades of education have a 25 percent chance of dropping out compare with only 2 percent for students with mothers who have completed high school or have a higher level of education. A multiple regression analysis (Annex Table 6.1) indicates that area of residence, income, and mother's education level are all significant factors in early school leaving, yet the level of education achieved by the mother is the most influential determinant of the participation of children in upper secondary education. In other words, if a child completes compulsory education, then it is much more a matter of his or her mother's education (because of the support given and the value assigned to education) than of money or geography.

There is a rich supply of empirical evidence that the acquisition of skills is beneficial to the individual and accounts for many desirable outcomes throughout the individual's lifecycle. For example, the OECD's Survey of Adult Skills has shown that highly skilled adults are twice as likely to be employed and almost three times more likely to earn an above median salary than are low-skilled adults.²⁶⁰ In particular it has been found that skills inequality is reduced by the existence of a strong vocational sector, especially at the upper secondary level.²⁶¹ This happens because those at the bottom of the skills distribution perform better in these systems. In other words, vocational education has the ability to foster inclusion. On the other hand, it has been found that early ability tracking or streaming leads to greater skills inequality without actually delivering the benefit of being educationally effective.²⁶²

The dropout rate in vocational schooling has been of particular concern to Romanian policymakers and has prompted some policy changes. In 2009-2010, the government's decided to abolish the Schools of Arts and Trades in the vocational system, primarily because of their poor quality and design. This had a significant impact in the following academic year with the dropout rate among VET students almost doubling from 8.6 percent in 2009-2010 to 19.8 percent in 2010-2011. This impact may have extended to students in lower secondary who had little prospect of succeeding in the theoretical/academic streams and who may no longer have felt that they had any reason to remain in school until the end of lower secondary once the VET alternative was no longer available. In December

²⁵⁷ An analysis of the factors driving early school leaving, in the supply and demand framework, is presented in the World Bank study on early school leaving, 2014: 26-28.

²⁵⁸ Badescu et al (2014: 27).

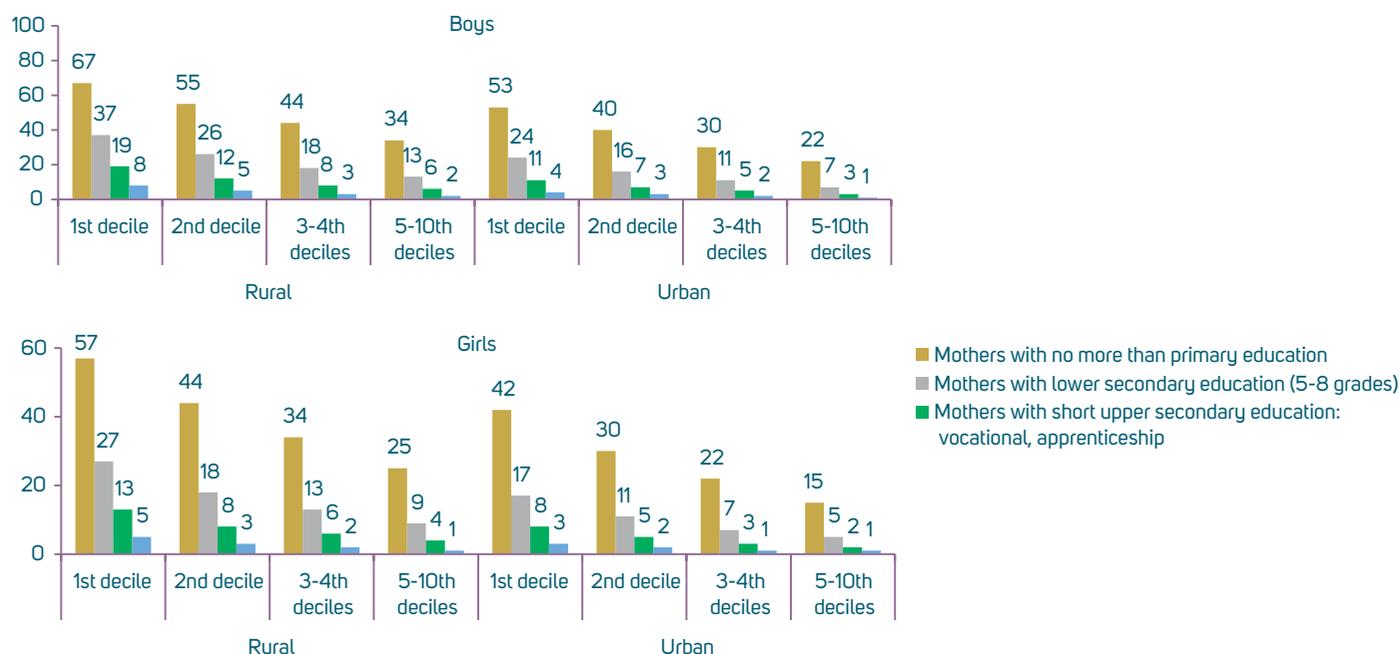
²⁵⁹ Pricopie et al (2011).

²⁶⁰ OECD (2013a).

²⁶¹ Checchi et al (2014).

²⁶² Checchi et al (2014).

FIGURE 35: Proportion of Adolescents aged 15 to 18 Not Enrolled in Education or Training by Gender, Area of Residence, Mother's Level of Education, and Income Decile (%)



Source: World Bank calculations using data from the 2009-2012 HBS (pooled data).

Note: The first decile indicates the 10 percent of people with the lowest income in the country. The 5th to 10th deciles indicate the half of the population with medium to high incomes.

2013, the government changed the VET system by ordinance and opened up opportunities for students to enroll in vocational programs (entering what are called *scoli professionale*) right after grade 8 when they had completed the gymnasium level. Under the new rules, students would no longer have to enter upper secondary before being granted access to the VET system.²⁶³

Participation in Initial Vocational Education and Training (IVET - ISCED 3c levels of education) is still very low, although increasing. On the one hand, the Professional Scholarship Program has been created with the aim of increasing demand in IVET. The program provides RON 200 monthly to any student who enrolls in vocational school. On the other hand, several disincentives exist that prevent students from enrolling in the academic tracks of upper secondary education, including the increased

requirements of the baccalaureate examination and the absence of any revisions of the income threshold for the Money for High school Scholarship. As a result, an increasing number of 8th grade graduates have chosen to enroll in vocational school instead, particularly those from poor and disadvantaged backgrounds because vocational education enables students to acquire skills quickly and to make a faster transition into the labor market.

Increasing the attractiveness of IVET would lead more students to enroll. Lower secondary students from disadvantaged socioeconomic backgrounds are often not properly informed about the economic opportunities open to graduates of vocational schools and the various available schools and their respective specialties. This partially explains why, notwithstanding the relatively limited supply of vocational and professional training, the demand is

²⁶³ World Bank (2014b: 26).

still weak. In order to increase the demand for IVET, the measures proposed in the ESL Strategic Framework include career counseling services in schools and more vigorous promotion of IVET within and outside schools (by teachers, school counselors, school mediators or media), focusing on career opportunities and further education flexibility.

Alongside these actions to increase demand, policymakers also need to take steps to increase the supply and relevance of IVET. Many of the existing vocational schools provide qualifications and skills that do not match the needs of the labor market. This is another reason why 8th grade graduates from disadvantaged groups are choosing not to follow the vocational stream in upper secondary school. For example, rural agricultural schools still focus on farming organization and technologies that are suited to large enterprises even though the average farm in Romania is now relatively small. This happens because of historical dependencies (path dependencies) as well as material constraints that mean that the schools cannot afford to modernize their infrastructure or diversify their offerings. However, there has been some progress in terms of increasing supply in recent years. Government orders have increased the number of places available in VET schools

for those graduating from grades 8 and 9 from 20,000 in 2012 to 26,000 in 2013 and to 51,000 for 2014-2015. (The number of internships was also increased to 5,000 for 2014-2015. Currently, when schools are setting up IVET courses, they need to produce a signed agreement between the students and their families, the school, and one or more company that will offer internships to the students. Without this agreement, the Ministry of Education will not grant official approval to the school to create the course. For this reason, the supply and quality of IVET courses depends strongly on the companies' interest in and commitment to training VET students.

Some useful actions that policymakers should consider in this area include:

- Setting up apprenticeships within IVET courses.
- Redesigning the IVET curricula to focus on several key industrial sectors in each region.
- Developing national sponsorship programs with large companies and fostering partnerships with local private companies.

BOX 30

Best Practice - Kronstadt Vocational School

The qualitative research carried out as background to the development of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 has revealed two contradictory findings. On the one hand, there is a pressing need for qualified workers in all counties and localities where the interviews were conducted. On the other hand, the technical and vocational schools in those areas use outdated curricula, and the work experience courses with employers are insufficient and partly irrelevant, since the students do not acquire the actual skills related to the qualification in question.

In this context, the Kronstadt Vocational School in Romania is a worthy example of a vocational program that can successfully train top-level professionals and improve their employment prospects. The school boasts an almost 100 percent employment rate following graduation. The school's management board is comprised of representatives of 12 large entrepreneurs active in the local market (most of the employers are operating in the Brasov area). The main activities

related to the school are undertaken under a partnership agreement, which covers the selection and training of teaching staff, the examination process, the development of the curricula, and the teaching of both theoretical and practical courses. At the admissions stage, the students are required to choose the type of qualification that they are interested in as well as their prospective employer.

The Kronstadt School is operating on the site of the old professional school (Grup Scolar Industrial) affiliated with Rulmentul Brasov's factory until 1997, when the latter was declared bankrupt. Many of the former employees of Rulmentul were hired, starting in 2005, by the newly established Schaeffler enterprise, thus meeting in part the international company's demand for a skilled labor force. However, the existing personnel needed to be retrained in modern production techniques, although many of them were approaching retirement age, and the fresh graduates emerging under the existing educational system were not being equipped with relevant skills. A local study prepared for Schaeffler's management,



BOX 30 (continued)

prior to the vocational school project, identified that the curricula did not reflect modern production techniques and that the laboratory practice was insufficient. To compensate for the shortage of trained employees, the Kronstadt School was established. Schaeffler employs around half of the school's graduates, although it is not the largest of the companies involved.

The school began operating in 2012 when the new building was constructed by the city hall and the companies equipped the classrooms. Currently, the local council is renovating the school's workshop, while the participating firms will ensure the provision of technical equipment. The major features of the Kronstadt School include: (i) high pedagogical and technical standards of education and practice; (ii) careful practical training carried out both by employers' instructors and by school staff at the employer's site and using high-tech devices; (iii) a qualification certificate that is internationally recognized; (iv) transportation to the work sites, together with meals and a boarding regime for those children coming from other areas supported by the employers; (v) an allowance of RON 200 per month paid by the employers during the student's studies in addition to the RON 200 professional allowance received from public funds; and (vi) an almost 100 percent employment rate after graduation as shown by the 93.7 percent employment rate of the first generation of graduates in 2014.

To ensure a broad admissions base, the employers carry out active promotion and recruitment activities in gymnasiums and via public advertisement campaigns. The school organizes a promotional road-show in the counties where the employers have their headquarters. Many students learn about the school via word-of-mouth, with the former workers of Rulmentul and current Schaeffler employees, who were originally residents of the Northeast and other distant parts of Romania, spreading the information. The school's promising educational and employment prospects attract a high number of applicants annually - six times more than the 375 places allocated in 2014-15 - with 60 percent of the students being from counties outside Brasov, such as Iasi, Maramures, Buzau, and Vaslui. The admission test is a combination of general knowledge in certain fields (such as logics and mathematics) and skills considered relevant to the technical/practical aspects of the job (such as

concentration, coordination, and dexterity).

The students are trained in two-year programs (starting in 10th grade) or three-year programs (starting in 9th grade), with the option of several specialties such as computer numerical control operator (the most widespread profile), electromechanical machine tools operator and industrial facilities operator, mould toolmaker, or leather-sewing technician. Occasionally, the school offers six-month adult training courses, and the prospect of preferential employment is reported to attract higher education graduates as well.

Every student attending the Kronstadt School must sign a contract, which, among other obligatory conditions, requires a 95 percent attendance rate. The learning curricula are closely adapted to the standards and requirements of the economic environment, reflecting the technological characteristics of the production process. Professional practice is coordinated by the employers, with a ratio of one tutor and one teacher to 12 students. The proportion of practical training in the curriculum increases gradually and eventually overtakes theoretical teaching in the students' senior years. For example, practical work accounts for 25 percent of instruction time in the 9th grade, progressing to 75 percent in the 11th grade over the three-year path. The contract provisions do not oblige graduates to accept a job within their originally selected enterprises, but the high salary levels and the incentive packages in general tend to ensure that they do. There were no dropouts among the first generation of Kronstadt's students, though six students switched to other schools. In an agreement between the school and a private health network, the network provides healthcare, hygiene, and family planning activities, as well as psychological and professional training.

In the case of the Kronstadt School, the involvement of major investors was a great help in pushing forward the institutional arrangements and providing constant financial and technical support. At the same time, the city hall of Brasov, one of the most economically developed localities in the country, provided RON 10 billion of the RON 16 billion worth of initial investment. In order to establish similar schools in other urban and rural areas that are less developed, it will be necessary to have the support of local authorities and to devise a strong strategy for recruiting entrepreneurs, along with clear strategies relating to both the educational system and labor market services.

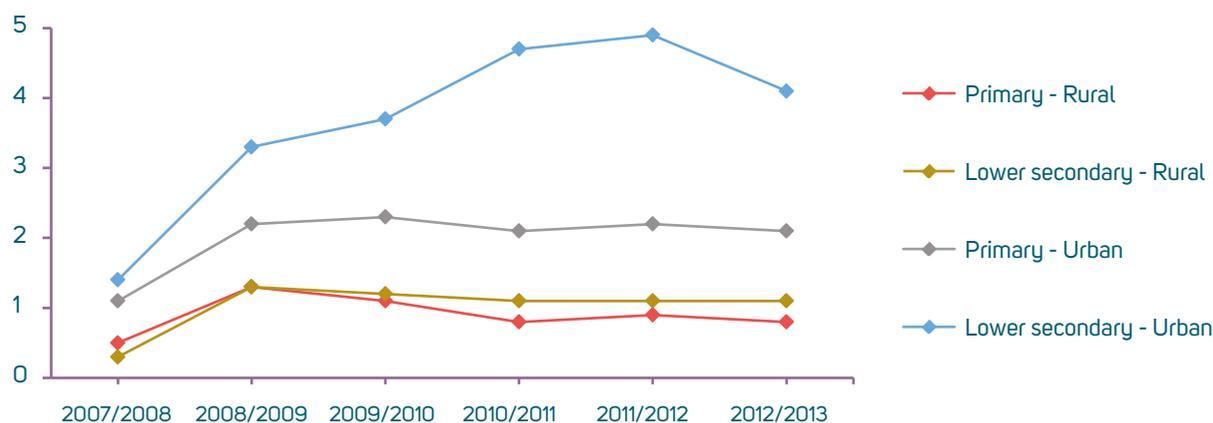
Improving the quality of IVET is a key priority for making it more inclusive. The dropout rate in IVET is the highest of all the levels of education. The recently introduced Vocational Scholarship is expected to cover part of the direct and indirect costs to poor students and their families of participating in vocational education, but it is unlikely to cover enough of those costs to significantly reduce dropouts, especially among students who have completed the 10 years of compulsory education. Moreover, the substantial dropout rate from vocational schools is an indicator of students' lack of engagement with the courses, which in turn indicates problems with the quality of teaching, with the degree of academic and social adaptation, and with students' expectations. The absence of vocational programs tailored to the needs of youths who are already active in the labor market (such as evening classes and apprenticeship programs) is another reason why participation is so low.

Some actions that policymakers should consider taking to improve the quality of IVET include:

- Redesigning IVET programs take into account those students most at risk of dropping out.
- Monitoring the school attendance and performance of students at risk.

A reform of Romania's vocational education and training (VET) system is currently underway but it needs further review and support. As the ESL Strategic Framework²⁶⁴ states, the VET reforms face two main challenges: (i) VET does not provide the high-quality technical skills that would help students to enter the labor market and (ii) it fails to provide an adequate level of generic skills that would give students a sound starting point for further learning. In other countries, VET has become an effective way to reduce early school leaving and has become an excellent pathway to lifelong learning (LLL). Some projects and programs have been implemented in Romania²⁶⁵ and have demonstrated some encouraging results. However, most of these projects have been small-scale pilot interventions, and a more comprehensive approach will be required to ensure the full implementation of these reforms.

FIGURE 36: Number of Students Enrolled in Second Chance Education Programs (2007/2008–2012/2013), (thousands)



Source: World Bank (2014b) using data from the Ministry of Education.

²⁶⁴ World Bank (2014b: 60). The ESL Strategic Framework includes two measures aiming at increasing the attractiveness and relevance of VET. These are: (i) redesigning VET pathways to increase its flexibility and permeability and reforming the curriculum and (ii) providing teacher and management staff training.

²⁶⁵ In various areas: teacher training, curriculum development, linking VET with market needs, opening schools to the community and business environment, and the development and monitoring of School Action Plans. For example, see <http://www.tvet.ro/index.php/ro/proiecte-de-dezvoltare-a-invariantului-profesional-si-tehnic/88.html> or <http://www.tvet.ro/index.php/ro/proiecte-de-dezvoltare-a-invariantului-profesional-si-tehnic/191.html>.

Second Chance education is the main reform that has been implemented by the Ministry of Education.²⁶⁶ Figure 36 shows that the largest enrollments in Second Chance courses are in urban areas, with the highest numbers being at the lower secondary level. Other measures include the introduction of evening classes for secondary education and low frequency classes for primary and secondary education.

Given the number of children under 18 years of age who are not currently in school, it is essential to find alternatives for those who are unable to attend Second Chance classes beyond lower secondary. Second Chance VET is the only second chance program available beyond lower secondary. Low enrollments, however, indicate that a large number of out-of-school children under 20 years old are not being served. Of a total enrollment in Second Chance VET of 8,143 students in 2012-2013,²⁶⁷ two-thirds (5,372) were at least 20 years old.

2.4.3. Promoting Broader Access to Tertiary Education by Under-represented Groups

The main challenges that policymakers face in the area of tertiary education consist of enhancing access to, supporting participation in, improving the quality of, and increasing the relevance of the subsector. Enrollment in tertiary education has decreased by 35 percent, from 716,464 (in 2005/06) to 464,592 (in 2012/13). According to the NIS, the enrollment rate in tertiary education for young students aged 18 years old (in other words, the tertiary education entrance age) decreased by 50 percent from 2005/06 to 2012/13. In addition, as is the case worldwide, in Romania there is a strong correlation between socioeconomic status and those who enroll in and graduate from tertiary education. As of 2009, more than 50 percent of the 25 to 29 age group in Romania's richest quintile held a tertiary degree, whereas in the poorest quintile the rate of tertiary completion among this age group was

only 5 percent (as of 2009). While the situation improved somewhat between 2002 and 2009, students from poorer (and rural) households continue to lag substantially behind their more well-off peers in terms of tertiary attainment.

Some priority actions for policymakers to consider include:

- Developing clear progression routes from vocational and other secondary education streams into tertiary education.
- Replacing merit-based fee waivers with a more limited set of need-based grants.
- Launching a student loan program as swiftly as possible.
- Encouraging tertiary institutions to reach out to students from under-represented groups and to non-traditional learners, including adults.
- Increasing the transparency of information on educational opportunities and outcomes and providing appropriate guidance to students to inform their study choices and reduce dropout rates.

2.4.4. Increasing Access to Lifelong Learning and Training for Disadvantaged Youths and the Working Age Population

The participation of disadvantaged groups in lifelong learning (LLL) is particularly low. The goal for Romania, as set out in the European Union's Europe 2020 targets, is to increase the participation rate of adults (those between 25 and 64) in LLL to 10 percent by 2020. Between 2007 and 2013, Romania did not make any significant progress in this regard, with the rate barely increasing from 1.3 percent to only 2 percent. The rate in 2012 (1.4 percent)

²⁶⁶ Second Chance education was piloted by the Ministry of Education as early as 2001 with a focus on those between the ages of 14 to 24 years old to help them to complete lower secondary education. This approach was eventually extended to other educational areas. A new curriculum for Second Chance education for primary and secondary education has been developed and implemented. Second Chance education aimed specifically at at-risk groups, especially the Roma population, has also been piloted.

²⁶⁷ With an allocation of RON 18,326 million in 2013.

was significantly below the EU-27 average of 8.9 percent. Romania has one of the lowest average increases in that respect in the EU and is failing to make the minimum progress required by the European Commission. A lack of financial resources hampers participation in LLL programs, particularly for disadvantaged groups. In a 2014 survey carried out by the World Bank, 22.8 percent of the almost 400 stakeholders involved in lifelong learning in Romania stated that the cost of education and training is a barrier to increasing participation.²⁶⁸ This is a peculiarly important factor for social inclusion policy because LLL is essential for empowering those at risk of exclusion.

The Strategic Framework for Lifelong Learning in Romania (2014) includes initiatives and specific measures aimed at increasing participation in LLL. The Framework recommends enhancing counseling services on education and training for students in upper secondary and tertiary education, adults who have left the formal education system, job seekers, and underrepresented groups. It also recommends providing vouchers and grants to the unemployed to enable them to continue their education. The combination of grants and vouchers and intensive counseling to help prospective trainees make sound choices should expand demand for LLL services.

2.4.5. Increasing Access to Quality Education for Children from Vulnerable Groups

This section focuses on children with special educational needs, children with disabilities, Roma children, and children living in rural remote areas.

Children with Special Educational Needs and Children with Disabilities

Disabled people in Romania are trapped in a vicious circle of limited access to education, discrimination, low employment, and poverty.²⁶⁹ Several assessments published in recent years have shown that the various programs funded by the government and/or the EU aimed at increasing the participation of disabled people in education and the labor market have produced very few improvements in their situation.²⁷⁰ This has been because a lack of support from teachers, parents, and employers, as well as a lack of enthusiasm for decisive action on the part of local and state authorities.

A standardized methodology for annual statistics and a dedicated permanent and reliable monitoring mechanism is needed to document access that children with special education needs (SEN) and/or disabilities have to education.²⁷¹ Official statistics are fragmented among many different departments and ministries and are only systematically collected and reported by the Department for Protection of Persons with Disabilities (DPH) and by the National Authority for the Protection of Child's Rights and Adoption (NAPCRA), both under the Ministry of Labor, Family, Social Protection, and the Elderly (MLFSPE). However, these two sets of statistics are not comparable as NAPCRA also includes children in residential settings, while the DPH has no access to these data. Thus, at the end of 2013, the DPH reported that the number of children with disabilities in Romania was 60,993 whereas NAPCRA reported the number as being 70,647.²⁷² NAPCRA's data on the participation in education by children with disabilities come from the County Directorates for Social Assistance and Child Protection (DGASPCs). Occasionally, the Ministry of Education also releases data on the number of children with disabilities in schools as it did, for example, within the Response of the Government of Romania to the UN's Office of the High Commissioner for Human Rights' (OHCHR) questionnaire on the right of people with disabilities to receive an education²⁷³ issued in December 2013). Again,

²⁶⁸ World Bank (2014c).

²⁶⁹ Guttman (2011).

²⁷⁰ Preda (coord., 2009), Szekely (2012), and Tudorache et al (2013).

²⁷¹ See, for example, European Agency for Development in Special Needs Education (2009).

²⁷² In December 2013, the DPH reported 60,993 children with disabilities, of which 31,740 children had severe disabilities, 11,922 had marked disabilities, 16,494 had medium disabilities, and 837 had mild disabilities (MLFSPE (2013 Statistical Bulletin Persons with Disabilities). For the same period, NAPCRA reported 70,647 children with disabilities, of which 34,905 children had severe disabilities, 13,861 had marked disabilities, 20,121 had medium disabilities and 1,760 had mild disabilities (MLFSPE, 2013 Quarterly Bulletin on Children with Disabilities).

²⁷³ <http://www.crj.ro/userfiles/editor/files/Response%20by%20the%20Government%20of%20Romania.doc>

there were differences between the official data provided by the NAPCRA and those released by the Ministry of Education. In addition, various studies have given yet another different set of statistics.²⁷⁴ With regard to children with special educational needs (SEN), no monitoring system is in place, and no government agency issues any regular reports on their circumstances. Some children with SEN also have disabilities, but most are prodigies or, more commonly, have behavioral disorders or have developmental delays associated with being from extremely poor families. The reverse is also true, in that some children with disabilities have also special educational needs, but not all of them (in other words, most of these children have a physical disability but no mental or intellectual disability). Due to the lack of consistent data, it is not possible to analyze the relationship between these two categories of children (with SEN and/or disabilities) or to quantify their actual participation in education. The proportion of people with disabilities within the total Romania population is estimated to be about 3.5 percent. Of these, fewer than 10 percent are children, with the result that the incidence of disability among children in Romania appears to be much lower than the worldwide level of about 10 percent. This is likely to be because of the problems faced by the Romanian authorities in trying to identify all cases of disability.²⁷⁵ These problems are largely caused by a lack of effort from the government compounded by the stigma associated with disability, which makes individuals unwilling to admit to being disabled.²⁷⁶ As is often highlighted in the literature on disability, the underreporting of the incidence of disability and special educational needs indicates that many children in need are not being provided with appropriate care and education.

In order to increase the participation of children with disabilities in education, the evaluation of special educational needs should be improved and better coordinated with the annual evaluation and confirmation of children's disabilities by the DGASPCs. In the education sector, the County Resources and Educational Assistance Centers (CJRAEs) are in charge of the integration in education of children with special needs. The CJRAE are also required to provide schools, parents, and teachers with support and professional assistance to ensure that education is inclusive (Law 1/2011, Article 99 (6)). In the

child protection sector, the Complex Evaluation Service under the DGASPC confirms the diagnosis of disabled children every year and issues proposals for including them in the education system with a particular recovery plan. Regarding the schooling of children with disabilities, the CJRAEs and the DGASPCs cooperate within educational orientation commissions, which are organized in different ways from one county to another. This commission decides the educational pathways for each disabled and SEN child in preschool, primary school, and secondary education and issues a certificate recommending the type of school for each school cycle of four years (the primary, lower secondary, and upper secondary cycles), as well as recommendations for an individual services plan for each child.

According to national legislation, children and young people with disabilities can receive their education in mainstream schools, in special schools, or in special classes integrated into mainstream schools. In theory, the option that is best for each child is decided by their families in consultation with their county's educational orientation commission. Consistent with Romanian legislation, the degree and type of a child's disability should determine which educational path is chosen. However, during the qualitative study carried out for this project, various problems were highlighted by professionals in education, special education, and child protection, by NGOs, and by families with children with SEN and/or disabilities:

- The Complex Evaluation Service of the DGASPC informs children with disabilities and their families about the educational orientation commission, but it is left to the family to decide whether or not to present themselves to this commission. At the same time, there is no formal mechanism by which the full list of children with disabilities can be shared between the Complex Evaluation Service and the educational orientation commissions, which would facilitate the monitoring of these children and their participation in education. This means that decisions about how a child with disabilities participates in school are left solely to the parents without any assistance or guidance. As a result, a large number of children with disabilities remain out of school.

²⁷⁴ Vrășmaș et al (2010).

²⁷⁵ Preda (coord., 2009) and Hatos (2010).

²⁷⁶ UNICEF (2007).

- Even if the parents go to the orientation commissions, the commissions often do not consider the opinions expressed by children with disabilities and their families but tend to direct them to special schools. Nonetheless, the law on education states that children with disabilities should primarily be educated in mainstream schools (Law 1/2011, Chapter 2, Article 50).
- According to the legislation, a child does not need to hold a disability certificate in order to be assessed for specific support in schools (either mainstream or special). The identification of children with SEN is done by a specific evaluation service that functions within the CJRAE. The inclusion of children with SEN in mainstream or special schools is decided by the educational orientation commissions. A request for a child to be evaluated by the CJRAE is made by parents, educators (in crèches or kindergartens), teachers, school psychologists, and/or other professionals who may work with the child at a given stage of his or her development. The evaluation and orientation of children with SEN (especially those without disabilities) is distorted because of the following practices:
 - Often, parents are “ashamed” that their child might have special educational needs so they do not approach the educational orientation commission even when the signs are evident.²⁷⁷
 - Parents with little education may not know how to recognize the signs of SEN and prefer to say that their child “doesn’t like school” and are too willing to allow him or her to drop out of school rather than looking for an alternative solution that is in his or her best interest.
 - Sometimes parents from extremely poor households discover that various in-kind benefits and support services (such as food, clothes, and school supplies) that are not available in mainstream schools are made available for pupils in special schools. In an effort to obtain these benefits, they approach the educational orientation commission. In many cases, their children are accepted because they have a two-year lag in development as a result of living in extreme poverty without proper support and care in a challenging and non-stimulating environment.
- Some teachers, especially from top schools and top classes, who may be excessively focused on academic performance, tend to refer to the educational orientation commission any child from a low-income or troubled family who happens to be assigned to their classes, often with the support of the other pupils’ families.
- Some teachers refer some of their low-achieving pupils in their classes to the educational orientation commission specifically because teachers can receive annual performance bonuses by identifying children with SEN and integrating them into their classes.
- Teachers tend to refer adolescent pupils with poor school performance to the educational orientation commission, particularly those from challenged family environments or those with behavioral disorders, mainly because they themselves are not trained to deal with these difficult cases and the schools have no counselors or psychologists to effectively support these children.
- The task of monitoring a child’s situation throughout his or her entire education should be clearly assigned to one or more specific agency such as the CJRAEs, the schools, or the School Inspectorates. The situation must be constantly (re)assessed, and any support measures must be periodically adapted to the child’s changing needs.
- Many children with complex disabilities finish compulsory education but cannot pass the examinations required to attend upper secondary school or the baccalaureate, mainly because of a lack of support services (such as counselors), and of a failure to adapt the curriculum and their individual intervention plans to reflect their needs. Thus, one of the most difficult problems for people with disabilities is the passage from one education cycle to another. During these stages, additional coordination is needed between the various bodies involved, including the Complex Evaluation Service and the educational orientation commission. Similarly, the educational orientation commission needs to work in tandem with vocational training programs or the courses offered by professional schools.

²⁷⁷ UNICEF (2012: 42).

The development of an inclusive culture in schools and communities is essential for increasing the participation of children with disabilities in education and for fostering their integration in mainstream schools. Various research, reports, and interviews with families of children with disabilities have illustrated the key problems that families encounter when their disabled children enter the education system.²⁷⁸ It has not proved to be easy to educate disabled children in mainstream schools, mainly because many teachers and families of non-disabled children are not in favor of their presence in schools. There is no culture of inclusiveness in schools, nor is there any respect for differences or for maximizing individual potential. A focus on competition and knowledge in the Romanian education system compounded by the marking system creates significant pressure on students, teachers, and families. The parents of disabled children have frequently identified this attitude as the major obstacle to accessing education for their children. This has meant that they often prefer to send their children to special schools as long as they can find an adequate educational pathway for their child in this special sector. In order to promote a more inclusive culture in schools, policymakers should consider taking the following actions:

- Creating further programs to train parents, tutors, and teaching staff in interacting with and helping children with SEN and/or disabilities, possibly using Human Capital Operational Program (POCU) funds.

- Including the topic of tolerance of disabled people and diversity in the educational curriculum in order to reduce the stigma and rejection associated with disability and SEN.

Collaboration between teachers and families needs to be strengthened. At present there is no framework for a real and constructive partnership between teachers and the parents of their students, which means that expectations on both sides are often unrealistic and biased by misconceptions and prejudices. It would be advisable for policymakers to consider mandating the creation of some consistent institutional arrangements within schools (such as parent/teacher associations) that would facilitate the building of trust, cooperation, and dialogue between teachers and parents.

The government should create and pass a specific all-inclusive education law as recommended by the Office of the High Commissioner for Human Rights of the United Nations (Box 31). The legislative framework that regulates access to education for people with disabilities is extensive and covers all aspects of education from preschool to tertiary education and vocational training (see Annex 6, Section II. Romania ratified the UN Convention on the Rights of Persons with Disabilities (UNCRPD) in December 2010 but has not yet provided the UN Committee on the Rights of Persons with Disabilities with an official national report on the implementation of the Convention (as it should have done in 2013).

BOX 31

An Opportunity to Introduce Inclusive Education Legislation

In 2013, the Office of the High Commissioner for Human Rights within the United Nations produced a Thematic Study on the Rights of Persons with Disabilities to Education. This following quote is from the conclusions and recommendations section of that report.

“Through inclusive education laws, States should establish an inclusive education system under the aegis of their respective ministries of education that prohibits rejection from mainstream schools on the basis of disability and provides for reasonable accommodation. A transformation plan should provide the framework for the implementation of an inclusive education system

with measurable goals. States should put in place training programs for teachers, create reasonable accommodation funds, provide for accessible materials, promote inclusive environments, improve testing methods, promote the transfer from special schools to mainstream schools, promote monitoring through indicators on inclusive education, provide adequate support to students, and use appropriate communication means and formats. Schools need to be properly funded, while at the same time availability of resources should not be a basis for denying access to the right to education for a student with disability.”

Source: UNHCR (2013).

²⁷⁸ For example, Horga and Jigău (2010), Ghergut (2011), Toth (2013), European Centre for Disabled Children's Rights (2013), and Chiriacescu (2014).

The rights of people with disabilities to be educated in mainstream schools is included in Article 24, paragraph 2(a) of the UNCRPD, which states that no student can be rejected from general education on the basis of disability. As an anti-discrimination measure, this “no-rejection clause” has immediate effect. Policymakers should ensure that a new dedicated education law is passed that explicitly includes a “no-rejection clause” that makes it illegal to deny admission to mainstream schools to disabled students and that guarantees continuity in their education. The current impairment-based assessments for assigning students to schools should be discontinued, and instead disabled students should be evaluated to ascertain their support needs to participate effectively in mainstream schools. The Ministry of Labor, Family, Social Protection, and the Elderly is currently developing a Strategy on the Social Inclusion of Persons with Disabilities (2015-2020).

Children with special educational needs (SEN) and children with disabilities are among the groups most likely to be out of school, especially in rural areas. As the 2011 Census indicated, one in every three children aged 7 to 14 years old with a disabling incapacity (total or partial) has either never been enrolled in or has dropped out of school. According to official data, the total proportion of children with disabilities not attending any kind of school (either mainstream or special) varies between 24 percent and 40 percent depending on the source of data.²⁷⁹ Also, 5,191 children do not benefit from educational support services, although they were identified as having SEN by the CJRAE’s evaluation service. In addition, various studies have shown that most children with disabilities who are not attending school come from rural areas (see Table 33).²⁸⁰ From these data, it is clear that a large number of children with disabilities are falling through the “net” of education in Romania.

TABLE 33: Numbers of Romanian Children with Disabilities who are Not in School by Degree of Disability, Age group, and Area of Residence, 2011

Degree of disability	3-6 years old	7-10 years old	11-14 years old	Rural	Urban	Total
Mild handicap	364	23	33	236	184	420
Medium handicap	1,490	364	393	1,081	1,166	2,247
Marked handicap	1,211	479	521	1,266	945	2,211
Severe handicap	3,805	2,454	2,369	4,867	3,761	8,628
Total	6,870	3,320	3,316	7,450	6,056	13,506

Source: UNICEF (2012: 25).

Note: The total number of children with disabilities at that time was 60,269 according to DPH official statistics.

Families and NGOs are raising the alarm about the inappropriate ways in which many schools (mainstream and special) currently accommodate:²⁸¹

- Children with autistic spectrum disorders.
- Children with behavioral problems.
- Children with ADHD.
- Children with HIV/AIDS and with rare diseases.

- Children with severe intellectual disabilities.
- Children with complex disabilities (such as associated impairments or functional limitations and complex dependency needs).

Increasing the number of vocational training programs for adolescents with disabilities in accordance with their capabilities and with available labor market opportunities has become a necessity. A research study conducted in 2009²⁸² showed that the percentage of people with disabilities aged 18 to 55 years old with no formal education

²⁷⁹ These data were provided by the Ministry of Education within the Response of the Government of Romania to the OHCHR’s questionnaire on the right of persons with disabilities to education, December 2013.

²⁸⁰ UNICEF (2012).

²⁸¹ European Centre for Disabled Children’s Rights (2013).

²⁸² Motivation Foundation and the Academic Society of Romania (2009).

was seven times higher than among the general population and the dropout rate after primary school was twice as high. The study also found that only 17.5 percent of disabled people in this age group finished high school, and only 8.3 percent had attended tertiary education institutions. The same study argued that making professional and special vocational education more accessible to disabled people would increase their employment opportunities since many of them are currently following this path of education. However, in practice, employment rates are no higher for disabled graduates of professional schools, mainly because professional education has not been adapted to take into account either people's capabilities or market demands. The current vocational training system for disabled people qualifies them for professions or activities that are no longer needed in the labor market or for occupations that individuals with disabilities cannot properly perform. As a consequence, most of the few youths with disabilities

who actually manage to obtain a qualification encounter significant challenges in finding employment. In conclusion, policymakers should consider designing and implementing new vocational streams at the upper secondary level, possibly funded by the EU, to teach qualifications that are appropriate for people with disabilities and that are in demand by social economy projects.²⁸³

Increasing the genuine inclusion of people with disabilities in the labor market will require increasing their participation in education, enlarging the spectrum of lifelong learning programs, and making qualification systems more flexible. Currently the opportunities for lifelong learning and continuous education for people with disabilities are extremely scarce. Only 1.5 percent of adults with disabilities were involved in a continuous training process in 2008, a proportion equal to that of the general population in Romania, but much lower than the EU-28 average of 9.3 percent.

BOX 32

The Current Education Network Available for Children and Young People with Disabilities in Romania

Currently the following education institutions are available to children and young people with disabilities:

- Mainstream kindergartens, schools, high schools, post-high-school education (with or without support or mobile teachers).
- Special kindergartens, schools, high schools, post-high-school education.
- Daycare centers (with an educational component).
- Integrated special education consisting of: (i) Special classrooms integrated into the mainstream kindergartens, schools, and high schools or (ii) Children with SEN being integrated individually in mainstream classrooms.
- Alternative schools developed by NGOs or public institutions (for example, Freinet, Montessori, pedagogia curativă, Planul Jena, Step by

Step, and Waldorf) following the existing curricula accredited for these alternative education methods in Romania. A National Commission for Alternative Education regulates these alternative schools.

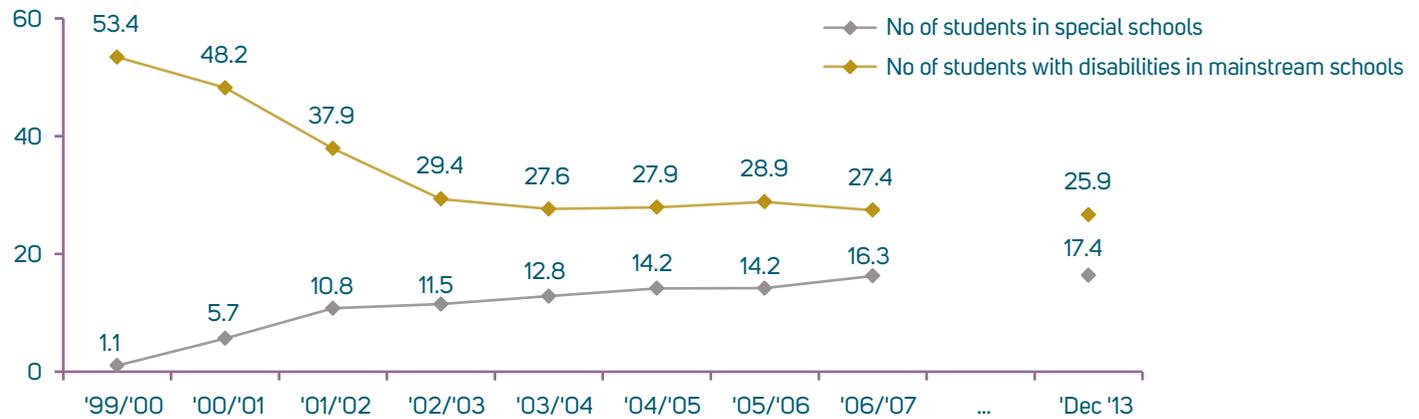
- Vocational schools.
- Special vocational schools.
- Technological special high schools.
- Inclusive education centers.

For more specific needs, mainstream or special education can be provided for people with disabilities either in their homes or in groups or classrooms that are organized in hospitals and rehabilitation centers (for children with chronic illnesses or children who need a rehabilitation/hospitalization period of no longer than four weeks).

Source: Law of Education, no.1/2011 and Order 3283/2012 of the Ministry of Education.



²⁸³ See, for example, European Agency for Development in Special Needs Education (2006).

FIGURE 37: The Number of Children with Specific Educational Needs in Schools in Romania, 1999–2013

Source: Vrășmaș et al (2010: 70) adapted for December 2013 with data provided by the Ministry of Education within the Response of the Government of Romania to the OHCHR's questionnaire on the rights of persons with disabilities to education.

The transition of children with SEN and/or disabilities from special schools into mainstream schools has progressed and should continue in the coming years. Since 1998, several laudable measures have been taken to transfer more disabled students into regular classes. A major policy reform in 2000 gave the Ministry of Education the role of ensuring the inclusion of children with SEN into mainstream schools. Four years later the Ministry issued an order encouraging schools to enroll children with SEN (Order no. 5379/Nov. 25, 2004). As a result, the number of SEN students in special schools has been reduced by half (from 53,000 in 2000 to less than 26,000 in 2013), while the number of SEN students enrolled in regular schools reached over 17,000 by the end of 2013 (Figure 37). The current legal provisions (Law 1/2011, Chapter 2, Article 50) recommend that most children with disabilities should be educated in mainstream schools. In addition, according to the official data, there are 5,191 students who have been certified as needing special education support who are not receiving this individualized educational assistance (probably because of the insufficient number of support teachers) and 1,137 students who are being educated at home. It is important to highlight that the closure of Schools of Arts and Trades decreased the number of SEN students enrolled in the special vocational education system (învățământ profesional special) from 12,468 in 2000 to 2,094 in 2012, with a further drop to 1,628 in 2012-2013.

Investing in the County Resources and Educational Assistance Centers (CJRAEs) to enable them to become real resource centers for inclusive education would constitute a major breakthrough for the education of children with disabilities. The CJRAEs, if properly financed and staffed with highly professional staff and equipped with support services available for all schools and families in the county, would contribute greatly to the promotion and development of inclusive education. For example, the CJRAEs already provide speech therapy centers (centre logopedice interscolare) as well as centers for psycho-pedagogic assistance that provide counseling services for teachers, students, and families. In 2013, the budget allocation to CJRAEs was RON 460,372 million for the support of 16,609 children with SEN.

The government should support the transformation of special schools into inclusion resource centers to provide pedagogical assistance to mainstream schools should be resumed and supported. This would use the expertise of teachers from special schools to support the education of children with disabilities within mainstream schools rather than as a way to maintain segregation. Although the reform initiated in 2000 aimed to modernize the special education sector, the process was never completed, and these special schools currently have fewer resources, staff, and opportunities for modernization than in the early years of the reform. The years of economic austerity (2008-

2013), along with the freezing of public positions, contributed significantly to this difficult situation. The number of special schools has also been gradually reduced from 180 schools in 2006 to 167 schools in 2013. These schools are mostly located in the main cities of each county and have residential facilities to accommodate children from neighboring localities. Considering the large number of children with severe and marked disabilities (almost 44,000 children living in families as of the end of 2013), it is evident that these special schools are completely insufficient, and therefore a large number of children with complex disabilities are falling through the education net at the present time.

Extending and adapting the available transport systems for children with disabilities is absolutely necessary. Adapted transportation is not available at national level, and therefore many children with neuromotor or associated disabilities cannot attend school, except in cases where their parents or an NGO finds suitable transportation to and from the school. In smaller cities (such as Roman in Neamt county), where public transportation is not even available for local inhabitants, people with physical disabilities are practically isolated in their homes. In rural areas, school transportation is unevenly distributed. The initial school buses provided by the Ministry of Education are currently the responsibility of local councils and therefore their maintenance is inconsistent. In winter, a large number of children in rural or remote areas, even those with no any disabilities, are isolated at home, because of a lack of transportation options.

A program of investment in essential infrastructure is needed to ensure that students can access all public educational institutions at all levels. This investment could potentially come from the Structural and Cohesion Funds. National and local policymakers could help by imposing regulations that require all educational and care institutions to be made fully accessible for the physically disabled. Access to schools and instructional materials, both mainstream and special, remains unevenly distributed. While special schools started investing in accessibility infrastructure from 2004-2005 onwards, mainstream schools are usually inaccessible for wheelchair users and for people with sensorial or associated disabilities. Additional challenges are encountered by children with mobility difficulties, especially in secondary education,

when their classrooms or laboratories are not on the ground floor, and the building is not provided with elevators or mobile electric platforms.

It will also be necessary to adapt the information technology used in existing schools in order to integrate children with SEN and/or disabilities. Easy-to-read information, pictograms, and specific learning areas for children with complex educational needs are rare in mainstream schools. Moreover, there are no assistive devices or technologies,²⁸⁴ except in those schools that already integrate children with sensorial disabilities. In addition, no interpreters for sign language are assigned to mainstream schools, and therefore it is very difficult for children with hearing or associated sensorial disabilities to function in a mainstream school environment. A national program for assistive technologies in schools would be of great benefit for children with SEN and/or disabilities.

The provision of social, health, or rehabilitation services is common in special schools but is almost non-existent in mainstream schools. This is a major barrier to integrating children with disabilities into mainstream schools. Children enrolled in special schools benefit from physiotherapy and speech therapy within the school, because special schools are entitled to hire these professionals directly. However, children in mainstream schools who need rehabilitation services such as speech therapy, physiotherapy, intensive medical treatment, and cognitive or behavioral therapies are forced to adjust their daily program in order to include these services after (or before) school hours when they are enrolled in mainstream schools. These services are rarely available in locations close to the student's home, which means that families have to make extra efforts to try to find the most practical solution for these daily arrangements. In order to keep these schedules flexible, the families are forced to use private sector therapists (instead of services covered by health insurance or by public institutions), which creates an additional financial burden for families.

Currently there is little pedagogical support available to mainstream schoolteachers who have students with disabilities in their classrooms, despite the existence of some continuous training projects initiated by the CJRAEs in several counties. There is little cooperation between mainstream and special schools, and therefore no

²⁸⁴ Assistive devices include any device that disabled children (or adults) might use to help them to learn and function more effectively. They include wheelchairs, hearing aids and amplification devices that improve hearing, glare-reduction screens, screen magnifiers, Braille note-taking devices, and voice-recognition software and technologies that enable severely disabled students to control their computers simply by following letters and commands on the computer screen with their eyes. In Romania, the development of such assistive devices is not very advanced. Producers are reluctant to enter the market because a large majority of devices are still not covered by the National Health Insurance, which means that most potential users cannot afford to buy these devices.

dialogue and exchange of practices between teachers on pedagogical methodologies and instruments for teaching children with disabilities. Nationwide, the number of school counselors and school-community mediators is very small - 2,184 and 232 respectively as of the end of 2013. There is an average of one school psychologist for at least every 800 students. Under these circumstances, the inclusion of children with disabilities often depends on a motivated or charismatic teacher or schoolmaster rather than on legislation, human rights, or existing professional norms.

Children in rural or remote areas are particularly negatively affected by the lack of support services. Mobile (interdisciplinary) teams are almost nonexistent in many counties. These children are often diagnosed later, or not at all, and often they fall completely through the net of education and social security.

The Ministry of Education has piloted a variety of prevention and remedial programs such as School-After-School, which provides after-school remedial support and extracurricular activities to students needing extra help. This program was piloted at the beginning of the 2012-2013 school year, with 5,500 beneficiaries and a budget of RON 61.395 million in 2013. Having had some success, this program will be progressively scaled up and will include a grant scheme to promote innovation at the school level. However, so far, financing for these preventive measures has been insufficient and ad hoc in nature. The ministry has also fostered the introduction of counseling services, school mediators, and support/mobile teachers (see below).

The development of inclusive education will not be possible without proper selection and training, of and funding for an extensive network of support or mobile teachers for mainstream schools and remote or isolated areas. Educational services are delivered to children with SEN and/or disabilities, both home-schooled and in mainstream education, by support or mobile teachers (*cadru didactic de sprijin* or *cadru didactic itinerant*). The number of support teachers is very small, and no new support teachers have been hired in recent years on any significant scale - only 1,310 for the entire country relative to about 20,000 children who are home-schooled or integrated in mainstream education (as of December 2013).

The regulations relating to the weekly workload of support or mobile teachers need to be revised in order to ensure that each child receives high quality support. The current norm is that a support teacher in a mainstream school will provide 16 hours of direct support per week for either eight children with mild or moderate disabilities or four to six children with marked, severe, or associated disabilities. The weekly

workload of a mobile teacher for home-schooled children with severe or marked disabilities is 16 hours per week, divided between four to six children. Actually, in practice, the same professional may have to work in several different schools or may spend some of his or her time as a support teacher in a mainstream school and the remainder as a mobile teacher for a small number of children, sometimes situated in different locales. Thus, the quality of the service is affected by these high workloads. The families of the students served by these teachers have complained that these hours are completely insufficient, especially when the children being supported by a given teacher are not located in the same school or classroom. Parents and mainstream schoolteachers believe that, in order to provide effective support to a child either in a classroom or at home, a support teacher cannot work with more than one (maximum two) children with disabilities per week.

The evidence of the last 20 years has proved that the existing resources in the education system cannot guarantee a quality for children with challenging behavior and complex dependency needs who are being educated at home. There were 1,137 such home-schooled students in Romania as of December 2013 as reported by the Ministry of Education. The assigned mobile teacher spends several hours per week with the child, and the entire social network of the child is compromised as a result of his/her isolation at home. While home education might be a good solution over short-term periods (for example, after complex surgery or during periods of intense medical rehabilitation), it is not a recommended solution for the long term.

There is a strong need for extensive and continuing training of teachers in this sector, in both mainstream and special schools, along with the modernization of pedagogical interventions, instruments, and methodologies. There is a significant lack of information and knowledge among teachers (in both mainstream and special schools) regarding the education of children with SEN, including those with very complex needs. Many teachers in mainstream schools find it difficult to adapt the curriculum to the needs of disabled children because they are not familiar or at ease with them. Even more experienced teachers have difficulties in adjusting their practices to the needs of children with autistic spectrum disorders, behavioral problems, ADHD, complex dependency needs, HIV/AIDS, rare diseases, severe intellectual disabilities, and other conditions that are considered obstacles to learning. Several CJRAEs (for example, in Botosani, Cluj, Neamt, and Valcea) have used local or EU funds to initiate courses or projects with the aim of expanding the skills and knowledge of teachers and counselors in the area of inclusive education. However, there are still very

few of these initiatives. In the future, initial training could be provided at the level of Departments for Preschool and Primary Education (within the Faculties of Educational Sciences) as well as in universities. Subsequent training could be provided at the level of Casa Corpului Didactic or at the level of the CJRAE. Additionally, all practicing teachers at all levels should take a mandatory module (of a minimum of five working days on average) covering the principles and practices involved in inclusive education.

The current poor training of teachers is reflected in the lack of adaptation and differentiation of the curriculum. Children enrolled in special schools benefit from a specialized curriculum at all levels of education, and they are also entitled to exceed the maximum age of school attendance by two years on average. In special schools for sensorial disabilities (hearing and visual impairments), children follow the mainstream curriculum, adapted only in terms of the communication methodologies and manuals used. Children with disabilities enrolled in mainstream schools are supposed to be taught according to a curriculum that is adapted to their needs and challenges in accordance with the recommendations included in their individual plan of intervention.²⁸⁵ These adaptations are theoretically made by teachers with the support of counselors or support teachers. However, adapting and differentiating the curriculum is not a simple process, and the majority of teachers are not familiar or at ease with the process, nor are they capable of adapting it in the best interest of the disabled child. Moreover, the younger generation of preschool and primary school educators, who have been obliged to graduate from a specialized three-year university program since 2011, have usually received only a very small number of hours of training on the subject of inclusive education and of special psycho-pedagogy. As a result, they have no real understanding of the specific needs and requirements of children with disabilities when they start work in the professional field.

Teachers are not trained in the use of specially adapted evaluation methods. As a result, the assessment of disabled children's school progress is not always adapted to the unique abilities and needs of the child, despite the legislative requirements. Children with complex disabilities often find it difficult to take annual examinations. Many of them finish compulsory education but cannot pass the examinations required to attend upper secondary school or the baccalaureate.

The financing mechanism for mainstream schools that have integrated children with SEN and/or disabilities needs to be adjusted, and an adequate budget should be allocated for the promotion and development of inclusive education. The government provides specific cash and in-kind benefits, such as food allowance and grants for school materials (Government Resolution no. 1251/2005), to children with disabilities who attend mainstream or special schools. At the school level, special schools receive extra funding in addition to their per capita financing, and they offer their students a series of in-kind benefits and services, such as hot meals, school supplies, and personal hygiene facilities (adapted toilets). However, this is not the case with mainstream schools that integrate children with SEN and/or disabilities. The costing methodology for per capita financing includes correction factors both for children with SEN and children with disabilities. However, the extra funding resulting from the application of correction factors is granted only if the school develops special programs for these children. These programs must have been incorporated into the school curriculum after being approved by the School Board and subsequently by the local council, the county council, the Ministry of Education, the ministry responsible for public administration (currently the Ministry of Regional Development and Public Administration or MRDPA), and the Ministry of Public Finance. Because of this long and complicated process for applying for supplementary funding, most mainstream schools that have integrated children with SEN and/or disabilities receive only the basic per capita financing. The interviews conducted under the current study highlighted this fact as a source of frustration for these schools, especially because the per capita financing formula seems to conflict with the regulations governing the number of children assigned per class, according to which one pupil with SEN is counted as two regular pupils. So, while the formula for assigning the number of children per class promotes smaller classrooms, thus making it easier to adapt the curriculum and to give special attention to students with SEN, the per capita financing system pushes schools to maximize the size of their classrooms in order to secure the most funding possible. Therefore, the financing mechanism diminishes the quality of education for children with SEN and/or disabilities, which has already been undermined by the underdevelopment of the support services discussed above.

In addition, public funding should be made available to support any educational centers provided by public-private

²⁸⁵ The Ministry of Education's regulations specify how the school curriculum can be "adapted to" or "differentiated in relation to" the needs of each child (HG 1251/2005).

partnerships or by NGOs (including specialized centers) that have been accredited by the Ministry of Education. Support should particularly be provided to those centers that provide

education in smaller communities close to children's homes. A good example of such initiative is provided in Box 33.

BOX 33

Good Practice - The Only Private Special School Accredited by the Ministry of Education for the Primary and Secondary Education of Children with Severe Disabilities

The Christian foundation RCE Hope for Children in Arad county is a non-governmental non-profit organization created from the merger of two non-governmental organizations, the Association of Christian RCE Arad (created in 1992) and Hope Children's Christian Association (created in 1994) Arad, both of which had the same sponsor - Romanian Christian Enterprises USA. Although initially focused on supporting micro enterprises through training and the provision of interest-free loans, the foundation's vision has been adapted to take into account local needs and priorities. The foundation's programs have been redesigned to reduce dependence on the state and to address basic human needs, especially the needs of vulnerable children. Thus RCE Hope for Children is a private body authorized and accredited as a legal entity, with no religious and political conditionalities, carrying out child protection, assistance, and support programs for various categories of vulnerable people.

The purpose of the organization is to facilitate the placement or adoption of abandoned children in Romania, to support abandoned children in orphanages and care centers and street children, to help those in need who cannot help themselves (children, youths, the elderly, people with mental or physical disabilities, orphans, and others with special needs), to support and train entrepreneurs in developing and expanding their organizations by hiring young people with disabilities, and to support education in schools and care centers for children and the elderly.

The organization's mission is professional service of abandoned children in institutions, families and the elderly in need. The objectives of the organization are to ensure social inclusion and rehabilitation services for abandoned children and children with special needs,

to improve the quality of life for the elderly in need, and to organize educational camps.

RCE Hope for Children runs the Sun Ray School, an educational center that works to integrate children with disabilities into the education system. The school consists of six classes, each with six to seven children between the ages of 3 and 14 years old who live either with families or in placement centers in Arad and surrounding localities. Each class has a teacher and an assistant.

Each student benefits from an educational plan designed to meet his or her specific needs including reading, mathematics, writing, language, and socialization.

In addition to special education, students benefit from physiotherapy, speech therapy, and counseling provided by qualified staff. The school's social networking programs are delivered two times a week and include going to a puppet theater, going on trips, going to the park, riding the tram, or visiting the farm, the baker's, or the transport company. During the school year, celebrations are prepared for various events such as Christmas, the 8th of March, Easter, and the end of school.

The educational center has 29 employees of whom 21 are teachers. In 2009 the Ministry of Education approved the extension of the school's education services to include a special school gymnasium and kindergarten. In 2014, 60 children were enrolled and six children were on the waiting list. The center's budget for is 11,000 lei per month plus donations (for example, for supplies, food, and clothes).

Extracurricular activities include a chorus of bells, sewing tapestry, teaching computers, music, and movement, swimming, and going shopping. Children are transported to and from school and are provided with two meals and a snack daily from Monday through Friday.

Source: <http://www.rcesperantacopiilorarad.org>



Roma Children

In Romania, the Roma population faces the most widespread and severe forms of deprivation, among which the lack of access to education is of the utmost relevance and gravity. The recent World Bank study²⁸⁶ on increasing the social inclusion of Roma in Romania drew attention to some alarming facts concerning the participation of Roma children in education. The participation rates for Roma children in all levels of education are significantly lower than for non-Roma children, with this inequality increasing sharply in upper secondary education.²⁸⁷

Few Roma children have access to quality preschool education. Only 37 percent of Roma children between 3 and 6 years of age are enrolled in preschool as opposed to 63 percent of their non-Roma neighbors (Figure 38). This low preschool enrollment undermines the school readiness of Roma children and their chances of attaining higher educational levels and acquiring employment skills later in life. International evidence demonstrates that early intellectual stimulation in the home and in preschool develops the foundations of cognitive and socio-emotional skills, improving a child's chances of socioeconomic success later in life, especially for vulnerable groups.²⁸⁸ For example, while only 5 percent of Roma children aged 4 to 6 who do not attend preschool can identify at least 10 letters of the alphabet, the percentage in the same age group goes up to 40 percent if they attend preschool.²⁸⁹ The same study states that the costs of preschool contribute to the low preschool enrollment rates of Roma children. Roma parents with children in preschool have reported spending €7.50 per month on preschool, approximately 4 percent of their household income, with children bringing lunch from home in more than three-fifths of all cases. Although this may seem a comparatively low amount, costs are nonetheless commonly cited by Roma parents as a constraint to sending their children to preschool. The small number of available places in local preschools and the generally low quality of the early education available to Roma communities further limit the access of Roma children.

The participation rates of Roma children in compulsory education are low. The results of the survey of Roma in Central and Southeast Europe undertaken by UNDP, the World Bank, and the European Commission in 2011 showed that the compulsory education enrollment is significantly lower for Roma than for non-Roma (78 percent versus 95 percent, see Figure 38). The same survey indicates that the main reasons that parents of Roma children for their children not going to school "costs are too high," they feel their children are already "sufficiently educated" or they "need to work for income."²⁹⁰ Increasing the participation of Roma children in compulsory education will require policymakers to take actions such as:

- Developing an early warning system to identify students at risk of dropping out would enable schools to take effective measures before the students become alienated from school, play truant, or even drop out. The Ministry of Education could commission Romanian or international experts to identify the most reliable and effective instruments for identifying disadvantaged children at risk from both Roma and non-Roma backgrounds.
- Expanding and enhancing mentoring and tutoring activities in order to help individual pupils to overcome particular academic, social, or personal difficulties. Either in one-to-one approaches (mentoring) or in small groups (tutoring), pupils would receive targeted assistance from educational staff, community members, or their peers.
- Other policies could include: (i) making schools more inclusive, relevant, and welcoming to Roma children; (ii) facilitating parental involvement in education; and (iii) investing in the transportation of Roma children who live far away from schools.

Education and employment policies should focus on increasing the skills and employability of Roma children in a coordinated manner. Roma have low rates of secondary

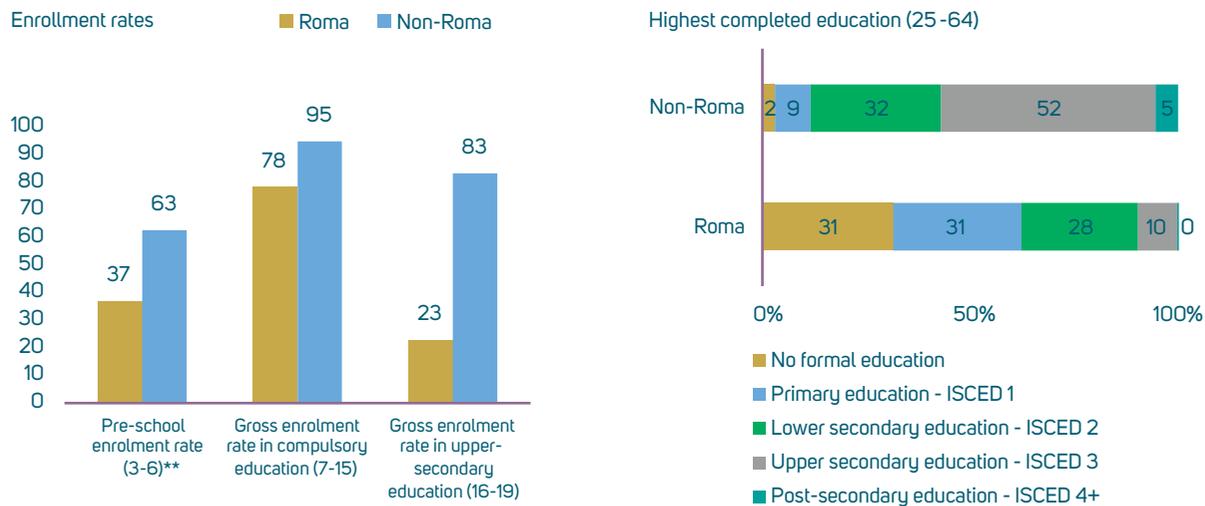
²⁸⁶ de Laat (coord., 2012) based on the regional UNDP/World Bank/EC regional Roma survey (2011).

²⁸⁷ The data on Roma have to be considered cautiously - each of the data sources having its own pitfalls (the survey on Roma communities not estimating right the situation of the dispersed Roma, while the Census underestimating the number of Roma and capturing most probably only the most deprived Roma - the other ones not having declared their ethnicity).

²⁸⁸ Kendall et al (2008).

²⁸⁹ de Laat (coord., 2012: 35).

²⁹⁰ FRA, UNDP and European Commission (2012).

FIGURE 38: The Gap in Education Outcomes between the Roma and Non-Roma

Source: World Bank estimations based on UNDP/WB/EC Regional survey 2011.²⁹¹

school completion. Secondary education in Romania lasts four years: grades 9 and 10 (lower secondary) are compulsory, while grades 11 and 12 (upper secondary) are not. According to the UNDP/WB/EC survey, 90 percent of the Roma aged 25 to 64 have completed lower secondary education or less, while the percent is only 42 in the case of their non-Roma neighbors (Figure 38). The gap between Roma and non-Roma enrollment is especially wide among young people aged 16 to 19 - only 23 percent of Roma youths are in upper secondary education, compared with 83 percent of non-Roma; completion rates are particularly low among Roma women – only 18 percent of Roma women aged 16 to 19 are still in school, while the percent of Roma men is 29.²⁹² Other indicators point in the same direction. Rates of computer literacy and participation in vocational training are about half as high among Roma as among their non-Roma neighbors. As a result of these significant gaps in early child development and education, Roma have access to fewer job opportunities in adulthood than the non-Roma. Actions that policymakers could consider in order to close this gap include:

- Scaling up and increasing the effectiveness of the Roma school mediator program.

- Introducing second chance education and traineeships, including adult literacy programs.
- Creating traineeships, internships, and placement programs in administrative positions at the central, regional, and local levels, especially for young Roma women.

Enhancing the capacity of teaching staff is crucial for the effective delivery of inclusive education to Roma children. The following actions could be considered:

- Developing and introducing cultural competency modules within the mandatory curriculum for initial and in-service training of public officials.
- Expanding the teacher training university curriculum with courses focusing on teaching children from disadvantaged groups (including Roma).
- Practical training with classes in disadvantaged schools, to accompany the above measures.

To achieve comprehensive inclusion of the Roma population, combating negative stereotyping is crucial.

²⁹¹ http://www.eurasia.undp.org/content/dam/rbec/docs/Roma_survey_data_-_Romania_2011.xls

²⁹² World Bank (Anan et al, 2014).

Roma children often experience exclusion on the basis of their ethnicity in school. A UNICEF study presented evidence that the risk of school dropout as well as the risk of early school leaving is negatively correlated with parents' level of education, household income, and household expenses related to school.²⁹³ However, they are also positively correlated with ethnicity (for example, being Roma), with rural location, with having a higher number of children in the household, and with birth order.²⁹⁴ Within households with many children, the younger children have a significantly higher risk of leaving school early than their older siblings. However, ethnicity was the only significant determinant in multiple regression models²⁹⁵ of risk of school dropout or early school leaving. Consequently, being identified as Roma by a teacher significantly increases a student's chance of only completing eight grades at most, all other things being equal or constant. This reflects the existence of discrimination against Roma children within schools, a finding which confirms existing evidence about highly persistent anti-Roma attitudes among parents, members of local authorities, teachers, school managers, and even non-Roma children. Research conducted in some of the largest Roma communities has shown that Roma frequently face discriminatory remarks at school.²⁹⁶ As shown in Section 2.7 on social participation, Roma still experience discrimination and prejudice in Romania because of their ethnicity, despite the continued efforts of Romanian authorities, civil society, and international donors to fight the problem. Some measures to tackle this social problem are suggested in the same chapter, to which the following recommendations may be added:

- Introducing a third-party ombudsperson to monitor the observance of non-discrimination principles by public service providers (for example, in health care, social assistance programs, and schools).
- Enforcing the law against discrimination more effectively and consistently by amending the law and the institutional framework of the National Council for Combating Discrimination.

For the effective inclusion of Roma population, it will be essential to rigorously pursue anti-segregation policies and to continue the desegregation of Roma schools. Discrimination and prejudice lead to segregation, segregated classrooms, and even segregated schools. As a recent research report showed, ethnic prejudice among teachers is one of the major obstacles preventing desegregation.²⁹⁷ Consequently, the opportunities for Roma children to develop skills are further hindered by the high level of segregation of Roma pupils in classrooms. Nearly a quarter of Roma children currently attending basic education are in classes where most of the children are Roma.²⁹⁸ This is worrying, given the evidence that school segregation has strong negative implications for the quality of education and skills development of Roma students. Findings from international studies suggest that students in integrated schools, both Roma and non-Roma, perform better on standardized reading comprehension tests and in the development of non-cognitive skills and attitudes of tolerance.²⁹⁹ The ESL Strategic Framework recommends that the government should help communities and schools to achieve a representative population balance in classrooms.³⁰⁰ The Framework suggests a set of activities that would expose families, communities, and schools to Roma and other cultural minority groups. This initiative would be complemented by targeted community events to disseminate information on social inclusion to dispel the myths that are often developed about ethnic minorities. It also proposes appointing more mediators to help school principals to ensure an ethnic balance in the classrooms and to facilitate dialogue with parents.

Investing in school mediators would be beneficial for the Roma, as these mediators appear to play a positive role in enhancing the participation of Roma children in compulsory education. The number of school mediators is low and has been declining in recent years. A recent study by 'Împreună' NGO showed that over half (55 percent) of the surveyed schools lack a school mediator, including schools with over 50 percent Roma children. Between 2003 and 2013, through various programs, a total number of 1,001 school mediators were trained in Romania, but only 232 were reported to be actively employed as school mediators at the

²⁹³ Stănculescu et al (2012: 63).

²⁹⁴ Within households with many children, the younger children have a significantly higher risk of leaving school early than their older siblings.

²⁹⁵ All other things being equal, being Roma increases significantly the probability of a child dropping out or leaving school early irrespective of the child's age, gender, and health status, the mother's level of education, the number of children within household, the number of parents at home, the location of the household, and household spending related to education (or household income).

²⁹⁶ ERRC (2013: 10).

²⁹⁷ Fox (2012: 2).

²⁹⁸ World Bank (Anan et al, 2014: 37) based on the regional UNDP/World Bank/EC regional Roma survey (2011); See also Surdu (2008).

²⁹⁹ Kezdi and Suranyi (2009).

³⁰⁰ World Bank (2014b).

national level by the Ministry of Education as at December 2013. Some local mayors have diverted resources from the Roma mediator program to other areas, while in other cases, the Roma mediators themselves have opted out because of the low salaries being paid. In future, it will be vital to improve the regulation of the role of Roma mediators. For example, at present, mediators are required by principals to do administrative work or even cleaning. In other cases, they are assigned to teach Roma children while the teachers themselves only teach the non-Roma students.³⁰¹

Children from Rural and Urban Marginalized Areas

Further investment in rural schools will be needed to ensure equal access to quality education for children in deprived rural areas. Rural areas are at a disadvantage compared with urban areas (see the chapter on rural marginalized communities), as are rural schools in comparison with urban ones, in terms of available funding, human resources, infrastructure, and accessibility.

Although the costing methodology for per capita financing uses a correction factor in favor of rural schools, in many cases it does not succeed in compensating these schools for the low number of students per class. Consequently, schools with a smaller number of students receive an insufficient budget and are regularly subjected to the budgetary re-equilibration mechanism to cover salaries and taxes. Their available budget for “material expenses”³⁰² is also small and does not allow them to develop or fully equip themselves. The standard cost per student for the acquisition of goods and services is RON 296 in rural areas compared with RON 347 in urban areas.

Despite continued investment, many rural schools, particularly smaller ones in remote villages, still have poor infrastructure and are ill-equipped with teaching materials and modern equipment, such as ICT and connections to the Internet. Many of them have not been granted sanitary certification because of a lack of proper toilets and sewage systems. Moreover, many rural schools lack safe and effective heating systems.

There are few qualified full-time teachers in rural areas, so the schools have had to employ a large number of part-time, poorly qualified teachers who commute from a distance. Consequently, there is high turnover of personnel at rural schools.

The limited amount of quality infrastructure and of school directors and teachers is noticeable in rural areas at all levels of education but especially in vocational and technical education and training. The increasing professionalization of farming is making it necessary to provide rural students with relevant programs of basic and technical education. The ESL Strategic Framework includes recommendations that mirror the priorities set by the National Strategy for Strengthening the Agri-Food Sector.³⁰³

Investment in the transport infrastructure and related projects is essential for ensuring access to quality education for children in remote and poorly connected rural communities. There are two programs available to support most pupils commuting to and from school, namely free school buses and transportation reimbursement. During the 2012/2013 school year, 2,238 school buses were available nationwide, and the Ministry of Education reported that a total of between 150,000 and 170,000 students received transportation reimbursements. While use of the school bus program has increased sharply in 2013 and 2014, the transportation reimbursement was delayed and downsized in terms of both the total budget and method of assessment, so that the average amount reimbursed to a child for the same distance has been almost halved.³⁰⁴ The number of rural children whose transportation to and from school is not reimbursed is still significant.³⁰⁵ This problem particularly affects preschool children and primary and secondary school students living in remote areas that do not have functioning roads. Many rural households that are dependent on subsistence agriculture cannot afford the travel expenses associated with sending their children to school. It is also educationally ineffective for students to live a long distance from the school. This is especially the case with several large vocational schools that provide training and education for many rural teenagers, for whom

³⁰¹ World Bank (Anan et al, 2014: 19).

³⁰² This covers all costs related to the maintenance and operation of the educational unit, including the purchase of goods, repairs, books and publications purchased for the library, expenses incurred in conducting training sessions, and other expenses authorized by statutory provisions.

³⁰³ World Bank (2014b). These recommendations include measures to: (i) “accelerate the structural transition towards professional commercial farming, while aligning with demographic trends and ensuring an equitable phasing out of surplus farm labor” and (ii) “reinstate Romania as a net agri-food exporter, in accordance with its sector production potential and in response to strong global food demand agricultural development.”

³⁰⁴ According to a monitoring report of the Ministry of Education in 2013, the six-month delay and the downsizing of the program were the result of the high, unforeseen costs of the passes (supposed to be reimbursed). The value of the passes greatly varied from one locality to another, the most costly being 10 times higher than the lowest value pass for a journey of the same distance.

³⁰⁵ A public report indicated that there are no school buses or other sustainable solution for transporting local children to and from school is available in several counties - Argeş, Mehedinţi, Vaslui, and Suceava (Avocatul Poporului, 2013). With regard to the transportation reimbursement, the actual numbers of students commuting to school in other counties is higher than the number of applicants for reimbursements because some of the students use the services of private transportation providers that do not always issue transportation passes.

the transportation reimbursement program has been vital, especially those from low-income backgrounds. Therefore, this very popular program needs to be restored to its former level of support as a matter of priority. Policymakers may wish to consider several other actions, including:

- Extending the school bus service to cover the transportation of preschool children (and, where longer distances are involved, their parents) in rural areas where other means of transport are not available.
- Revising the school bus program so as to include clear and explicit criteria, such as the number of children with special needs attending non-residential schools who need transporting to and from school.
- Providing adequate financial support to the localities where buses are available to ensure the sustainability of the program. At present, fuel and drivers' salaries are usually funded by a combination of direct payments from the county governments and payments from the school budget.
- Designing a means-tested scheme for children from poor and vulnerable households to fully cover their transportation costs in cases when the actual transportation scheme does not do so.
- Investing in boarding facilities for schools.

Greater investment is also needed in disadvantaged schools in urban marginalized areas. In urban areas, there are also some schools with a large proportion of children from vulnerable groups, including children with special educational needs, children with disabilities, Roma children, or children from low-income or extremely poor families. Some of these urban schools are also segregated, either geographically or in ethnic terms or both, particularly those that concentrate children from marginalized areas. Most urban disadvantaged schools have equivalent infrastructure to regular schools, but some (particularly the segregated ones) may lack sanitary facilities and proper heating. However, most of these schools lack educational materials and modern equipment and are subject to high staff turnover because young inexperienced teachers usually

leave to work elsewhere as soon as an alternative presents itself. This has a negative effect on children since younger teachers have limited knowledge of working with vulnerable children (and their families). A high staff turnover means that continuity in care and nurturing for needy students is lost, and the bonds and the trust relationships between teachers on the one hand, and students and their families on the other become more tenuous (Coleman, 1988). The status and prestige of these schools is also low, and consequently better-off parents tend to bypass them.

The School Infrastructure Rehabilitation program,³⁰⁶ which began in 2004 and will end on December 31, 2015, aims to rehabilitate, upgrade, and furnish primary and secondary school buildings. The program is managed by the Ministry of Education and is financed by a loan from the European Investment Bank and the Council of Europe Development Bank. Its main objective is the rehabilitation, upgrading, and furnishing of the 1,336 Romanian primary and secondary schools and 16 dormitories to restore the safety of school buildings and improve their sanitation and comfort. In 2013, the program was operating in 320 locations throughout Romania, with an allocation of RON 250 million. However, more investment is needed in this area.

Making Funding Mechanisms Responsive to Students' and Schools' Needs

Above all, improving the quality and equity in education in Romania will require an increase in overall financing for education. In Romania, the level of funding for education is among the lowest in Europe and is decreasing. Total education spending as a share of GDP has declined substantially from 4.25 percent in 2007 to 3.1 percent in 2011 (Figure 39). The amount that a government spends in a given social sector depends partly on its overall fiscal constraints and partly on the priority given to that particular sector in its public resource allocations.³⁰⁷ Therefore, the country's fiscal context³⁰⁸ is the main driver of the relatively low spending on education as Romania has an overall government spending level of 39.4 percent of GDP (in 2011) as against an EU-27 average of 47.9 percent. However, government education spending accounts for only 7.8 percent of total government expenditure (decreasing from

³⁰⁶ <http://www.schoolrehabilitation.ro/>

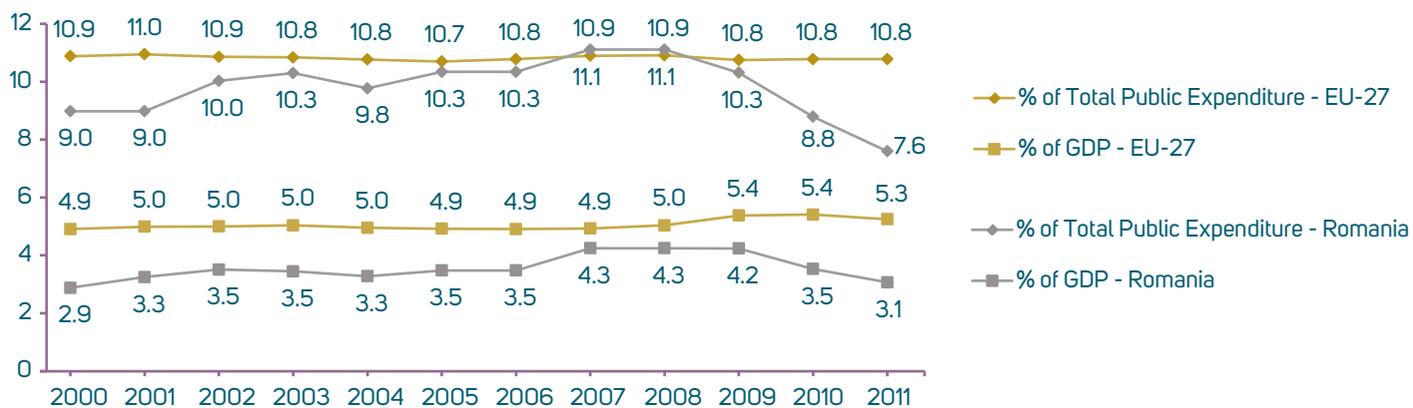
³⁰⁷ This relationship was demonstrated for health care by Kutzin and Jakab (2010).

³⁰⁸ The fiscal context refers to the current and expected spending capacity of a government. More affluent countries tend to be more effective at mobilizing tax revenues and thus have higher levels of public spending as a share of GDP, whereas when a country has more limited fiscal space, this usually results in low government spending, including on education and health care.

11.1 percent in 2007) compared with a constant EU value of 10.8 percent, meaning that the central government gives a fairly low priority to the education sector. In addition, private expenditure on education has also decreased in Romania

from 0.5 percent of GDP in 2007 to 0.11 percent of GDP in 2011, which was almost seven times lower than the then EU-27 average of 0.74 percent.

FIGURE 39: Relationship between Education Spending, Fiscal Context, and the Priority Given to the Education Sector in Romania and in the EU-27 in 2011 (%)



Source: Eurostat.

BOX 34

Improving Equity and Quality in Education

The 2012 OECD report *Equity and Quality in Education* spelled out the funding strategies required to improve equity and quality in education as follows: “Available resources and the way they are spent influence students’ learning opportunities. To ensure equity and quality across education systems, funding strategies should: guarantee access to quality early childhood education and care (ECEC), especially for disadvantaged families;

use funding strategies, such as weighted funding formula, that take into consideration that the instructional costs of disadvantaged students may be higher. In addition it is important to balance decentralization/local autonomy with resource accountability to ensure support to the most disadvantaged students and schools.”

Source: OECD (2012a: 10-11).



The per capita financing of Romanian schools is based on a weighted funding formula that takes into consideration the fact that the instruction costs of disadvantaged students may be higher than average.³⁰⁹ These per capita costs apply only to basic funding. The costs associated with educating poor and vulnerable children come under the complementary funding or supplementary funding sections of the budget. Complementary funding consists of expenditure on canteens, boarding schools, school allowances, and national support programs (for example, those covering the costs of school supplies and high school scholarships), which comes from the budgets of the local authorities from the amounts that they deduct from VAT. Supplementary funding finances programs encouraging ethnic minorities to enroll in school, school dropout prevention programs, and support for students with social problems or disabilities. Supplementary funding comes from both the central and local budgets. Despite these various sources of funding, most school managers report that their budgets are barely sufficient to cover their basic expenses (mainly salaries).³¹⁰

The per capita based funding of Romanian schools seems to be inadequate to meet the actual needs of schools located in or serving disadvantaged communities, particularly in rural areas. Within the basic funding, per student unit costs³¹¹ take into account schools' characteristics including their location (in urban or rural areas), their utility needs (for those with high winter utility bills), the level of education (preschool, primary, or secondary), what educational streams they offer (in other words, theoretical, vocational, and so on), their teaching profile (full-time, part-time, or distance learning), and type (public or private). School financing is decentralized to the local authorities, though the state sets the formula per student to ensure that schools do not lack funds, irrespective of how limited local revenue-generating possibilities may be. However, a recent UNICEF study³¹² showed that many schools have a systematic budget deficit, particularly these categories of schools:

- Schools in small villages with dwindling numbers of students, which are usually unable to attract children from neighboring localities in order to enhance their number of pupils.

- Schools, usually in rural areas, that have lost their official status because they had fewer students than the legal minimum, thus becoming part of one larger institution whose management transfers only the minimum amount to the original school.
- Large prestigious schools with highly qualified staff in urban areas (with high staff salaries).
- Vocational schools where the teaching process involves one-to-one activities.
- Apprenticeship schools where practical learning activities require expensive materials.

Thus, many rural schools are facing serious financial difficulties that are negatively affecting the quality of the education that they provide. This is the case even though the financing formula is weighted in favor of rural schools in order to compensate for their lower numbers of students per class. The stated intention of the Ministry of Education to close financially unsustainable schools in remote areas goes against the need to ensure that all children can access education. A more equitable financing system that incorporates social criteria in calculation of per capita funding might allow some of these schools to become sustainable and remain open.

In addition, supplementary funding, which is currently based on a weighted funding formula for children in vulnerable situations, needs to be reviewed, but should also be properly delivered to all mainstream schools where such children are enrolled. The base funding includes various correction factors to cover the additional costs to schools of teaching children in minority languages, but all other groups are covered by correction factors to the supplementary funding as can be seen in Table 34. However, as already explained above in the section on children with SEN and/or disabilities, supplementary funding is usually received only by special schools and often does not reach those mainstream schools that have students from vulnerable situations. This supplementary funding is only available to mainstream schools if they develop special programs for those children. As shown before, these programs must have been incorporated into the school curriculum after

³⁰⁹ The new financing system was introduced in the 2011 National Education Law and implemented later with government decisions spelling out the costing and allocation methodology (GD 1274/2011 and GD 1165/2013) and the actual standard costs. A subsequent legislative provision (GD344/2013) allows a redistribution of budgetary funds to schools in cases where the per capita allocation does not entirely cover expenditure.

³¹⁰ Fartusnic et al (2014).

³¹¹ The reference unit cost is decided every year by Government Ordinance and is estimated for a gymnasium student in an urban area by dividing the value of the average teacher salary by the average number of students per teacher.

³¹² Fartusnic et al (2014).

TABLE 34: Correction Factors for Supplementary Funding

Categories of vulnerable students	Correction factors	Observations
Roma pupils	3.07%	Applied only if specific programs are directed toward these students within the school.
Pupils with disabilities	2.59%	Applied if there are children with disabilities within the school.
Pupils from disadvantaged groups	6.31%	Applied only if specific programs are directed toward these students within the school.
Pupils with SEN	0.68%	Applied only if there are approved specific programs for these children.
Pupils with special social needs	high risk area - 0.65%	Depends on the area in which the school is located, with the degree of risk determined by the County Directorate for Statistics.
	medium risk area - 0.43%	
	small risk area - 0.21%	

Source: www.isj.dj.edu.ro.

Note: The correction factors are applied to the standard unit cost.

being approved through a long and complicated process for applying. Consequently, these schools, although they have higher than average proportions of disadvantaged students, have limited resources and are usually unable to implement any activities that support students who are at risk of repeating grades, absenteeism, or dropping out.

Policymakers might consider providing supplementary funding counting all children from very poor families given their high risk of dropping out of school or early school leaving (Figure 35). The UNICEF study cited above³¹³ evaluated several alternative measures for improving equality within the Romanian education system and concluded that the simplest and most accurate measure would be to ensure that the families of these students receive the GMI (soon to be called the Minimum Social Insertion Income or MSII). The advantages of using this measure include: (i) it is a nationally provided benefit that uses standard criteria; (ii) it is effective in identifying families with the highest risk of social exclusion; and (iii) the necessary social enquiries are made by the social assistance department of the local authority. This supplementary income could be used by the school only within the school and only to cover the cost of services for

eligible children such as hot meals, after-school programs, special support programs, and incentives to attract teachers to work with children from disadvantaged groups.

2.4.6. Enhancing the Effectiveness of Welfare Programs in Education

The Romanian Government and local authorities operate a plethora of cash and in-kind schemes to help poor and vulnerable families to overcome the financial barriers to educating their children. A summary of these schemes is presented in Table 35. However, even with all these financial programs in place, students still cite financial barriers as the main reason for not participating in upper secondary school. High school dropout rates are rising, and fewer people are applying for most of the schemes. Individually and collectively, the schemes have not been successful in reversing the sharp decline in participation in upper secondary schooling in Romania.

³¹³ Fartuşnic et al (2014).

TABLE 35: Summary of Cash and In-kind Schemes Aimed at Facilitating Access to Education for Disadvantaged Pupils

National Level – Cash Grants	<p>The Money for High School program provides a large cash grant (180 lei or US\$51) every month to high school pupils with incomes per family member under 150 RON</p> <p>The Professional Scholarship program provides an even larger cash grant (200 lei or US\$57) every month to students in the professional stream, regardless of income, in both public and private schools.</p> <p>The Transport Reimbursement program reimburses the actual cash value of transportation (up to 50 kilometers) for pupils who travel beyond their locality to attend school. A Government Decision enforced a 26 RON threshold for the 3 km distance, with 2 RON added for every additional km.</p>
National Level – In-kind Support	<p>The School Supplies program provides a fixed package of goods of very low value (25 to 30 lei or US\$7 to US\$8.5) once per year to students from the poorest decile in grades 1 to 8 for students in families with earnings less than one-half of the minimum wage per household member.</p> <p>The Euro200 program provides a one-time voucher to families in the poorest decile to purchase a computer.</p> <p>School buses have been purchased to ease transportation barriers, especially in rural areas.</p> <p>The milk, breadstick, and apple program provides basic food to all pupils in grades 0 to 8 and kindergartens.³¹⁴</p>
Local Level	<p>A range of local bursaries exist, notably for excellence and performance (high grades), study (good grades by students whose families earn less than the national minimum wage per capita), and social bursaries (for students whose families earn less than half the national wage per capita, are suffering from certain medical conditions, are orphans, or cannot attend a school near their home). The amounts awarded, the eligibility criteria, and the actual distribution of these bursaries are highly discretionary.</p>

The theory behind social assistance benefits says that, where markets exist, a cash transfer is usually the best kind of benefit to provide because it allows families to optimize their consumption choices, and the evidence bears this out. Giving the cash transfer to the mother of a family increases the chances that the money will be spent on the children and for productive purposes. In places where there is a thriving financial market, delivering a family's cash transfer to a bank account or savings card can promote financial inclusion and encourage savings. Benefit levels should be set high enough to prevent extreme hardship but low enough not to create any disincentives to work. Adding conditions to the receipt of these cash transfers (specifically in this case requiring the family to ensure that their children stay in school) works best where there is a supply of services available that are not being used because of financial constraints on potential users.

In countries where multiple social assistance schemes exist, the costs to families of submitting applications are often high, and the administrative costs of these multiple schemes can also be high. When these programs have management information systems that are linked to other databases (such as tax records, land registries, or civil

registries), this can reduce the amount of administrative work required for each application, while also providing controls against fraudulent applications. Harmonizing the eligibility requirements and application forms for multiple benefits and/or allowing automatic entry if an applicant has already qualified for another scheme can reduce the private costs to individual applicants.

The following observations can be made about the current welfare system as it pertains to poor and vulnerable students:

- Three schemes (the School Supplies program, the Money for High School program, and Euro200) use an extremely low eligibility threshold of 150 lei (US\$43 or approximately US\$1.5 per day) per adult income. This is well within the income level of households in the poorest decile (who earn between 0 and 187 lei per adult equivalent income). This threshold has not changed in 10 years, except when the Money for High School program increased the threshold for one year in 2008 to 200 lei, which temporarily reversed the decline in enrollment in the scheme, which increased by 10 percent in that year.

³¹⁴ A comparative analysis of the school fruit schemes across the European countries, including Romania, is available in AFC Management Consulting AG and CO CONCEPT Marketing Consulting (2012). For an analysis of the milk and breadstick program, see Arpinte et al (2009).

- Each scheme requires applicants to produce a significant amount of notarized paperwork and to go to the town hall to get their documents verified. In the case of the School Supplies program, the cost of application is thought to equal or exceed the value of the goods provided, and in the case of the Euro200 scheme, the pupil still has to pay any cost of purchasing the computer over and above the voucher amount.
- Families with multiple children have to apply for each scheme separately and for each child separately each year, thus multiplying their private costs.
- The Money for High School program requires a minimum amount of school attendance by the child (85 percent), with no possibility of re-entering the scheme if this threshold is not met, even though in rural areas children of high school age are often expected to participate in agricultural activities for several weeks or months.
- The Transport Reimbursement scheme suffered a setback when transport companies raised their prices, knowing that the full amount would be reimbursed, leading to a six-month delay in sending payments to pupils. Some private transport providers do not even issue invoices.
- In the Money for High School program, applicants apply through and receive cash from the school, thus creating potential for petty fraud by school administrators. It also risks stigmatizing students who are seen applying for and receiving cash from the Principal's office every month.
- Under the Money for High School program, the amount provided to the student in cash exceeds the per adult income for their household, thus raising questions about whether the funds are used optimally. Further, the amount does not increase when school stops being compulsory (in 11th and 12th grades) when other supplies are no longer provided free.

A few more general observations can be made about the administration of these schemes. Those involved in administering the schemes (including school principals, the staff of the School Inspectorates, and Ministry staff) believe that the schemes foster high school participation

by students from poor and vulnerable families. However, we have been unable to find any evidence that any of the schemes have been evaluated for their impact or cost-effectiveness, nor does there appear to have been any strategic overview within the Ministry of Education of the compatibility and consistency between national and local schemes or between the programs provided by the various ministries at the national level.

Furthermore, the Ministry of Labor, Family, Social Policy, and the Elderly (MLFSPE) administers a range of cash social assistance schemes, including the Family Allowance (soon to become part of the Insertion Minimum Income that is also conditional on children staying in school. The eligibility threshold of the Family Allowance has been increased twice in recent years and is now at 530 lei. This is three and a half times higher than the 150 lei threshold for the Money for High School program, but the benefit level is four and a half times lower at 40 lei (soon to rise to 74 lei) compared with the 180 lei benefit paid by the Money for High School program. There are considerable overlaps between schemes in terms of their objectives, and the School Inspectorates are required to issue separate attendance lists to the Ministry of Education for the Money for High School scheme and to the Ministry of Labor, Family, Social Policy, and the Elderly for the Family Allowance program.

There are several recommendations that stem from these observations that range from very minor to ambitious:

- Very minor technical changes that might be considered include: (i) merging the School Supplies and Money for High School programs into a single cash grant for all pupils, increasing eligibility thresholds for the cash schemes; (ii) limiting the Professional Scholarship program grant to students from poorer backgrounds; (iii) and/or reducing the application requirements for some or all schemes.
- A moderately ambitious action might be to harmonize the application requirements and eligibility thresholds for all programs, resulting in a one-stop application process, with automatic enrollment for students throughout school years (unless they have been suspended due to absences) and with the onus on the applicant to advise administrators of a positive change in their household circumstances.

- More ambitious still would be to revamp the whole series of cash programs, acknowledge that they are in reality social assistance, and merge the national cash programs into the MLFSPE's Family Allowance (soon to be the IMI) program, which has low application costs and considerable monitoring and oversight capacity.

For education policymakers to make the best decisions for children at risk of social exclusion, capacity in the area of monitoring and statistical data collection needs

to be increased.³¹⁵ The Ministry of Education has just implemented a complex new system for collecting data about kindergartens and schools (with information on, for example, the number of children enrolled by grade, the characteristics of schools, and the number and qualifications of teachers). Continuously updating the information from such a system will not only improve the design, monitoring, and adjustment of policies but will also yield the evidence necessary to inform thorough and reliable impact assessments of the various programs and measures for fighting exclusion from education and employment.

BOX 35

Meals for Vulnerable Children in Disadvantaged Schools in Arad

Two hundred vulnerable children from six disadvantaged schools in Arad benefit from a local program delivering hot meals. These beneficiaries are children from destitute families (with an income below RON 470 per family member), exposed to extreme social risk (at risk of separation from their families or of dropping out of school), and who are attending primary education in targeted local schools.

The social assistance office in Arad, namely the Department for Community Development and Assistance (Direcția de Dezvoltare și Asistență Comunitară – DDAC) finances, coordinates, and monitors the program. The social canteen, owned and operated by the DDAC, provides the catering, which is delivered after classes on the premises of the selected schools. The DDAC program is supplemented by a daycare center, Curcubeu, where children from the poorest school in the city (School No. 2), which is located near the daycare center, attend after-school activities and receive a broad spectrum of services, including food support. This daycare center serves 127 poor children in total, most of whom are from School No. 2.

The declared objectives of the food support program are: (i) to ensure the upkeep, remediation, and development of the capacities of such children and their parents to withstand the critical conditions that may cause

separation from their family or school dropouts and (ii) to support children in achieving the best possible school results. Three target groups have been set: (i) children at risk of separation from their parents; (ii) children reintegrated into their families after leaving the special protection system; and (iii) children at risk of dropping out of school.

The cost of the hot meal, subsidized by the local authorities, is RON 8 per child, and covers only the financing of the meals provided by the social canteen. The cost of the program targeted to vulnerable children from disadvantaged schools is comparable to the costs covered by parents in the after-school programs in better-off schools, which are reported to range from RON 6 to RON 12 (with the menu being at the discretion of the parents).

The institutional arrangement for the program is formalized in a cooperation protocol entered into between the DDAC and the County School Inspectorate (Inspectoratul Scolar Judetean - ISJ). The Local Council Decision establishes, among other aspects, the RON 470 eligibility threshold per family member, a threshold that is much higher than the value set by the outdated Social Canteen Law 208/1997 (which uses the Guaranteed Minimum Income threshold for a single person).

The DDAC submitted a formal petition to the ISJ, which selected the most disadvantaged schools. However, it is not clear what selection criteria were used as there is no system in place (at either the national or county



³¹⁵ An extended analysis and recommendations can be found in World Bank (2014b: 72-83). Chapter 5 covers monitoring and evaluation (M&E) mechanisms, including their rationale, proposed indicators, processes for tracking change, the frequency of M&E activities, and the assignment of responsibilities.

BOX 35 (continued)

level) for establishing which are the most disadvantaged schools. Within these schools, the class masters establish an initial list of children, relying on their knowledge of the economic and social situation of the individual pupils and their families. The DDAC performs a social inquiry and compiles an application file for each pupil, which includes the application form, identity documentation, and other civil status documents, as well as papers certifying the family's income sources (salaries, pensions, and social allowances). Around 10 percent of the schools' proposals are rejected following the DDAC's social inquiry.

The critical points of the program appear to be: (i) securing the cooperation of parents in the application process; (ii) the condition that the food be delivered in individually wrapped cutlery in accordance with hygiene standards in those schools without a canteen or dedicated refectory (which slightly raises the total costs); and (iii) the unclear targeting mechanisms for the selection of schools and children.

In general, satisfaction with the program is reported to be high both among managers (the DDAC, the ISJ, and the schools) and beneficiaries. The complete hot meal (three courses) is regarded as an excellent intervention given that "it might be the only cooked food that these children have for the day" according to

one school administration representative. The program is particularly relevant in the context of the ongoing public debate about whether to change the targeting of the program and whether to provide hot meals instead of the current milk, breadstick, and fruit package. Other than its intrinsic benefit in providing a healthy and nutritional meal, the program appears to be, in the eyes of the stakeholders, an important incentive for securing school attendance and preventing school dropouts. It is not clear, however, if it improves students' performance in school given that the complementary educational and social support activities have been temporarily abandoned.

In the context of the debate about introducing a national food support program, the implementers of the Arad program suggest a range of available solutions in order not to restrict the access of better-off children. One simple idea would be to distribute meals according to the income thresholds of families, in other words, free of charge for the poorest children and with progressive costs charged for income-earning families if they are interested in participating. Keeping the program open to all children could prove to be an important feature, especially considering that more than one in five families in Romania cannot afford a meal with meat, chicken, fish or a vegetarian equivalent every second day, according to Eurostat data for 2013.



2.5. Health

"We want to see better health and well-being for all as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance. We must tackle the root causes (of ill health and inequalities) through a social determinants approach that engages the whole of government and the whole of society."
(Margaret Chan, WHO Director-General)



Main Objectives

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2.5. Health

Health and poverty are strongly interrelated. Poverty is a direct contributor to ill health, while poor health, in turn, can be a major contributor to poverty, reducing a person's ability to work and leading to high costs in treatment and care. For example, at the EU level, there are significant differences between various income groups in terms of how healthy they are, in the extent to which their personal activities are restricted because of illness and disability, and in their life expectancy at birth, with the gaps between the lowest and highest socioeconomic groups being up to 10 years for men and six years for women.³¹⁶ Romania's healthy life expectancy - the average number of years spent in good health - is far below the EU-15 average of more than 70 years as is also the case in most other South-Eastern European countries.³¹⁷ Also, evidence shows that Roma are particularly affected. High poverty, limited education, and low employment rates among the Roma population all contribute to poor health, resulting in a life expectancy that is, on average, six years lower than that of the non-Roma population.³¹⁸

Poor and vulnerable people become ill sooner and die earlier than the general population. Poverty creates ill health through inadequate living conditions (lack of decent houses, of clean water and/or of adequate sanitation). It leads to poor nutrition and an unhealthy diet, making the poor vulnerable to disease. Poverty also creates illiteracy, leaving people poorly informed about health-promoting behavior or health risks. Last but certainly not least, poverty makes it difficult for people to access health care and medicines when needed. There is strong evidence that health gets progressively better as the socioeconomic status of people and communities improve (this is called the social gradient of health). Consequently, preventing illness and providing access to effective and affordable healthcare are important ways to combat poverty.

Cross-sectoral policies that take into account the social determinants of health are the most effective way of

improving the health of the poor. The theory of the social determinants of health (Scheme 6), which was developed some decades ago, is the foundation of all strategies and interventions aimed at reducing the health gap between the poor and the general population around the world. As shown in Scheme 6, access to health services is just one of the determinants of good health so increasing access, while essential, can only make a limited contribution to improving health outcomes among the poor. Only an integrated approach that includes not only greater access to social and healthcare services (with a focus on prevention) but also improving education, nutrition, and housing conditions, including water and sanitation, will lead to a significant improvement in the health outcomes of the poor. This is what the WHO Regional Office for Europe report *Health 2020: a European Policy Framework*³¹⁹ has recommended as an essential approach for achieving the strategic objectives of improving health for all and reducing health inequalities. With this aim, the member states of the European Union have called for inclusive and sustainable cross-sectoral policies aimed at reducing the health gap between the poor and the general population. In addition, the European Platform against Poverty and Social Exclusion, one of seven EU flagship initiatives supporting the social objectives of Europe 2020, highlights the urgent need for national health policies to increase efficiency while simultaneously ensuring universal access to quality healthcare.

As acknowledged by the European Commission in June 2014,³²⁰ Romania has made some progress³²¹ in pursuing health sector reforms aimed at increasing efficiency and accessibility and improving quality in accordance with the 2013 country-specific recommendations of the European Council. The Commission praised Romania's National Health Strategy 2014-2020³²² for pursuing more equitable access to quality health services, but it considered the prevalence of informal payments³²³ as a significant

³¹⁶ European Commission (2010b).

³¹⁷ The most recent World Health Organization estimates of the disability-adjusted life expectancy (DALE) indicated a healthy life expectancy of 65 years for Romanians in 2007. (<http://data.euro.who.int/hfad/b/>, data downloaded November 20, 2014).

³¹⁸ World Bank (Anan et al, 2014).

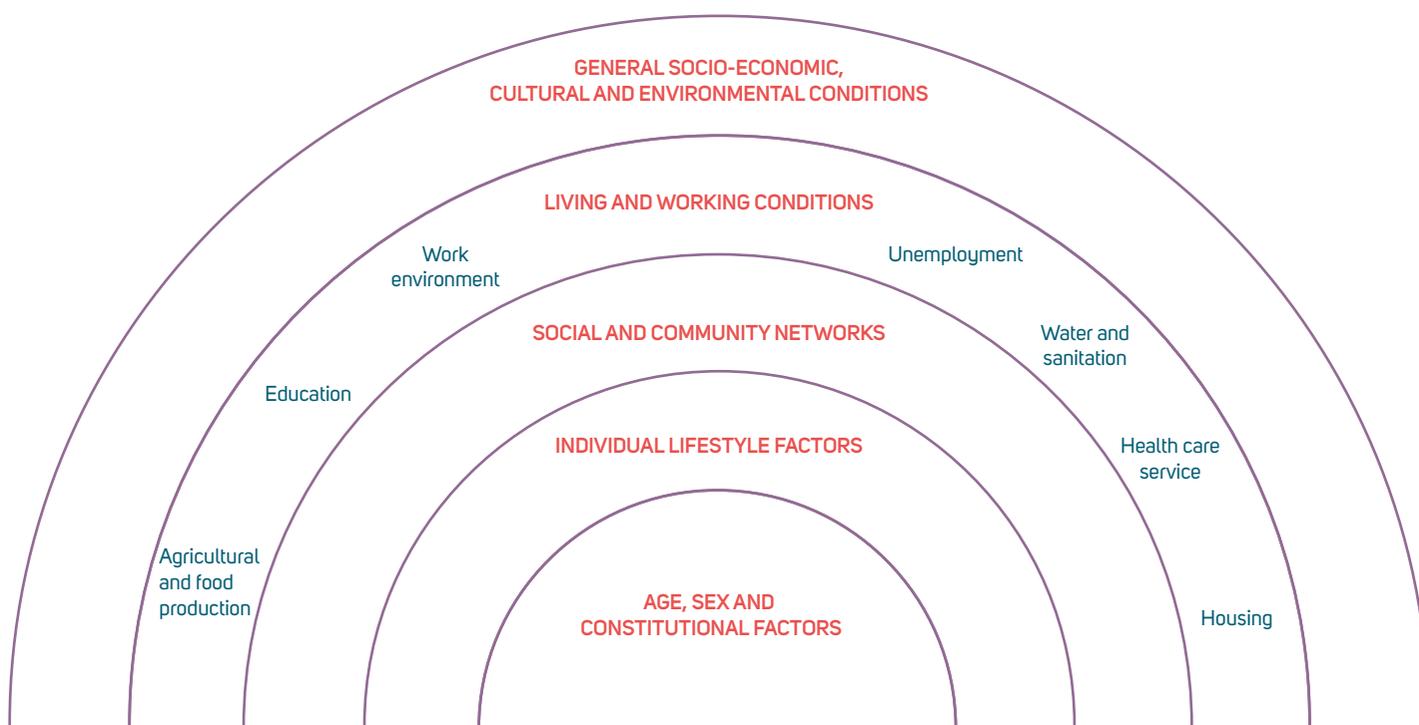
³¹⁹ WHO (2012c).

³²⁰ European Commission (2014b).

³²¹ According to the standardized categories used by the EC to assess progress in implementing the 2013 country-specific recommendations (CSR): "Some progress means that the Member State has announced or adopted measures to address the CSR. These measures are promising, but not all of them have been implemented yet and implementation is not certain in all cases."

³²² Ministry of Health (2014).

³²³ Informal payments are defined as a monetary or in-kind transaction between a patient and a staff member for health services that are officially free of charge in the public sector.

SCHEME 6: Social Determinants of Health

Source: Dahlgren and Whitehead (2007: 20).

barrier to accessibility, especially for the most vulnerable. Therefore, reforming the health sector remains one of the Commission's eight country-specific recommendations for Romania as follows: "Step up reforms in the health sector to increase its efficiency, quality, and accessibility, including for disadvantaged people and remote and isolated communities. Increase efforts to curb informal payments, including through proper management and control systems."³²⁴

2.5.1. Improving Health Equity and Financial Protection

The government has initiated strategies and policies aimed at increasing health equity, and this process needs to be accelerated in the future. Key measures have included the program compensating pensioners earning less than 700 lei per month for 90 percent of their medicine expenses, which has more than 1,000,000 beneficiaries,³²⁵ and the increase of around 34 percent in the health insurance budget allocated for homecare services in 2014 compared with the previous year. The main challenge is to put the promised reforms into practice in the relatively near future. These promised health reforms consist of:

³²⁴ European Commission (2014b: 7).

³²⁵ National Reform Program 2014, Government of Romania, April 2014 (cumulative data starting 2011, OPSNAJ Health Insurance Fund are not included).

(i) an improved minimum healthcare package, aimed at providing prevention services (assessment of health risks) and treatment to the uninsured population in addition to emergency services and the care to which they are currently entitled; (ii) a revised basic healthcare package covered by social health insurance that will allocate more resources to primary and secondary preventive care; (iii) a revision of the existing national health programs to focus more on prevention and targeted interventions; (iv) a shift in health service delivery from hospitals to ambulatory and primary healthcare providers; and (v) a revision of the list of reimbursable medicines. In November 2014, the government approved the National Health Strategy 2014-2020 that set out the strategy for reducing health inequalities, but no consistent interventions yet exist to put this strategy into practice. For example, simple but cost-effective regulations need to be devised to encourage doctors' to prescribe generic drugs, to exclude drugs with limited evidence of effectiveness, to confine the use of some drugs to very specific conditions, and to exclude the use of no cost benefit drugs or those with an available generic equivalent.

Making Funding Responsive to the Specific Needs of Vulnerable Groups

Above all, improving the quality and equity of health care in Romania will require an increase in overall financing for the sector. Spending on health is not merely a cost but is also an investment with a long-term impact on a country's socioeconomic development.³²⁶ In Romania, the level of total health spending is among the lowest in Europe and is decreasing. Total health spending as a share of GDP has declined from about 6 percent in 2010 to 5.1 percent in 2012 (Figure 40), but the official figures do not take into account the widespread use of informal payments within the health system. The amount that any government spends in a given social sector depends partly on its overall fiscal constraints and partly on the priority that it gives to that particular sector in its public resource allocations.³²⁷

Therefore, the country's fiscal context³²⁸ is the main driver of the government's relatively low spending on health since Romania has an overall government spending level of 35.2 percent of GDP (in 2012) compared with an EU-27 average of 48 percent. However, public health spending accounts for only 14.5 percent of total government expenditure (which has decreased from 16.3 percent in 2005) compared with a constant EU average of about 20 percent, meaning that the central government gives a fairly low priority³²⁹ to the health sector. As a result, Romania's total health expenditure per capita is nearly four times lower³³⁰ than the EU-27 average - US\$873 PPP compared with US\$3,346.³³¹ These data are consistent with the OECD and European Commission's recent report "Health at a Glance: Europe 2014," which found that Romania has the lowest health expenditure per capita (€753 PPP) among the member states, three times lower than the EU-28 average. Between 2009 and 2012, expenditure on health in real terms (adjusted for inflation) decreased on average by 0.6 percent (due to cuts in health workforce and salaries, reductions in fees paid to health providers, lower pharmaceutical prices, and increased patient co-payments), while in Romania the annual average growth rate in per capita health expenditure in real terms was 0.4 percent (2009-2012), compared to 9.1 percent in the previous years (2000-2009).³³² Despite these overall figures, Romania constantly increased its expenditure on public health, and this spending will continue to increase.

The budgetary allocations to primary healthcare need to be increased, and better monitoring is needed of the services provided by general practitioners. Although all European governments have declared primary healthcare a priority, it has always had low budget allocations. In 2008, the Ministry of Health initiated a costly but questionable population screening exercise, which was the cause of a sudden increase in the primary healthcare budget, which dropped back down in subsequent years (Table 36). Various international organizations have encouraged Romania to increase its primary healthcare budget by at least 10 percent of the National Health Insurance Fund budget. Increasing the availability of primary healthcare is undoubtedly the best way to increasing the access of poor

³²⁶ European Commission (2007).

³²⁷ Kutzin and Jakab (2010).

³²⁸ The fiscal context refers to a government's current and expected spending capacity. More affluent countries tend to be more effective at mobilizing tax revenues and thus have higher levels of public spending as a share of GDP, whereas when a country has more limited fiscal space, this usually results in low government spending, including on education and health care.

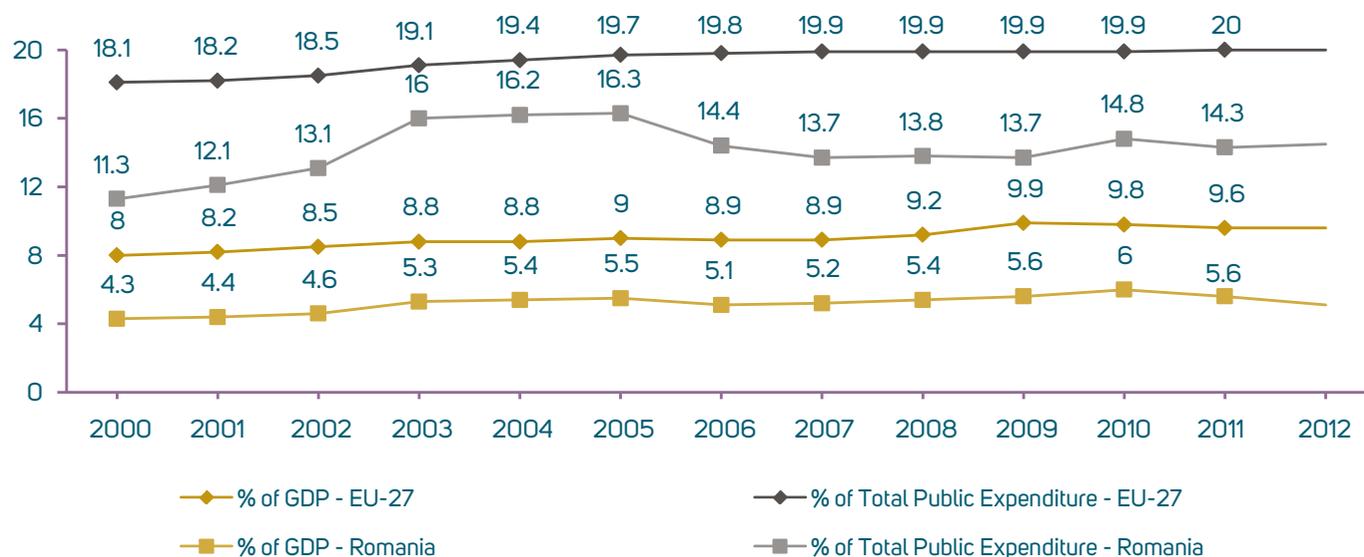
³²⁹ However, the priority given by both the Romanian government and the EU to the health sector has been consistently higher than that accorded to the education sector.

³³⁰ Nevertheless, with respect to total health expenditure in PPP\$ per capita, the gap between Romania and EU-27 has continuously narrowed, from more than eightfold in the late 1990s to less than fourfold in 2012.

³³¹ WHO estimates for 2012, <http://data.euro.who.int/hfad/>

³³² OECD (2014).

FIGURE 40: Total Public Expenditure on Health as a Percentage of GDP/Total Public Expenditure in Romania and in the EU-27



Source: World Bank calculations using data from the European HFA Database, WHO/Europe, November 2014.

and vulnerable groups to quality healthcare, particularly by means of health promotion and education and disease prevention. The budget of a family doctor contracted with the Health Insurance Fund consists of a combination of a capitation fee (50 percent) and a fee for service (50 percent), but GPs also charge their patients a consulting fee even though this ought to be covered by the capitation fee. The primary healthcare services that they provide should only carry a fee for service if they are aligned with public health priorities³³³ or, as in other countries, if GPs reach a certain target related to a public health priority (for example, reaching a 90 percent vaccination rate for all eligible children in a given catchment area such as a village, regardless of whether eligible children are included on the GP's capitation list or not).

Measures aimed at improving the health of the poor and vulnerable population should receive adequate funding. A good example is family planning. While one out of every ten live births is registered to a teenage mother, the state allocates no more than RON 20 per person per year for family planning and a maximum of two reimbursed visits per year to a family doctor or GP for counseling about contraceptive methods. Over a year, GPs earn more money by releasing a death certificate than by providing family planning services to an uninsured woman. If that doctor is a senior GP, then the death certificate has almost the same financial value as the post-natal care delivered by a regular GP to an uninsured woman (RON 33 versus RON 37).³³⁴

³³³ The list of Romania's strategic areas of intervention together with their corresponding general objectives can be found in Ministry of Health (2014: 26).

³³⁴ The framework contract and its application in the 2014-2015 service delivery within the National Health Insurance System (Gov. Decision 400/2014; Ministry of Health-Health Insurance House Ordinance 619-360, May 2014).

TABLE 36: Primary Healthcare Budget 2005–2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014 (approved)
Health Insurance Budget (RON million)	9.3	10.1	12.9	16.6	15.3	17.5	17.8	19.5	23.1	22.6
Primary Healthcare Budget (RON million)	0.5	0.5	0.7	1.5	1.1	1.1	1.1	1.2	1.3	1.5
Primary healthcare expenditure as % of total health insurance budget	4.9	4.6	5.8	8.8	7.2	6.3	6.2	6.2	5.7	6.6

Source: Data aggregated from National Health Insurance reports (www.cnas.ro).

Ensuring the Financial Protection of Poor and Vulnerable Groups

Out-of-pocket and informal payments are a barrier to accessing to healthcare services for poor and vulnerable people who cannot afford to pay. Patients' co-payments for publicly insured services represent a relatively small component of total health expenditure, but out-of-pocket payments³³⁵ are significant and increasing. Estimates from WHO show that households' private out-of-pocket payments on health as a share of total health expenditure have continuously increased since 2007 from 17 percent to almost 22 percent in 2012. This compares with a constant 16 to 17 percent EU-27 average during the same period.³³⁶ This prevents many people with lower incomes from accessing health care and thus has a negative effect on their health outcomes. According to the World Bank's Functional Review of the Health Sector,³³⁷ 62 percent of the poor in Romania pay for medicine, and almost 60 percent of people admitted to hospital said that they had made informal payments in 2008, up from about 30 percent in 2001. Furthermore, 63 percent of households in the poorest quintile pay out of pocket compared with 88 percent of the richest. Many of the poor who are in need of healthcare services do not seek care. Because the average rate of reimbursement for the poor is the same as for all other income groups and because the use of healthcare services

is higher among higher-income groups, it is obvious that the middle classes and upper-income groups benefit the most from subsidized health services.

The government needs to design, implement, and budget for a clear policy on informal payments in the public healthcare system nationwide. Statistics on out-of-pocket payments probably underestimate the phenomenon as patients also pay informally for healthcare services (whether voluntarily or not). Several studies of informal payments for healthcare in Romania have shown that these are widespread in both ambulatory and hospital care and are almost universal for operations, childbirth, and life-threatening procedures. A study conducted by the Romanian Institute of Evaluation and Strategy in 2011 showed that, out of all of the informal payments for public services reported by the population (11 percent at the national level), those for healthcare are the most common (5 percent for doctors and 2.5 percent in hospitals).³³⁸ However, most of the reported informal payments were given in gratitude for healthcare, as only 1.2 percent patients declared that the staff had solicited the payments. A national representative survey carried out in 2012 indicated that gifts (such as coffee, chocolate, meat, flowers, and cigarettes) accounted for 88 percent of informal payments in Romania, while informal cash payments represented approximately 37 percent. Most gifts were given at the end of treatment while most cash payments were given before or during treatment.³³⁹ Usually, the amount that patients pay informally for care reflects the seriousness of

³³⁵ Defined by WHO as including non-reimbursable cost sharing, deductibles, co-payments, and fee-for-service but excludes payments made by enterprises that deliver medical and paramedical benefits, mandated by law or not, to their employees. It also excludes payments for overseas treatment.

³³⁶ WHO/Europe, European HFA Database.

³³⁷ World Bank (2011a).

³³⁸ IRES (2011).

³³⁹ Spridon (2011).

the illness. Thus, a survey done in 2013 in the capital city Bucharest showed that the informal payment for a GP was around 34 lei (about €8), while in hospitals for a problem that did not require surgery, it increased to approximately 360 lei (or €80)³⁴⁰ and reached 1,130 lei (or €250)³⁴¹ in cases involving surgery.³⁴² Wealthier, better educated, and younger patients tend to pay more often as a way of obtaining better quality treatment. A recent literature review that covered eight South-Eastern European countries³⁴³ concluded: "After 1990, informal payments had become more frequent, explicit, increasingly in cash, and less affordable. Informal payments stem from patients desiring better treatment, the low wages of staff, acute funding shortages, and tradition. Attitudes to informal payments range from strongly negative (if solicited) to tolerant (if patient-initiated), depending on the circumstances. However, generally speaking tolerant attitudes towards such practices are prevalent both among patients and medical staff."

Informal payments may be associated with cultural and historical factors, but they have mainly arisen because the public healthcare system is unable to provide adequate access to basic services. So the actions recommended in the next sections relate mainly to strengthening and improving the quality of primary healthcare and developing the community-based healthcare network. In addition, the government should implement regular information campaigns on the benefits of the changes targeted both to healthcare system stakeholders and the public.

Lack of resources also makes it difficult for the national healthcare system to supply proper treatment and medication. One of the EU health indicators relevant for social inclusion is the self-reported percentage of unmet need for medical examinations. The Eurostat data show that 9.6 percent of the Romanian population declared in 2012 that they could not afford medical care or considered it to be too expensive (compared with 0.1 percent in United Kingdom and Finland, 0.2 percent in the Netherlands, and 5.9 percent in Bulgaria). There were significant differences based on socioeconomic status from 13.3 percent for those in the lowest income quintile (the poorest 20 percent of the population) to 3.5 percent for those in the highest income quintile (the richest 20 percent of the population). Although these percentages had decreased compared

with the previous year, Romania is still one of the top three EU member states in terms of unmet healthcare needs for households at all income levels.

In this area, the government should consider:

- Finding ways to make prescribed generic drugs, medical consumables, and assistive technologies affordable to the most vulnerable and to rural and remote communities.
- Planning and implementing consumer awareness campaigns regarding the cost savings, safety, and quality of generic medicines.

Ensuring appropriate healthcare coverage for all social groups is the key to reducing health inequities. There are still major inequalities in healthcare coverage in Romania. A large share of self-employed workers in agriculture and of the rural Roma population is not covered by health insurance. The percentage of people enrolled with a family physician as part of the Healthcare Insurance System increased significantly from 87.8 percent in 2008 to 95.9 percent in 2010 and then declined to 85.3 percent in 2012. All throughout this period, there was a considerable and constant difference between urban and rural health coverage, with coverage being up to 20 percent higher in urban areas as of 2012 - 94.1 percent coverage in urban areas as opposed to only 74.6 percent in rural areas.³⁴⁴ Except in rare circumstances, the uninsured are not entitled to any ambulatory examinations or to medicines recommended or prescribed by their family doctor, even though the health insurance budget for ambulatory paraclinical examinations and services was doubled in 2014. Apart from emergencies, pregnancies, and certain infectious diseases, the uninsured are obliged to pay for their own medical care. This leads to aggravated health conditions and/or to an overuse of emergency pre-hospital and hospital care (ambulance service, the Mobile Emergency Service for Resuscitation and Extrication, and hospital emergency departments) where treatment and examinations are provided free of charge. The combination of poverty, illiteracy, and the healthcare system's lack of capacity to provide preventive services or access to basic care leads to high rates of ill health among the poor as well as to the high costs involved in treating the poor with severe

³⁴⁰ On average, 76 percent went to doctors and 24 percent to nurses.

³⁴¹ On average, 60 percent went to surgeons, 24 percent to anesthetists, and 16 percent to nurses.

³⁴² Stoica (2013).

³⁴³ Stănculescu and Neculau (2014: 48). The countries were Bulgaria, Croatia, Kosovo, the FYR Macedonia, the Republic of Moldova, Montenegro, Romania, and Serbia.

³⁴⁴ National Social Health Insurance House (2013: 113).

or life-threatening medical conditions in inpatient facilities. The government should issue legislation on private health insurance for those who can afford this option to decrease pressure on the public budgets, which could then be reallocated in ways that will improve and increase the services included in the minimum benefit package and/or targeted evidence-based programs addressing the needs of the most vulnerable.

2.5.2. Improving Healthcare Provision in Specific Areas Relevant to Poor and Vulnerable Groups

Within the sphere of healthcare reform in Romania, certain areas of intervention are particularly relevant for poor and vulnerable groups (Scheme 7). In terms of health outcomes, Romania has the highest under-5 mortality rate of all of the EU-27 countries and a risk of maternal mortality at birth five times higher than the EU-27 average.³⁴⁵ The country also has the highest child poverty rate of all of the 35 countries covered in the analysis of child poverty carried out by UNICEF in 2012.³⁴⁶ Therefore, mother-and-child health and reproductive health should be priority areas for interventions aimed at increasing health inclusion in the 2014 to 2020 period. At the same time, Romania has a life expectancy at birth that is considerably lower than the EU average and an age-standardized death rate for males that is almost twice that of the lowest EU countries - over 1,200 per 100,000 compared with an EU average of 866.³⁴⁷ The two main causes of death are cardiovascular disease (Romania having one of the highest rates in the WHO European Region) and cancer, with both trends on the increase. For this reason, the government should focus on reducing chronic diseases through health promotion and disease prevention as a way to improve the health of the poor and vulnerable, especially as current evidence unequivocally demonstrates that non-communicable diseases are largely preventable.³⁴⁸

Although communicable diseases have a low prevalence due to the constantly improving surveillance system and increasing immunization coverage, Romania has the highest tuberculosis (TB) incidence within the European Union, and the number of multiple drug-resistant TB cases is increasing. Also, sexually transmitted infections (STIs), including HIV/AIDS, still represent a challenge.³⁴⁹ Within the European Union, moderate to high prevalence rates of viral hepatitis B, C, and D are found only in Romania and three other countries.³⁵⁰ Tuberculosis is strongly correlated with poverty,³⁵¹ while socially conditioned diseases³⁵² have the greatest negative impact on life quality and duration and are among the main causes of poverty, discrimination, and marginalization.³⁵³ Consequently, infectious diseases should constitute another area of intervention relevant to increasing health inclusion in 2014-2020.

Scheme 7 shows the specific areas of intervention relevant to poor and vulnerable groups. They are set within the strategic framework that needs to be used for the health sector, which is aligned with the integrated approach to social services that is used in Romania. This involves multi-disciplinary teams of community workers at the local level and multi-agency cooperation and coordination between the social sectors at the national level (see Section 2.3 on Social Services). The primary healthcare and community-based healthcare network undoubtedly constitutes the best framework for implementing our recommended interventions on an adequate scale. These recommendations will be presented in the final section of this chapter.

The specific areas of intervention relevant to poor and vulnerable groups are discussed in the next sections with a focus on preventive services, early detection, and outreach services as well as on the monitoring and evaluation of interventions. In all areas, the Ministry of Health needs to change the paradigm of public health policy by:

- Increasing its allocations to evidence-based preventive services while at the same time building programmatic capacity at all levels of the health system

³⁴⁵ WHO/Europe, European HFA Database.

³⁴⁶ UNICEF Innocenti Research Centre (2012).

³⁴⁷ OECD (2012b).

³⁴⁸ WHO (2011).

³⁴⁹ Institutul Național de Boli Infecțioase "Prof. dr. Matei Balș" (2013).

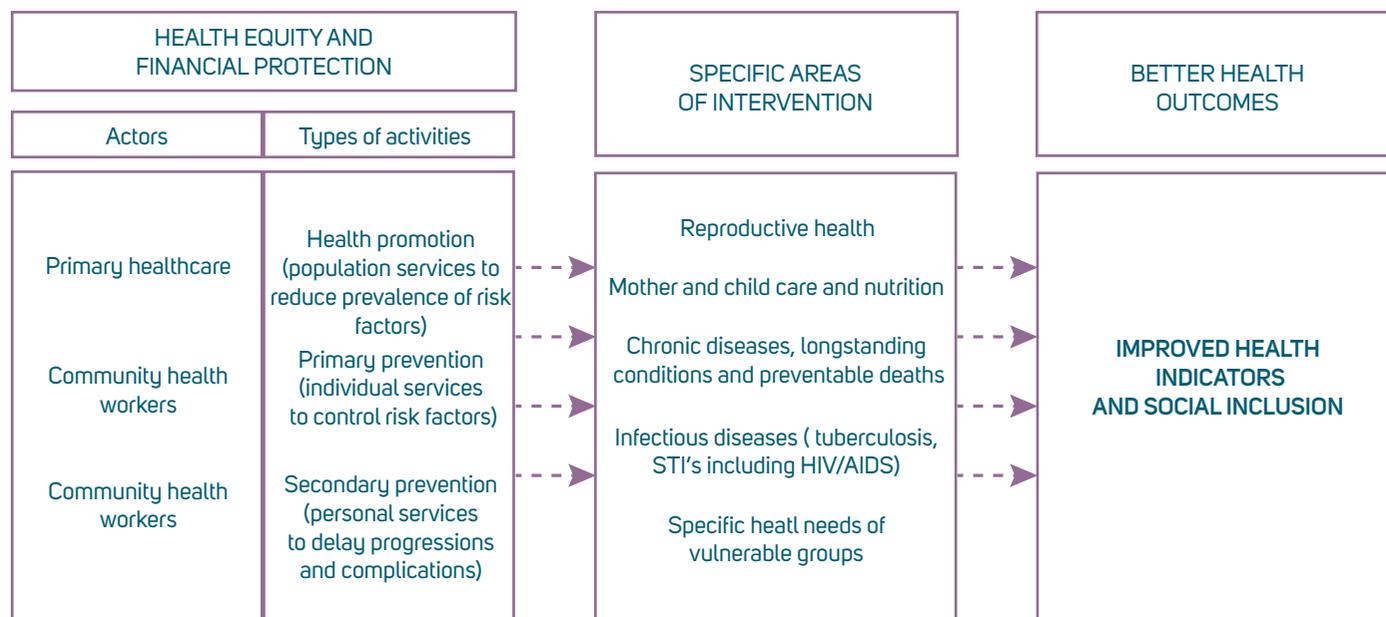
³⁵⁰ Bulgaria, Latvia, and Turkey (Rechel et al, 2011).

³⁵¹ WHO and ECDC (2014).

³⁵² Socially conditioned diseases are those that cannot be explained exclusively by heredity but are influenced by a person's lifestyle and socioeconomic environment.

³⁵³ United Nations (2008).

SCHEME 7: Specific Areas of Intervention Relevant to Increasing the Inclusion and Improving the Health of Poor and Vulnerable Groups



Source: Dahlgren and Whitehead (2007: 20).

- Implementing effective mechanisms for needs analysis, service planning, the coordination, monitoring, and evaluation of interventions, and the control of service providers.

Improving Reproductive Healthcare Services

The percentage of unwanted pregnancies in Romania is over 50 percent among girls aged 19 or younger, while one in ten live births is registered to a teenage mother (aged between 15 and 19 years old). According to the most reliable latest data from the 2004 Reproductive Health Survey (carried out jointly by the Ministry of Health, USAID, UNFPA, UNICEF, and the World Bank), the percentage of unwanted pregnancies was 50.4 percent among teens aged 15 to 19 and 48.7 percent among women aged 15 to

44. Early motherhood, especially when the pregnancy is unwanted, can lead to child abandonment, school dropout, and even social exclusion. Therefore, it is important to reduce the rate of unwanted pregnancies. There is evidence that current family planning services are ineffective, especially in the case of poor and vulnerable women. This is evident in the still high number of unwanted pregnancies resulting in abortion, particularly among girls younger than 19, and the increasing number of newborns abandoned in maternity units in the last few years (918 children in 2012 up from 762 children in 2010). The increased percentage of births out of wedlock, from 15 percent of all births in 1992 to almost 28 percent in 2010, and 31 percent in 2012, is a demographic phenomenon with significant socioeconomic and health consequences. The percentage is higher in rural areas (34 percent), where traditional attitudes to reproduction seem no longer to apply.³⁵⁴

³⁵⁴ NIS 2012 and 2013b.

Preventing early motherhood and unwanted pregnancies will require all women of reproductive age (in particular girls and young women) to be able to access affordable and high-quality sexual and reproductive health services.³⁵⁵

The number of Ministry of Health reproductive health interventions targeting the vulnerable population has gradually decreased since 2008, as have the related budgets. The regulations, methodologies, and tools of the Ministry of Health's National Program have not been updated, including the criteria for the vulnerable groups eligible for free reproductive health services, the management information system governing contraceptives and their distribution, and the list of free contraceptives. The network of family physicians' offices providing reproductive health services has become unstructured, due to a lack of incentives, training, and budgets and a lack of interest in this program on the part of decision-makers at the national and county levels. There are no sustained medical education programs for family physicians on reproductive health. Only some family physicians - far fewer than are needed nationwide - have agreed to distribute free contraceptives, and the effectiveness of this free contraception program also suffers from a low budget and a high degree of inconsistency in procurement and distribution. There is a lack of accurate data on the activities of community health workers (community nurses and health mediators for Roma communities) in the area of reproductive health, and since these personnel no longer benefit from training programs or any guidelines or educational materials, it is quite likely that their services are infrequent and/or of poor quality. The decentralization of responsibility for healthcare services from the central government to local authorities, which was poorly coordinated and insufficiently regulated, coupled with the recent economic crisis have led to the current situation.

The priority actions that we recommend that the government take over the next few years are:

- Revise the criteria for the free distribution of contraceptives.
- Specify priority beneficiaries (such as rural areas, poor and deprived communities, and specific age groups).
- Ensure continuity of access to a range of free contraceptives for vulnerable women of reproductive age.

- Expand the network of GPs who are willing to deliver free contraceptives and ensure fair geographical coverage.
- Train and retrain community healthcare providers (family doctors, community nurses, and Roma health mediators) in delivering quality sexual and reproductive health services.
- Establish partnerships with specialized and grassroots NGOs to deliver reproductive health services and interventions.
- Plan, implement, monitor, and evaluate information-education-communication (IEC) campaigns and outreach interventions in the field of reproductive health, tailored to the particular needs, beliefs, and traditions of the most vulnerable communities.

The Ministry of Health's National Program interventions in the field of reproductive health and family planning must be revised and updated. There are no disaggregated data or recent studies to draw on to design cost-effective reproductive health interventions, nor has a coherent and systematic approach been developed to govern the required policies and actions. Until 2007, with the support of UN organizations, the World Bank, and bilateral agencies (such as USAID), reproductive health was one of the priority areas of health system reform in Romania, which was a direct contributor to the subsequent improvements in infant mortality and maternal mortality. The interventions that were put in place were based on coherent strategies resulting from needs analyses and impact studies that used internationally validated methodologies. The Reproductive Health Survey (RHS) was fielded in 1994, 1999, and 2004 on a sample of more than 10,000 women of fertile age. The resulting studies demonstrated how certain effective and sustainable interventions had positively influenced health indicators and recommended that these interventions should primarily be targeted to the rural population, the poor, and certain vulnerable groups. According to the RHS data, between 1990 and 2007, with international support and technical assistance (from UN organizations and bilateral agencies like USAID), the government designed and implemented consecutive reproductive health strategies, the Ministry of Health mother-and-child healthcare program (which included all reproductive health and safe motherhood

³⁵⁵ A comprehensive definition of reproductive healthcare includes other priority public health areas such as: (i) family planning; (ii) sexual health; (iii) safe motherhood; (iv) unsafe abortion and STIs, including HIV; and (v) cervical cancer. This section focuses particularly on family planning and sexual health, while the other areas are covered in the next sections.

interventions), and community healthcare and health mediation activities for Roma communities. The government also developed and strengthened the family planning network, distributed free contraceptives to poor women and/or women at risk based on objective criteria, and put in place a highly functional logistics management system that ensured the continuity of contraceptive supplies.

In order to revise and update the Ministry of Health's National Program on reproductive health and family planning, we recommend that policymakers consider taking the following actions:

- Carrying out a round of the Reproductive Health Survey every five years to gather sound data for baseline indicators and to measure the outcomes and impact of interventions, taking advantage of the expertise of the organizations that implemented the previous rounds (the National Institute of Statistics, public institutions, and NGOs). We recommend fielding the survey both before and after implementing the Strategy on social inclusion and poverty reduction 2015-2020.
- Setting up a sound logistics management information system built on proven best practices.
- Designing interventions targeted to the poor and the most vulnerable based on evidence from periodic assessments of the achieved outcomes.
- Designing and developing sound monitoring and evaluation mechanisms for all programs, including those targeted to the poor and vulnerable groups.

Partnering with NGOs in providing community-based services is essential, both now and in the future, particularly since NGOs can be a catalyst for the development of a coherent national approach to reproductive health interventions. In the absence of sustainable funding, many NGOs active in the area of reproductive health - former partners of the Ministry of Health and of international organizations - have had to scale down or stop providing services to beneficiaries, most often the poorest communities or vulnerable groups, such as Roma communities. Currently, most of them implement projects based on the priorities decided by the existing funding sources rather than on the needs of their beneficiaries. Many NGO interventions that were once seen as best practices (between 1992 and 2007) ended because public institutions failed to take over ownership. Also, the Ministry of Health lacks the mechanisms and regulations required to

contract with NGOs to implement the interventions included in the national public health programs.

The government should increase the budgetary allocations for preventive services in the field of reproductive health and should implement effective mechanisms for monitoring and evaluation and for the control of service providers. The current strategic documents governing the Ministry of Health provide an adequate general framework for conducting reproductive health interventions that target vulnerable people. According to the 2014-2020 National Health Strategy, developed by the Ministry of Health at the end of 2013 (and approved by the government in Nov 2014): "The success of the family planning intervention depends a great deal on strengthening the capacity for program management at the central level, on continuing the training of primary healthcare physicians and nurses, on the access to free-of-charge contraceptives for vulnerable people, and on a better targeting of this category of the population with the help of the emerging community healthcare network in Romania." However, these strategic documents need to be translated into effective and evidence-based interventions. For instance, although the government planned to review or amend the national health programs in 2014, this has not yet happened. This year, the national mother-and-child healthcare program (which includes all reproductive health interventions) has been allocated a budget of RON 10,330,000, which is less than half of the 2013 budget (RON 24,336,000) and is five times less than, for example, the national organ, tissue, and cell transplantation program (RON 52,123,000). In fact, ever since preventive and curative programs were combined into "public health national programs" funded from the state budget, the programs that included a significant prevention component started having progressively lower budgets, while the budgets for curative programs increased.

Improving Healthcare Services for Mother and Child Health and Nutrition

Although the Government of Romania has developed a National Mother and Child Healthcare Program and a National Immunization Program, health outcomes for Romanian mothers and children are showing some alarming trends.

Children from poor and Roma households face significant disadvantages in terms of their health and wellbeing, disadvantages that may occur in the very earliest stages of childhood.

A recent UNICEF study³⁵⁶ indicated that households with total income per person below the national poverty threshold, single-parent families, and families with a large number of children living in poor conditions and relying on social benefits are the categories with the highest long-term child health and development risks.

In Romania, 11 percent of all live births are premature, and prematurity and its complications are responsible for more

than half of all neonatal deaths. Most premature and/or underweight babies are born to teenage mothers and/or to mothers in the lowest socioeconomic groups and/or of Roma ethnicity, those with low levels of education, and those living in rural areas. Mothers in these groups either do not use prenatal care services or use them inadequately, and 40 percent of women who give birth prematurely do not receive systematic or regular prenatal visits.³⁵⁷

BOX 36

Testimony of Family Physicians about their Respond-Only-If-Asked Approach Related to Prenatal Care Services in Rural Areas

“Minor mothers are registered by the family doctor and are supervised during pregnancy, their babies are also registered. Supervision means that she receives services but only if and when she comes to the physician... The family doctor is not supposed to go to her home and to say: come on, please. So, although insured because of being a minor, many of them do not receive the services precisely because they do not come to a family physician’s office. And then, she comes when she is already nine months pregnant and she is close to giving birth to the child. Why she hasn’t come so far? Lack of information, shame, poverty, she doesn’t have clothes to wear, she has no way to get

there, who knows? And at this first visit, I give her a referral to the laboratory, one to the ultrasound scanner, and one for a consultation with a gynecologist. With all these three referrals she has to travel. The nearest hospital, the Botosani Maternity, is 70 to 80 kilometers away. She doesn’t have the money to travel so she will not go. Moreover, she will not come to me the second time, because all I do is giving her unrealistic tasks and not real solutions to her problem.”

Source: Group discussion with the Family Doctors’ College, the Family Doctors’ Association, and the Family Doctors’ Employers Association, County Botoșani, World Bank qualitative study carried out in July-August 2014 for preparing this background study.

Although infant mortality is in a declining trend, it is still too high, especially in rural areas and among the most vulnerable groups. A significant share of the deaths under the age of 1 occur at home, while most newborns die without having benefited from any healthcare to address the disease that led to their death.³⁵⁸ While the infant mortality rate has declined from 18.4 in 2001 to 8.5 per 1,000 live births in 2013, it remains the highest in the EU (with an EU-28 average of 3.8 per 1,000 live births in 2012). Also in 2013, the infant mortality rate was higher in rural areas than in urban areas (10.4 per 1,000 live births and 939 deaths of children under 1 year in rural areas compared with 6.8 per 1,000 live births and 741 deaths of children under 1 year old in urban areas). Significant differences between

counties continue to exist, with the highest rates reaching 13 to 15 infant deaths per 1,000 live births.³⁵⁹ The under-5 mortality rate has also significantly dropped yet remains considerably higher than the EU-27 average - 12.2 versus 4.8 per 1,000 live births in 2012.³⁶⁰ The risk of a child dying before reaching 5 years old provides a robust measure of the health of children and is a sensitive indicator of poverty and social exclusion. Children in Romania are at greater risk of dying before the age of 5 if they are born in rural areas, to poor households, or to a mother denied a basic education. More than half of the deaths of children under the age of 5 are due to diseases that are preventable and treatable by simple and affordable interventions.³⁶¹

³⁵⁶ Stănculescu et al (2012).

³⁵⁷ Stăvilă and Stoicescu (2011).

³⁵⁸ Ministry of Health (2013).

³⁵⁹ National Institute of Statistics, Tempo Online database.

³⁶⁰ WHO/Europe, European HFA Database.

³⁶¹ WHO (2013a).

Romania has a serious problem of child nutritional deficiency because of limited access to food and of child diseases. This problem requires an urgent response. Child nutritional deficiency is measured by the prevalence of a low weight-to-waist ratio, and in Romania it exceeds UNICEF's international standard of 10 percent. The prevalence of a low weight-to-waist ratio (a predictor of under-5 mortality) has significantly increased in recent years from 4.4 percent in 2004 to 10.4 percent in 2010, with considerably higher rates in rural areas than in urban areas as shown in a recent study.³⁶² This study, which assessed the effectiveness of the Ministry of Health's national programs on the nutritional status of children under the age of 2, showed that children with nutritional deficiency who have not benefitted from early breastfeeding, exclusive breastfeeding until the age of 6 months, or a minimum diversified diet³⁶³ are more likely to have teenage and/or less educated mothers. Also, the exclusive breastfeeding rate is clearly lower among children raised in poor or extremely poor households. The same research has pointed out the significant positive correlation between providing prenatal breastfeeding counseling to mothers and the duration of any breastfeeding. In this respect, only one in two mothers had discussed breastfeeding with their ob/gyn. Adolescent mothers (those aged between 15 and 19 years old), less educated mothers, and women in rural areas are the groups with the fewest mothers who had received counseling during their pregnancies. The proportion of Roma mothers who benefitted from breastfeeding training during pregnancy was almost twice as low as the proportions of the other ethnic populations. With regard to the post-partum training provided in maternity hospitals and units, only 33 percent of mothers claimed to have been trained in exclusive breastfeeding, and there were no significant differences between rural and urban areas. Finally, the high prevalence of anemia among children under 2 years old (40 percent in 2010) confirms that Romania has a child nutritional deficiency problem. Children in rural areas eat up to 15 percent fewer iron-based foods (meat, eggs, or milk) than those in urban areas. Family physicians who participated in the study admitted that patients rarely asked them about diet issues and expressed their belief that it is the mother's duty to ask for

their advice to justify their respond-only-if-asked approach.

There has been an alarming decrease in national immunization coverage. Coverage of the DTP³⁶⁴ vaccination has decreased from 99 percent in 2001 to 89 percent in 2013. Rubella and measles outbreaks occurred in Romania at the end of 2011 and 2012. Due to the high numbers of young adults who were contracting rubella, this outbreak infected large numbers of pregnant women with this virus, which led to a large number of infants who were born with congenital rubella syndrome. According to WHO experts, coverage of the measles vaccination among children is not sufficiently high to stop the transmission of measles. In general, the lack of disaggregated data (except by age, sex, and geographical location) makes it impossible to identify susceptible groups and therefore to target interventions. While GPs and other specialists claim that the public has a low level of acceptance of vaccination, the Ministry of Health and its technical bodies should work to ensure a higher level of routine vaccination coverage and should initiate public awareness campaigns aimed at increasing the public's confidence in the long-term benefits and acceptance of immunization.

Although maternal mortality is declining, it is still high and occurs mainly among socially disadvantaged groups. Romania's maternal mortality rate remains much higher than the EU-27 average - 11.44 as opposed to 5.05 maternal deaths per 100,000 live births as of 2012.³⁶⁵ It is worrying that the number of deaths resulting from abortion has doubled and that maternal mortality increased as a result of direct obstetrical risk in 2013 compared with 2012. These statistics indicate that pregnant women are not being monitored and registered in due time to allow for early detection of obstetrical risk and to prevent abortions. A recent analysis of 2011-2012 maternal mortality in Romania³⁶⁶ showed that most of the women who die from direct obstetrical causes are poorly educated (86 percent of the sample were illiterate and graduates of only primary or secondary education), unemployed (74 percent), and/or single mothers (40 percent). The maternal mortality rate is slightly higher in rural areas than in urban areas, and more than 65 percent of the women who died in 2011-2012 were not provided with prenatal services.³⁶⁷

³⁶² Ministry of Health et al (2011).

³⁶³ At a minimum, an improper diversified diet does not include sufficient meat, eggs, or vegetables and that some types of fruits are preferred over others (for example, bananas over apples).

³⁶⁴ Diphtheria, tetanus, and pertussis vaccine (WHO-UNICEF estimates for Romania, available at http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveredtp3.html)

³⁶⁵ WHO/Europe, European HFA Database.

³⁶⁶ Stativă (2013).

³⁶⁷ More than 125 children became motherless as a result of the 53 maternal deaths, 23 of which occurred as result of direct obstetrical risk (11 during pregnancy, six during delivery, and six post-partum).

These disquieting facts indicate that improving nutrition and health outcomes for all women and children should be a priority for the government over the next few years. The Ministry of Health's current mother-and-child healthcare interventions are discontinuous, inadequately funded, poorly coordinated and monitored, and have not been particularly effective. Therefore, the Ministry of Health should evaluate its current national public health programs on mother-and-child care and retain only those that are cost-effective while introducing new ones based on evidence of best practices and of the real needs of vulnerable groups. The government should provide adequate funding for preventive interventions, including those designed to provide mothers and their families with education and information on prenatal care and healthy lifestyles. Parenting education should be included in these interventions and should be focused on improving children's health, especially the health of children from disadvantaged populations.³⁶⁸

In order to deliver prenatal and postnatal care and childcare at a consistent standard of quality countrywide, policymakers will need to increase access to and enhance the quality of the existing mother-and-child healthcare services. Access to mother-and-child healthcare services is limited, sometimes because services are too far away from their target populations or because the pregnant woman cannot afford to pay for transportation into town for tests (simple ultrasounds or lab tests) or, indeed, for the tests themselves. Although by law these tests should be provided free of charge, this is often not the case in practice because the health system budget is insufficient to cover these costs. Another factor that limits access is that many rural communities lack family physicians or even community nurses. This is partly because few family physicians seem interested in practicing in those communities but also partly because the authorities fail to oversee and control their activities other than on paper. There are no mechanisms for evaluating the quality of the services provided by family physicians, for example, assessing their compliance with practical guidelines and protocols on pre- and postnatal care or on infant care.

Therefore, research is needed to determine what factors prevent pregnant women, nursing mothers, and infants from accessing health services and to suggest ways to remove the barriers through legal regulations or coherent measures

for monitoring and control. For improving the delivery of prenatal and postnatal care and childcare, we recommend the following priority actions:

- Developing clinical protocols, guidelines, and standards of practice and requiring physicians to submit to clinical audits by their peers.
- Developing and implementing specific immunization coverage for vulnerable children left out of the national immunization campaigns.
- Increasing the coverage of basic healthcare service providers (family doctors, community nurses, and Roma mediators) at the local level countrywide.
- Training or retraining community healthcare providers (family doctors, community nurses, and Roma health mediators) in the delivering of quality prenatal and postnatal care and childcare.
- Monitoring, evaluating, and controlling the delivery and quality of care.

Reduce the Number of Chronic Diseases, Longstanding Conditions, and Avoidable Deaths

A serious challenge for Romania's health sector is the limited access of the poor to healthcare services for chronic diseases. The minimum healthcare package that is designed to meet the needs of the uninsured does not cover these services (see Annex Table 7.1). There is also the possibility that the poor are unaware of their need for care. In surveys, almost half of poor respondents who state that they need healthcare do not actually seek care. The gap between the poor and the better-off is particularly evident in the treatment of chronic disease with 42 percent of the poor not receiving this kind of care compared with 17 percent of those who are better-off. Simulations by the World Bank that assumed that the need for chronic care is similar for the poor and for the better-off showed that 85 percent of the poor who need chronic care do not receive it.³⁶⁹ The cost of medicines and the widespread practice of making informal

³⁶⁸ Especially given that most deaths in children under the age of 1 that have occurred at home are correlated with "the parents' inability to recognize the disease in time or to correctly assess its severity." (Angheliescu and Stativă, 2005).

³⁶⁹ World Bank (2011a).

payments to health professionals have both been reported as being barriers to accessing care for chronic diseases. Segregation and discriminatory practices at all levels of the healthcare system are additional obstacles faced by the Roma population in trying to access healthcare services.

Innovative interventions tailored to the dominant risk factors faced by poor and vulnerable groups are needed to reduce the rate of chronic disease among these populations. These interventions need to be designed, implemented, monitored and evaluated within each national public health program for chronic diseases. Currently, the Ministry of Health's national public health programs do not focus sufficiently either on the prevention and early detection of major diseases or on the main determinants of the burden of disease. Since June 2014, GPs have been required to carry out a health risk assessment for each insured person on their capitation list, but no such assessment is envisaged for uninsured people either under health insurance or through the Ministry of Health's national public health programs. Therefore, there is a strong need for effective information campaigns, the provision of culturally sensitive health services,³⁷⁰ and preventive programs for the most relevant diseases and risk factors. Non-communicable diseases are very prevalent in Romania and account for 91 percent of all deaths. Among the non-communicable diseases, cancer-related deaths rank second only to cardiovascular disease. The three risk factors that have accounted for the greatest disease burden in Romania are dietary risks, high blood pressure, and tobacco smoking. In 2010, the leading risk factors for children under the age of 5 and adults aged between 15 and 49 years were household air pollution from solid fuels and alcohol use respectively.³⁷¹ Smoking is a real health issue for males and females, especially for younger age groups. There is an inverse socioeconomic gradient prevalent among males but not among females.³⁷² Smoking is the main risk factor related to cancer. The prevalence of smoking is higher among males than females (37.4 percent versus 16.7 percent), but female smoking has increased very significantly in the last decade. Romania ranks first among all EU countries in terms of alcohol consumption, with a rate that is 130 percent higher than the EU average.³⁷³ The mortality rate due to cirrhosis and other effects of alcohol consumption has increased substantially in recent years. In terms of the number of years of life lost

due to premature death in Romania, cirrhosis of the liver was among the highest ranking causes in 2010.³⁷⁴

Thus, we recommend that the government consider developing local, regional, and national plans for reducing the incidence of unhealthy behavior and for preventing chronic diseases. Also, within the national public health programs, the Ministry of Health should design and implement evidence-based health promotion interventions. These should focus on: (i) reducing harmful alcohol consumption, especially in rural areas, with a focus on those who are less educated; (ii) developing smoking prevention programs in urban areas, including among the better educated; and (iii) initiating outreach interventions in specific communities identified as being the most vulnerable.

In the forthcoming years, the efficacy of the national screening program for the early detection of cervical cancer must be evaluated. Romanian women still have the highest mortality rate from cervical cancer in the EU despite the fact that this disease is easily preventable or curable by early detection. The most common cancers in women are breast, colorectal, and cervical cancers, while lung, colorectal, and prostate cancers are the most common among males. In 2012, the Ministry of Health initiated a population-based cervical cancer screening program, which is still ongoing but needs a specific component targeted to the most vulnerable women. The program targets women between the ages of 25 and 64 years old and tests them every five years. Family physicians provide the program with lists of their female patients in the target age group who are then sent an invitation to participate in the screening. However, this means that uninsured women are unlikely to be included, even though this is a national public health program. A number of health professionals have claimed that not all women who are diagnosed with cervical cancer after being screened receive follow-up treatment, particularly the poor and women in rural and remote locations, because of the costs of transportation, treatment, and care and the lack of appropriate health infrastructure and a specialized healthcare workforce for treatment and care (mainly the oncological services). Also, in the Ministry of Health's Activity Report 2013,³⁷⁵ the staff of the program's implementation unit identified many bottlenecks in the

³⁷⁰ One example of a culturally sensitive health service is approaching specific Roma communities with reproductive health services.

³⁷¹ IHME (2013).

³⁷² Irimie (2012).

³⁷³ Alcohol consumption among adults aged 15 years and over was 16.2 liters of pure alcohol per person per year in 2008, compared with the EU average of 12.45 liters (WHO, 2012b: 115).

³⁷⁴ WHO (2012b).

³⁷⁵ Ministry of Health (2013).

program's design and implementation and suggested simple but effective ways to improve cervical cancer screening and the continuity of the cycle of early detection, treatment, and care. Clearly, better planning, monitoring, and overall management of the cervical cancer screening program is needed.

The government should also initiate and fund a mammography screening program for breast cancer focused on poor and vulnerable women and those in rural areas. The program should target women aged 50 to 69 years old and should include culturally appropriate interventions for the poor and the vulnerable, including Roma.

Investing in palliative and long-term care in the near future is a must, given the aging population and the high and increasing cancer mortality rate. Palliative and long-term care and rehabilitation services are not sufficiently developed within the national healthcare system, and this is a challenge that has not yet been consistently addressed in Romania. Most long-term care is provided by the patient's family, and there are few resources available to support informal carers. What little professional long-term care and home care exists is mainly funded by donations and other third-party contributions (charities or NGOs funded by private donations or membership fees; some countries receive funding from the EU).³⁷⁶ The availability of palliative care services is still very limited. Palliative care professionals say that currently only about 5 to 10 percent of people in need of palliative treatment actually receive it. According to the 2010 data provided by the Romanian National Association of Palliative Care and Hospice (Casa Sperantei), specialized palliative care is available only in 16 counties. There are a total of 46 palliative care units, but the distribution is uneven (12 of them being located in Bucharest and another 12 in Brasov). Most patients in the advanced stages of cancer are treated at home and remain in the care of general practitioners, who usually lack training and practice in this field. The health insurance reimbursement for palliative care is insufficient (up to 90 days of care per patient), and palliative care facilities claim that in practice health insurance funding covers only 20 to 50 percent of the real costs.

Improving Healthcare Services for Infectious Diseases

The control and treatment of infectious diseases, especially tuberculosis (TB) and HIV/AIDS, should remain high on the policy agenda as they are particularly prevalent among vulnerable groups, including Roma. TB remains a critical problem in Romania, mostly affecting adults in the second half of life. The geographical distribution of TB by counties is inversely correlated with income and education level.³⁷⁷ Although HIV/AIDS patients have free access to drugs and the survival rate is around 30 times higher than it was in 1990, the problem is still of major concern, because no public budgets or services are available for prevention, especially for vulnerable groups such as injection drug users (IDUs).³⁷⁸

TB is a disease of poverty, so tuberculosis control remains a critical public health priority in Romania. The links between poverty and the disease burden of TB have been documented for many years. The incidence and prevalence of the disease in Romania has been declining continuously over the past decade, but WHO still lists Romania as among the 18 high-priority countries in the WHO European region due to its high number of multidrug resistant cases of TB (MDR-TB).

There are many challenges facing Romanian TB patients. Generally, GPs have no particular interest in TB prevention or care. There is also a waiting time for seeing a GP, and therefore patients often prefer to seek emergency medical care in hospital. Late diagnosis and excessively long hospitalization by international standards are the norm, and there is limited availability and often discontinuity of prescribed drugs. Many patients do not receive supervised treatment or any of the psychological support that they need to continue their treatment outside hospital. Social support is restricted to 100 percent of the patient's salary for one year of medical leave but only for those patients who were employed prior to the start of their treatment. No public funds are available to support the unemployed, the self-employed, people working in agriculture, or vulnerable groups such as the homeless. Local authorities lack the necessary knowledge of and thus the commitment to support TB control interventions.

³⁷⁶ Genet et al (2012).

³⁷⁷ World Bank (2011a).

³⁷⁸ Institutul Național de Boli Infecțioase "Prof. dr. Matei Bals" (2013).

Although Romania has made remarkable progress in detecting and treating tuberculosis over the last few years, the TB notification rate remains the highest of all of the EU member states. Data from the National TB Control Program (NTP) within the Ministry of Health³⁷⁹ show that there are significant disparities among counties varying from a low of 26 per 100,000 inhabitants to a high of 114 cases as of 2013. TB notification rate is, however, up to seven times higher among prisoners (479 cases per 100,000 in 2013 compared with 74 cases per 100,000 among the general population). Furthermore, the TB prevalence among homeless people is fifty times higher than that in the general population (6,700 cases per 100,000 in 2011), while in some Roma communities from rural areas it may reach a high of over two hundred times higher than that of the general population (27,000 cases per 100,000 in 2012). Furthermore, the use of Direct Observed Treatment (DOT), one of the most effective ways to control the spread of the disease in its early phases, has declined in Romania in recent years.³⁸⁰ There are few options available for receiving DOT ambulatory treatment. TB treatment during the continuation phase is provided by family physicians who tend to be unmotivated to provide DOT for TB and MDR-TB patients in the absence of any financial incentives from the Ministry of Health. Patients have to travel to county TB dispensaries to be treated, or on weekends when the dispensaries are closed, they usually have to self-administer the treatment. Alternative DOT providers, such as community nurses, Roma health mediators, and family members, are rarely used, and there is still no patient-centered approach in place.

The goal of the government in this area should be to increase access to TB care and prevention by means of an integrated, patient-centered approach that takes into account the high burden of disease in Romania and its direct correlation with poverty and vulnerability. To achieve this aim, the government should reform its national TB efforts to bring them in line with the recommendations issued by WHO and the European Center for Disease Prevention and Control (ECDC) in 2014. The Prime Minister officially launched a National Plan to Prevent and Control M/XDR-TB³⁸¹ 2012-2015 on October 2, 2012 during the visit to Romania of the WHO Regional Director and the European Commissioner for Health and Consumer Policy. However, its implementation has been delayed by the lack of financial resources despite joint WHO-ECDC follow-up missions to put pressure on the government.

Our recommendations for redesigning the National Plan to Prevent and Control M/XDR-TB 2012-2015 are as follows:

- Provide adequate funding and include specific measures are included that target the most vulnerable groups and communities.
- Include social support and interventions targeted to the poor, such as vouchers for transportation to medical facilities and subsidies to MDR-TB patients for appropriate nutritional or psychological counseling. Also, develop (and allocate adequate budgets from national and international funds for) specific interventions for vulnerable groups such as IDUs, street children, the homeless, prisoners, and Roma. A large range of interventions aimed at reducing TB among the most vulnerable populations have been tested around the world and are strongly recommended by WHO and its technical bodies (Stop TB Partnership).
- Reinforce the Direct Observed Treatment Strategy (DOTS) through regulatory measures and county-based mapping of resources. Use GPs and available community healthcare workers (especially in rural areas) to rigorously apply DOTS. Develop cycles of planning, implementation, monitoring, and evaluation, ensure appropriate funding, develop guidelines and procedures for implementing DOTS, and ensure that NTP coordinators provide appropriate guidance, supervision, and control. Most importantly, periodically train and/or retrain DOT providers.
- Improve the identification of people with TB through health communication interventions. Engage and train health care providers (TB county managers network GPs, community nurses) and DOTS supporters. Inform and train community stakeholders to identify TB cases. Design, periodically update, and distribute IEC materials to providers and patients. Contract with NGOs to reach the most remote communities countrywide. Raise awareness within communities and local authorities of TB and the availability of treatment services. Plan, monitor, and evaluate outreach interventions to educate vulnerable groups, patients, and communities about TB. Run IEC campaigns targeted to poor households, rural populations, Roma, and other vulnerable groups at higher risk of TB.

³⁷⁹ National TB Control Program, "Marius Nasta" Pneumology Institute, 2014 data.

³⁸⁰ DOT means that a trained health care worker or other designated individual (other than a family member) provides the prescribed TB drugs and watches the patient swallow every dose.

³⁸¹ M/XDR-TB means multi-drug and extensive drug-resistant TB.

- Review the NTP information system and collect disaggregated data at both the county and the national level. Develop sound criteria for defining the poor and most vulnerable patients among both suspected and confirmed cases. Conduct a periodic analysis of the data collected by the revised NTP health information system. Document all targeted interventions in each round of the NTP.
- Develop procedures and guidelines for HIV/TB detection and care based on international recommendations and protocols. Invest in HIV/AIDS prevention focusing on specific vulnerable groups.

BOX 37

International Support for Romania to Control Infectious Diseases

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has been supporting Romania's efforts to combat TB since 2004. The Global Fund for Romania approved four grants totaling US\$68.8 million for fighting TB and HIV/AIDS between 2004 and 2014. The Global Fund for Romania on HIV/AIDS ended in 2009. Romania is still eligible for support on TB due to the country's high burden of disease. The current Global Fund grant was awarded to help the government to scale up the provision of high-quality MDR-TB treatment and care. Other grant-aided activities include the training of healthcare providers and targeted education and adherence programs for the poor, homeless, prisoners, Roma, and rural communities. In 2015-2016, Romania may receive up to US\$12.8 million for TB control, conditional upon the government

having endorsed and budgeted for its National Plan to Prevent and Control M/XDR-TB for 2014 to 2020. Thanks to the Global Fund's long-term support, there is a network of NGOs in Romania that are active and knowledgeable in the TB control field.

The Norway Financial Mechanism supports the Ministry of Health's public health initiatives, including TB control, through the program called Public Health Initiatives, which focuses on MDR-TB, HIV/AIDS, and hepatitis B and C. The program has a budget of €5.3 million and prioritizes increasing the access of vulnerable groups such as Roma to primary care and community care services. A second TB project proposal of about €5 million was approved by the Norway Financial Mechanism in the summer of 2014. Both programs will have been implemented by the end of April, 2016.



2.5.3. Increasing the Access of Vulnerable Groups to Quality Healthcare

This section focuses on the primary healthcare and community-based healthcare network in Romania, which constitutes the best framework for the effective implementation of the recommendations made in the previous sections. Family physicians, GPs, and their nurses together with community nurses, social workers, school mediators, and Roma health mediators are the key stakeholders for ensuring access to health services for poor and vulnerable groups and in poor or marginalized

communities (both rural and urban). We recommend that all of these stakeholders become part of multi-disciplinary teams at the local level that will implement the integrated approach to delivering social services over the next few years (see Section 2.3.5. Developing the Integrated Intervention Community Teams).

Strengthening and Enhancing the Quality of Primary Healthcare Delivery

At present, the primary healthcare network in Romania is ineffective in providing healthcare to the poor. There are two broad reasons for this: (i) a lack of human resources, incentives, and appropriate budgets, especially in rural areas and (ii) the behavior of family doctors who operate with little monitoring of their daily activity.

The primary healthcare network must be extended and strengthened. The family doctor profession was introduced as part of the overall primary healthcare reform in mid-nineties. It entails four additional years of postgraduate studies than is necessary to become a GP, which requires only graduate studies. This reform also eliminated the difference between primary healthcare providers for adults and those for children. Family doctors have become independent service providers under contract with the National Social Health Insurance Fund (NHIS). Each year, they negotiate and sign contracts with the Fund for the provision of a “basic package of services” to the insured (eligible beneficiaries registered on their own practice list) and non-insured populations (who are entitled to receive a “minimum package of health services”). Although primary healthcare is associated with physicians, a very important role is played by the nurses employed by the family physicians from their own medical practice budget.

In order to tailor the provision of primary healthcare services to the needs of the most disadvantaged, we recommend that the government consider taking the following priority actions:

- Developing and piloting new models of primary healthcare delivery such as diversified services and health providers’ networks (primary healthcare, ambulatory care, hospitals, long-term care, home care, and palliative care) in certain areas and increase the role of primary healthcare providers in patients’ case-management especially for the chronic diseases and with a focus on primary and secondary prevention.

- Developing, as a matter of priority, community-based healthcare services in those villages with no permanent family doctor’s practice (See Section 2.3: Social Services).
- Exploring innovative alternative solutions such as telemedicine for reaching remote communities and for overcoming the uneven distribution of healthcare resources and professionals. As a prerequisite, putting legislation in place to enable such an approach.

On the supply side, there is still no effective health workforce strategy, particularly for attracting staff to rural areas and keeping them there. The availability of all types of medical professionals in Romania is well below the European average, particularly in rural areas (Table 37). A large number of doctors and nurses have left medicine and even the country in search of better pay, working conditions, and/or social recognition. Between 2000 and 2005, about 10 percent (5,180) of the total number of medical doctors and 5 percent (4,440) of nurses trained in Romania worked in OECD countries.³⁸² The EU expansion in 2007 and the economic downturn in 2009-2010 considerably increased these existing migration flows towards the western EU countries.³⁸³ Given that family medicine is one of the most demanded specialties in some EU countries, it is most likely that existing inequalities in access to primary care services will increase even further if the emigration of family doctors and nurses continues and/or increases.

TABLE 37: Resources in Healthcare Services in 2011 (number)

	Different resources per 100,000 inhabitants					
	GPs	Active physicians	Specialist medical practitioners	Pharmacists	Nurses	Hospital beds
Romania	68	239	70	68	551	611
EU-28	79	346	92	*	836	540

Source: WHO/Europe, European HFA Database, November 2014.

Note: *Data not available.

³⁸² Simoens and Hurst, (2006). These percentages were higher for Romanians than for citizens of any other former communist country. For instance, the equivalent percentages for Bulgarians were 6.2 percent of medical doctors and 2.6 percent of nurses.

³⁸³ Galan et al (2011). Around 3 percent of all practicing medical doctors in Romania (1,421 doctors) left in 2007 alone. In 2009-2010, a freeze on hiring and a 25 percent cut in public sector salaries (as part of the government’s “austerity policies”) contributed to higher outflow numbers. According to the National College of Physicians, from 2007 to December 2014, more than 16,000 certificates of recognition of medical diploma in the EU space were issued to Romanian medical doctors by the competent authority.

To reduce socioeconomic inequalities effectively, the government needs to develop a national plan for healthcare services, followed by prudent investment in infrastructure and human resources. The lack of sufficient healthcare professionals and their uneven distribution together with geographical inequities in the distribution of health infrastructure have contributed to inequalities in access to healthcare. Most medical infrastructure is located in urban areas,³⁸⁴ while rural areas account for only 8 percent of hospitals, 8 percent of specialized medical clinics/offices, and 24 percent of the total number of pharmacies. This is the case even though about a half of the national population lives in rural areas. For this reason, Romania has the longest travel times to a major hospital in Europe after Northern Norway, Northern Scotland, Southern Italy, the Greek Islands, and Eastern Poland.³⁸⁵ Consequently, primary healthcare providers and community nurses (see Section 2.3 on Social Services) hold the key to ensuring access to health services in most rural or poor communities. Nevertheless, the nationwide density of family physicians and GPs is only 0.5 per 1,000 inhabitants in rural areas compared with 0.73 per 1,000 inhabitants in urban areas.³⁸⁶ So, in most rural areas, the departure of even a few health specialists can substantially reduce service provision. The migration of health professionals has been a major matter of concern for policymakers, particularly because the most economically deprived North-East region and the rural areas with the lowest coverage of medical doctors have had some of the highest emigration rates of medical doctors and nurses.³⁸⁷ A recent study showed that, in rural areas, primary healthcare services are unevenly distributed geographically, the widest gaps being identified in the North-Eastern, Southern, and South-Eastern regions.³⁸⁸

Thus, in the coming years, we recommend that the government should consider:

- Reviewing and revising the existing financial and non-financial incentives designed to attract and retain physicians in rural and remote areas.
- Setting up local, county, and regional healthcare service plans to be consolidated into a national plan of health services and to be followed by prudent investments in infrastructure and human resources.

- Investing in health infrastructure and technology in a cost-effective way in accordance with the requirements of the national plan of health services and based on documented evidence.

In addition, the government should consider allowing local authorities to hire GPs in special circumstances, with funds from the National Health Insurance Fund. In a recent case in a commune of fewer than 800 inhabitants in the North-East region, the family physician died, and his/her heirs put the medical practice on the open market. The local authority was unable to provide the commune's inhabitants with any kind of healthcare because the current regulations in force do not allow the opening of a second medical practice (or workstation/facility) in a location with so few inhabitants.

To reach the goal of ensuring access to quality healthcare for all, the government will need to implement measures to ensure continuity of care at all system's levels and to set up a reliable referral system from primary care doctors to specialists and back. At present, insured patients can only access specialist and inpatient services by referral from their family doctors or GPs. By international standards, the rate of referral to specialized healthcare structures is high in Romania - 9 percent in rural areas and 12 percent in urban areas. However, this may partly be due to the rules imposed on family physicians by the National Health Insurance Fund that prevent them from providing certain tests and treatments themselves. Therefore, the government should consider:

- Developing methodologies and standards of care aimed at integrating community-based services, GP delivery of healthcare services, and specialized care.
- Including in the health sector's Unique Information System a module aimed at monitoring continuity of care.
- Analyzing results of the monitoring activity at county and national levels and using them as input into local, county, and national plans for healthcare services.

The quality of primary healthcare services must be considerably improved and systematically monitored and controlled, particularly in relation to the services provided to the poor and vulnerable population. A range of different

³⁸⁴ NIS (2013c).

³⁸⁵ Bertolini et al (2008).

³⁸⁶ NIS (2013c).

³⁸⁷ Galan et al (2011).

³⁸⁸ Schaapveld et al (2011).

local and central stakeholders have expressed a general dissatisfaction with the performance of family physicians and GPs.³⁸⁹ A significant number of family physicians are exclusively business-oriented and lack empathy with their patients and their communities, especially the poor (Box 38). They have a family physicians' association, which is similar to a trade union, and frequently threaten to go on strike if their current rights, contracts, or payments are affected. They also threaten to strike when they are given additional duties with no financial compensation, even though their current (official) incomes are comparable to those of hospital physicians, if not higher. Also, many family physicians refuse to participate in preventive health programs financed by the Ministry of Health unless they are paid extra for such work, despite the fact that the beneficiaries of these programs are likely to be insured individuals for whom the doctor already receives per capita funding from the NHIF. A good example is the cervical cancer screening program, for which family doctors are given extra payments by the Ministry of Health from funds allocated to the program, even though most of the women who are screened are already enrolled in the doctors' per capita lists of beneficiaries. As a high-level decision-maker declared during an interview for a recent study, "Many general practitioners are like boutique salesmen. They open at 9am and close at 5pm, have no time or interest for prevention activities, and know nothing about the patient other than what is in the medical record."³⁹⁰ In addition, the interviewed specialists tend to believe that family physicians spend most of their days writing prescriptions for subsidized drugs, for which they are paid the same as for a

regular consultation, with a fee per service without actually providing any patient consultations^{per se}. Nonetheless, the family physicians themselves tend to complain that they provide more consultations per day than they are reimbursed for, as their NHIF service provider contracts pay for only a limited number of consultations in addition to the capitation fee. Finally, there is virtually no monitoring of or control over the activities of family physicians. Both the Ministry of Health's county-level offices and the County Health Insurance Houses have limited capacity and operate under unclear regulations that prevent them from controlling primary healthcare providers. As a result, there have been cases of family physicians who signed contracts to provide services in more than one location but who rarely visited their second and third contracted locations, which are often poor, isolated communities with just a few hundred inhabitants.

Therefore, we recommend that the government consider taking the following actions as a matter of priority:

- Carrying out a clinical audit³⁹¹ of primary healthcare providers.
- Setting up national mechanisms and clear responsibilities for the regularly monitoring and evaluation of primary healthcare services.
- Developing a system of collecting data about patients and implementing a system of disaggregated data collection and analysis on primary healthcare delivery.

BOX 38

Opinions of Family Physicians about Providing Healthcare Services to the Poor

The qualitative research conducted for this report in June 2014 highlighted the opinions of family physicians about providing healthcare services to the poor and vulnerable population, as expressed by the representatives of their professional associations:

"People come to us, but they are not informed, and usually they delay. Nevertheless, they ask for attention

and start to complain and say: what should I do? I will die! So what, I respond, there are plenty of priests, leave me alone. I cannot take it anymore, people are simply too demanding, with no respect or consideration for us. They mistake us, family doctors with a university education, with community-based healthcare. They mix apples with nuts. To be clear, at the present time, the Insurance House forces me only to take care of the insured patients because this is how I get paid. And to be frank,



³⁸⁹ Stănculescu and Neculau (2014) and qualitative research conducted for this background study.

³⁹⁰ Stănculescu and Neculau (2014: 88).

³⁹¹ A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care and the implementation of change.

BOX 38 (continued)

I do not have the time, given the low pay, to treat the uninsured... the vulnerable ones. From time to time, I do some charity work because people know me and I don't want to get my face spat on or to have stones thrown at my car. But, they, the community, do not think that our relationship should be a kind of yin and yang... In the case of the insured patients I am paid by the Insurance House, and in the case of the vulnerable, of course, I can deliver services but only if and when the community asks for them and pays a certain amount, let's say, enough for hiring an additional nurse or even a second medical doctor.... Of course, family doctors would treat vulnerable people or the uninsured ones if we were given an incentive. Let's say, the senior colleague who has only blond patients with blue eyes, give him 2 RON per point, but pay him 100 RON per point for a gypsy.

Then, of course, I would treat the gypsy community in my area, but not otherwise... the provider must be given an incentive." (From a group discussion with representatives of the Family Doctors' College, the Family Doctors' Association, and the Family Doctors' Employers Association, County Botoșani.)

"If the patient can make a choice between family doctors, in the same way, I can also say: I don't want to register him or her on my list. If, moreover, this person is not insured, you cannot register him. Earlier it was possible, but nowadays the Insurance House simply cuts them from the list, and I get no pay." (Interview with a representative of the Family Doctors' College, County Arad.)

Source: World Bank qualitative study carried out in July-August 2014 for preparing this background study.

On the demand side, the Ministry of Health should increase the usage rates of primary healthcare services by developing health education and disease prevention services. The use of primary healthcare services by the population is low. Data from the 2012 pilot of European Community Health Indicators Monitoring (ECHIM) showed that Romania has one of the lowest mean number of self-reported visits to GPs per capita per year in the EU - 2.7 among people aged 15 and over as opposed to 4.8 in the EU. The contrast is even more striking for those aged 15 to 64 years old - 1.9 consultations per person per year versus the EU average of 4.1 consultations per person per year. The fact that the many among the general population do not understand their right to healthcare as enshrined in the Constitution contributes to healthcare inequalities and to the low usage of primary healthcare. The most disadvantaged categories are the poor and vulnerable people – who are more likely to be uninsured - who cannot afford to visit a family physician from whom they receive no encouragement to use his or her services.

Increasing the use of primary healthcare will require the introduction of health education and disease prevention measures aimed at reducing the health gap between the poor and vulnerable population and their more advantaged neighbors. In all specific areas of intervention relevant to poor and vulnerable groups, the Ministry of Health should plan and implement IEC campaigns and outreach interventions tailored to the particular needs, beliefs, and

traditions of the most vulnerable, while also ensuring that these interventions are monitored and evaluated.

At the same time, demand could be increased by tailoring the provision of primary healthcare to the needs of the poor and vulnerable groups. The Ministry of Health has defined a new basic package of healthcare services to be provided to the insured population as of mid-2014. It has also revised the minimum package of healthcare services for the uninsured population, but the implementation of this entered into force only starting January 2015. Although the Ministry of Health finalized the minimum package at the same time as the basic package of healthcare services, only the insured are benefitting from these improved services, including prevention programs. This is the case even though the budgets for both primary healthcare and ambulatory specialized care were increased in 2014 by over 11 percent and 10 percent respectively. The basic package of services explicitly includes disease prevention for the first time with a health risk assessment being standardized and included in the primary healthcare services to be provided to the insured population. The revised minimum package also includes additional primary care preventive services addressing specific chronic diseases and long-standing conditions (as well as pre-natal and post-natal care and family planning counseling provided in ambulatory specialized care), but these services for the uninsured will only come into effect in 2015. Meanwhile, the budget for ambulatory oral healthcare increased by 450 percent in

2014 compared with 2013 but not for the uninsured. They are only entitled to oral healthcare services in emergencies and have to pay for any additional required examinations (including x-rays or drugs) out of their own pockets, while a yearly visit by an insured adult to the dentist (as a preventive measure) is reimbursed to the tune of RON 80. As in the past, in 2014 an uninsured person can register with any GP on a separate list and benefit from a limited range of healthcare services (Annex Table 7.1).

In order to tailor the provision of primary healthcare services to the needs of the most disadvantaged, the government should consider the following priority actions:

- Reviewing and diversifying the interventions included in the minimum and basic benefits packages delivered by family doctors and increasing the share of services that proved to be effective (evidence-based services) delivered to the poor, with a focus on health prevention, early detection (such as cancer screening), and home visits.
- Periodically assessing the effectiveness and cost-efficiency of those interventions.
- Developing and implementing continuous medical education programs for family doctors and their nurses, tailored to the health needs of the most disadvantaged.

- Developing, implementing, and monitoring practice guidelines, clinical protocols, and management procedures on the interventions and services delivered to the poor by the primary healthcare network.

Developing the Emerging National Network of Community-based Healthcare Workers

Despite the government's efforts to develop primary care, certain parts of the population still find it difficult to access adequate health care, especially poor and vulnerable households, residents of rural areas and small towns, and the Roma population. The barriers faced by rural residents, especially those from remote villages, are mainly geographical barriers, but they are also less likely to be covered by health insurance and are usually poorer and less educated and informed than the urban population. Roma suffer from worse health than the non-Roma population, with a higher burden of infectious and chronic disease. Roma children also have a lower vaccination rate, which is largely attributable to a lack of information and education as well as of the absence of identification papers. In Romania, 42 percent of Roma do not seek healthcare when they actually need it, and over 80 percent of those who do not seek needed care say it is because of financial constraints or the lack of health insurance.³⁹²

BOX 39

Community-based Healthcare Workers in Romania - Definitions and Activities

Community Health Nurses (CHNs) are trained nurses who operate in the field, providing mainly health promotion and education, disease prevention, and home-based care and counseling.

In fact, the CHNs are a revival of the community nurses that used to exist prior to 1989. Today, they continue to provide health and social services and/or to facilitate access to primary healthcare services for disadvantaged groups (such as people with physical or mental

disabilities, the elderly, marginalized people including Roma, and rural communities with no family physicians or general practitioners).

The activities of the CHNs as defined by current regulations are to:

- Provide community health education and interventions related to environmental health and to health and social counseling.
- Provide health education regarding health risk behavior and a healthy lifestyle.
- Provide secondary and tertiary prevention.



³⁹² World Bank (Anan et al, 2014).

BOX 39 (continued)

- Provide reproductive health and family planning education and counseling.
- Provide home-based healthcare services for pregnant and postpartum women, newborns, and children.
- Provide homecare services for chronically ill patients, people with mental disabilities, and the elderly.

The Roma Health Mediators (RHMs) program was designed to improve the health status of Roma and increase their access to healthcare services. The RHM program was initiated by the Ministry of Health based on a good practice model set by an NGO (Romani Criss).

These health mediators are mainly Roma women with a medium (or low) level of education, who have been recommended by local communities and who have successfully completed a brief training course.

The activities of the RHMs as defined by current regulations are to:

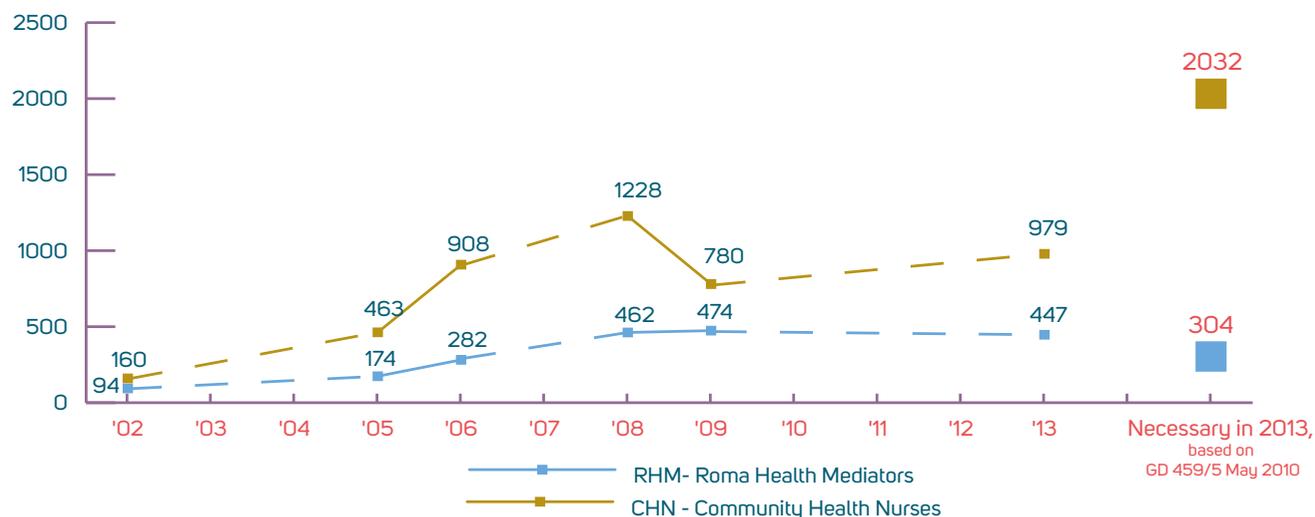
- Provide health education.
- Serve as a liaison between Roma communities and healthcare practitioners.
- Help Roma to access healthcare.
- Support public health interventions in Roma communities.

In 2002 the government set up a national network of community health nurses (CHNs) and Roma health mediators (RHMs) in an attempt to increase the access of poor and vulnerable groups to basic health services. This was initiated after the failure of primary healthcare reform to increase access to reproductive health services and mother-and-child care for the most vulnerable populations.

The community-based nursing system must be extended and strengthened as it represents the most powerful “equalizer” in the health system. Currently, the community-based healthcare system is largely underused (Figure 41). Between 2002 when the system was set up and 2008, the number of community-based healthcare workers, both CHNs and RHMs, gradually increased. In 2009, during the economic downturn, the government began decentralizing responsibility for healthcare to local governments, which meant that community-based healthcare workers became employees of the local authorities though they continued to be financed by the Ministry of Health. In the beginning,

decentralization created confusion on all sides, with most local authorities failing to understand the role of community health workers. Some of them refused to take on the community nurses and Roma health mediators in their own facilities, despite the fact that their salaries continued to be paid by the Ministry of Health although the Ministry did not cover the other operational costs related to their work.³⁹³ Consequently, the number of CHNs dropped considerably (from 1,228 to 780 at the national level). The number of RHMs has stayed more or less stable as they are better organized than the CHNs. As of 2013, the community nursing system had started to recover, yet it was functioning with less than half of the workers needed to cover the whole country according to the current legislation (Government Decision 459/5 of May 2010). A major cause of this situation, besides the lack of trained specialists and the small wages, is that, even today, the secondary legislation regarding community healthcare workers is not sufficiently clear or precise (see Box 40).

³⁹³ Even in the census of the Public Social Assistance Service (SPAS) carried out for this report in May 2014, only about a quarter of the Roma health mediators were declared as SPAS employees of local authorities in rural areas and small towns (of less than 50,000 inhabitants).

FIGURE 41: The Number of Community-based Healthcare Workers in Romania

Source: Ministry of Health.

Notes: Data for 2009 at the time of the decentralization of healthcare on June 30. Data for 2013 are for February 1. The number of necessary community-based healthcare workers was estimated according to the current regulations.

BOX 40

The Need to Improve Regulations Regarding Community-based Healthcare Workers

The qualitative research conducted for this report highlighted that the existing regulations governing community healthcare nurses (CHNs) represent a major barrier for the development both of the profession and of a national network. On the one hand, CHNs are hired by local authorities and as employees of the mayoralities they have to carry out the activities decided on by the mayor or vice mayor. On the other hand, their wages are paid by the Ministry of Health and, consequently, the County Directorates for Public Health monitor and coordinate their methodology. Sometimes the local authority and the County Directorate come into conflict, with the CHN caught in the middle. Furthermore, often the family doctor or the GP of the community asks the CHN to complete various tasks related to healthcare delivery, which are not included among the CHN's duties as defined by the local authority. Under these circumstances, many CHNs have only a limited

amount of time to devote to community nursing and often have to give up home visits and outreach activities. All of these factors diminish the effectiveness of the network of community health workers.

"Community health nurses are trained medical assistants. They have completed special training sessions so they know what they are supposed to do. We still have many localities with community health nurses, but some of them do not perform the work they were trained and know to do. Instead they do paperwork for some cash benefits or various other office tasks given to them by the mayors. So many ill people who are unable to move and have no one to help them do not benefit from care services precisely because of the lack of coordination between the social and health services and of the unclear status of the community nurses."

Source: County Directorate for Public Health, Botoșani, World Bank qualitative study carried out in July-August 2014 for preparing this background study.



Improving the quality of the basic health services available to poor and vulnerable groups will require significant investments aimed at strengthening the capacity of community-based health workers to deliver the needed services. There is a lack of any organized workflow, activity planning, or periodic results assessment for community-based health workers. The duties of CHNs are vaguely defined in the legislation. In general, local authorities have a limited grasp of the concepts of health promotion and primary and secondary preventive services. The capacity of the Ministry of Health and its decentralized directorates to control, evaluate, and coordinate CHNs' activity decreased dramatically when responsibility for the CHNs was transferred to the local authorities and as a result of the frequent changes in the Ministry of Health's structure and staffing at both the local and national levels. The County Directorates for Public Health fail to conduct any activity in the community healthcare area, not even the half-yearly orientation meetings that the regulations require them to hold, except for handling the monthly transfer from the Ministry of Health to the local authorities of the salary budgets for CHNs and RHMs. Except for various NGOs that have been providing community workers with training sessions under several different projects, there has been no initial or continuous medical training system for CHNs for over five years since decentralization.

We recommend that the government consider taking the following priority actions to improve the quality of the basic health services delivered by the community healthcare workers (CHNs and RHMs):

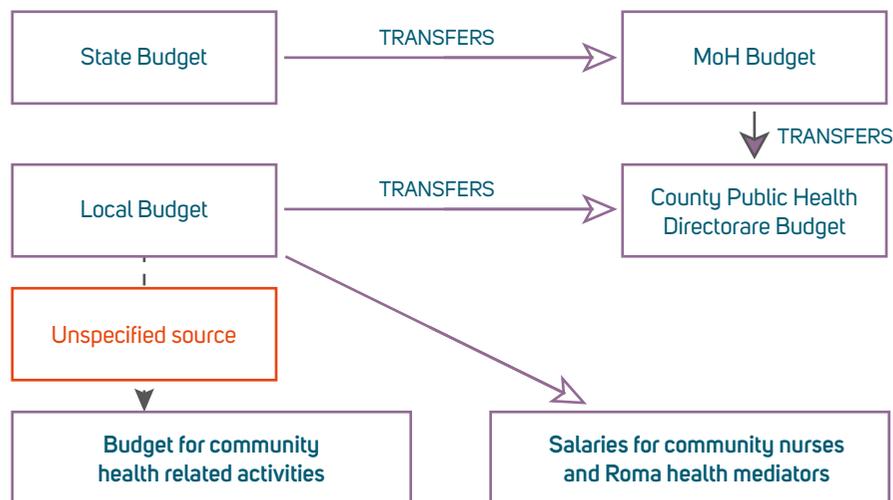
- Revising, updating, and endorsing the tasks and job descriptions of community health workers, implementing a standardized system for planning, reporting, monitoring, and supervising the community health workers' quality of work, and periodically assessing results vis-a-vis the planned targets.
- Periodically training and retraining community health workers, carrying out regular assessments of training needs, and developing short and practice-oriented training sessions.
- Enhancing the role and the capacity of the County Directorates for Public Health to provide professional support and supervision to community health workers.
- Developing a standardized process of planning and of periodic assessment and renewal of the basic

necessary equipment for the work of community nurses and Roma healthcare mediators, including basic medical kits, IEC materials, vehicles and transportation and vouchers, and an IT infrastructure.

- Implementing integrated community-based social, health, and educational services and promoting partnerships with specialized or grass-roots NGOs, while building the capacity of local authorities to plan and manage these integrated community-based services.

The government should ensure adequate funding for the development of the community-based healthcare services and should clarify the provisions governing operational expenses and ancillary costs related to their delivery. There are advantages and disadvantages to the present financial flow arrangements (Scheme 8). In terms of advantages, community workers being employees of the local authorities means that they are close to their direct beneficiaries, and the Ministry of Health being in charge of the salary budget is the safest option. However, the disadvantages are that shared responsibility means that neither party takes direct responsibility for the community health workers, and neither the local authorities nor the Ministry of Health bodies at the county level consider themselves to be in charge of the planning coordination, monitoring, and evaluation of community-based healthcare services. The local authorities have neither the knowledge nor the capacity to do this, and the County Directorates for Public Health do not have enough staff for this purpose. As a result, for the time being at least, the community healthcare network is in a vacuum, with no adequate professional guidance, methodological support or control, and no legal provisions to ensure the sustainability of funding for its operational expenses, other than salaries. Because of an error that has not been remedied over the past five years, no legal document specifies who is responsible for funding community healthcare activities or from what source, and local authorities find it impossible to cover the related expenses of the network (such as medical kits, travel expenses to villages, and attendance by community health workers at training meetings organized by the County Directorates for Public Health in the county capitals). At present, there are cases in which the family physician (formally or informally) hires the community nurse to make house calls or to work in the physician's medical office. Thus, the state ends up paying twice for the same service, once by paying the CHN's salary and twice by reimbursing the family physician for the services provided, in fact, by the same community nurse. This is a

SCHEME 8: Financial Flow of Community Healthcare Services (Community Nurses and Roma Health Mediators)



simple example of the lack of coherence and control within the health system.

The cost-effectiveness of the national network of community healthcare workers should be analyzed to identify the most appropriate ways to respond to the needs of poor and vulnerable groups and to determine how much financing will be needed to integrate (primary) social services at the community level. For now, it is impossible to tell whether community healthcare work is cost-effective or not since there is no analysis or available data on its interventions and outcomes. Anecdotally, its beneficiaries generally declare that the CHNs and RHMs are a great help to them and their communities. A 2011 regional qualitative review of Roma health mediators³⁹⁴ showed that

mediators have generally been successful in increasing the knowledge of health care providers about Roma and in changing their negative attitudes. The mediators reported seeing less discriminatory behavior and less use of abusive language by the doctors with whom they worked. As a result, the mediators felt that this had led to more effective interactions between physicians and their Roma patients and thus to better medical care. A later World Bank report entitled *Diagnostics and Policy Advice for Supporting Roma Inclusion in Romania*³⁹⁵ emphasized that local health mediators can help to change the social norms that have discouraged the uptake of health services by reducing the social stigma associated with accessing counseling services, reproductive health services, and tests for sexually transmitted infections.

³⁹⁴ Open Society Foundation (2011).

³⁹⁵ World Bank (Anan et al, 2014).

BOX 41

The Positive Impact of the Community Nurses Network in Botosani County

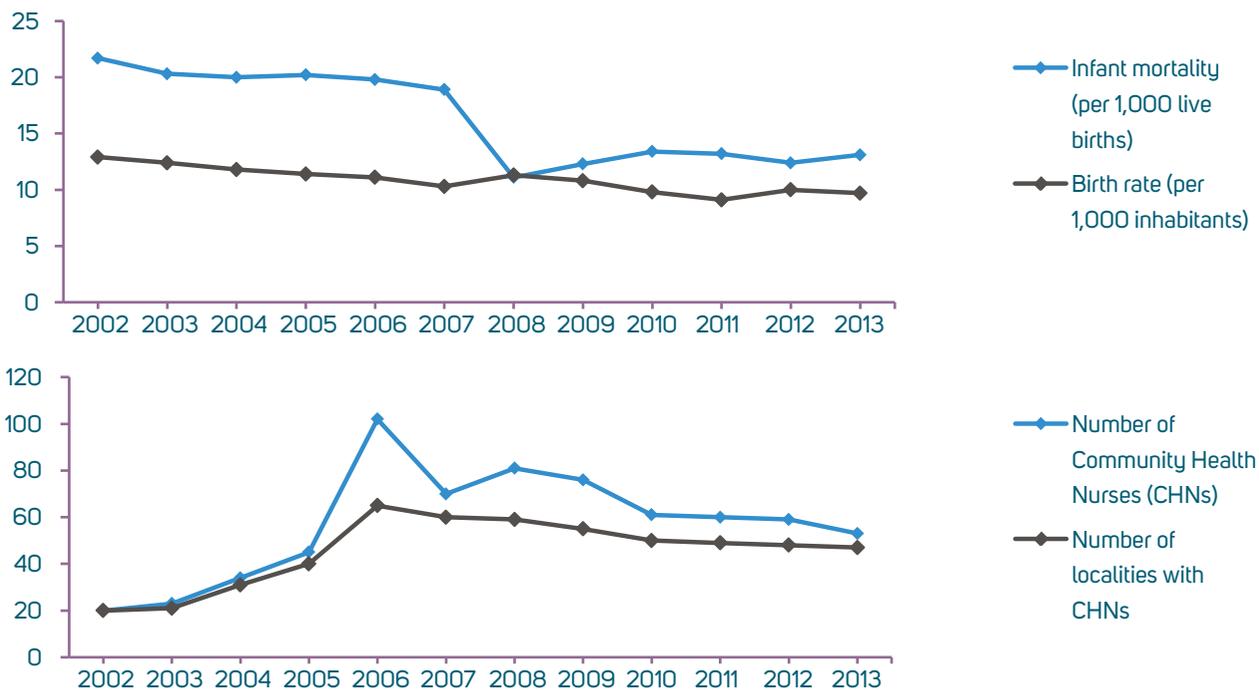
“The impact [of the community nurses network] is highly visible in the steep decrease in infant mortality. This is one of these indicators with a positive trend precisely because of the work of the community nurses. They manage the register of pregnant women, they go to them and explain to them the importance of going to hospital and of regular consultations, and therefore the pregnant women are constantly monitored and informed about the possible risks. Sometimes the pregnancy itself is at risk and therefore needs more intense monitoring by the family doctor and the gynecologist.

When the family doctor considers that it is a problem that needs a specialist, he or she sends the woman to the gynecologist. The community nurse facilitates the process and offers continued support to the pregnant woman in this situation, and this is how we had a drop in infant mortality... Also, cases of teenage mothers abandoning their children have dropped considerably from 33 abandoned children in 2009 to only two cases in 2013.”

Source: Interview with Inspector in the Department for Medical Care for Disadvantaged Communities, County Directorate for Public Health Botosani, Qualitative study under this background study, July 2014.



The Relation between Infant Mortality, the Birth Rate , and the Network of Community Nurses



Source: Data on CHNs reported by the County Directorate for Public Health, Botosani. Rates of births and infant mortality from the National Institute of Statistic, Tempo Online database.
 Note: The birth rate is the number of births per 1,000 individuals per year.

The qualitative research conducted for our background study in July 2014 yielded some additional evidence of the positive effects of community healthcare workers. Botosani county is one of the few counties that had an adequate supply of community nurses before decentralization that has succeeded in maintaining this network since 2009. Especially in the rural areas of the county, community nurses have had a substantial positive impact on the decline of infant mortality from about 25 infant deaths per 1,000 live births in 2002 to fewer than 14 per 1,000 live births in 2013. The MoH recently announced an initiative to extend the community healthcare and health mediation network, but it is difficult to know whether this will be enough to achieve the ministry's declared goal of increasing the access of poor or vulnerable people to health services in the absence of other measures to address the other problems faced by the network.

At the national level, an insufficient number of localities benefit from the services of a community health nurse. According to Ministry of Health data, at the beginning of 2014 there were almost 1,000 CHNs nationwide,³⁹⁶ of whom only 18 were employed by the local authorities. In the previous year, these CHNs provided community health services to nearly 1 million people, including about 250,000 children. With regard to the health mediators for Roma communities, Ministry of Health data indicate that, in 2013, the 447 RHMs facilitated access to health services for approximately 200,000 Roma. However, there is no systematic data collection process to monitor the community health workers network, and therefore no reliable data are available to be analyzed regarding the types of services offered, the characteristics of the beneficiaries, or medical outcomes.

Nevertheless, it was possible to do a mapping exercise using official data collected from the websites of the National and County Health Insurance Houses regarding the availability of family doctors, GPs, pharmacies, community health nurses, and/or Roma health mediators within each locality between September and November of 2014.³⁹⁷ The exercise showed that over 6 percent of all localities have no family physicians, no community nurses, and no Roma health mediators. Most of them

(almost 5 percent of all localities) are “white spots” in terms of the absence of community-based and primary healthcare services, while the others have only a pharmacy. The “white spots” are all rural localities and are spread throughout the country (with the exception of four counties, namely Arges, Braila, Dolj, and Gorj), with a higher prevalence in Buzau, Ialomita, Caras-Severin, Vrancea, and Hunedoara. Most “white spots” are small communes with fewer than 2,000 inhabitants (which are also likely to lack social workers, see Section 2.3), with a generally low level of human development,³⁹⁸ in a municipality with low fiscal capacity,³⁹⁹ and with a relatively low number of (self-identified) Roma. Map 4 indicates that the “white spots” are more likely to be found near the borders of counties. The explanation for this may be that it is not the distance to any city that influences the availability of health services at local level but the closeness to the administrative center of the counties. Health professionals may be more inclined to search for jobs in localities close to their county centers for both economic (in general, incomes are higher in such cities) and career development reasons. However, both in rural and urban localities, most communities tend to have one or more family physicians along with one or more pharmacies. About 10 percent of all localities may be considered “champions” because they have family physicians, pharmacies, and community healthcare workers. These “champions” are located in all counties, particularly in cities⁴⁰⁰ but also in larger communes where there is a generally high level of human development (according to the Local Human Development Index), where the municipality has relatively high fiscal capacity and where there are higher numbers of (self-identified) Roma. They also tend to have a Public Social Assistance Service with more staff and financial resources. In conclusion, there is a polarization in terms of service delivery between small and poor rural communities, which lack all types of social services, and larger and better developed rural communities and cities, which have succeeded in developing more and more diversified services at the local level. Consequently, the extension of the national network of community health workers should start as a matter of priority in the “white spots” and in those communes with no permanent family doctor's practice.

³⁹⁶ The total yearly salary costs to the Ministry of Health of these activities can be roughly estimated at around RON 20 million as the average annual salary of a community health worker is approximately RON 20,000.

³⁹⁷ Data for four counties - Calarasi, Giurgiu, Mehedinti, and Timis - became available too late to be included in this analysis. Ministry of Health data collected in July 2014 regarding the Roma health mediators who were contracted in 2013 overlapped with data from the census of the Public Social Assistance Services carried by the World Bank in 2014.

³⁹⁸ Estimated against the Local Human Development Index (LHDI), which measures the total capital of rural and urban administrative units in Romania, looking at four criteria: human capital, health capital, vital capital, and material capital (Ionescu-Herouiu et al, 2013a). Human capital is measured based on the indicator of education stock at local level (for population aged 10 and over). Health capital is measured as life expectancy at birth at local level. Vital capital is measured using the indicator of mean age of the adult population (those aged 18 or over). Finally, material capital is assessed as a factor score of three specific indicators that focus on living standards: dwelling space, private cars to 1,000 residents, and distribution of gas for household consumption in the particular territorial unit. The aggregation of the four measures of the dimensions of community capital is achieved by another factor score.

³⁹⁹ First quartile of the variable: share of own revenues in total revenues at the local budget, average annual value for 2009-2012.

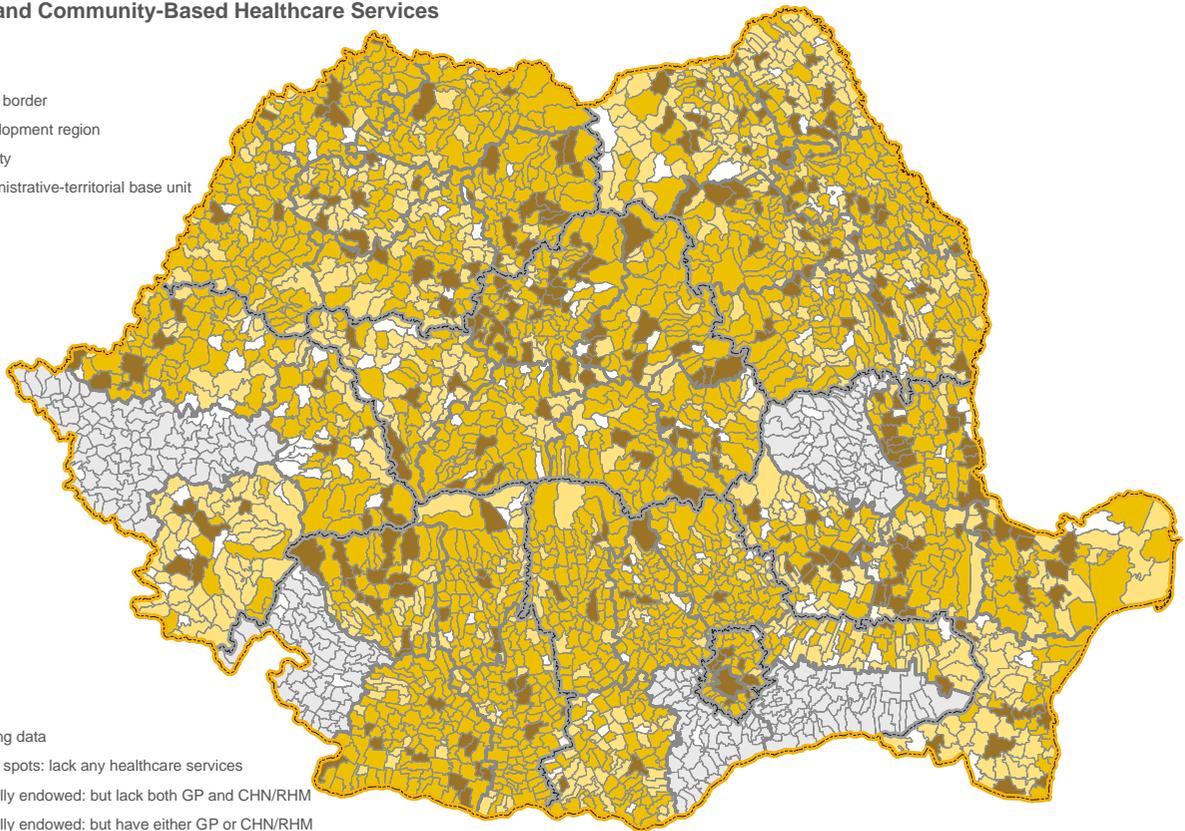
⁴⁰⁰ The rate of “champions” is 36 percent among urban municipalities and only 6 percent among the rural ones.

MAP 4: Coverage of Community-based and Primary Healthcare Services

Primary and Community-Based Healthcare Services

Legend

-  State border
-  Development region
-  County
-  Administrative-territorial base unit



-  Missing data
-  White spots: lack any healthcare services
-  Partially endowed: but lack both GP and CHN/RHM
-  Partially endowed: but have either GP or CHN/RHM
-  Dominant pattern: GP and pharmacy
-  Champions: fully endowed





2.6. Housing

The government should aim to increase access to housing services, particularly for the homeless and other people who cannot afford accommodation.



Main Objectives

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2.6.1. Increasing the Affordability and Improving the Quality of Housing, Especially for the Vulnerable Population	256
2.6.2. Developing Social Housing Services	262
2.6.3. Ensuring Efficient Emergency Support for the Homeless while Building Capacity for Social Reintegration and Early Prevention	267

2.6. Housing

Housing deprivation and homelessness are extreme forms of poverty and social exclusion in today's society. Access to adequate and affordable housing is a fundamental right, and it represents the cornerstone upon which safe, healthy, and productive lives can be planned. For people in extreme poverty, food and housing represent their most basic needs, which consume an inordinate proportion of their financial resources to the detriment of other aspects of their lives such as health or access to education. The incapacity to procure or to sustain decent housing leads, in itself, to other vulnerabilities, cutting the destitute off from the normal cycle of development.

At the European level, the recent economic crisis has heightened concerns about housing affordability, especially for the worst-off social groups. According to the European Commission (2010b), increasing access to housing is key to achieving the Europe 2020 strategy of decreasing the number of people in - or at risk of - poverty or social exclusion. Actually, since 2007, social housing has been recognized as a social service of general interest,⁴⁰¹ suitable for state aid, which broadens the scope of opportunities for policymakers.

In Romania, guaranteeing the right to affordable accommodation still represents a significant challenge. Appropriate policy responses and budgetary allocations in the area of social housing are very limited, while many vulnerable groups in extreme poverty, such as the homeless and people living in illegal settlements, in marginalized areas, or in inadequate dwelling conditions, are insufficiently covered by the existing housing support programs.

The main evolutions⁴⁰² in the housing field after 1990 have largely been outside the control of the government. Thus, most development has been left to private initiatives (based, among others, on the argument in favor of owner-

occupancy) and to the market. In time, the housing sector disappeared from ministerial names as well as from the organizational charts of ministries. Data on housing from the censuses had never been coherently or deeply analyzed⁴⁰³ and were almost never used for the justification and/or design of housing policies.

As a result, the programs addressing various housing related problems were not very coherent or integrated. In addition, responsibility for social housing was decentralized to local authorities as social housing has always been considered a local interest and responsibility, even though it was known that the housing stock still in municipal hands was either insufficient or/and in a bad state. Given that many cities and the majority of rural settlements had shrinking or collapsing economies, local budgets have been totally insufficient to support any housing investments. As a result, sizeable discrepancies in the condition of the housing stock emerged between the different regions of the country, especially between urban and rural areas but also between municipalities of the same size and/or type.

2.6.1. Increasing the Affordability and Improving the Quality of Housing, Especially for the Vulnerable Population

At the national level, a legal and institutional framework⁴⁰⁴ for the housing sector exists, but the government has never developed either a policy or a strategy for the sector. Also,

⁴⁰¹ Huber et al (2007).

⁴⁰² During the 1990 to 1999 period, there was only limited housing construction, mainly in certain (more wealthy) rural areas. In the same period, the de-industrialization of the economy led, in the housing area, to the decay or abandon of "bachelor hostels/blocks of one-room flats" (camine de nefamilisti / blocuri de garsoniere). Also, the increasing rates of migration for work abroad seriously affected the construction sector as many professionals and skilled workers left Romania. The period of economic growth (2000 to 2008) was the golden period of larger housing schemes, particularly in large cities, as well as expansions and sprawl generated by green field housing developments in nearly all cities. This was also the pre-EU-accession period of SAPARD programs for increasing water and sewage access in small towns and rural areas, including the rehabilitation of distribution networks. The post-accession period, after 2007 and up to 2009 (the beginning of the global crisis), was marked by an increase in housing construction and improvements, fueled particularly by the remittances sent home by the migrants working abroad. After 2009, many construction projects were put on hold with some real estate investors disappearing before the completion of the work, a slow-down in construction, and decreases in housing high prices.

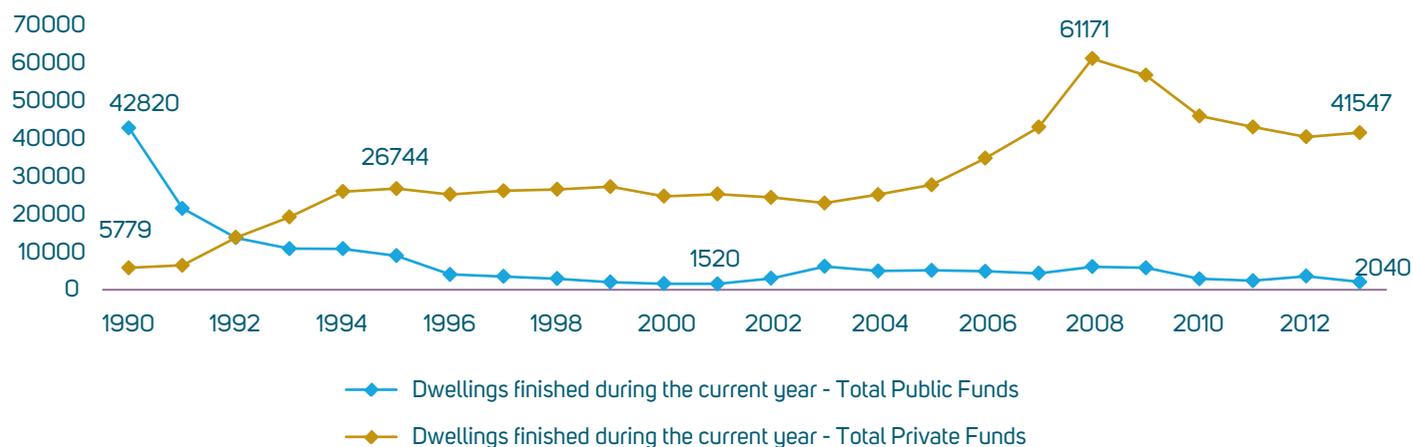
⁴⁰³ Except for describing general housing conditions in the otherwise meritorious studies done by various research institutes.

⁴⁰⁴ For example, Law 50/1991 allowing leases on municipal land for housing construction, the massive privatization of the state-owned housing stock between 1991 and 1993, Law 10/2001 related to real estate, particularly housing, nationalized between 1945 and 1989 (involving many evictions with unhappy consequences), the Housing Act (Law 114/1996), the creation of the National Housing Agency (with only a limited effect on housing conditions), and Law 190/2013 on Regional and Urban Planning (which had a few moderately successful outcomes).

as shown in section 2.3, Romania's public spending on social housing has constantly been very low compared with other European countries.⁴⁰⁵ More generally, public

funds devoted to housing construction dropped steeply in the early 1990s and have remained at extremely low levels ever since (Figure 42).

FIGURE 42: Total Public Expenditure on Health as a Percentage of GDP/Total Public Expenditure in Romania and in the EU-27



Source: World Bank calculations using data from the European HFA Database, WHO/Europe, November 2014

Romania ranks first among EU countries in terms of private ownership of housing stock - 97 percent compared with an EU-28 average of 70.4 percent in 2012 (Annex Table 8.1). This appears to be a comparative advantage in terms of dwelling security,⁴⁰⁶ but it also has some drawbacks. For example, owners often struggle to afford to maintain their properties, there is little accommodation available for those seeking new employment opportunities in a new area, and there is only a limited supply of affordable housing to rent or buy for the younger generation. The combination of a lack of affordable housing, the scarcity of economic opportunities to enable young people to be able to afford independent housing, and a Romanian culture that encourages young people to continue to live with their parents⁴⁰⁷ has resulted in a high share of young people

living with their parents. According to Eurostat, almost two-thirds of young people (aged 18 to 34) and 45 percent of youths in full-time employment still live with their parents (Annex Table 8.2). The lack of housing may be one of the factors influencing young people to postpone major family decisions such as getting married or giving birth. The difficulties faced by the young in establishing their own households coupled with the economic and/or physical dependency of some of the elderly has led to many large overcrowded households in Romania. More than half of the population lives in overcrowded dwellings,⁴⁰⁸ which is the highest percentage among all of the European countries and is three times higher than the EU-28 average (16.8 percent). Overcrowding is even more acute among the poor population. The 2012 Household Budget Survey (NIS)

⁴⁰⁵ In 2011, social housing services were allocated 2.66 PPS per inhabitant in Romania compared with an EU-28 average of over 145 PPS per inhabitant.

⁴⁰⁶ According to the 2011/2012 European Quality of Life Survey, a total of 90.8 percent of Romanians stated that it was very unlikely that they would consider leaving their accommodation in the next six months as a result of it becoming unaffordable compared with 81.5 percent of Europeans on average.

⁴⁰⁷ Particularly in rural areas, this is aimed at keeping multiple generations of a family within the same house to maximize the household's agricultural production and to take advantage of intergenerational support for bringing up children and carrying out domestic work.

⁴⁰⁸ Defined as those that do not meet the following standards: at least one room for each single person aged 18 or for a pair of single people of the same gender between 12 and 17 years of age and/or one room per pair of children under 12 years of age.

data indicate that the number of people per room varies from 0.73 in households in the highest income decile to 1.44 among those in the lowest income decile, as shown in Annex Table 8.3.⁴⁰⁹ In the same time, the available space in the dwelling decreases from an average of 29.4 square meters per person for better-off households to less than 15 for the poorest (Annex Table 8.4).

The quality of housing stock is rather weak. Besides overcrowding, severe housing deprivation affects 23 percent of the Romanian population, four times more than the EU-27 average (Figure 43). Although the situation improved after 2007 (Annex Table 8.5), severe housing deprivation has remained consistently acute for the poor (49 percent) and for households containing children (37 percent of children).

Given the high share of the population living in rural areas, the most severe deprivation is apparent in the area of sanitary facilities with 35 percent of people living without an indoor bath or shower and 37 percent living without an indoor flushing toilet for the sole use of that household (Annex Table 8.6). According to the 2011 Census, out of the 8.72 million dwellings in Romania, 3.96 million are located in rural areas and 4.76 million in urban settlements. In rural areas, most dwellings are individual houses (3.81 million) consisting of two to three rooms that were built before 1970 of poor quality materials (abode or framework) and that lack hot running water, indoor baths or showers, and a connection to the sewage system. In urban areas, most dwellings are apartments in blocks (3.22 million) or individual houses consisting of two to three that were built between 1960 and 1990 with reinforced concrete or were prefabricated units and that are connected to utilities. Thus, the housing stock is obsolete, and only one in four houses complies with current seismic standards.

Housing affordability is also problematic, although almost the entire population lives in owner-occupied dwellings with no loan or mortgage. In 2012, Romania was one of the countries in Europe with the highest housing cost overburden rate (the percentage of the population living in households where total housing costs represent more than 40 percent of disposable income).⁴¹⁰ Utilities costs are considerably higher in some localities than in others, which

results in a high share of indebtedness among the low-income population of those areas. Furthermore, the housing cost overburden rate is substantially higher among people at risk of poverty (41.4 percent compared with the national rate of 16.5 percent). The 2012 Household Budget Survey (NIS) data show that the situation is critical, especially for poor people in urban areas (see Figure 44). Thus, the costs of utilities (electricity, thermal energy, gas, firewood/coal/petroleum, water, and sanitation) account on average for more than 52 percent of the total monthly expenditures of households in the lowest income decile in urban areas compared with 20 percent of the expenditures of better-off urban residents.⁴¹¹ Specifically, Eurostat figures for 2012 show that more than one-quarter of Romania's total population and one-third of households with children were in arrears with their utility payments for the previous year compared with an EU-28 average of about 10 percent.⁴¹²

The Roma population is generally excluded from the housing market, as was documented in a recent World Bank study:⁴¹³

- Most Romanian Roma live in segregated communities. The Regional Roma Survey (RRS) found that 56 percent of Roma households live in settlements where the dominant ethnicity is Roma, indicating a high level of spatial segregation. Spatial segregation is highly correlated with lower health status, early school-leaving, low labor market attachment, and costly access to other services (such as public transport and health facilities).
- A significant proportion of Roma live in poor quality houses with inadequate infrastructure, overcrowding, and a lack of secure tenure. The housing conditions of Roma households are consistently worse than those of non-Roma households. The RRS data show that 30 percent of Roma households live in a dilapidated house or slum compared with only 4 percent of non-Roma households living nearby. Only about half of the Roma households in urban areas have access to housing of relatively good quality such as newly constructed housing, dwellings made of traditional materials in older settlements, or social housing provided by the local authorities.

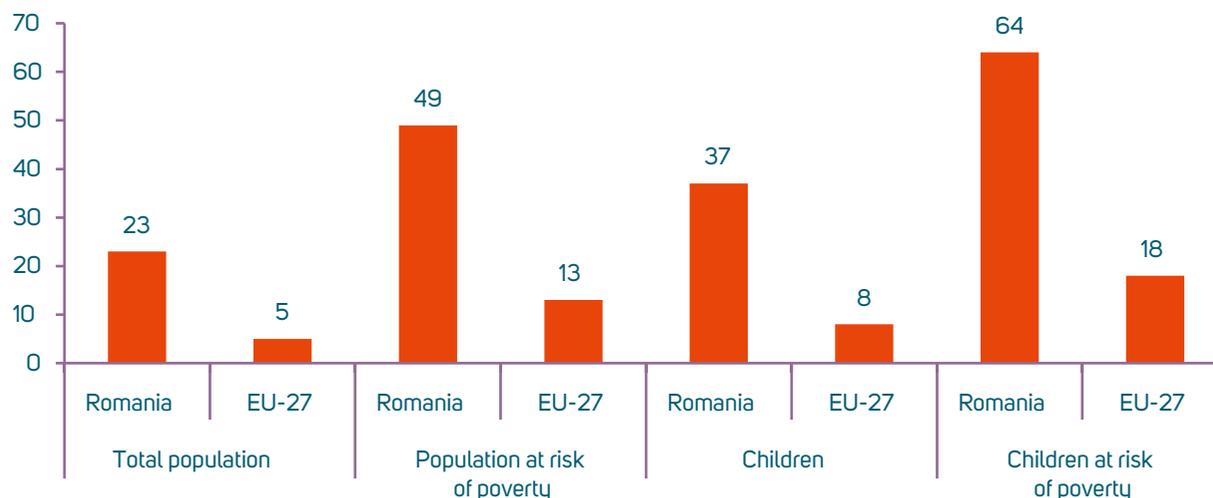
⁴⁰⁹ Income deciles based on the total monthly household per capita cash income (without self-consumption).

⁴¹⁰ This measure is crucial for keeping track of the risk of homelessness. According to Eurostat, the proportion of the population living in households where housing costs exceeding 40 percent of their disposable income was the highest in Greece (33.1 percent), followed by Denmark (18.2 percent), Germany (16.6 percent), Romania (16.5 percent), and Bulgaria (14.5 percent). For comparison, the EU-28 average was 11.2 percent, while much lower values were found in Malta (2.6 percent), Cyprus (3.3 percent), Finland (4.5 percent), Luxembourg (4.9 percent), and France and Slovenia (both 5.2 percent).

⁴¹¹ However, in absolute values, the poor households (D1) from urban areas spend a monthly average of 225 lei on their utility bills, while the better-off households (D10) pay about 500 lei.

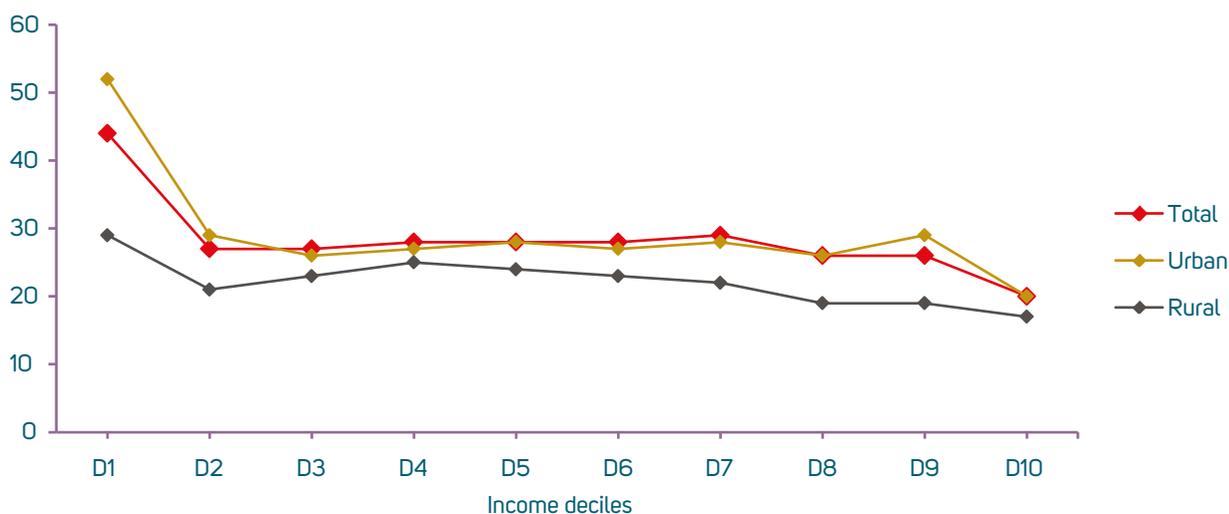
⁴¹² Other types of arrears, such as rent and mortgages, are less common among Romanians.

⁴¹³ World Bank (Anan et al, 2014) using data from the Regional Roma Survey undertaken in Europe by UNDP, the World Bank, and the European Commission in 2011.

FIGURE 43: Severe Housing Deprivation by Poverty Risk and Age (Children), 2012 (%)

Source: Eurostat.

Note: The poverty threshold is set at 60 percent of disposable income per equivalent adult.

FIGURE 44: Costs of Utilities as Percent of Total Household Monthly Expenditures by Income Deciles, 2012 (%)

Source: World Bank calculations using data from 2012 HBS.

Notes: Utilities refer to electricity, thermal energy, gas, firewood/coal/petroleum, water, and sanitation.

Income deciles are based on total monthly household per capita cash income (without self-consumption). The figure shows the average values per decile.

The remaining 40 to 45 percent live in low-quality multi-story blocks or slums or in temporary camps with poor-quality structures and inadequate infrastructure, while only 20 percent of the neighboring non-Roma live in such poor conditions. In rural areas, about one-third of Roma households live in poor quality housing.

- A large number of Roma households lack access to water and sanitation. Only about 17 percent of Roma households have indoor sanitation (a toilet, a bathroom, and a sewage connection), while about 44 percent of nearby non-Roma families have these amenities. Similarly, only about 17 percent of Roma households have access to drinking water indoors compared with 34 percent of their non-Roma neighbors. About 36 percent of Roma households report that there is no or only collection of waste in their area compared with 18 percent of their non-Roma neighbors.
- Many Roma still lack identity documents, which has further restricted their access to services and credit. One major hurdle has been the need to show proof of residence, which many Roma lack because of their informal housing situations. Other barriers include their lack of literacy as well as discriminatory attitudes among the personnel in charge of issuing the documents.

The massive privatization of the housing stock between 1991 and 1993 was probably the most important action affecting housing and the housing market. Justified by policymakers as politically and socially necessary, the privatization was achieved by offering previously public housing for sale at very low prices, allowing virtually all occupants (who had previously been renting their apartments from the state) to buy their homes. The overwhelming majority of privatized housing stock consisted of apartments in collective housing units of all types and quality, and the new owners bought one part of the collective housing building, with the rest of the property becoming part of the private domain of the local public property. The regulations concerning the co-ownership of collective housing (condominiums) were adopted only

years after the privatization process. The restructuring of the economy after 1990, which mainly involved de-industrialization, widened the income gaps between flat-owners. In many cases, families that had recently arrived in town decided to move back to their rural municipalities, but often they decided to retain their urban apartment. The new laws regulating businesses made it possible for them to convert their urban flats into business premises. Not only did this lead to co-management problems in the buildings themselves, but it also diminished the size of housing stock and put upward pressure on prices (as firms were more willing to pay higher rents than families in need of housing). One of the consequences of the low costs involved in buying apartments in collective housing was that some new owners tended to be careless about the maintenance of their recently acquired property, either because of the small amount they paid for it⁴¹⁴ or because they simply lacked the resources to do so. Somehow pre-1989 attitudes were perpetuated, with the new owners continuing to invest only in the interior of their flats - upgrading, remodeling, changing fixtures (such as windows and sanitary fixtures), and general maintenance - but neglecting to maintain the communal spaces (such as staircases or elevators) and the exteriors of buildings.⁴¹⁵ There was (and still is) a chronic lack of interest from owners in the state and quality of hidden fixtures such as water and sewage distribution pipes within the building, which has caused this infrastructure to deteriorate. Although analysts have issued warnings about the gravity of these problems, policymakers have yet to come up with any coherent policies or programs to address them.⁴¹⁶

A number of housing programs have been developed and implemented with the aim of increasing the affordability and improving the quality of housing. However, most of them are concentrated in urban areas where housing demand is higher and severe social problems have emerged in the last few decades. In rural areas, the persistent housing deprivation and severe material deprivation (energy poverty) have not yet been addressed by specific policies.

The most important program in terms of the number of public sector housing units has been the Youth Housing Program administered by the National Housing Agency (NHA). The program constructs rental housing for youths

⁴¹⁴ The gap between the "appetite for the status of owner" and the "responsibilities generated by this status" has been characterized as a kind of "divorce." The ownership of the dwelling (flat or house) became, after this massive privatization, a must-have "social norm" (Voicu and Noica, 1999).

⁴¹⁵ The negligent attitude of property owners towards leaking roof terraces is typical. They are seen as only a problem for those on the upper floors. This will be the case at least until clear regulations have been established governing co-ownership of buildings.

⁴¹⁶ It was recently reported in the media that "inner building piping improvements" might become eligible for co-financing from EU money in the 2014-2020 period, together with thermo-insulation works, which are already eligible.

and young professionals. Since its inception in 2001, the program has built 31,244 dwellings in about 195 cities across the country. The program targets young people who cannot otherwise afford to buy an apartment or to rent a privately owned housing unit. If the local authority has evidence of demand for accommodation from people displaced by restitution (from nationalized houses), 20 percent of the units built under the Youth Housing Program may be assigned as social housing. This is relatively good quality housing and is considered to be much better than the average housing stock in Romania. The rents are typically a small fraction of the market rent, which may be incrementally increased to a maximum of 70 percent of the market price for tenants older than 35 years old. Thus, in terms of subsidies, the Youth Housing Program resembles the social housing program but with very different targeting. According to Law 152/2011, the Youth Housing units may now be sold⁴¹⁷ to the holders of those contracts with an average income per family member that does not exceed the national average upon their request and after a minimum of one year of continuous rental, notwithstanding the applicant's age. Local authorities appear inclined to sell these houses, mainly because the rents are too low to cover the maintenance costs. Nevertheless, at the national level, fewer than 3 percent (about 900 units) have been sold so far. This is because some tenants have incomes higher than the national average (so are not eligible to buy the units), while other tenants cannot afford even the subsidized sale price. Also, the very low rents for these units and the absence of any cap on the total number of years during which they can be rented means that many prospering tenants prefer not to move out, even though their units could be allocated to a lower-income or younger tenant.

Other government housing programs are small or very small-scale. The government-supported mortgage-financed housing units are designed for Romanian citizens who can take out a mortgage from a bank to pay for the construction of his or her housing unit, while the National Housing Agency is responsible for acquiring serviced land from local authorities for free.⁴¹⁸ A program of housing

units for resident doctors who cannot afford to rent or to privately own a house (even under the Youth Housing Program) has so far built 534 units in Bucharest, Cluj Napoca, Iasi, Sibiu, Falticeni, Timisoara, and Radauti. The program Rebirth of the Romanian Village (GD 151/2010) aims to build service housing units for young specialists in communes.⁴¹⁹ Also, 70 urban municipalities have a total of about 800 service housing units available for young specialists. Another program aims to provide temporary leases of necessity housing units (similar to social housing) to people and families whose dwellings have become unusable.⁴²⁰ However, necessity dwellings are very rare in rural areas,⁴²¹ while in urban areas only 46 local municipalities have a total stock of approximately 1,000 such units. Law 15/2003 regulates the awarding of land plots⁴²² from territorial-administrative units done by local authorities to young people aged between 18 and 35 years old to construct houses. However, data on these land plots allocations are available only for urban areas. Out of all urban municipalities, 152 allocated more than 11,500 land plots to young people. In an attempt to use housing to reduce social marginalization, Law 116/2002 stipulates that county councils may raise funds in order to facilitate access to housing for young people aged up to 35 who cannot afford to buy a dwelling on their own. The specific access criteria can be set by the county councils, but their priority must clearly be young people from placement centers and orphanages, individuals aged under 35 years old with children, individuals aged under 35 years old with no children, and all other individuals under 35 years old. No data are available on the amounts that county budgets currently allocate to this program. Also, no evaluations of any these housing programs are yet available.

The government has also introduced some housing finance initiatives (for example, Prima Casa program and subsidies for savings products) and various programs for housing and related infrastructure, such as heating subsidies, tax incentives, mass thermal insulation of collective housing units (GEO 18/2009), the Green House program, and seismic retrofitting (GO 20/1994).

⁴¹⁷ The selling value of the unit is established by the local public administration authorities (or the central authorities in the case of young specialists in education and health) according to GO 2401/2013.

⁴¹⁸ Between 2000 and 2014, 3,200 housing units were completed in 16 counties and in Bucharest. Almost half of the units (1,589) were built in Bucharest.

⁴¹⁹ This is funded from the state budget and is targeted to public sector employees working in rural areas, including teachers, doctors, nurses, and police officers. These are two or three room houses, not exceeding 100 square meters and 120 square meters respectively, on land plots of 500 square meters. A maximum of 10 to 15 houses can be built per commune. Priority is given to applicants who are under 35 years old. Public workers can rent the units only during the duration of their job contract in the respective locality.

⁴²⁰ Necessity housing units are financed and built under the same conditions as the social housing. The necessity housing units can be used as social housing units if they are free, or the social housing units can be used as necessity housing in cases of emergency.

⁴²¹ In 2005, a special program managed by the NHA was made available to people affected by floods. Under this program 1,617 houses have been rebuilt and 16,076 households have been provided with building materials to renovate their own dwellings.

⁴²² The size range of the land plot varies by location: 150 to 300 square meters in the cities and districts of Bucharest, 250 to 400 square meters in cities, and 250 to 1,000 square meters in communes and villages.

These programs are analyzed in Inputs for the National Housing Strategy recently prepared by the World Bank for the Ministry of Regional Development and Public Administration.⁴²³

As a conclusion, all existing programs that aim to rehabilitate and modernize the housing and utility stock should be redesigned to be targeted more to the poor and vulnerable. In addition, all programs designed to increase energy efficiency need to be targeted to low-income households and to protect vulnerable consumers (should compensate low-income households for a share of the costs of making their homes energy-efficient in proportion to their financial constraints and energy needs).

2.6.2. Developing Social Housing Services

A European Parliament resolution of June 11, 2013 on social housing in the European Union (2012/2293(INI)) “reminds the Commission, the Member States, and local and regional authorities that spending on social and affordable housing is in keeping with fundamental rights, enables urgent social needs to be met, and, as a strategic social investment, helps in a sustainable way to provide local jobs that cannot be off-shored, stabilize the economy by reducing the risk of property bubbles and household over-indebtedness, promote labor mobility, counter climate change, combat energy poverty, and alleviate health problems stemming from overcrowding and poor living conditions; insists, therefore, that social housing should not be considered a cost to be cut but an investment that pays off in the long term through better health and social wellbeing, access to the labor market, and the empowerment of people, especially the aged, to live independent lives.”

There is a lack of a commonly accepted definition of social housing at the European level. In Romania, social housing is defined under the Housing Law 114/1996⁴²⁴ as a dwelling that is allocated by a public authority for a small rent (subvention) to individuals or families who cannot otherwise afford to buy or rent a house from the free housing market. This definition of social housing does not include housing services for vulnerable groups such as shelters or refuges

for the homeless. Under the same law, the social housing construction program (administered by the MRDPA) began in 1997 and is funded from both the state and local budgets. Under this program, local authorities are responsible for building new dwellings or refurbishing old buildings to use as social housing.

The social housing sector is severely underfinanced in Romania compared with other EU member states (see Section 2.3.1 on financing social services). The social housing stock is under the control and responsibility of the local councils located in the territorial-administrative units. According to the 2011 census, at the national level, only 122,538 dwellings are state-owned (or 1.4 percent of the total housing stock), out of which only a small proportion is used as social housing. Of these, 26,156 (21.3 percent) are in rural areas and 96,382 in urban areas. The construction of new social housing units has also been very slow. In 2012 and 2013, only around 200 social houses were completed for people displaced by restitution from nationalized houses (GD 74/2007) in 26 localities (in 2012) and 23 localities (in 2013). During the same period, the number of social houses available for other types of eligible beneficiaries (according to Law 114/1996) has also fluctuated around 200 units per year, much lower than the 2,000 units per year that built on average in the period between 1998 and 2007.

The scarcity of available social housing has constantly been a general problem after 1990.⁴²⁵ Local public authorities own and manage housing stock to be rented to the poorest population, but this fund is not “social housing” as it does not comply with the legal requirements. Most often this stock includes nationalized or low-quality houses that have been neglected in the past few years and are located in unattractive, difficult to access, and poorly endowed urban areas, with a low market price.

In October 2014 as part of the preparation of this background study, the World Bank in collaboration with the Ministry of Regional Development and Public Administration (MRDPA) conducted a Situation of Social Housing (SSH)⁴²⁶ survey in all urban municipalities.⁴²⁷ The SSH showed that about 28,000 to 29,000 state-owned dwellings are officially registered as social housing units, of which 19,000 to 20,000 are in apartment blocks and 8,000 to 9,000 are in other types of buildings. These units are not evenly distributed among cities - 131 have no social

⁴²³ World Bank (2015a).

⁴²⁴ Currently, the MRDPA in collaboration with the MLFSPE is drafting amendments to this law.

⁴²⁵ Constantinescu and Dan (2005).

⁴²⁶ The SSH survey was also part of the preparation of the National Housing Strategy (World Bank, 2015a).

⁴²⁷ Out of all 319 urban municipalities and six sectors of Bucharest, 19 urban municipalities and three sectors did not respond to the survey. See more details in Annex 8 Section II.

housing units at all,⁴²⁸ while the others have anything from one to 2,500 units (Annex Figure 8.1). What is clear is that the supply of social housing is much lower than the demand. The number of applications received by urban mayoralties exceeds 67,000, while the local authorities estimate that the need amounts to 55,000 to 60,000 units (Annex Figure 8.2). Local authorities have a manifest interest in expanding the existing stock of social housing in response to mounting local demand, but the resources available to do so are minimal, both financially and in terms of vacant lands and buildings.

To qualify for social housing, households must have earned an average net monthly income per person in the previous 12 months that was less than €380 (the national average monthly net income).⁴²⁹ As this national average monthly net income tends to be about the 90th percentile of the total population, most households in Romania are income-eligible for social housing. In addition, the eligibility criteria include other broad categories of the population, including people evicted from restituted nationalized houses, married people under 35 years of age, youths leaving the child protection system, disabled people, war veterans and widowers, and victims of the communist regime and the revolution, according to the laws regulating their rights (118/1990 and 341/2004). Under these conditions, many local authorities grant priority access to social housing to families with a small number of children and with sufficient income to pay the utilities (Annex Figure 8.3). The result is that the poorest families and those with a large number of children (especially Roma) are often excluded from social housing. Actually, the SSH shows that considering all types of social housing the total occupancy rate is about 97 percent, of which only 57 percent are rented to low-income families while the other 40 percent are let to other people. Nonetheless, local public authorities allocate social housing units according to a list of criteria that they set annually.⁴³⁰ The qualitative study carried out for this background study analyzed several local council decisions and found that poor families with children are in fact given priority access to dwellings with a subsidized rent but less to those that comply to social housing standards.

The low quality of the social housing stock is another major problem. Although Law 114/1996 stipulates minimum technical standards for newly built social housing units,

these standards do not apply to older buildings. The Situation of Social Housing (SSH) survey confirms that, in 2014, most social housing units consist of apartments of one or two rooms covering 10 to 37 square meters and are lived in by numerous families (Annex Figure 8.4). Common spaces tend to be obsolete, damaged, and/or dirty, and services such as electricity, sewerage, and water supply are either missing or have been disconnected due to payment arrears. Massive overcrowding leads to a serious pressure on the apartment blocks, which are not technically designed to support such a large number of users. As most infrastructure is old and broken, the basements of these blocks are usually flooded with water and dirt. As a result, the walls and roof are eroded and full of damp, which puts the residents' health at risk. Some of these areas of social housing are at risk of becoming - or have already turned into - pockets of poverty (especially ghettos), with inadequate housing conditions and general unemployment. Local authorities typically act simply as the financial managers of the buildings, and existing social housing programs are not designed to include any incentives to encourage or require tenants to participate in the active labor market or in education or to access other social services.

The financial management of the social houses is complicated by these units often have high levels of accumulated arrears on rent and especially public utility payments. The latter often leads to whole buildings being disconnected when they do not have individual consumption meters for each unit. The rent charged by the local authority cannot exceed 10 percent of the income of the occupants, with the difference up to the nominal value of the rent being subsidized from the local budget. Since the residents are typically poor, this level of rent may not even cover the maintenance costs, which makes social housing a major drain on local finances. In the case of social housing, the local authority's accounting system attributes arrears in rent to the unit rather than to the renter, which means that any overdue debt is passed to the next tenant. The system of cancelling overdue debts that could not be recuperated is administratively difficult (as it would require the local council to create a regulation which means that many new social housing tenants are considered liable for the arrears associated with their new home. For more detail, see Box 42.

⁴²⁸ Nonetheless, 34 of these cities have state-owned dwellings rented to low-income households that are not officially registered as social housing units.

⁴²⁹ If the average net monthly income per household surpasses the specified level by 20 percent for two consecutive fiscal years, the contract is terminated (Article 42 of Law 114/1996).

⁴³⁰ Each local authority sets its own criteria for allocating the social housing units under its management (Article 43 of Law 114/1996). Service housing and necessity housing are allocated according to the same criteria as social housing. The criteria cover: household composition, income level, current dwelling tenure, ratio of square meters per person in the current dwelling, length of application, special social or dwelling situations, and education levels. There are also requirements for eligibility established at the national level, for example, the family must not have ever owned another home.

BOX 42**Distorted System of Overdue Debts for Rent in Social Housing**

For social housing beneficiaries from disadvantaged communities, paying even a low monthly rent of 20 to 104 lei (about €4 to €23) can be too heavy a burden. Historic debts are accruing fast, while the low levels of residents' monthly earnings are insufficient to cover the basic necessities of daily life, not to mention to pay off their own arrears and those of the previous tenants of their housing unit. The local authority rules requiring old arrears to be carried forward to the existing tenants are causing severe hardship to already disadvantaged residents of social housing.

Under current Romanian legislation, interest and penalties are calculated by the fiscal authorities for any unpaid taxes owed to the state or local authorities. The applicable rates are established by government ordinance or decision. The generic term "taxes" is used here to include other budget revenues, including rents payable for social housing facilities.

Late Payment Interest

Interest is added to any unpaid tax owed to the state or local authority from the next day that the payment of tax is due to the date of the actual payment. Late payment interest rates are currently set by government ordinance but used to be regulated by government decision in the past. Currently, the interest rate for failing to pay a tax is 0.04 percent per day. The interest is assessed on the unpaid amount of tax.

Penalty for Failure to Pay

The late payment penalty applies to any portion of the tax owed to the state or local authority that is unpaid as of the payment due date. Starting with the next day that the tax payment is due to the state, the central fiscal authorities impose a failure-to-pay penalty of 0.02 percent per day calculated on the unpaid amount of tax.

As an exception from the general rule that applies to state budget taxes, the late payment penalty rate for overdue local taxes is 2 percent per month, which amounts to 0.06 percent per day or 0.07 percent per day depending on the number of days in each month. Late penalties are owed for every month or fraction of the month until the complete payment is made and are assessed on the unpaid amount of tax.

The Termination of Fiscal Obligations through Voluntary Payments: Order Rules

Some general rules apply to the termination of fiscal obligations through voluntary payments. When the debtor owes several types of taxes or other fiscal obligations with different due dates and when the amount actually paid does not cover all of the fiscal obligations due, the paid amount is distributed by the fiscal authorities to terminate existing obligations according to the order established by law and presented as follows in a simplified form:

- First, all fiscal debts (principal, interest, and penalties) included in the fiscal payment facility plan, as approved by the fiscal authorities and due when the payment is performed, are terminated. All other fiscal obligations whose payment is required as a precondition for the continuation of the payment facility are terminated.
- Second, all principal fiscal debts are terminated in chronological order.
- Third, interest and penalties are terminated in chronological order as well.
- Fourth, future fiscal obligations are included in the payment facility plan.

However, few members of disadvantaged communities that are entitled to social housing services have the benefit of an approved fiscal payment facility plan. One of the reasons is that collateral is required by fiscal authorities in order to approve a payment facility plan, and beneficiaries of social housing services generally cannot produce such collateral.

Thus, most of the disadvantaged community members find themselves in the second and third stages of rent payment, namely they have accumulated unpaid rents or sometimes even inherited them from previous tenants, and these historic debts have accrued late payment interest and penalties.

The Unbreakable Debt Spiral

The debts spiral is unbreakable in such situations. The following hypothetical example illustrates the mechanism more clearly. A family from a disadvantaged community living in a social house rented from the mayoralty consists of four members: two adults and two children.



BOX 42 (continued)

The family's total net average earnings (including all types of available allowances) come to 600 lei per month.

Their earnings are cashed in on the 25th of each month. The rent due for their social house is 60 lei per month and the rent due date is on the 10th of each month. Despite the fact that the family moved in only at the beginning of the year (January 1st, 2013), they inherited from the previous tenants historic debts representing the unpaid rent for the entire year of 2012 amounting to 863 lei, out of which:

- 720 lei represent unpaid rent for the previous 12 months
- 54 lei represent interest
- 89 lei represent penalties.

First of all, the family has to pay the rent on the 10th and only receive their social allowances on the 25th of each month. They do not receive enough income to make any savings, so the family cannot pay the current month's rent from their previous month earnings. Thus, from the 10th until the 26th (the day when they are able to make a payment one day after their earnings are cashed in), namely for 16 days, interest and penalties accumulate both on the historic debt and on the rent that is currently due.

The total amount of debt accrued at the payment date (January 26, 2013) is 943 lei, out of which:

- 780 lei represent unpaid rent for the last 12 months plus the current month rent
- 62 lei represent accrued interest
- 101 lei represent accrued penalties.

The family's current month's earnings will barely cover the interest accrued to date but, under the current regulations will, in fact, be used to cover the rent due 12 months ago (January 10, 2012). No part of the current month's rent, interest, and penalties are going to be covered. The rest of the historic rent and the current month's rent will continue to generate interest and penalties, and this mechanism will perpetuate the indebtedness spiral although the family will continue to pay the rent due each month.

Possible Solutions

- (a) The creation of more flexible fiscal arrangements for the most disadvantaged families, including reducing the collateral requirements related to social housing services
- (b) The urgent settlement of the historic debts related to social housing services and the abolition of the imposition of existing rent debts on new tenants.

Paying utilities charges can be a considerable challenge for the poor residents of social housing. Some local authorities have managed to develop systems that prove to be sustainable while still helping people to cover their monthly utility costs. For example, the Cuprom facility in Baia Mare is fully endowed with utilities, which is very much appreciated by its inhabitants (463 people in 135 families). In this system, the residents receive their utilities for free in their first three months of residency. In the following three months, they are required to pay make small payments (20 lei, respectively 30 lei, depending on the number of rented rooms). Then, their bills are gradually raised every three months up to a limit of 100 lei per month for a one-room apartment and 120 lei per month for a two-room apartment, of which 50 lei represents the rent and 70 lei accounts for the running costs. Overdue debts are low, and nobody has been evicted. In order to ensure heating during the winter, the mayoralty provides the residents with portable radiators

that are taken back at the beginning of the spring. Baia Mare is also cited as best practice area because it has a very large complex that includes social services, an elementary school, and a high school, thus facilitating access to education for all the children in the area.

Evicting tenants is the final step in the case of unsettled arrears. According to the law, the term of the rental is five years, with the possibility of extension. However, cases have been reported where local authorities decide to lease the social housing units for much shorter terms (as little as three months) to make it easier for them to evict renters who do not pay their rents or utility bills. To prevent renters from building up overdue debts for social housing costs, some municipalities evacuate people to make them "responsible and accountable." Thus, while the housing department of mayoralty is just applying the law in evicting people with arrears, the public social assistance service either is not being informed or does not intervene. It is

not clear where the evicted end up, and these vulnerable people, including their children, live through a traumatic life event with no protection at all. In their cases, human and children's rights are definitely not being observed by state institutions. Specifically to address the problem of evictions

due to overdue rent or utilities, this volume proposes the introduction of the Minimum Social Insertion Income (MSII) program, including a housing component targeted to the most vulnerable people (especially families with children) living in social housing.

BOX 43

Main Problems Identified by the Local Public Authorities in Managing Social Housing

The public local authorities present at the Stakeholders' Meeting organized by the World Bank within the project Regulatory Impact Assessment (RIA) Framework in Romania, held in Bucharest on February 12, 2015 identified the following problems in managing and developing the housing stock:

- Decentralization of responsibilities, but not of financing;
- The low income of tenants leads to (a) huge overdue debts and (b) evictions, which both create significant problems to local authorities;
- The fact that social housing is not accompanied by other social assistance;
- The insufficient available housing stock compared to the demand;
- The poor quality of existing social housing stock. However, social housing units that respect the standards imposed by the law imply high utility costs that cannot be covered by the beneficiaries;
- The problem of identity papers in the locality of residence where the social housing is located;
- Lack of available land lots for the construction of new social housing units;
- The need for clarifications of the definition and eligibility criteria for social housing. Special attention to the criteria regarding previous ownership over a dwelling should be given for special cases;
- The definition of family to cover also consensual unions.



With regard to the Roma population, the government operates a social housing program (GD 1237/2008) that aims to build 301 housing units⁴³¹ in line with the government's strategy for improving conditions of the Roma people.⁴³² The government has assigned 10 million lei for this project, but no housing unit has yet been completed. As shown in the recent World Bank report *Inputs for the National Housing Strategy*,⁴³³ this is likely to be because it has not been mandated by law and because no local authority will willingly co-finance social housing specifically for the Roma when the demand for social housing for the general population is so high. In fact, it might not be a good idea to build social housing exclusively for the Roma, given the evidence of the poor maintenance of such buildings

because of the associated stigma and the risk of further social excluding the Roma residents.

Various qualitative studies have highlighted the popular resistance to extending social housing on the grounds that its occupants are likely to be the less desirable elements of society, in particular the Roma who suffer prejudice in many different ways.⁴³⁴ Therefore, there are multiple political and financial disincentives that are preventing the government and local authorities from building new social housing. The government should assess the need for social housing for all vulnerable groups (including the homeless, post-institutionalized youths, ex-prisoners, victims of domestic violence, people evicted from restituted houses, and people

⁴³¹ The housing must meet the minimum standards stipulated in the Housing Law. The number of units/ rooms for each location has to be determined according to the number of applicants and the structure and size of their families.

⁴³² The program targets 11 localities in the following counties: Arad (49 dwellings), Bihor (28 dwellings), Bistrita-Nasaud (21 dwellings), Brasov (21 dwellings), Constanta (49 dwellings), Iasi (49 dwellings), Mehedinti (28 dwellings), Olt (28 dwellings), and Sibiu (28 dwellings).

⁴³³ World Bank (2015).

⁴³⁴ World Bank (Anan et al, 2014).

with drug dependencies). It should then establish a clear national strategic framework for its housing policy involving inter-sectoral coordination and cooperation between the central and local authorities. The range of social housing instruments should be enhanced, and the government should consider awarding housing allowances to those most in need. To this aim, financing for social housing services should be increased.

2.6.3. Ensuring Efficient Emergency Support for the Homeless while Building Capacity for Social Reintegration and Early Prevention

No reliable recent assessment of the scope of homelessness in Romania has been done, even though some data are available from the 2011 Census and from previous studies.⁴³⁵ The profile of the homeless that can be derived from the Census is generally consistent with the findings of earlier research.⁴³⁶ The vast majority of homeless people are located in urban areas (95 percent), 88 percent of them being concentrated in county towns and the capital city (one-third living in Bucharest). More than three-quarters of the homeless are men and active-age adults (three-quarters are aged between 25 and 64 years old). Worryingly, more than one in ten homeless people are children.

Several groups of the population are at extreme risk of homelessness or precarious housing unless early intervention housing measures are taken:

- Youths leaving residential institutions – more social apartments and houses are being made available for these young people but the capacity at the local level is still insufficient.

- People facing eviction as a result of rent and utility arrears.
- People leaving hospitals and mental health and disability facilities.
- People leaving penitentiaries.
- Victims of domestic violence.
- Elderly people who are victims of property scams.
- People with severe drug dependency.
- The remaining occupants of formerly nationalized houses returned to their former owners - special legal provisions⁴³⁷ have been created in order to facilitate the allocation of social housing to this category of people, but the city halls lack the required housing stock.
- Victims of human trafficking.
- People in illegal settlements and in improvised houses.

The capacity of shelters for the homeless seems to be growing. Of all of the urban municipalities that participated in the Situation of Social Housing survey,⁴³⁸ 63 reported having one to 10 shelters. In total, as of September 1, 2014, 104 shelters for homeless people existed in urban areas, with a total of 2,525 places available. However, the qualitative research conducted for our background study suggests that they do not yet fully meet the existing needs. Specialized shelters have become available in some areas, for instance, for victims of domestic violence. Although shelters should be regarded as a transitional solution, many of them tend to become long-term accommodation for their current residents, mainly because of the lack of social housing or alternative accommodation. As result, the “new” homeless people have to rely on other types of low-value accommodation, such as privately managed, improvised, or insalubrious houses and hostels, or shared rent in extremely low-value areas and marginalized communities.

⁴³⁵ Only 1,542 people were counted as homeless in the Census, whereas even the most optimistic previous estimates were at least three times higher (Ministry of Regional Development estimates based on figures reported by local authorities in 2008). Some estimates went as far as to suggest that there were as many as 10 times more homeless people living in Romania than the number recorded in the Census.

⁴³⁶ For example, Samusocial (2010), Paraschiv (2013).

⁴³⁷ Government Decision 74/2007.

⁴³⁸ World Bank and Ministry of Regional Development and Public Administration, October 2014.

In the years to come, the capacity for emergency interventions to house people living in the streets has to increase in the following ways: (i) outreach services for the homeless have to improve in order to meet their basic needs for food, water, and medical assistance; (ii) as the incomplete picture of the territorial distribution of homelessness seems to indicate, more shelters are needed in the county towns and other large urban localities; (iii) there is a need to pilot programs that provide integrated packages of social services for the homeless, including housing; and (iv) the problem of this “invisible population” should be brought to the attention of the general public to build support for these interventions and at the same time advocate for the abandonment of harmful practices (such as begging).

However, merely improving the institutional set-up will not alleviate chronic homelessness and extreme poverty. In order to gradually shift the policy emphasis towards prevention, social housing services should be delivered within an integrated package of social services for people leaving prisons, childcare institutions, asylums, and hospitals, the victims of domestic violence, and the drug dependent. An improved strategy for keeping track of

and controlling illegal and improper settlements should be developed and followed up with special programs that help their residents to access to physical and social infrastructure. Illegal evictions and evictions in the absence of any alternative accommodation should no longer be carried out.

As an urgent matter of principle, child homelessness must be drastically reduced and then eradicated. In order to do so, child protection services need to be more proactive in their outreach efforts with the support of local service providers and the SPAS as referral entities. Support should be provided to enable children to attend school without the need for complex documentation requirements, and free transportation and other necessary material should be provided for them.

The size of the homeless population at the national level and in all major cities has to be quantified on the basis of more reliable data. In order to create a system for the timely recording and monitoring of homelessness, collaboration will be needed between all relevant public institutions, NGOs, and statistical and research institutions.

BOX 44

The Priority Intervention Program – Providing Integrated Services in an Urban Marginalized Roma Community

A community development project being implemented in the extremely poor Roma neighborhood called Bora on the outskirts of Slobozia, Ialomita county, has an international reputation as a good practice example of improving the living conditions of marginalized communities. The project is one of 133 projects of the wider Priority Intervention Program, which is being implemented throughout the country by the Romanian Social Development Fund (RSDF) under a broader Social Inclusion Project (SIP). The key characteristic of the Priority Intervention Program is its focus on Roma communities. Its projects tackle various aspects of Roma social exclusion, such as low access to education, health, social protection, and different types of infrastructure (such as a lack of road construction within their communities).

The 214 beneficiaries of the Bora project – 129 of whom children – are among the poorest of the approximately 1,700 Roma living in the neighborhood. Bora is characterized by multiple deprivations, including general poverty, widespread unemployment, school

dropouts (70 percent) or a total lack of access to school (unregistered children), and limited access to utilities.

The project has two key components: (i) infrastructure – the building of a multifunctional social centre built on land made available by the Town Hall and (ii) community-based social services – including educational, school, and after-school activities, leisure and traditional cultural activities, social and legal counseling for adults, and health-related education and information. The project involves a complex participatory process, with 30 representatives of the community belonging to an initiative group that is in charge of identifying problems, designing solutions, and facilitating dialogue. The project’s implementation is monitored by a special monitoring unit, community facilitators and project supervisors from the RSDF, and representatives of the Town Hall.

The project has had several successful outcomes. For example, 50 Roma children benefit from school and after-school activities, including the provision of free meals, and 214 Roma parents are involved in networking and counseling activities in support of the children’s participation in school. As a result, school



BOX 44 (continued)

absenteeism and abandonment have decreased by 20 percent.

A key strength of the project has been the involvement of the community from the very earliest design stage. Some of its most effective participation approaches could be replicated in projects in other disadvantaged communities such as those living in social housing, including the use of facilitators throughout the project cycle, knowledge exchanges with other

similar communities elsewhere, the development of cooperative relationships between different communities, providing beneficiaries with help to access other kinds of support, and carrying out constant monitoring and evaluation on the ground with the community's involvement.

Source: World Bank qualitative study carried out in Slobozia as part of this background study.

Failing to address the problem of homelessness in the future will result in further costs to society. Several crucial measures need to be taken in the near future: (i) eradicate child homelessness by requiring child protection services to be more proactive in their outreach efforts and by encouraging local service providers and SPAS social workers to be more systematic in referring at-risk people to the specific services they need; (ii) assess the size of the homeless population in all major cities; (iii) increase the capacity of shelters; (iv) increase capacity for making emergency interventions in

the street by ensuring that the basic need for food, water, and medical assistance of those in need are met as well; (v) adopt regeneration programs to tackle the problem of illegal settlements; (vi) cease all illegal evictions; and (vii) adopt prevention policies to protect people at risk of ending up in the streets including people leaving prisons, childcare institutions, residential centers, and hospitals, victims of domestic violence, drug addicts, and vulnerable, lonely, and elderly people.

2

PEOPLE-BASED POLICIES



2.7. Social Participation

To guarantee that they are full members of the democratic system, individuals need to be informed and active citizens, to have opportunities to join the ranks of others, and to work together to achieve common goals. Social participation is not only beneficial itself but also has multiplicative effects: it improves the welfare of vulnerable groups as well as local governance and, in general, makes society more cohesive. The government should encourage both volunteering activities through which the general population can help vulnerable groups as well as other types of social participation through which the voices of the deprived and marginalized can be directly and immediately heard.



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2.7. Social Participation

Social participation includes a wide range of dimensions such as volunteering, voting, and participating in political activities. The current volume focuses on two key forms of social participation that directly affect the socially excluded: (i) volunteering activities through which the non-vulnerable can help vulnerable groups (social participation for the deprived) and (ii) other types of social participation through which the voices of the deprived and marginalized can be directly and immediately heard.

Participation rates in different types of voluntary organizations⁴³⁹ are much lower in Romania than in most other countries in Europe, while participation in voluntary activities for vulnerable groups is almost non-existent. On average, 26 percent of Europeans participate in voluntary and charitable activities (activities outside of their paid work) either regularly or occasionally,⁴⁴⁰ whereas only 15 percent of Romanians do voluntary work (only four other countries have fewer volunteers – Greece, Bulgaria, Portugal, and Poland). Only 3 percent of Romanians have declared in surveys that they do voluntary work in a human rights, environmental, or charitable organization (this percentage includes those doing such activities only occasionally). The percentage is as low as 1 percent for those involved only in charitable activities.

The social participation of vulnerable groups is often a stated aim of development projects that are designed to empower vulnerable groups by, among other ways, increasing their access to information. In this sense, participation is defined as a “process through which stakeholders influence and share control over the development initiatives and the decisions and resources which affect them.”⁴⁴¹ Within this conceptual framework, analysts often present the empowerment⁴⁴² of marginalized groups as one of the ways in which poverty can be sustainably reduced in deprived communities.⁴⁴³ Moreover, empowerment is not only a means of reducing monetary poverty but is also a goal in itself, the lack of power being one of the aspects of poverty.⁴⁴⁴ From the same theoretical

perspective, the empowerment of the poor may improve different aspects of their lives, for example, increasing their access to basic services, improving local and national governance, promoting economy-wide reform and pro-poor market development, and increasing their access to justice.⁴⁴⁵

In conclusion, the social participation of and for vulnerable groups can be fostered by creating a positive social climate, increasing institutional trust, and increasing tolerance and reducing discrimination. It is equally important to create the institutional mechanisms through which poor or marginalized groups can be empowered to participate more in their communities and through which social innovations can be developed that will foster participation.

2.7.1. Improving the Social Climate and Increasing Trust in Institutions

The social climate creates the environment within which people act. It can be cohesive and conducive to social participation or it can be fragmented, thus fostering isolation, marginalization, and even social conflict. People may or may not be satisfied with how things are going, with their own lives, with institutions or with other public stakeholders. Dissatisfaction often results in the inhibition of people’s personal development skills and community involvement, as well as with self-isolation and a refusal to take part in social life.

The social climate in Romania is much less cohesive than in the other EU member states, and it deteriorated immediately after the crisis against a backdrop of economic recession, austerity measures, and political crisis. The results of the five Eurobarometer⁴⁴⁶ surveys aimed at

⁴³⁹ The range of voluntary organizations is large including religious organizations, professional organizations, trade unions, cultural associations, sports clubs, and political parties.

⁴⁴⁰ Moreover, only 2 percent of Romanians are involved in these activities on a regular basis instead of only occasionally (Romania is situated at the lowest end of the distribution together with Bulgaria and Poland).

⁴⁴¹ World Bank (1996: XI).

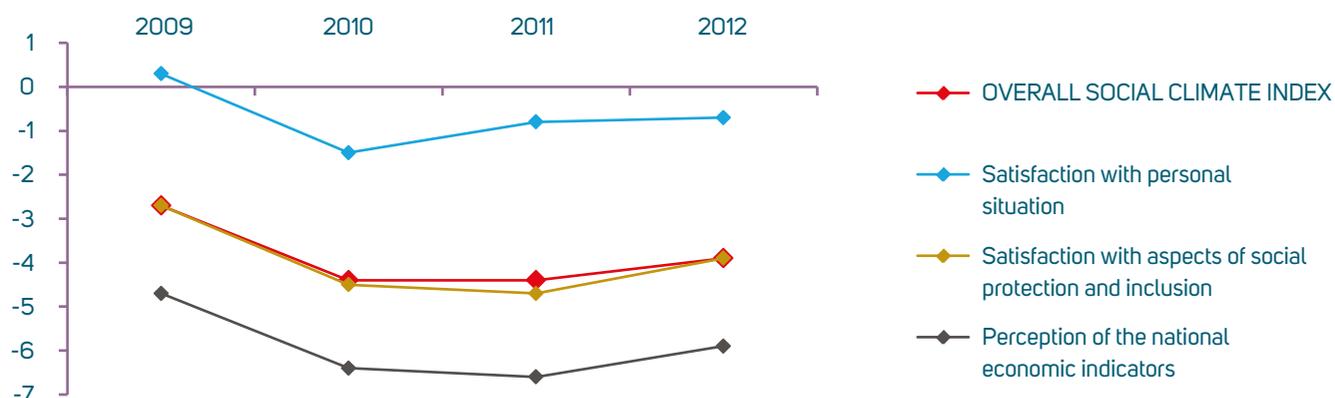
⁴⁴² Empowerment represents the “capability of poor people and other excluded groups to participate in, negotiate with, change, and hold accountable institutions that affect their wellbeing” (Klugman, ed., 2002: 2).

⁴⁴³ Narayan (2000), Pozzoni (2005), and Eberlei (2007).

⁴⁴⁴ Klugman (ed., 2002: 2) and Pozzoni (2005: 14).

⁴⁴⁵ World Bank (2002: vii).

⁴⁴⁶ Eurobarometers were conducted in Romania by TNS Opinion & Social at the request of the Directorate-General of Employment, Social Affairs, and Inclusion.

FIGURE 45: The Social Climate in Romania, 2009–2012

Source: EC, 2005-2012 Eurobarometer.

Notes: The graph presents the average values determined on 15 scores varying from -10 ("not at all satisfied"/"very bad") to +10 ("very satisfied"/"very good"). Satisfaction with one's personal situation is the average value of four scores that rate the respondent's satisfaction with his or her life: (i) life in general; (ii) area of residence; (iii) personal job situation; and (iv) household financial situation. Perception of the national economy consists of an average of six scores in the following areas: (i) the cost of living; (ii) the affordability of energy; (iii) the affordability of housing; (iv) the efficiency of public administration; (v) the overall situation of the economy; and (vi) the employment situation nationally. Satisfaction with aspects of social protection and inclusion is the average score in five areas: (i) healthcare provision; (ii) the provision of pensions; (iii) unemployment benefits; (iv) relations between people from different cultural or religious backgrounds or nationalities; and (v) the way in which inequality and poverty are addressed by the government. The overall social climate index is the average of all these 15 scores.

monitoring the crisis impact (2009 to 2010) and the special Eurobarometers on social climate (2011 and 2012) highlighted a disturbing reality. Among the EU member states, Romania and Greece ranked at the bottom in the three main dimensions that were being measured: (i) the respondents' satisfaction with their personal situation; (ii) their satisfaction with aspects of social protection and inclusion; and (iii) their perception of national economic indicators.⁴⁴⁷ Romanians' perceptions of the state of the national economy are overall quite bleak, with most people being close to the bottom end of the satisfaction scale (not at all satisfied). The indicator significantly decreased immediately after 2009 and registered a slight positive trend after 2011. Moreover, in the minds of the

public - starting with the crisis - poverty has become more widespread, people's financial resources have decreased considerably, and it has become increasingly difficult to cover household, utility, and medical bills. The situation has been aggravated by the fact that public administration and healthcare services are perceived as functioning in an unsatisfactory manner, and protection from poverty and inequality is considered inadequate. In fact, a recent survey among the younger population clearly showed that corruption, poverty, and unemployment represent the major problems that need to be addressed in Romania.⁴⁴⁸

The social climate can be changed by a sustainable improvement of the economy that has a direct impact on

⁴⁴⁷ The only countries with similar scores were Hungary, Bulgaria, and Portugal, but they were in better shape at least in some respects.

⁴⁴⁸ Sandu et al (2014).

the population's welfare, by a decrease in perceived levels of corruption and in the inefficiency of public administration, and by the provision of services and key social protection benefits. In the absence of these elements, all other efforts to directly increase participation are likely to have only a limited impact.

Institutional trust is also a prerequisite for successfully fostering social participation. The main reason why people have to have at least some trust (some authors refer to this as having cautious trust) in the institutions of state is that most social participation involves interactions with central, regional, or local institutions. If people do not trust these institutions, then they have no desire to interact with them, and the result is a civil society that is separated from the state and in a relationship of conflict rather than cooperation.

Trust in institutions is also low and has been declining since 2009.⁴⁴⁹ Various surveys have shown decreasing levels of trust in institutions after 2009. This reached a point in 2012 (according to the World Value Survey) where only about 30 percent of people had trust in the government, and just 20 percent had trust in the Parliament (both with large year-to-year variations) and in the Presidency (the previous five years having shown a significant drop from the levels recorded in the 2000s). The fact that, at most, one-third of the respondents have trust in institutions suggests that citizens do not have any reason to believe that the political system is going to be responsive to their demands or to their social participation. If this is true, then people are going to have little incentive to use social participation as a tool to achieve their goals and might opt to use other strategies that they expect to be more effective under these circumstances, such as corruption or extreme litigiousness.⁴⁵⁰

To increase the level of institutional trust, public institutions with responsibilities in specific social domains (such as employment, higher education, and child protection) are (or should be) open to everyone. If the public has a negative perception of how these institutions carry out their responsibilities, then they have little incentive to interact with them. The solution to this problem is twofold. First, state institutions should improve the ways in which they respond to people who interact with them and make demands of them – in other words, their clients. Second,

examples of “successful” interactions between citizens and institutions (both in Romania and globally) need to be widely disseminated to demonstrate how similar problems have been solved and thus encourage social participation in the long term.

2.7.2. Increasing Tolerance and Decreasing Discrimination

Tolerance is one of the main prerequisites for social participation. While social participation can also occur in contexts characterized by intolerance, this type of social participation is of a kind that does not attempt to create bridges from one group to another. Nor does it attempt to understand and accept the “other” regardless of how this is defined. Social participation in intolerant contexts is social participation within one’s defining group, it is social participation behind closed doors, and it is social participation that eliminates any potential for additional, more developed engagement, which eventually ends up fragmenting society or the community. Participation in contexts characterized by high levels of tolerance, however, is of the type that opens the doors for the possibility of more engagement. The “other” is accepted as a valid interlocutor, as an acceptable (if not valued or trusted) partner. Moreover, this type of participation brings together people from different groups, and by putting them into contact, it increases inter-group tolerance and the chances of future cooperation among groups.

Tolerance towards vulnerable groups has grown significantly in Romania in recent years, but discrimination continues to put these groups at risk of social exclusion.⁴⁵¹ Table 38 indicates that discriminatory kinds of behavior are still likely to be adopted in everyday interactions given the great number of people with negative attitudes towards vulnerable people motivated purely by these people belonging to a certain group. According to the European Values Survey in 2008, the adult Romanian population had the least tolerance for three groups that could be seen as

⁴⁴⁹ The level of institutional trust in Romania is highly dependent on the particular moment of the electoral cycle when the measurement was taken (for example, see Tufiş, 2012).

⁴⁵⁰ For more details, see Sztompka (1999).

⁴⁵¹ While there is no single, generally accepted measure of tolerance, most of the experts in this area use one of three measures (for more details, see Gibson, 2013). The results we present here are based on one of these three measures. The higher the number of people that comprise a group, the higher the level of intolerance within the population towards that particular group tends to be.

possible threats: heavy drinkers, drug addicts, and people with a criminal record.⁴⁵² This type of intolerance, however, can be explained. All three groups are comprised of people that seem to have a higher propensity to engage in violent (or at least disturbing) acts, acts that can be interpreted as a personal threat, and all previous literature has identified the perception of threat as one of the most important predictors of intolerance.⁴⁵³ What is worrying is that high shares of Romanians were still intolerant of some vulnerable groups such as people with HIV/AIDS or homosexual.

Roma continue to be on the receiving end of discrimination because of their ethnicity. The European Values Survey data showed a high level of intolerance towards Roma that is based on prejudice. It showed that 40 percent of the adult population of Romania would not like to have Roma neighbors, double the percentage of people who would reject a neighbor with other characteristics including being Muslim (23 percent), of a different race (21 percent), immigrant (21 percent), or Jewish (19 percent).

Roma are excluded on the basis of their ethnicity from both service provision and in markets. Focus group discussions with Roma communities carried out by the World Bank in 2014 showed that the discriminatory attitudes of service providers are the main barrier preventing Roma from accessing services.⁴⁵⁴ For example, with respect to education, a UNICEF study showed that a student being (hetero-) identified as Roma by a teacher considerably increases the chances that the teacher expects that student to complete only eight grades of education at most, all other things being equal or kept constant.⁴⁵⁵ In the area of health, discriminatory practices toward Roma patients are manifested in “avoiding physical contact with patients; non-involvement of patients and of their family in choosing the treatment; omission of explanations concerning the risks of administering a certain type of treatment; using aggressive procedures.”⁴⁵⁶ Roma also report experiencing discriminatory practices in the labor market. In a survey of 402 Roma in Romania, Bulgaria, the Slovak Republic, the Czech Republic, and Hungary, 64 percent of working age

Roma reported that they had faced discrimination in the process of job search based on their ethnic background.⁴⁵⁷ An alarming 49 percent indicated that employers had openly said that they were treating them differently because they were Roma, and a further 5 percent had heard the same from labor offices.

Education is a good indicator of the level of tolerance towards and trust in others. There is a strong relationship between the level of intolerance and education for all groups except heavy drinkers and drug addicts. Data on high school students in Romania presented in Annex Table 9.2 show three important patterns. First of all, high school students are significantly more intolerant than the general population with respect to any considered group. The difference can be explained by a combination of factors including the tempering effect of education on intolerance, the tendency of teenagers to exaggerate their beliefs, and teenagers’ lower compliance with the common standards of political correctness. Second, the higher the educational stock of the family, the lower the intolerance levels. Third, this relationship between education and intolerance is completely reversed in the case of Roma in that the more educated a family is, the higher the chances that they will be intolerant towards Roma.

Advocacy is needed to raise awareness and increase tolerance of diversity (including various categories of marginalized or discriminated groups) and to create a social and institutional environment that facilitates the social integration of vulnerable groups. This advocacy should be targeted not only to the general population but also to decision-makers and employers. Including representatives of vulnerable groups on local decision-making committees and bodies (both formal and informal) would help to establish their role and position within their communities. Education is also key to increasing acceptance of marginalized groups. Reducing early school leaving in general and increasing the number of people with tertiary degrees has the potential to reduce the level of intolerance in the medium to long term.

⁴⁵² The level of intolerance was measured by the percentage of the total population who had expressed antipathy to having the listed groups as neighbors.

⁴⁵³ Gibson (2006).

⁴⁵⁴ World Bank, 2014.

⁴⁵⁵ Stănculescu et al (2012). Ethnicity is the only significant determinant in multiple regression models of the risks of both school dropout and early school leaving. *Ceteris paribus*, being a Roma child significantly increases the probability of school dropout/early school leaving irrespective of the child’s age, gender, and health status, the mother’s level of education, the number of children within household, the number of parents at home, the residential area, or the level of household school-related expenditures (or household income).

⁴⁵⁶ Wamseidel et al (2012).

⁴⁵⁷ ERRC (2007).

TABLE 38: The Percentage of the Total Population Who Have Expressed Antipathy to Having the Listed Groups as Neighbors

	Population aged 18 years or over			High school students
	1993	1999	2008	2011
Large families	22%	14%	16%	-
People of different race	-	-	21%	27%
People with HIV/AIDS	66%	47%	39%	65%
Roma	72%	52%	40%	71%
Emotionally unstable people	64%	53%	45%	-
Homosexuals	-	-	55%	74%
People with a criminal record	67%	69%	56%	-
Drug addicts	76%	74%	61%	-
Heavy drinkers, alcoholics	79%	77%	63%	-

Sources: European Values Survey for 1993, 1999, and 2008 and Open Society Foundation (2011).⁴⁵⁸

2.7.3. Increasing Participation in Volunteering Activities with and for Vulnerable Groups

The current legislative framework governing volunteering does not encourage social participation. The Law on Volunteering (No. 95/2001) was passed in 2001, modified in 2006, and revised again in 2014 (Law no. 78/2014). However, the current legal framework presents some obstacles to the development of social participation for several reasons. The requirement to sign a contract deters short-term and spontaneous volunteering. Also, the provision of health and accident insurance pertaining to any risks involved in the voluntary activity does not appear to be mandatory for voluntary organizations, and there are no provisions to induce employers to encourage their employees to volunteer.⁴⁵⁹

To increase participation, the mass media have a role to play in fostering awareness of best practices and of the

value of participation. However, companies have the most to contribute to promoting volunteering. Until now, few companies have supported volunteering activities and have at most encouraged their employees to volunteer after working hours and on weekends. In future, companies could give their employees of all ages and levels of seniority time off to volunteer. In addition, they could also ensure that their pre-retirement programs and counseling routinely include information about volunteering opportunities and benefits.

2.7.4. Empowering Poor and Marginalized Communities through Active Social Participation

The community driven development (CDD) approach is a popular financing mechanism at the community level that aims to empower the poor. CDD gives control over planning decisions and investment resources for local development projects to community groups. Its promoters claim that CDD ensures an optimal allocation of resources,

⁴⁵⁸ Survey on Religion and Religious Behavior carried out in June 2011 on a sample of 1,204 persons aged 18 years or over, <http://www.fundatia.ro/romanii-devin-mai-toleranti-religios>. Calculations done by Claudiu Tufis.

⁴⁵⁹ World Bank (2014a). These changes would not only encourage the employees to participate but might also help young people to build skills and gain work experience while volunteering.

increases the efficiency and efficacy of small investments, and makes these investments more sustainable. In addition, they claim that not only are resources used more efficiently but the poverty level decreases and services and facilities are better targeted towards the poor (in a progressive distribution of resources). In addition to the economic effects, development through communities is designed to increase the transparency of the decision-making process, to increase the capacity of the authorities, and to make those authorities more accountable. In theory, all of these positive goals can be accomplished by increasing the amount of information available to individuals and their participation (particularly of the poor) and by increasing their social capital.⁴⁶⁰

The CDD approach perceives the poor as a resource, not as a social problem that needs to be solved. CDD is the type of development that aims to give “control of decisions and resources to community groups.”⁴⁶¹ In other types of project, the poor are considered as a social problem that needs to be solved by experts with competencies and resources, but the theory of development through community emphasizes that the poor are a key resource for their own development. Therefore, the promoters of CDD state that the poor have the necessary capacity to “effectively organize to provide goods and services that meet their immediate priorities... given clear rules of the game, access to information, and appropriate support.”⁴⁶²

The CDD approach is based on an explicit logical model of inputs, activities, and outputs that must be followed when implementing such a project in order to get the desired outcomes:

- The inputs consist of the resources needed to implement the project and the efforts that must be made to change the legal and policymaking environment at the local level. What is significant here is that the manner in which resources are distributed and used is decided within the community and in accordance with the community’s needs.
- The effect of this use of these resources is expected, on the one hand, to be an improvement in infrastructure (which will improve quality of life or even increase incomes in the long term), and on the other, to change the policymaking and legal

framework (which will impact the norms/rules that govern the functioning of an institution). These effects remain under the direct control of the actors who are using the resources, and, because of this, they are considered outputs (direct results) of the projects.

- If resources are used appropriately and the desired results are obtained, the expected outcome will be an increase in the influence of communities, with community members having greater control over the way in which decisions are made and public resources are distributed.
- Because of the increased empowerment of communities and of the increased accountability of authorities, the long-term impact of a CDD project can be expected to be a major improvement in the lives of the poor and the start of a sustainable development process for these households.

While the picture painted by the advocates of such an approach is appealing, the impact around the world of CDD projects has been mixed, including those of the Rural Development Project (RDP) implemented by the World Bank in Romania in 2002 to 2006 (see Box 45). Several lessons can be learned from the accumulated evidence:

- The participatory mechanisms for targeting resources seem to be useful only when the projects aim to reach out to poor communities rather than to dispersed poor households. In other words, geographical targeting may be progressive, but this is only rarely the case with the targeting of poor households in general.⁴⁶³ Moreover, some studies have pointed out that the effectiveness of geographical targeting is also dependent on the inclusion of the poor in the participatory spaces created by CDD interventions so if the inclusion of the poor is not consistent, the targeting of such programs will fail.⁴⁶⁴ Another study has shown that the poor can only be reached effectively by a participatory mechanism if the financing agencies carry out their work at an adequate pace, with efficient monitoring and means of evaluation. If the financiers have “little experience in participatory approaches” and “the pressing need for quick and visible results”, the results can be disastrous.⁴⁶⁵

⁴⁶⁰ Klugman (ed., 2002) and Mansuri and Rao (2013).

⁴⁶¹ Klugman (ed., 2002: 303).

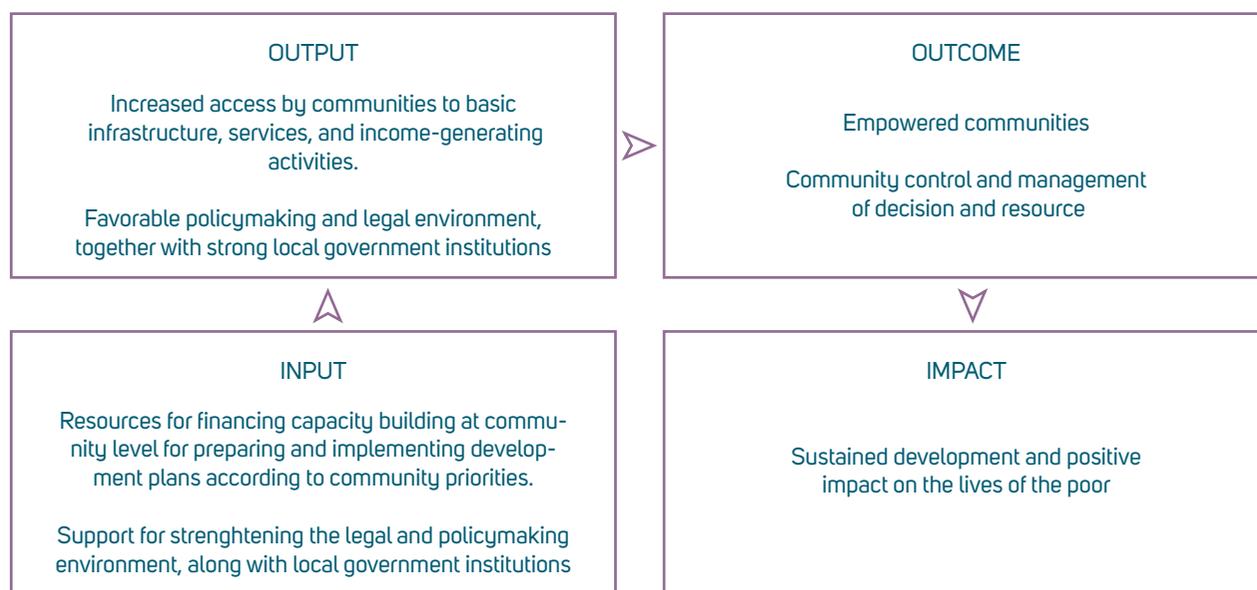
⁴⁶² Klugman (ed., 2002: 303).

⁴⁶³ Wassenich and Whiteside (2004: 82).

⁴⁶⁴ Mansuri and Rao (2004: 17) and World Bank (2005: 23).

⁴⁶⁵ Platteau (2002: 10).

SCHEME 9: The Results Chain in a Bank-supported CDD Intervention



Source: World Bank (2005: 57).

- The evidence concerning increases in empowerment through such projects is also not convincing. What works in theory does not always do so in practice, because progress depends on local authorities being motivated to encourage the CDD approach (see the evidence from the evaluation of the Romania RDP in Box 45).⁴⁶⁶
- The often praised sustainability of the CDD approach seems also to be highly dependent on how it is implemented. The sustainability of investment is highest in the following circumstances: (i) in those communities where households choose the type of investment and its location; (ii) when NGOs and individuals are involved in the project who are in a position to increase the level of communication within communities and to increase the access of deprived people to information and to decision-making processes; (iii) when both authorities and citizens are trained in how to adequately use, maintain, and operate the infrastructure (such as water/sewage

systems); and (iv) when there is an organization at the community level that can administer and oversee the investment projects (for example, collecting money for repairs or for individual consumption and penalizing households when they do not pay or meet their responsibilities).⁴⁶⁷

In conclusion, poor and other vulnerable groups should be empowered by increasing their access to information and their participation in decision-making processes. Three key measures are needed to make sure that this becomes reality: (i) whenever small infrastructure projects are implemented at the local level, a participatory approach should be built in by default with an emphasis on the inclusion of the poor and vulnerable; (ii) the government should provide the relevant local authorities and the target population with technical assistance on the operation and management of such projects; and (iii) local authorities should be trained to understand the relevance of the including poor and vulnerable groups in the decision-making processes (including in the design and implementation of small investment projects).

⁴⁶⁶ Poteete (2003).

⁴⁶⁷ Sara and Katz (2000) and Mansuri and Rao (2004).

BOX 45

Evaluation of the Rural Development Project, 2002-2006

Project description: The Rural Development Project (RDP), implemented between 2002 and 2006, was designed to build government capacity for rural development in five counties (Sălaj, Dolj, Botoșani, Tulcea, and Călărași) and in 100 communes within these counties and to provide funds for investment grants (water supply and roads). These grants were designed to “facilitate learning-by-doing, while improving living standards for rural inhabitants.” Local governments – both counties and communes – were expected to “establish investment priorities and strategies, choose from a list of infrastructure types and technologies, and coordinate the implementation, operation, and maintenance of investments.” The final objectives were to: “(i) increase the efficiency of local government decision-making and management; (ii) improve government accountability to citizens and community groups and increase their involvement in decisions; and (iii) increase the effectiveness of local government in delivering investment benefits to beneficiaries.”

Evaluation design: In order to evaluate the project, an elaborate design was followed with a baseline survey in 2002 and a follow-up in 2006 of both the project localities and some control communes (with a similar likelihood of participating in the program), and research instruments designed to collect data at the commune, village, and household/individual levels.

Targeting performance: Within the RDP communes, villages where road infrastructure sub-projects had been implemented were often administrative centers that already had better roads and greater access to institutions than other villages. There are several possible explanations for this. For example, the populations of these villages may have been better represented at the local administrative level, and/or they may have had larger populations. However, another reason may have been that these roads benefit not only the populations of the administrative centers themselves but those who dwell in various other villages.

Information about and participation in RDP activities: The current data show that about half of all survey respondents had been informed about the project,

mainly by the local authorities. Moreover, about one-fifth of them said they were involved in the decision-making process regarding these investments. However, there were wide variations in terms of how well-informed the respondents were. In those villages with infrastructure subprojects, information was more widespread than in villages without any kind of investments. Furthermore, the poor and the elderly were less likely to be informed than the general population. In general, people with lower levels of education were less likely to have participated in the decision-making process.

Empowerment and participation at public meetings:

The RDP seems to have had a direct positive impact both on participation (at public meetings) and on empowerment. Moreover, the project seems to have had indirect effects on trust and information, even after holding constant individual characteristics (such as gender, income, and education), community characteristics, and the initial level of the aspects being studied (participation, empowerment, trust, and information). In addition, when looking at the mechanisms explaining changes, it can be seen that the increase in participation seems to be due to a change in behavior on the part of the authorities (they were more likely to invite villagers to public meetings), while empowerment seems to have been influenced by participation in the decision-making process related to the RDP and even by being well-informed about the way in which RDP decisions were made.

Investment sustainability: In theory, one of the advantages of the CDD approach is manifested in the sustainability of the investment because citizens are more inclined to maintain them and to carry out public works. However, the impact evaluation came up with no clear results in this respect. While the public authorities do seem to be more willing to involve communities in such activities, the participation rate did not significantly increase in the project communities.

Welfare impact: Given the short period of time during which the RDP was implemented and the small amount of money invested in infrastructure, the evaluation did not show any major impact on the welfare of the beneficiaries (except for the water connection rate).

Source: Grigoraș (2015).



2.7.5. Increasing Access to Information and Knowledge through Social Innovation

Under the EU's Common Strategic Framework,⁴⁶⁸ actions that fit into the thematic objective of social inclusion should be aligned with actions listed under the thematic objectives of developing ICT, enhancing the competitiveness of small and medium-sized enterprises (SMEs), and investing in education, skills, and lifelong learning. The European Social Fund⁴⁶⁹ promotes social innovation in all sectors under its area of responsibility, and member states are invited to identify social innovation initiatives that meet a demonstrated need. Social innovation involves developing and applying new ideas (products, services, and models) to addressing social challenges in various fields, such as social inclusion. Social innovations related to social media have the potential to strengthen citizens' autonomy, to ensure access for vulnerable groups to information and social services and to the job market, and to enhance the participation of these groups in mainstream society. Consequently, ensuring nationwide Internet connectivity and supporting digital skills development are key empowering factors for social innovation.

New technologies, ICT, and innovative services are almost non-existent in the social sector. Between 1995 and 2005, the use of these technologies spread rapidly throughout Romania in many sectors, but there was a massive decrease thereafter because of legislative inconsistencies, gaps in funding, and a decrease in the number of professionals working in the system due. This has all contributed to a "subsistence" attitude to research rather than to innovation and outside-the-box thinking, particularly in the social sectors.

Investment is needed to increase the access of all vulnerable groups to information and knowledge in a wide range of formats. In some form or another, all forms of participation involve costs, and accessing information is no exception. People need time and/or money to access information sources. Some people may have reduced access to information sources because they do not

know how to read or because they need the information to be presented in a particular format such as braille, large print, sign language, or closed captioning, none of which are prevalent in Romania. Therefore, policymakers should consider taking the following actions: (i) providing accessible information in all areas related to public policies, services, and goods and developing technologies that will eliminate the barriers to communication for all vulnerable groups and (ii) developing accessible information points for people with disabilities as close as possible to their living environment, for example, by increasing the number (and training) of sign language interpreters and providing access to easy-to-read Braille material and more audio materials.

Particularly for people with disabilities, it will be necessary to ensure a barrier-free environment. People with disabilities are critically affected by the lack of accessibility of, for example, housing and communication, especially in rural areas or deprived urban areas. This restricts the movement of individuals with disabilities as well as their access to information, with the consequence that they often miss out on a wide range of opportunities and services.

The Digital Agenda for Europe presents technology-based options for increasing the participation of vulnerable groups in society. In addition to the forms of participation discussed up to this point, the technological developments of the last 20 years have opened the way for new forms of participation, forms that either occur entirely online or combine an online presence with on-street activities. While these new forms of participation have the potential to expand the number of active citizens and to encourage participation, especially in situations where this was previously difficult to achieve, they can also involve access costs that may be too high for some vulnerable groups.

First, in order to be able to access the Internet and participate online, the physical infrastructure must be available. This is not really a barrier in Romania except, perhaps, in the most remote areas because as of the end of 2013, fixed broadband covered 90 percent of homes in Romania (compare with an EU average of 97 percent). Even in rural areas, fixed broadband was available in 78 percent of homes.⁴⁷⁰

Second, there is an individual monetary cost. In order to be able to access the Internet and participate online, people need to have a computer and an Internet connection, both of which cost money. This may prove to be a prohibitive cost

⁴⁶⁸ European Commission SWD(2012) 61 final, Part II, Brussels, 14 March 2012.

⁴⁶⁹ ESF regulation proposal, COM (2011) 607 final.

⁴⁷⁰ <https://ec.europa.eu/digital-agenda/en/country/romania>

to many Romanians, given that half of those who are at risk of poverty and social exclusion cannot afford a computer and 42 percent cannot afford an Internet connection. The Digital Agenda data show that 56 percent of Romanian households had a broadband subscription at the end of 2013, which is still considerably lower than the EU average (76 percent) but higher than at the end of 2012.

Finally, there is an educational cost. Even if a person has access to a computer and an Internet connection, he or she still needs to be computer-literate in order to be able to access the Internet and participate online. This is not necessarily a problem for the younger generation, but it might be an insurmountable obstacle for at least some of the elderly population in rural areas, especially if they have never used a computer. In 2013, 45 percent of Romanians reported using the Internet at least weekly (regular users), well below the EU average of 72 percent. As many as 42 percent of the population had still never used the Internet - lower than in 2012 but still significantly higher than the EU average of 20 percent. The general population has very

few digital skills, and disadvantaged groups have even fewer, which means that computers and the Internet are an inefficient way of ensuring their inclusion and participation. Moreover, most users in Romania access the Internet only to get information or to socialize, whereas very few use it for economic, social, cultural, or political participation (for example, through e-commerce, e-sales, looking for jobs, e-learning, e-health, or e-governance). This behavior pattern is not only a reflection of people's preferences and skills but also of the underdevelopment of e-governance services. Very few public services are currently available online, and their level of sophistication is relatively low.⁴⁷¹ The national e-governance strategy (eRomania) has bold objectives (promoting transparency, increasing administrative efficiency by cutting costs and bureaucracy, ensuring broad and permanent access to information and public services, and preventing corruption through digital tools), but it is still being implemented at the desk level. All of this underscores the fact that the Government of Romania is not making enough effort to connect people to the knowledge-based economy and to prepare the way for social innovation.

BOX 46

Community Development through Social Innovation – A Good Practice Example

The Knowledge Economy Project, which was implemented between 2006 and 2012 by the Ministry of Communications and Information Society and financed by the World Bank, proved to be a positive link between ICT development and social inclusion. The project targeted 255 communes and small towns selected on the basis of their knowledge deprivation. The project increased rates of possession, access, and use of digital skills by citizens, companies, and local public services. The communities involved in the project changed from being disadvantaged to having knowledge indicators equal to or higher than national averages. In these communities, local public services (including social ones) have become more developed, local online services have multiplied (with their use rates being significantly higher than at the national level), and the social infrastructure has been substantially extended and modernized. Currently, many of these communities are top consumers of European development funds.

With regard to vulnerable groups, the most visible impact has been on children aged between 3 and 15

years old and youths between 16 and 24 years old. Irrespective of factors such as family economic status, ethnicity (Roma are statistically overrepresented in these communities), educational attainment, parents' employment status, or household amenities, children and young people from these communities use computers and the Internet on a regular basis at a rate comparable with the European average (70 to 80 percent). These young people have better digital skills than the rest of the population, and they are greatly involved in various community actions. In addition, young people have developed a preference for online means of information and interactions with public authorities. The main determinant of this behavior has been the schools with their ICT equipment and considerable increases in computer-assisted classes. Therefore, the Knowledge Economy Project is a model of social innovation using ICT to foster social inclusion and ensure equal opportunities for vulnerable groups, in particular to children and youths, women, Roma, and people with disabilities.

Source: Stănculescu and Arahamian (2013).



⁴⁷¹ Therefore, in 2013, only 5 percent of the population aged between 16 and 74 years old used e-governance services (as opposed to versus 41 percent in the EU-27).

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3. AREA-BASED POLICIES

3

AREA-BASED POLICIES



3.1. Geographical Dimension of Poverty

The government should aim to reduce geographical inequalities by improving the definition of urban and rural areas and by developing institutional solutions for the administration of functional urban areas that would enable dynamic cities to grow demographically and economically. The quality of life in rural communities should be improved by increasing the access of rural residents to quality basic infrastructure and services, while exploring the possibility of an administrative reform of rural localities. Finally, a program offering more resources and assistance for the recently declared small towns and for very small cities needs to be developed.



Main Objectives

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3.1. Geographical Dimension of Poverty

Poverty has a stark geographical dimension in Romania, so one of the government's main objectives should be ensure that resources are allocated according to the geographical distribution of need within the country at the regional, county, and local levels. To this end, this section discusses how poverty is distributed within the country and examines possible ways of reducing these geographical inequalities.

3.1.1. Reducing Geographical Inequalities

In the European Union's 2014 to 2020 multi-annual financial framework, €1 trillion have been budgeted to support growth and jobs and to reduce poverty and social exclusion. Success depends on developing the right policies and programs and targeting them effectively. Poverty maps can provide more detailed information on intra-country variations in poverty than was previously available and thus have the potential to improve resource allocation. The maps may also induce policymakers to give greater consideration to how best to allocate resources in ways that will raise living standards – whether by targeting poor areas or poor people. While the right combination of approaches will vary by country, the maps provide important information to help policymakers to arrive at the best solution.

The Local Human Development Index (LHDI),⁴⁷² which was devised to measure the overall level of development of each locality within a given county, also shows that community poverty in Romania has a strong geographical dimension. As Map 5 shows, localities in the East and South of the country, particularly those closer to the borders, tend to be

less developed. To some extent, the lack of development in these areas can be attributed to the limited trade that Romania has with countries like the Ukraine, Moldova, or Bulgaria and to their distance from the Western border through which 70 percent of Romanian exports are sent. As discussed in the draft National Territorial Development Strategy, the Carpathian Mountains also prevent localities in the East and South from accessing Western markets.

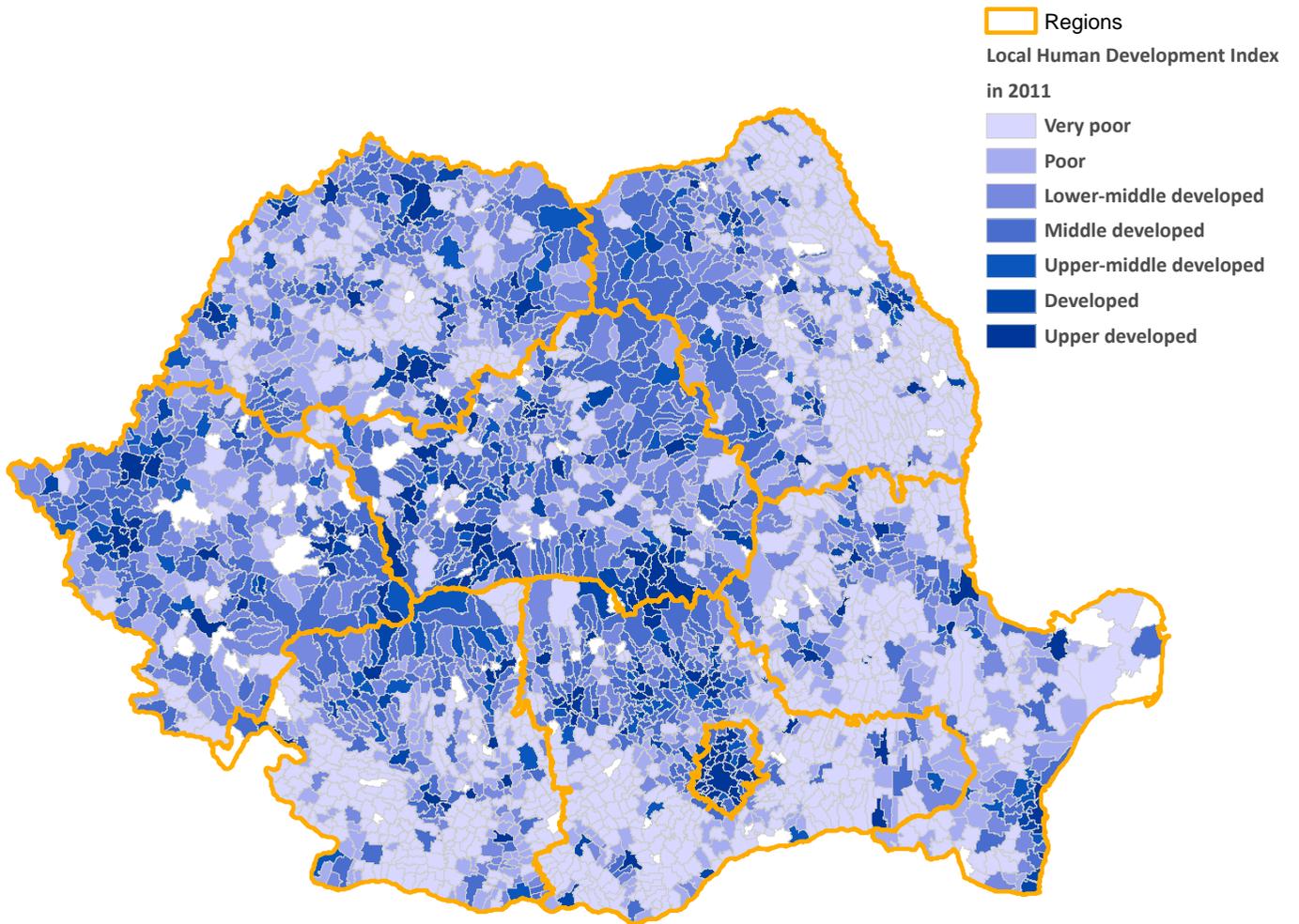
Another geographical pattern that emerges from Map 5 is the importance of cities in triggering development. Usually the closer a locality is to a developed city, the more developed it tends to be itself. As such, it is critical to increase access to dynamic urban centers as this is one of the most efficient ways of enabling more people to take advantage of the opportunities that these cities offer (such as jobs, education, healthcare, culture, and entertainment).

The poverty maps⁴⁷³ for Romania produced by the World Bank in 2013 confirmed existing knowledge about poverty in Romania but also revealed new insights. For example, previous surveys have shown that the Northeast region has the highest rates of poverty, and the county-level poverty map (Map 6) confirmed that all six counties in that region have an elevated risk of poverty. In contrast, the South region is heterogeneous, comprising some counties with very high poverty rates such as Călărași and Teleorman but also other counties with relatively low poverty rates such as Prahova. Similarly, Cluj county has the second-lowest poverty rate in Romania (after Bucharest), but its neighboring counties in the Northwest region (Bistrița-Năsăud, Maramureș, Sălaj, and Satu Mare) have poverty levels that are higher than the Romanian average. Knowing which counties have higher poverty rates can help policymakers to target resources for development and poverty reduction more efficiently.

⁴⁷² The LHDI measures the total capital of rural and urban administrative units in Romania on four dimensions: (i) human capital; (ii) health capital; (iii) vital capital; and (iv) material capital. Human capital is measured by education stock at the local level (for the population aged 10 years old and over). Health capital is measured as life expectancy at birth at the local level. Vital capital is measured by the mean age of the adult population (those aged 18 years old and over). Finally, material capital is assessed as a factor score of three specific indicators that focus on living standards: (i) the size of the dwelling space; (ii) the number of private cars for every 1,000 residents; and (iii) the distribution of the use of gas for household consumption in the particular geographical unit. The four measures of the dimensions of community capital are aggregated by calculating another factor score. (Ionescu-Heroiu et al, 2013a).

⁴⁷³ For details about the methodology of creating poverty maps at community level by combining survey and census data see Elbers et al (2003) and Elbers et al (2004).

MAP 5: The Local Human Development Index for 2011



Source: National Agency for Protection of Children’s Rights and Adoption.

Note: Residential care units including public and private placement centers, small group houses, and apartments.

Targeting poor areas is only likely to be effective if priority is given to areas that not only have high poverty rates but also contain large numbers of poor people. Policymakers are interested both in those areas where poverty is high and in those areas that have the largest number of poor people. These two are not the same. Areas that are very poor may also be sparsely populated, whereas large cities tend to have low poverty rates but large numbers of poor people because of their large populations. For example, despite its lower poverty rate, Cluj county has more people at risk of poverty than Sălaj. Also, Bucharest has more people at risk of poverty than 14 counties. The poverty maps suggest yet another approach to allocating resources for poverty reduction that takes into account the fact that many of the poor live in relatively rich areas. Both maps clearly illustrate that the Northeast - especially Botoșani, Iași and Suceava - have both high poverty rates and large numbers of poor people and thus should be given a high priority according to either criterion.

The Northeast and South regions of the country have been fare worse than other areas on nearly all socioeconomic indicators, especially in rural areas. As a general rule in Romania, the larger the proportion of the rural population, the more severe the poverty is in that region or county.⁴⁷⁴ So, inter-regional disparities are mainly the result of the large discrepancies between urban and rural areas. Actually, a recent study by the European Commission clearly showed that the rural-urban gap has been more marked in Romania than in the Western European countries.⁴⁷⁵ After 1989, as structural changes began to be made in Romania, the urban-rural gap widened, with rural areas being clearly at a growing disadvantage. Rural areas have been constantly characterized by a higher incidence of income poverty than urban areas (see Section 1.1.1 on Regional Disparities). Infant and under-5 mortality rates

have always been considerably higher among children in rural areas than those in urban areas.⁴⁷⁶ There has always been less infrastructure available in rural areas and of lower quality. Access to upper secondary education, healthcare, and social services has been much more limited in rural areas. Rural households are located, on average, much further from a high school or major hospital than urban residents (see the Health and Education chapters). Therefore, the next sections of this chapter analyze the quality of life in rural and small urban areas, as well as the availability of European funds to fund future community development.

The current administrative definition of rural and urban areas needs to be improved by taking account of emerging suburban or peri-urban areas that continue to be defined as rural areas. In the World Development Report 2009: Reshaping Economic Geography,⁴⁷⁷ the World Bank proposed a unified methodology for measuring urbanization (the agglomeration index). By this measure, Romania is around 65 percent urban and 35 percent rural when these suburban or peri-urban areas (otherwise known as “functional urban zones”) are defined as urban. In fact, the World Bank’s 2014 report⁴⁷⁸ on Competitive Cities: Reshaping the Economic Geography of Romania showed that, although the population of the country including the population of most large urban centers decreased between 1990 and 2010, some localities grew in population and, as the map below illustrates, the most pronounced population growth happened in the peri-urban areas of large and dynamic cities (Map 7). In order to serve as engines of growth, cities, especially the most dynamic ones, need to be defined as functional urban areas. Failing to do so can undermine even the best local strategies and can ultimately lead to suboptimal development outcomes.

⁴⁷⁴ Sandu (1999 and 2011), Sandu et al. (2009).

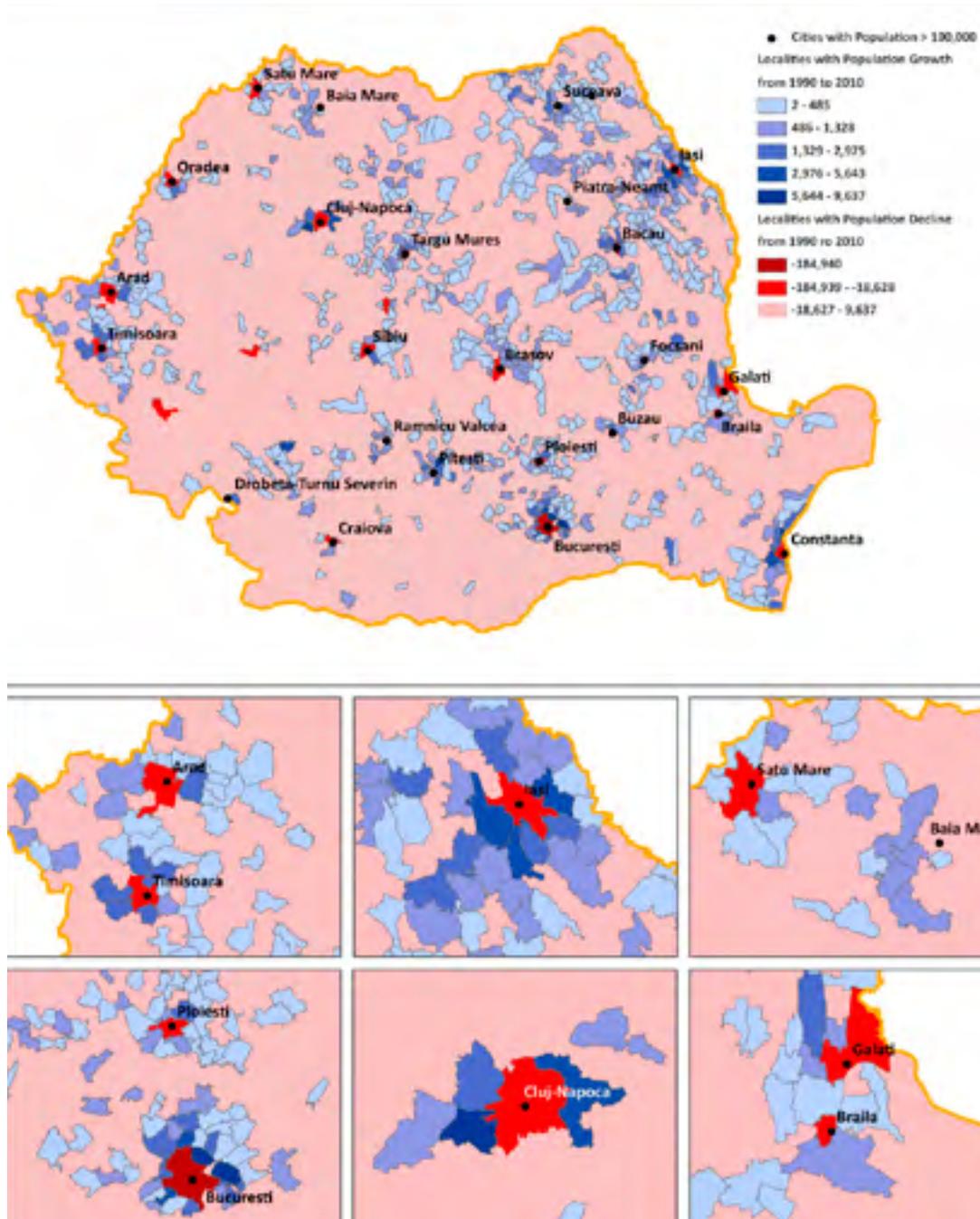
⁴⁷⁵ Bertolini et al. (2008).

⁴⁷⁶ For example, in 2013, the infant mortality rate was 10.4 live births to every 1,000 inhabitants in rural areas compared with 6.8 in urban areas (National Institute of Statistics, Tempo Online, <https://statistici.insse.ro/shop/>).

⁴⁷⁷ World Bank (2009).

⁴⁷⁸ Ionescu-Heroiu et al. (2013a).

MAP 7: Growing Functional Urban Zones



The 2011 census results have prompted many to talk about policy measures aimed at tackling the urban-to-rural migration that seems to be taking place in Romania. A look at the data shows, however, that most of this urban-rural migration is in fact the result of people moving to the suburbs of București, Cluj-Napoca, Timișoara, Constanța, Iași, and Ploiești, with most of these suburbs still being wrongly defined as rural areas.

Policymakers must also identify and implement adequate institutional arrangements for the management of functional urban areas to enable dynamic cities (or growth poles) to enlarge their demographic and economic mass. A World Bank study⁴⁷⁹ proposed the creation of Metropolitan Development Agencies, which would be similar to Romania's Regional Development Agencies, in that they would plan and manage functional urban areas and implement projects at the metropolitan level. Policymakers should help dynamic functional urban areas to grow in order to act as economic engines for the regions in which they are located. It is also important for policymakers to enable a larger number of people to access the opportunities that these cities offer (such as jobs, education, healthcare, culture, and entertainment). Because these growth poles have already attracted a significant amount of new investment, it will be vital to expand metropolitan public transport systems (ideally to areas with high population densities and with strong commuter flows), to develop new connective infrastructure, and to upgrade and properly maintain existing infrastructure.⁴⁸⁰

3.1.2. Improving the Quality of Life in Rural Communities

Nearly half of the population lives in rural administrative areas (46 percent according to the 2011 Census). Both the aging of the rural population and the migration of many rural dwellers in search of work abroad – notably of young people and women – are deepening the general impoverishment of rural areas.

Access to Quality Basic Infrastructure and Services in Rural Areas

The availability of reliable basic services and infrastructure is a vital prerequisite for ensuring a good quality of life and social inclusion in rural areas. In this section, we analyze: (i) the physical availability of basic infrastructure and services; (ii) financial and physical access to basic infrastructure and services; and (iii) the quality of basic infrastructure and

services. Each of these aspects of the problem will require tailored policy responses.

A. The Physical Availability of Basic Infrastructure and Services in Rural Areas

There is a pronounced urban-rural divide in Romania in terms of the physical availability of basic infrastructure and services, with rural communities being heavily disadvantaged. However, there are variations by type of infrastructure or service. The current rural-urban gap provides policymakers with a strong justification for rapidly increasing the supply of basic services and infrastructures in rural areas. This will require “hard” measures such as area-targeted investment projects funded primarily through the National Rural Development Program (NRDP), the Regional Operational Program (ROP), and, to some extent, through the Large Infrastructure Operational Program (LIOP). The main areas where these investments should be made are as follows:

Road network: In 2012, total road network in Romania covered 81,185 kilometers. The network of county and municipal roads totaled 67,298 kilometers, of which municipal roads represented 47 percent. The density of rural roads was 15 kilometers per 100 square kilometers of territory, which is less than half of the national average (35.1). These are among the lowest densities in the entire European Union.

Basic utilities: Rural areas lag significantly behind urban areas in terms of the availability of basic utilities such as water supply, the sewerage network, and natural gas, with the notable exception of electricity, which is available to virtually all rural dwellers. In 2012, only 13 percent (2,011) of rural municipalities were connected to a public drinking water supply, in contrast with 99 percent of cities. Only 4 percent (616) of rural localities were connected to a public sewerage network compared with 97 percent of urban districts. In addition, only 4 percent (650) of communes and villages could tap into the natural gas supply as opposed to 95 percent of urban dwellings.

Preschool facilities: Rural areas are even more severely affected as far as preschool facilities and vocational/career schools are concerned and are facing a major infrastructural deficit. Kindergartens accounted for only 7.4 percent of the

⁴⁷⁹ World Bank (Ionescu-Heroiu et al, 2013b).

⁴⁸⁰ These investments should be prioritized based on careful analysis of local and regional trends and according to a set of clear criteria (for example, the availability of resources to maintain and operate the new or upgraded infrastructure).

total number of such facilities registered at the national level in the 2012/13 school year. Similarly, in 2011, only 1 percent of Romania's 295 nurseries were located in rural areas. The lack of these preschool facilities in rural areas prevents parents from returning to full employment while their children are of preschool age, thus limiting household income.

Schools: The total number of public schools has dropped significantly in both rural and urban areas, though it has declined much more significantly in rural areas. Between 1996 and 2012, the number of urban schools fell by 55 percent while the number of rural schools fell by 85 percent. In contrast, the number of students fell by only 20 percent in both rural and urban areas during the same period. Indeed, while the population of Romania has been on a general downward trend, neither the urban nor the rural population has dropped by more than 10 percent since 1990, but the decline in the number of educational facilities has been much more precipitous. There are notable differences in these dynamics by education level. While the number of primary and secondary education facilities halved in urban areas, in rural areas they declined by 75 percent. In the case of secondary schools, there was a slight increase in total numbers in both urban and rural areas. Furthermore, it has been estimated that over 90 percent of primary and middle schools - 70 percent of which are located in rural areas - require modernizing.⁴⁶¹ Nevertheless, while the number of schools decreased, the number of teachers more or less followed the trend in student enrollment numbers in that they dropped by a similar percentage. On balance, student-to-teacher ratios are good, and there are no major disparities between urban and rural areas, at least in pre-university education.

Upper secondary education: The number of agricultural high schools has decreased by over 80 percent in the last 15 years, and only 34 were still operating in rural areas as of 2011. The lack of specialized agricultural education in rural areas leads to suboptimal management of agricultural holdings and reduces income-generating opportunities for vocational groups who are already dealing with reduced incomes and poverty.

Healthcare: As was the case with schools, the number of medical clinics in Romania has been on a significant downward trend as has the number of healthcare professionals. The decline in the number of medical clinics in rural areas (down by 38.9 percent since 2005) has been much more rapid than at the national level (down by 17

percent). More details on the urban-rural divide regarding healthcare resources are provided in section 2.5.3.

Information and communication technology: The uptake of ICT in Romania remains very low by European standards. In 2012, only half of all Romanian households had at least one computer and access to the Internet. Rural households are much further behind, with only 32 percent owning a computer and only 28 percent being connected to the Internet. This constitutes a major infrastructure gap that needs to be closed.

B. The Gap between Rural and Urban Areas in terms of Access to Basic Infrastructure and Services

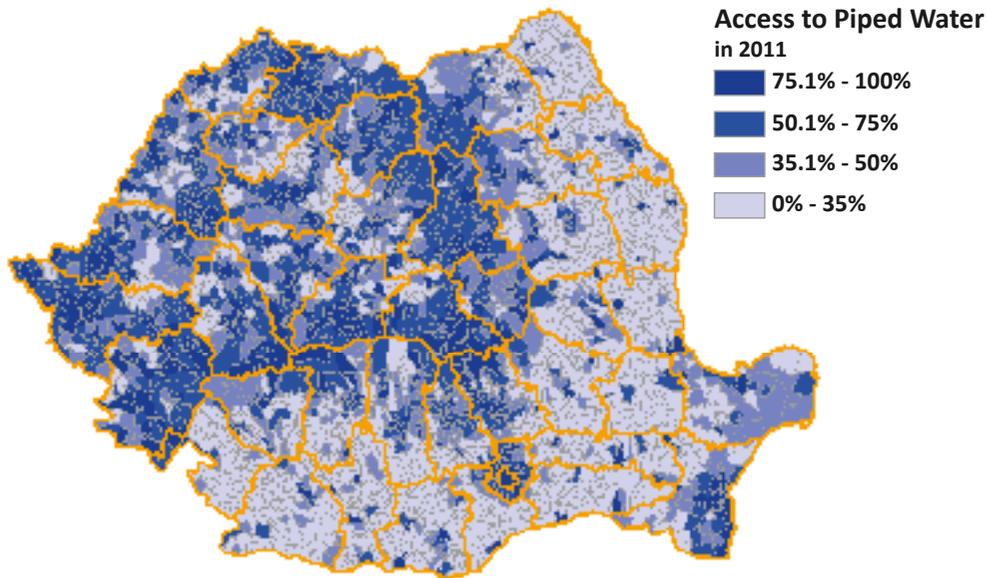
People in rural areas also face more physical and financial barriers to accessing basic infrastructure and services. The challenges identified in this subsection are best addressed by "soft" programs targeted to the most vulnerable groups. Along with social programs, the NRDP together with the Competitiveness Operational Program (COP) can help to boost rural incomes by creating jobs and supporting income diversification in ways that particularly benefit low-income people of working age (such as the rural unemployed or small farmers).

Road network: Only half of all communes have direct access to the national road network, meaning that the current road network only serves three-fifths of the total rural population. This is an important access gap that needs to be filled.

Basic utilities: In terms of economic access to basic utilities such as water supply, the sewerage network, electricity, and natural gas, available statistics do not indicate, at face value, any major differences between urban and rural households. In fact, 66.3 percent of urban households - compared with only 33.6 percent of rural households - faced difficulties and delays in paying their utility bills in 2012. However, the numbers are not fully analogous so this comparison may be misleading. The much lower availability of these services in rural areas also translates into a proportionally lower incidence of utility bills, which might be the main explanation for the difference (Map 8). Once the availability of these services is similar in rural and urban areas, the balance might shift back in favor of urban households, given their higher incomes.

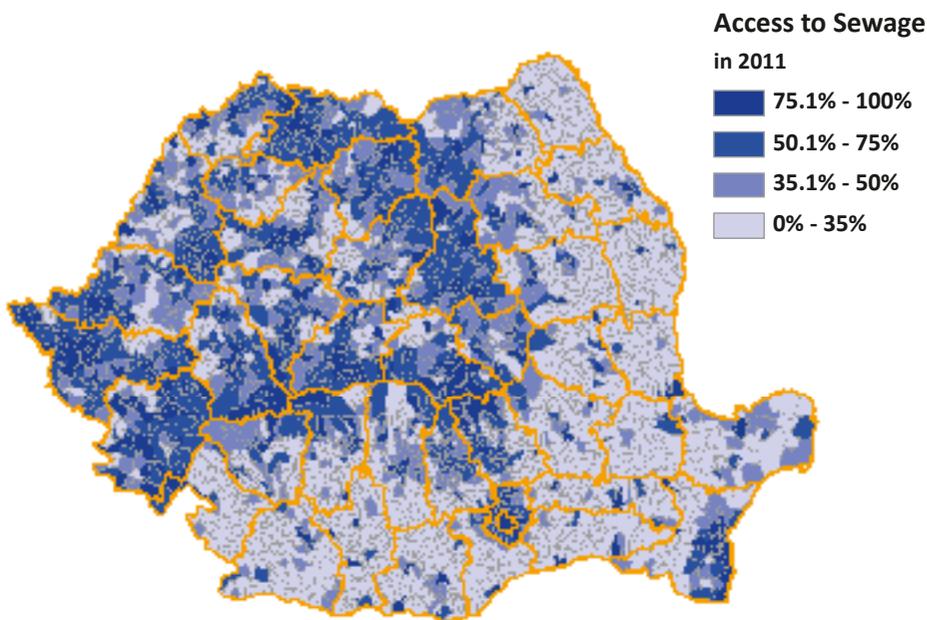
⁴⁶¹ Ministry of Regional Development and Tourism (2012).

MAP 8: Share of Population with Access to Piped Water (up) and Sewage (down), 2011



Generally, cities have better access to basic services, as they benefit from economies of scale.

Developed cities also enable neighboring communities to share the prosperity that they enjoy.



This fact should be taken into consideration when attempting to prioritize investments in the extension of basic infrastructure and services.

Education: In 2011, only 45.5 percent of rural children under 4 years old were enrolled in nurseries. Furthermore, the 256,856 rural children enrolled in kindergartens equaled only 80 percent of the corresponding urban enrollment. Nationwide primary educational attainment (grades 1 to 4) is satisfactory (over 90 percent), with no major urban-rural disparities. However, gaps start developing in the secondary education cycle (grades 5 to 8) where attainment levels as of 2012 were 66 percent in rural areas and 85 percent in urban areas, and this gap widened even further after high school. In 2013, three-quarters of all urban employees had completed high school or had a higher education degree, while 42 percent of rural employees had only primary or secondary education or none at all.

Employment: The urban-rural education gaps are reflected in the employment structure, which has direct implications for income levels and job opportunities. In 2013, one-quarter of the rural employed consisted of non-salaried family workers, while another third were self-employed. In contrast, in urban areas, over 90 percent of the workforce comprises salaried employees.

Healthcare: Apart from deficient infrastructure and an insufficient number of healthcare professionals, particularly in rural areas, financial constraints also limit access to healthcare services. In this regard, there are no major differences between urban and rural dwellers, with 75.8 percent and 74.2 percent respectively claiming that they cannot afford healthcare. However, there is a notable difference between urban and rural areas in terms of physical access, defined as living an excessive distance from health services or as a lack of public transportation to access them – 5 percent as opposed to 8.2 percent. There is a clear need to improve the rural transport infrastructure

in conjunction with expanding the network of healthcare facilities in rural areas.

Information and communication technology: The low incomes of most rural households are the main reason for the low penetration and use of broadband Internet in rural areas. In addition, digital literacy remains low in rural areas, although these areas are quickly catching up with the rest of the country. Approximately 60 percent of the rural population aged between 16 and 74 has never used a computer or the Internet, in contrast with 30 percent of the urban population (as of 2013). Yet the number of rural inhabitants who have used the Internet increased by 3.5 times between 2007 and 2013, a much faster rate than among urban dwellers.

C. The Quality of Basic Infrastructure and Services in Rural Areas

The quality of basic infrastructure and services in rural areas is as important as their availability and accessibility and should not be overlooked, although it is harder to substantiate with statistical data. Specific performance indicators (such as educational or health outcomes in urban versus rural areas) can provide some insights, although multiple factors are involved in determining these outcomes. Nevertheless, the government needs to make intensive efforts to monitor the quality of basic infrastructure and services and improve it wherever necessary. These efforts should primarily consist of programs financing the development of rural infrastructure (such as rural roads and utilities), as well as the monitoring of the quality of rural services by the responsible line ministries (such as the Ministry of Health or the Ministry of Education).

TABLE 39: Breakdown of Public Roads by Type and Degree of Modernization in 2012

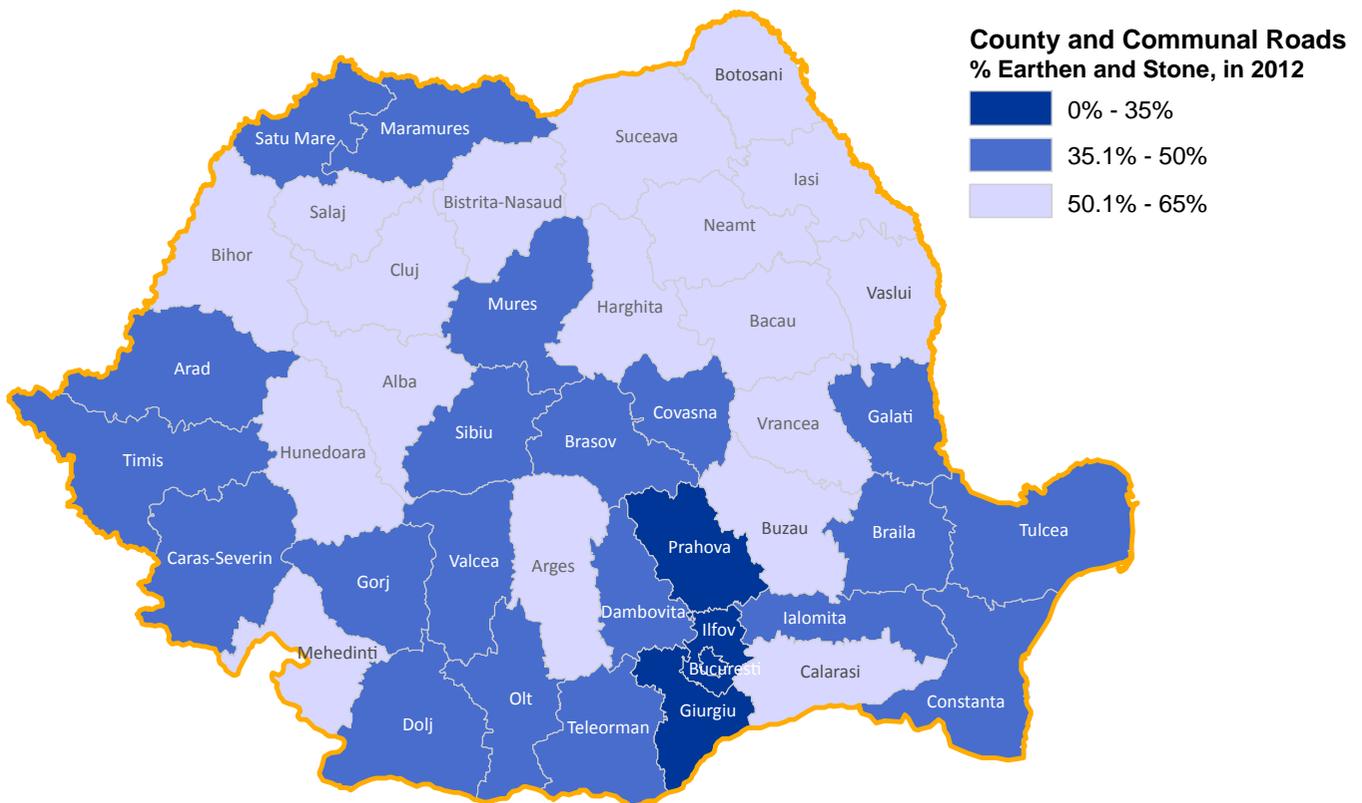
	National	County	Municipal
Modernized	93%	27%	8%
Light asphalt pavement	6%	45%	16%
Stone	2%	22%	47%
Dirt	0%	6%	28%

Source: National Institute of Statistics.

Road network: In the case of rural roads, poor quality is an even more significant constraint than physical availability or access. Rural roads are in much worse condition than national and county roads (Map 9). Only 8 percent of rural roads are modernized (compared with 93 percent of national roads), and 75 percent of them are stone or dirt roads. In cases of major rainfall or snowfalls, many of these roads become impassable, cutting off people’s access to vital supplies and services and disrupting economic activities. Of the 23,000 kilometers of county roads that connect with the TEN-T network, the European Union’s

unified transport network, 60 percent are in need of repair. Therefore, a significant proportion of the rural labor force is hampered from moving to urban areas in search of employment. Map 9 below indicates the counties with the highest shares of county and communal roads in need of modernization. Overall, according to the cost standards of the Ministry of Regional Development and Public Administration, modernizing all of the earth and gravel county roads in Romania would require around €3.4 billion, while the modernization of earth and gravel county roads would require around €4.7 billion.

MAP 9: Counties with Highest Shares of County and Community Roads Requiring Modernization, 2011



Source: National Institute of Statistics.

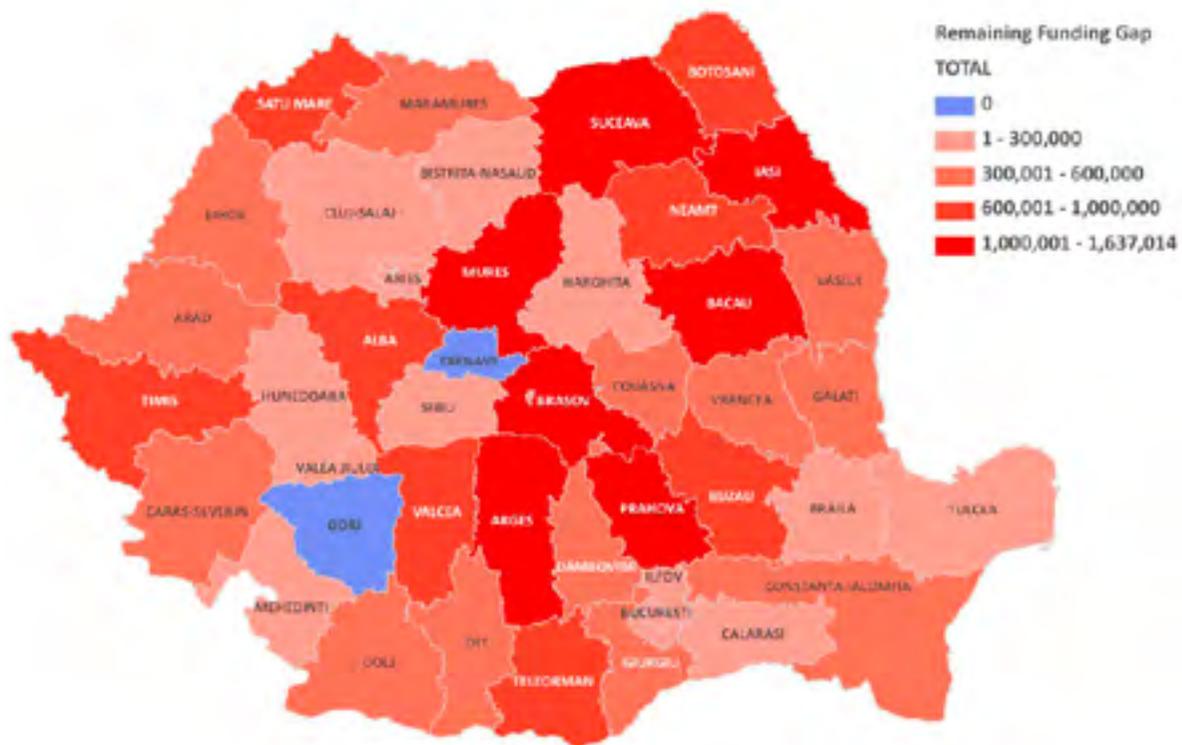
Basic utilities: The extremely low physical availability of basic utilities such as water supply, the sewerage network, electricity, and natural gas limits the extent to which it is possible to discuss their quality. However, it is evident that the most of the existing physical infrastructure is in great need of repair or reconstruction. The quality and reliability of Romania's water supply and wastewater services are generally poor, especially in rural areas where the quality of water does not always meet minimum hygiene standards. Romania's regional water master plans indicate that the investment needed in these two sectors is somewhere around €30 billion. Map 10 below shows those regions where the need is highest.

Education: The quality of rural pre-university education is worse than that of urban pre-university education. A study commissioned by the Ministry of Education in 2012 indicated that rural schools fall 10 percent behind their urban counterparts in scores based on standard quality indicators. By law, the Romanian education system must

undergo an external evaluation every five years. A set of 24 performance indicators – laid out in Government Decision no. 21 of 2007 – constitutes the basis for both the accreditation and evaluation of schools. Based on these indicators, a combined score is calculated for each school. The evaluation report concluded that rural students have access to lower quality education than their urban peers and that government efforts aimed at closing the quality gap needed to be intensified.

Healthcare: No clear evidence exists with regard to quality standards in the Romanian healthcare system. Quality assurance in this field is still in its early stages (see the Romania National Health Strategy 2014-2020,⁴⁸² with the notable exception of laboratories. Quality standards, procedures, and protocols for healthcare units are being developed but, so far, anecdotal evidence suggests that very often not even minimum standards are met, even if such standards already exist.

MAP 10: Water and Wastewater Investment Needs by Water Region, 2007-2018 (in €1,000)



Source: Regional water master plans.

⁴⁸² Ministry of Health (2014: 36).

Information and communication technology: Overall, Romania ranks high in terms of the quality of its broadband Internet service. According to a recent report by a major global Internet content manager, Romania ranked 18th in the world with an average connection speed of 9.3 Mbps as of the first quarter of 2014.⁴⁸³ According to the same report, the speed of adoption of the internet in Romania is also high, with the country ranking sixth globally in terms of its quarterly increases in broadband connectivity (of greater than 4 Megabytes per second). While no breakdown of the quality of Internet services exists between urban and rural areas, it is safe to assume that the quality of ICT services is not the main constraint for potential rural users. Instead, the government needs to focus on ensuring the availability of these services and increasing access to them, mainly by increasing rural income opportunities and rural digital literacy.

Small and Remote Rural Communities

Rural areas are highly heterogeneous. Rural areas in Romania are organized into 2,861 communes (administrative units) that include 12,373 villages.⁴⁸⁴ Villages are categorized by geography, population size, distance to a city, and administrative type (central or peripheral). Some 88 percent of communes have one central village and one or more peripheral villages. Central villages tend to concentrate the administrative and institutional resources of the commune (the mayoralty, health unit, school, library, post office, and police station). Public infrastructure, which is in need of modernization in most rural areas, is significantly poorer in peripheral villages. The most affluent villages are those located close to a city and/or to a European road.⁴⁸⁵ In fact, many of these developed villages are part of suburban or peri-urban localities.

Small and very small villages are the most disadvantaged, particularly those with an elderly population and/or those that are located in remote areas (see Annex Table 10.1). The 2011 Census counted a total of 3,172 villages with

fewer than 200 inhabitants, of which about a half (1,610 villages) are very small (with fewer than 100 inhabitants). About 3.4 percent of the total rural population (nearly 312,000 people) lives in small villages, of whom fewer than 1 percent live in the very small villages. Most of these small villages are peripheral within their communes (sometimes situated many kilometers away from the central village) and have elderly populations (Annex Table 10.4 and Annex Table 10.7). Over 41 percent of the populations of villages with fewer than 200 inhabitants and 45 percent of the populations of very small villages are aged 55 or older.⁴⁸⁶ Small and very small villages are spread all over the country but appear to be concentrated in the West and Center regions (Annex Table 10.2 and Annex Table 10.3). Also, villages with an elderly population are more likely to be found in the Western regions of the country (North-West, West, and South-West) (Annex Table 10.8). In terms of basic infrastructure, small and very small villages have similar development needs to those of the larger communities (Annex Table 10.5 and Annex Table 10.9).⁴⁸⁷ However, due to their population composition, small and very small villages have specific needs mainly related to the development of social services, specifically assistance in carrying out daily tasks (home help) for the elderly and better access to quality education (particularly early childhood education and primary school for younger children). This is because in many of these villages schools have been closed down or are severely underfinanced because of the small number of pupils (Annex Table 10.6).

Among rural municipalities, the small communes with fewer than 2,000 inhabitants are the most disadvantaged in terms of human and social development. In Romania, the size of the commune populations varies widely from a low of 119 to a high of almost 23,000 inhabitants.⁴⁸⁸ The small communes (those with fewer than 2,000 inhabitants) represent 26 percent of all communes (or 751) and are inhabited by over 1.1 million people (see Annex Table 10.10). These communes are spread throughout the country but tend to be concentrated in the West, Center, and South-West

⁴⁸³ Akamai (2014).

⁴⁸⁴ As at January 2015, the Nomenclature of Territorial-Administrative Units (NIS) reported 13,755 villages (SIRUTA units) nationwide, which were grouped in 3,181 administrative units (communes and cities). However, 129 villages have been 'fictive' (have zero inhabitants) and have no corresponding data in the 2011 Population and Housing Census (114 from rural and 15 from urban). As most of the analysis presented in the following sections is based on the 2011 census data, we will refer only to those villages that are 'valid', 13,626 SIRUTA units, of which 12,373 in rural areas and 1,253 in urban areas.

⁴⁸⁵ Sandu (2000) and Stănculescu (2005).

⁴⁸⁶ At the same time, children aged between 0 and 17 years old represent only 18 percent and 16 percent respectively of the total population of villages with fewer than 200 inhabitants and of very small villages. For comparison, in villages with more than 200 inhabitants, children represent 22 percent of the total population, while people aged 55 or older constitute 31 percent.

⁴⁸⁷ The villages with a high proportion of elderly inhabitants appear to have lower percentages of dwellings connected to utilities such as cooking gas, piped water, or the sewerage network, but usually the demand for these services is also lower (some elderly are too poor to afford gas and water tariffs, while others have no desire to invest in such facilities as they are used to getting their drinking water from wells or fountains).

⁴⁸⁸ Brebu Nou (Weidenthal) is the smallest commune in the country (with 119 inhabitants according to the 2011 Population and Housing Census). It is a former Saxon commune that includes two villages and is located in the Semenic Mountains in Caraș-Severin County in western Romania. The largest commune is Floresti, which is a peri-urban suburb of Cluj-Napoca city in Cluj County in the Center region.

regions, a pattern rather similar to that of small villages and villages with a high proportion of elderly inhabitants (Annex Table 10.11). With regard to the availability, affordability, and quality of basic infrastructure, small communes have a similar proportion of dwellings connected to utilities and of households that report difficulties and delays in paying their utility bills (such as heating, electricity, and gas) as other communes (Annex Table 10.12 and Annex Table 10.13). However, the Local Human Development Index (LHDI) indicates that small communes were and still are significantly less developed than the larger communes, even the remote ones (Table 40). In fact, Table 40 shows that, on the one hand, remote communes (those that have little connection to any city) are likely to be disadvantaged only when they are small (in other words, when they have

fewer than 2,000 inhabitants) and, on the other hand, small communes are generally less connected to their nearest cities than larger communes (in other words, they are more likely to be remote). Although infrastructure development in the small communes increased between 2002 and 2011 and these communes attracted a larger volume of European funds per inhabitant than the larger communes between 2009 and 2012, they have not succeeded in closing the development gap. Furthermore, as shown in the previous sections on social services, education, and health, small communes are clearly at a disadvantage in that they have few community workers (social workers, community health nurses, Roma health mediators, and qualified teaching staff), their local institutions have little capacity, and they have very few primary and community-based services.

TABLE 40: Human and Economic Development of Small Communes and Remote Communes

	Small communes (<2,000 inhabitants)	Remote communes 2,000+ inhabitants	Other communes (neither small nor remote)	Urban areas
Number of communes	751	375	1,735	320
Average population size (number of people)	1,474	3,558	3,932	34,000
Urban Connectivity Index (IURCON)	1.4	1.0	1.7	1.4
Share of remote communes (%)	23	100	0	-
Local Human Development Index 2002 (LHDI 2002)	29.8	32.7	33.5	44.3
Local Human Development Index 2011 (LHDI 2011)	33.5	36.7	37.7	47.2
Evolution of LHDI (2011 as % of 2002)	112	112	112	106
Total volume of expenditures on European funded projects, in the period 2009-2012 (Euro per capita)	174	153	112	61
Share of self-generated revenues in total revenues in the local budget, in 2007 (%)	12.9	16.0	17.4	38.6
Share of self-generated revenues in total revenues in the local budget, in 2012 (%)	19.1	20.8	22.8	41.6
Evolution of self-generated revenues (2012 as % of 2007)	148	130	131	108
Share of capital investments in total expenditures in the local budget, in 2007 (%)	26.0	22.6	25.4	19.4
Share of capital investments in total expenditures in the local budget, in 2012 (%)	20.7	18.4	20.4	16.5
Evolution of capital investments (2012 as % of 2007)	80	81	80	85

Source: World Bank calculations using the 2011 Population and Housing Census; World Bank (Ionescu-Heroiu et al, 2013a) for LHDI 2002 and 2011; and local budget execution data posted by the Ministry of Administration and Interior.⁴⁸⁹

Notes: IURCON provides an estimation of urban connectivity based on a set of distances between a commune and its neighboring small, medium, large, and very large cities. The higher the IURCON value, the better connected to cities is that commune. Remote communes are those localities in the lowest quintile of IURCON.

⁴⁸⁹ At present, the local budget execution data are reported by the Ministry of Finance. The Ministry of Administration and Interior is the Ministry of Internal Affairs.

At the same time, local budget indicators show that small communes are also disadvantaged in terms of economic development (Table 40). The extent to which local communities depend on support from the state budget is a relevant indicator of the potential for local economic growth. If a locality's budget contains few central budget transfers in conjunction with a high proportion of self-generated revenues (from local tax collection), then this is a sign that it is experiencing healthy economic development and that it has a large base of taxpayers (citizens and firms). Ministry of Finance data from the end of 2012 show that the average share of self-generated revenues (or independence from state budget transfers) of Romanian localities was only 24 percent. Within this average, rates differed significantly between urban areas (42 percent), communes (22 percent), and small communes (19 percent). Only a small number of localities managed to achieve an independence threshold of over 50 percent in 2012, namely 84 cities (or 26 percent of all cities apart from Bucharest) and 135 communes (of which 109 are neither small nor remote). Consequently, capital investments are low and have even decreased in recent years in all localities.

This indicates that policymakers should explore the possibility of reforming the local government administrative structure as a realistic and efficient way to enable rural development. At the moment, it is too expensive for most localities to invest in developing any basic infrastructure or service. Therefore, policymakers need to devise adequate

legislation to enable rural communes to merge and create fewer but larger communities that are better connected to urban areas (especially to the growth poles). This will help to reduce the existing inequalities between rural and urban areas as well as within rural communities.

The European Funds as an Instrument for Developing Basic Infrastructure and Services in Rural Areas

Romania is receiving funding from various European Union funds to improve health outcomes, social services, the physical environment, and economic infrastructure in Romania's less developed regions. These funds are the European Regional Development Fund (ERDF), the European Social Fund (ESF), and the European Agricultural Fund for Rural Development. The government is expected to allocate about €3.5 billion (10 percent) of these funds to meet the EU's Thematic Objective 9 to promote social inclusion and combat poverty and discrimination.⁴⁹⁰

To be as effective as possible, these funds will need to be carefully spent. In Table 41, we lay out the areas where investment is needed in basic infrastructure and services in rural areas and prioritize them according to the urgency of the need.

TABLE 41: Priorities for Investments in Basic Infrastructure and Services in Rural Areas

	Physical availability	Financial and physical access	Quality
Roads	Medium	Medium	High
Basic utilities:			
- Drinking water	High	High	High
- Sewerage	High	High	High
- Electricity	Low	Low	Low
- Natural gas	High	Low	High
Education	Medium*	Low	Medium
Healthcare	High	High	Unknown**
ICT	Medium	Medium	Low

Notes: *High only for pre-school education and vocational/career schools. **No quality assessment available.

⁴⁹⁰ The tentative breakdown of EU funding in support of Thematic Objective 9 in Romania is as follows: the ERDF (€0.5 billion), the ESF (€1.1 billion), and the EAFRD (€1.8 billion).

Given the priorities set out in Table 41, the European funding needs to be used to:

- Expand and modernize the physical infrastructure in rural areas, specifically roads and basic utilities (mainly water, sewerage systems, and natural gas).
- Expand and modernize education and healthcare facilities in rural areas and design incentives to encourage service providers (such as teachers and physicians) to work in these areas.
- Expand the ICT network in rural areas and develop policies to increase digital literacy in those areas.
- Create programs targeted to vulnerable groups (in both urban and rural areas) to increase their access to education and healthcare.
- Develop, monitor, and enforce quality standards for human development services (such as education and healthcare) in both urban and rural areas.

- Create programs aimed at diversifying rural incomes and creating additional job opportunities in rural areas (using funds from the EAFRD, the ERDF, and the ESF), and increasing labor mobility and skills acquisition (using funds from the EAFRD and the ESF) to overcome the income constraints that may prevent sections of the rural population from accessing to infrastructure and services.
- Empower local communities to take charge of their own development and prioritize their investment needs through LEADER,⁴⁹¹ a local development method developed by the European Network for Rural Development (ENRD) that allows local people to develop an area by using its inherent potential. This will help to direct funds to where they are needed the most.

In Table 42, we present a summary of these policy actions and the main source of funding for each of them.

TABLE 42: Key Policies to Enhance the Provision of Basic Infrastructure and Services in Rural Areas with Main Sources of Financing

	Investments to increase physical availability	Investments to facilitate financial and physical access	Investments to improve quality***
Roads	Local roads (EAFRD/NRDP), county roads (ERDF/ROP), TEN-T (ERDF and CF/LIOP)	n.a.	Same as for physical availability
Basic utilities:			
Drinking water and sewerage	Municipalities between 2,000 and 10,000 inhabitant equivalent * (EAFRD/NRDP), above (ERDF and CF/LIOP)	n.a.	Same as for physical availability
Electricity	n.a.	n.a.	n.a.
Natural gas	n.a.	TBD**	n.a.
Education	Kindergartens, nurseries, and afterschool units in rural areas, and agricultural high schools (EAFRD/NRDP), other education facilities (ERDF/ROP)	TBD**	Same as for physical availability
Healthcare	Rural clinics and community care centers (EAFRD/NRDP), regional and county hospitals, primary care and integrated community care centers (ERDF/ROP)	TBD**	Same as for physical availability
ICT	Small-scale ICT infrastructure in rural areas (EAFRD/NRDP), other ICT infrastructure (ERDF/Competitiveness OP)	TBD**	Same as for physical availability

Notes: *Municipalities with fewer than 2,000 inhabitants are put on hold at least until 2018, by which time the larger municipalities must meet specific EU standards. **"Soft" measures are people-based to be determined. ***Complementary measures (including adequate monitoring and enforcement) are not yet included in this table.

⁴⁹¹ Liaison Entre Actions de Développement de l'Économie Rurale or Links between the Rural Economy and Development Actions).

The EAFRD is providing about 50 percent of the resources delivered to Romania by the EU funds to pursue social inclusion and poverty alleviation objectives. These funds will finance the following actions:⁴⁹²

- The creation, expansion, and improvement of the network of local roads in rural areas. Connectivity to the main road network is an important principle guiding the EAFRD's investments.
- The creation, expansion, and improvement of the public water supply and sewerage networks (MO7, sub-measure 7.2). These investment projects are complementary to those undertaken under the Large Infrastructure Operational Program. They will be carried out only in rural localities with between 2,000 and 10,000 inhabitant equivalents (I.E.)⁴⁹³ subject to being part of the regional master plans. Localities with fewer than 2,000 I.E. will be allowed to finance investments in water infrastructure after 2018 if Romania meets its commitments to the EU in accordance with Directive 91/271/EEC. EU guidelines indicate that water infrastructure investments be carried out in localities with at least 50 people, while wastewater investments should be made in communities with at least 2,000 inhabitant equivalents.
- The creation, upgrading, or expansion of the education/care infrastructure (MO7, sub-measure 7.2): (i) the creation and upgrading (including the furnishing) of kindergartens, nurseries, and after-school units and (ii) the expansion and upgrading of secondary agricultural schools.
- The creation and/or upgrading of rural medical clinics and of community care centers (MO7, sub-measure 7.2).

Communes will be eligible to receive funding for these four measures, while NGOs may also be supported in upgrading education facilities (kindergartens) and social infrastructure (after-school units). A total of 1,151 operations are expected to be completed by 2023. In addition, the NRDP is investing in the maintenance, preservation, and renovation of local cultural heritage in rural areas (MO7, measure 7.6), including monastic settlements, and this is expected to have a positive impact on local tourism and to stimulate the development of local business.

The ERDF, through the EU's Regional Operational Program, is providing only about 14 percent of the resources to help Romania to increase social inclusion and reduce poverty. However, the ROP provides Romania with additional funds that have had significant positive effects on the quality of life in rural areas. The ERDF funds will finance the following actions:

- The development of a network of regional hospitals, the equipping of county hospitals with adequate technology, the development of a primary care system, and the setting up of integrated community care centers. A provisional budget of €400 million (EU contribution) is earmarked for this component. However, neither a breakdown by subcomponent nor targets are available for the time being. Integrated community care centers are of particular relevance for closing the rural healthcare access gap. By providing both medical and social services in the same location and by covering more geographical areas, they will be closer and more accessible to the ultimate beneficiaries.
- Investment in educational infrastructure, which will support the modernization of education facilities from pre-school through middle schools, as well as specialized high schools and universities. Provisionally, €340 million (EU contribution) is earmarked for this component. These investments are rooted in the National Strategy for Education and Vocational Training 2014-2020. While the strategy acknowledges that rural areas are facing greater challenges, it does not set specific targets for modernizing rural education facilities.
- Investment in road infrastructure. The ROP earmarks €900 million (EU contribution) for modernizing the county roads that enable TEN-T connectivity and for the development or repair of adjacent ring roads.

The LEADER approach can be used to increase access to small-scale ICT infrastructure to improve basic infrastructure and services. Support is granted to local action groups operating in rural areas and in small towns of under 20,000 inhabitants.

In addition, the Large Infrastructure Operating Program (LIOP) – combining resources from ERDF and the Cohesion Fund (CF) in the respective amounts of €2.5 billion and €6.9 billion – will contribute to the development of the TEN-T network

⁴⁹² As of July 1, 2014, no detailed financial breakdown was available by measure.

⁴⁹³ I.E. is the ratio of the sum of the pollution load produced during 24 hours by industrial facilities and services to the individual pollution load in household sewage produced by one person in the same time period.

and to the modernization of large water and sewerage infrastructure. While these investment projects will not focus specifically on rural areas, they will yield indirect benefits for the rural population.

In order to make the best use of EU funds in terms of alleviating poverty and social exclusion in rural areas, the government needs to provide more assistance to local authorities and local stakeholders in micro-regions (clusters of communes/LAGs) or rural communities to help them to develop basic social and integrated services. They can do this by: (i) assessing the need for social and integrated services (including home care and long-term care services, day centers, and leisure services); (ii) providing training and facilitation for the LEADER approach and for the LAG (local action group) framework; and (iii) increasing use of ICT infrastructure in community-based services, including new technologies that would meet the needs of rural residents.

3.1.3. Improving the Quality of Life in Small Urban Communities

Urban areas are substantially more developed than rural ones, but considerable discrepancies exist among different types of urban areas according to their population size. The 2013 Regional Yearbook (Eurostat) shows that the at-risk-of-poverty or social exclusion rate (AROPE) has a strong geographical dimension, in other words, a location effect, across Europe. However, the widest gaps by degree of urbanization were recorded in Bulgaria and Romania, in terms of the risk of poverty and social exclusion (AROPE), the risk of (monetary) poverty (AROP), and severe multiple deprivation. Romania recorded the second widest range of AROPE in Europe among three different degrees of urbanization – a difference of 19 percentage points between thinly and densely populated areas. Furthermore, Romania's at-risk-of-poverty rate (AROP)⁴⁹⁴ – one of the highest among the European member states – varies widely from about 7 percent in densely populated areas to 19 percent in intermediate density (small urban) areas and over 31 percent in thinly populated (rural) areas. Therefore, the differences (by degree of urbanization) suggest that the at-risk-of-poverty rate does not exclusively depend on personal characteristics such as education, employment status,

household type, and age since the rate in thinly (rural) areas is 4.5 times higher than in densely populated areas (medium and large cities).

Most urban centers in Romania are small towns with fewer than 20,000 inhabitants, that is 225 out of a total of 320 cities (Figure 46). However, the 2011 Census data indicate that most of the urban population (43.1 percent of the 10,859 million inhabitants) lives in medium-sized cities, 37.6 percent in large cities, and only 19.3 percent in these small towns (See Annex Table 10.14).

Investments are needed in the infrastructure of villages incorporated within cities in order to improve the quality of life of the population in small towns and to close the gap between disadvantaged small cities and other urban areas. In Romania, only 81 cities (out of 320) do not include any villages (defined as compact settlements of houses with a rural aspect usually located a few kilometers away from the city nucleus). By contrast, 88 percent of recently designated (between 2002 and 2006) small towns, 80 percent of other small towns, and 62 percent of medium-sized cities include between 1 and 21 villages, as shown in Figure 47. There are, for example, small towns that cover a mountain area where villages are spread at distances of more than 10 kilometers from the city center. In fact, many small towns are thinly populated areas and appear on the map as clusters of distant settlements with poor road links. In contrast, the medium cities are densely populated areas, and their growth has mainly been the result of the suburbanization process. In their expansion, some medium cities have reached the limits of some villages and have thus naturally incorporated those within their boundaries. Therefore, the existence of villages within a small town is usually a reflection of the town's effort to meet the administrative population threshold to obtain the status of an urban administrative unit, whereas the presence of villages within medium cities is more likely to be related to the actual enlargement of their functional area.

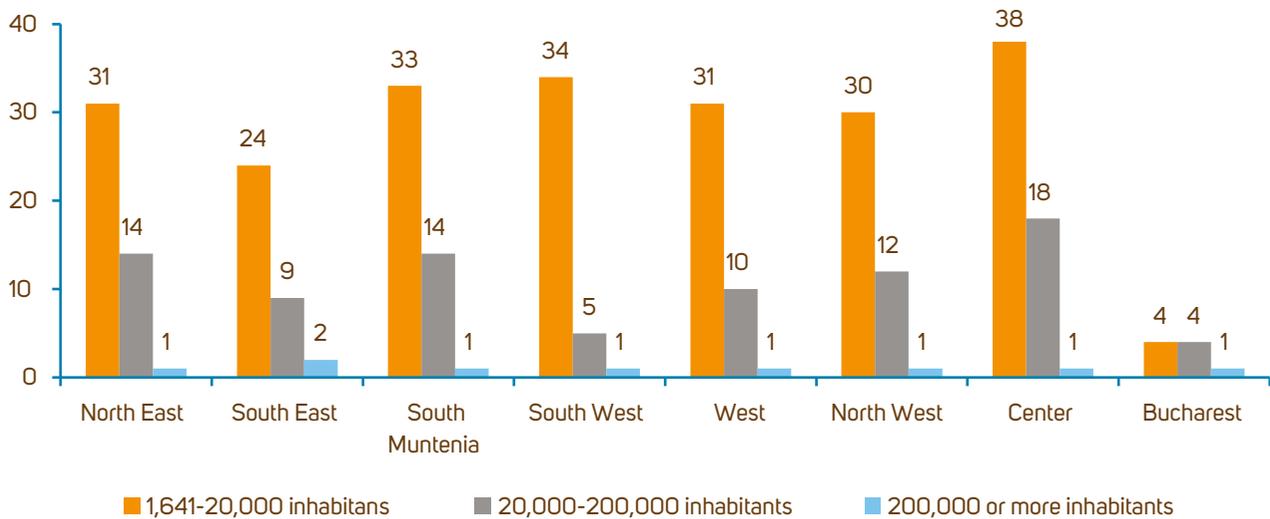
The number of village-neighborhoods is significantly correlated⁴⁹⁵ with the city's local level of human development; the larger the number of villages included within a city, the higher its probability of being underdeveloped (measured against the LHDI).⁴⁹⁶ Since the recently designated small towns and very small towns with fewer than 7,500 inhabitants have, on average, a larger number of villages (more than five), they have a much more accentuated rural character and are more likely to be underdeveloped than other urban areas.

⁴⁹⁴ The at-risk-of-poverty rate is not adjusted for differences in the cost of living between the different types of area, and therefore the gap between different areas may be overestimated.

⁴⁹⁵ The Pearson correlation coefficient between the number of incorporated villages and LHDI2002 is -0.18 (p=.001) and it is -0.23 (p=.000) for LHDI2011.

⁴⁹⁶ See the definition of the LHDI in footnote 470 at the beginning of this chapter.

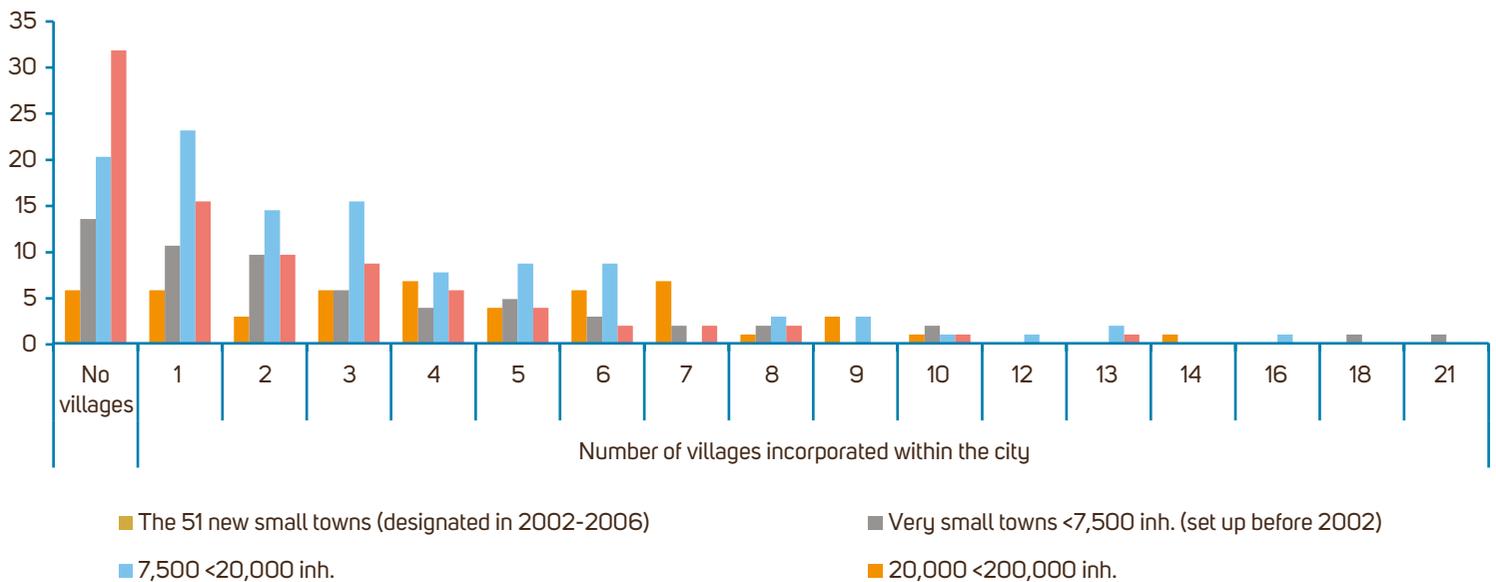
FIGURE 46: The Regional Distribution of Romanian Cities by Population Size (number)



Source: World Bank calculations using the 2011 Population and Housing Census.

Note: Only nine cities have more than 200,000 inhabitants (including the capital Bucharest with over 1.88 million people).

FIGURE 47: Romanian Cities by Population Size and Number of Incorporated Villages (number)



Source: World Bank calculations using data from the National Institute of Statistics (SIRUTA database).

Note: "No villages" refers to cities including those urban centers with no incorporated villages.

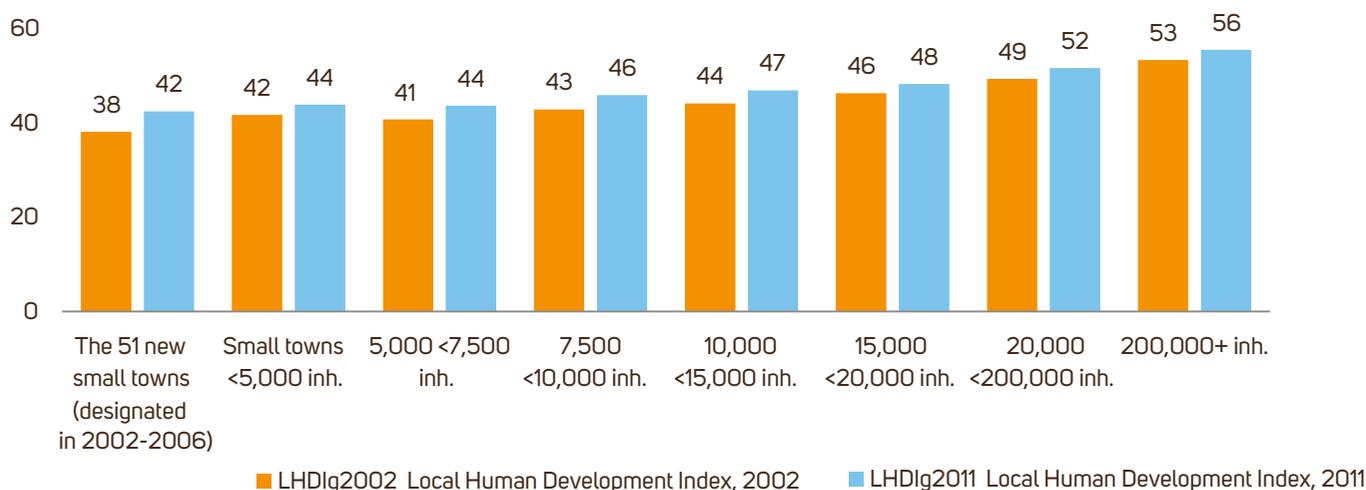
The Recent Small Towns

The category of small towns is highly heterogeneous, representing a mix of agricultural cities, former (mono) industrial cities, and tourism areas. Some small towns have a long history and tradition (especially in the Transylvania-Center region), while others were formed during the communist regime, as part of the industrialization process (particularly around a former large enterprise in heavy industry), and others were designated as cities in recent years (as a result of pressure to increase the proportion of urban population within the country). Out of the 225 small towns (with fewer than 20,000 inhabitants) in Romania, 79 came into being before 1950, 90 were developed during the communist era (1950-1989), 5 were officially included among urban settlements between 1990 and 2000, and 51 were designated as cities⁴⁹⁷ in recent years (2002-

2006). The total population of all of these recent small towns is about 385,000 people with an average population size of approximately 7,500 people (see Annex Table 10.15). The typical city in Romania is small, incorporates villages, has or used to have an industrial aspect,⁴⁹⁸ has no tourism or historical aspects,⁴⁹⁹ and is somewhat socially underdeveloped.

The most disadvantaged small towns are the 51 that were recently designated. These are in reality rural settlements with severely underdeveloped urban infrastructure, facilities, functionality, and appearance. The LHDl shows that they were and have remained considerably less developed than other urban areas (Figure 48). Furthermore, 57 percent of these recent small towns are among the least developed urban areas in Romania (the lowest quintile of LHDl2011). In addition, a large number (41 percent) of the

FIGURE 48: The Average Level of Local Human Development (LHDl) in Romanian Urban Areas by Type and Population Size, 2002 and 2011



Source: World Bank calculations using 2011 Population and Housing Census and World Bank (Ionescu-Heroiu et al, 2013a) for LHDl 2002 and 2011.

⁴⁹⁷ For example, Law no. 83/2004 through which 35 settlements were designated as urban - [http://www.lege-online.ro/tr-LEGE-83%20-2004-\(51035\).html](http://www.lege-online.ro/tr-LEGE-83%20-2004-(51035).html).

⁴⁹⁸ The dominant economic profile of small towns is post-industrial. A knowledge typology developed within a previous World Bank study (Stănculescu, 2005) showed that about 180 small towns (out of 225 in total) used to have an industrial element. The number, size, and economic sector of local enterprises varied, but in most small towns the former enterprises were closed down after 1990 and only small businesses were developed, mainly in the commerce and service sectors.

⁴⁹⁹ The historical dimension refers to the existence within the city of a historical center or area, which before the communist era was inhabited by Jews (in the Eastern regions) or by Germans (in the Central and Western regions of the country). Later, the houses in these areas were nationalized. After 1990, some were returned to their former owners, while others remained under the jurisdiction of the municipality that had used them as social housing. At present, in many cases, these areas accommodate poor, marginalized groups of population. However, as a rule, these areas are in prominent locations within cities and have a high value on the real estate market. Tourism is not necessarily associated with the historical dimension. Most often, tourism is associated with the existence of cultural, sports, or leisure facilities within the city. In small towns dominated by tourism, houses predominate, and because of their tourism-related uses, (for example, as hotels, restaurants, or tourist-oriented shops) they tend to be larger, more modernized, better maintained, and thus more expensive than in other small towns.

very small cities (those with fewer than 7,500 inhabitants) are among the least developed urban areas in the country.

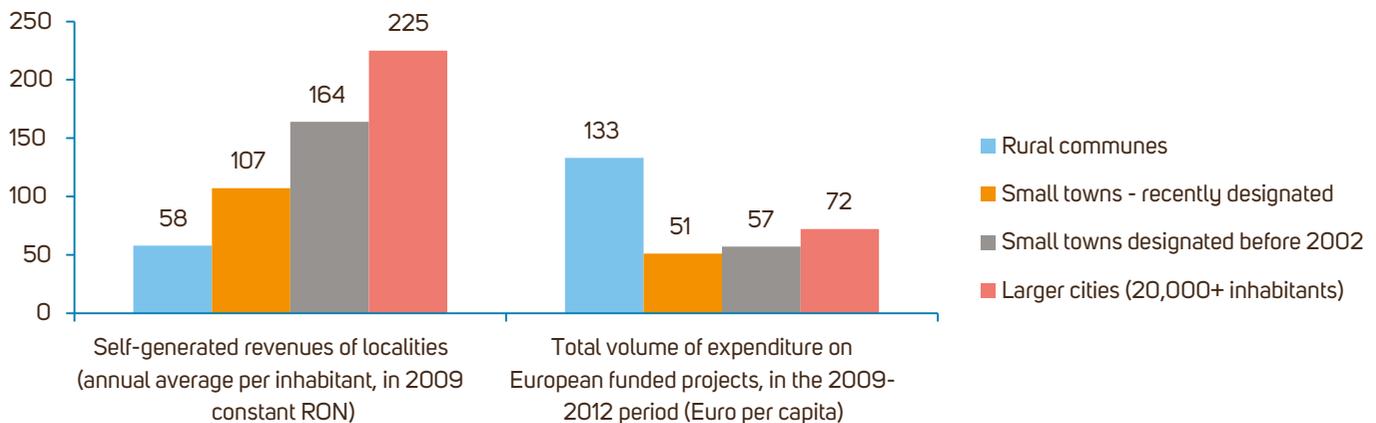
The recently designated small urban areas, although more developed than rural areas of comparable size, are the most disadvantaged urban settlements in many dimensions:

Local budget: Our analysis of local budget execution data⁵⁰⁰ indicates that (i) the per capita self-generated revenues⁵⁰¹ of small towns are two to three times higher than those of rural communities - even when population size and county are kept constant - but are much lower than those of larger cities; (ii) among urban settlements, the recently designated small towns have the lowest economic potential; and (iii) expenditures incurred in European-funded projects⁵⁰² are higher in rural communities than in small towns, especially for the very small localities with fewer than 5,000 inhabitants. These data are presented in Figure 49 and in Annex Table 10.18.

Basic utilities: There are far fewer basic services in small towns, particularly in the recently designated ones, than in larger cities, but considerably more than in rural localities. This is the case with respect to all of the following services: piped water from a public network; hot water from a public network; sewage disposal system connected to a public sewage disposal plant; electric lighting; and cooking gas from public network. For example, the percentage of dwellings connected to a public sewage system varies from 4 percent in rural communities to 22 percent in the recently designated small towns and up to 64 percent in small towns declared before 2002. These data are presented in Annex Table 10.18.

Education: The education level of the working age population is substantially lower in the recently designated small towns than in the other small towns (and especially with larger cities) but is higher than in rural areas (Annex Table 10.1).

FIGURE 49: A Comparison of Local Budget Indicators between Small Towns, Larger Cities, and Rural Communes



Source: World Bank calculations using local budget execution data from the Ministry of Administration and Interior.⁵⁰³

⁵⁰⁰ Data posted by the Ministry of Administration and Interior, available at: http://www.dpfbt.mai.gov.ro/sit_ven_si_chelt_uat.html (date of accession: January 10, 2014) as well as population data from 2011 Population and Housing Census (National Institute of Statistics). At present, the local budget execution data are reported by the Ministry of Finance. The Ministry of Administration and Interior is the Ministry of Internal Affairs.

⁵⁰¹ Self-generated revenues reflect the municipality's fiscal autonomy and local economic potential. In our analysis, they did not include the portions deducted from PIT (personal income tax) for equalization purposes, so that we could focus on those revenues over which the municipality holds a greater degree of control. The per capita formula makes it possible to make vertical comparisons (between localities of different sizes or between urban and rural areas) and horizontal comparisons (between localities of the same status but in different counties). They were computed as an annual average for the period 2009-2012 using local budget execution data. Revenues were computed in 2009 constant value using the index of inflation from the National Institute of Statistics.

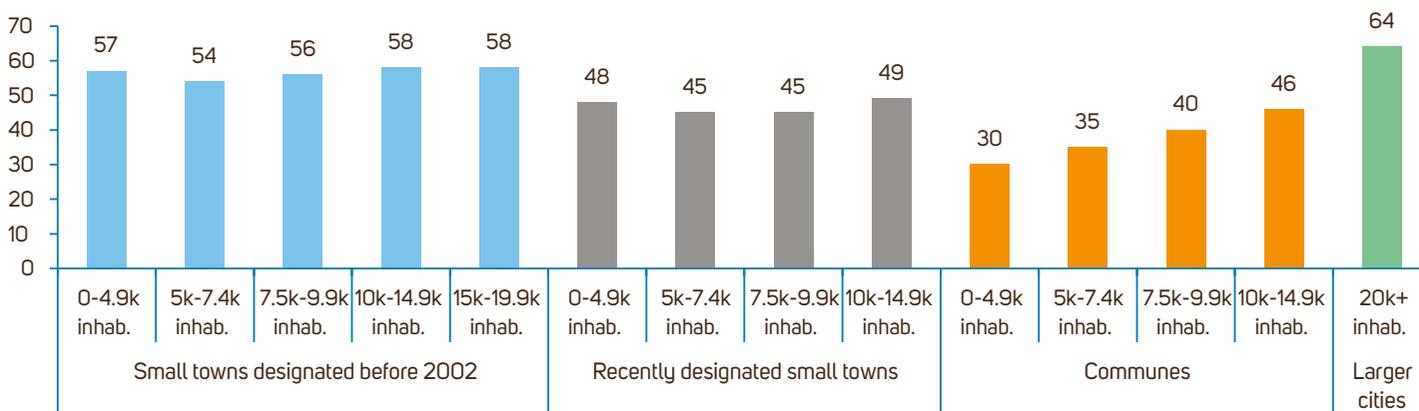
⁵⁰² Expenditures on projects financed from external sources include European-funded programs (structural funds, the National Rural Development Plan, and the Fisheries Operational Program) as well as other programs such as those financed by foreign embassies. However, it can be assumed that at a national level they mostly consist of the European-funded programs and, in the case of communes, expenditures financed by the National Rural Development Plan. We computed them as a proxy variable for the total volume of absorbed European funds in the period of 2009-2012, as the sum of all expenditures incurred in European-funded projects (in Euros per inhabitant), with the data transformed into Euro based on the annual exchange rate from the National Bank of Romania and using population data from the 2011 Population and Housing Census (National Institute of Statistics). Data on this type of expenditure was not available for the period of 2007-2008 in the administrative data from the Ministry of Administration and Interior.

⁵⁰³ At present, the local budget execution data are reported by the Ministry of Finance. The Ministry of Administration and Interior is the Ministry of Internal Affairs.

Employment: The employment rate in non-agricultural sectors is considerably higher in small urban areas than in rural areas but is lower than in larger cities, while in rural communities, employment in agriculture is substantial (see Annex Table 10.19). Correspondingly, Annex Table 10.19 and Annex Table

10.20 show that the share of employees in the working age population increases from 28 percent in small communes to 42 percent in the recently designated small towns and 51 percent in the other small towns, and reaches as high as 57 percent in larger cities with more than 20,000 inhabitants.

FIGURE 50: Share of Employees Among the Working Age Population (15–64 years) by Locality Size, 2011 (%)



Source: World Bank calculations using 2011 Population and Housing Census.

In conclusion, the 51 recently designated small towns (those with fewer than 20,000 inhabitants) and the 61 very small cities (those with fewer than 7,500 inhabitants) must receive more support and assistance to help them to catch up with other urban areas in every area of development.

The European Funds as an Instrument of Community Development

The local public authorities of Romanian small towns and communes have several different sources of revenue, the most significant of which are the state budget and the European Union. In this section, we focus on extra-budgetary investment expenditures financed from various European funds and compare them with programs financed by the state budget. Local public authorities can also be funded by their own revenues, equalization funds, transfers from the government's Reserve Fund, and bank loans, but

we do not consider these sources in this section. Three key questions are addressed:

- For which European funded programs are local public authorities eligible?
- Are there any eligibility criteria that vary between local public authorities?
- What are the main investment objectives financed by European Union and by the state budget?

Local public authorities (LPA) are eligible to receive financing from almost all European funds. Except for two operational programs (Transport and Technical Assistance), all other European programs (including the National Rural Development Plan and the Operational Program for Fisheries) include local public authorities as eligible beneficiaries. Annex 5 presents in detail each key intervention area (or measure) within which LPAs can apply for funding. However, the eligibility criteria differ between programs in terms of: (i)

urban versus rural areas (ii) the size of the local population; and (iii) the form of partnership involved.

The European funds have different eligibility criteria for urban and rural areas. The definition of urban and rural areas is based on Romanian legislation (which is different from OECD standards), which puts communes and villages in the rural category and towns/cities and administered villages in the urban category. A clear demarcation between urban and rural areas is included in the Regional Operational Program (ROP), the Sectoral Operational Program Environment for the Environment, and the National Rural Development Program (NRDP). The ROP is directed mainly to local public authorities in urban areas (county councils and urban municipalities), while the NRDP is targeted to rural areas. Nevertheless, both include indirect beneficiaries in the opposite areas (county roads in the case of the ROP and urban municipalities as part of the local action groups in the case of the NRDP). This creates further inequalities in terms of access to funding. In contrast with all other operational programs, the beneficiaries of the NRDP (mostly in rural areas) can also benefit from the Romanian Rural Credit Guarantee Fund, which provides credit for much more favorable conditions than those offered by financial institutions (such as banks). This fund provides funding opportunities for even the poorest communes in Romania,⁵⁰⁴ but it is not available to local authorities in urban areas. One solution to this problem is to develop different forms of urban-rural partnerships, as described below.

The eligibility criteria of the European funds vary also by the size of the population within the jurisdiction of the local authority. The Regional Operational Program (Priority Axis 1, Key Area of Intervention 1.1)⁵⁰⁵ the LEADER Axis under the National Rural Development Programme 506 and the Operational Program for Fisheries (Priority Axis 4)⁵⁰⁷ all have three population thresholds as eligibility criteria for urban localities - 10,000, 20,000, and 100,000 inhabitants. Even in those programs that do not specifically mention population size as an eligibility requirement, it plays a crucial role in funding investment projects. For example, in the case of water and wastewater systems, the Sectoral Operational Program for the Environment specifies that it is "for cost-efficiency reasons (output per

capita) strongly oriented towards medium or large-scale agglomerations."⁵⁰⁸ Furthermore, the number of inhabitants is also a strong predictor of an administrative unit's fiscal capacity, which is in turn important for ensuring co-financing from European funds or bank loans and, thus, the flow of funds to the project.

The development of partnerships by local authorities is key to attracting investment from European funds. These funds are open to applications from two main types of partnerships - intercommunity development associations and local action groups (LAGs or FLAGS) - as well as partnerships between local authorities and other eligible partners. Both IDAs and LAGs/ FLAGS were devised as ways to enhance the administrative capacity of local authorities. Partnerships increase a rural municipality's chances of being able to use EU funds effectively.⁵⁰⁹ A partner with either well-developed administrative capacity (including specialized human resources) or considerable fiscal capacity (to cover the costs of consultancy firms or feasibility studies) can help all members of the partnership to attract extra-budgetary revenues from European funds. Moreover, increasing the size of the population covered by the partnership can satisfy the fund's cost-efficiency conditions for large-scale investments. At the same time, these intercommunity development associations and LAG/ FLAGS partnerships have the potential to further the integrated development of both urban and rural areas in partnership with other private stakeholders. Even those local public authorities that are not explicitly eligible for particular European funds can build partnerships with other (eligible) beneficiaries to apply to those funds. For example, the Sectoral Operational Program for Human Capital includes the member institutions and organizations of the Regional and Local Partnerships for Employment and Social Inclusion as eligible beneficiaries. Another type of partnership with potential benefits for a large number of communes and small towns consists of associations of local authorities such as the Romanian Association of Communes and the Romanian Association of Cities. Both of these have carried out large-scale European-funded projects⁵¹⁰ that have had an impact in numerous localities.

⁵⁰⁴ Marin (2015). Poverty defined in terms of fiscal capacity (own revenues as a proportion of total revenues in the local budget).

⁵⁰⁵ Only towns with populations of over 10,000 inhabitants are eligible.

⁵⁰⁶ Both rural and small urban (under 20,000 inhabitants) areas are eligible but only as members of a local partnership (LAG) that might include one or more towns (only in exceptional cases). However, these small towns cannot have in total more than 20,000 inhabitants or over 25 percent of the total number of inhabitants living in the LAG (MARD, 2013: 396).

⁵⁰⁷ Both rural and urban (under 100,000 inhabitants) areas are eligible as members of a local partnership (the Fisheries Local Action Group or FLAG), but the overall population covered by FLAG has to be between 10,000 and 150,000 inhabitants (MARD, 2014: 86).

⁵⁰⁸ Sectoral Operational Program for the Environment February 2012: 68.

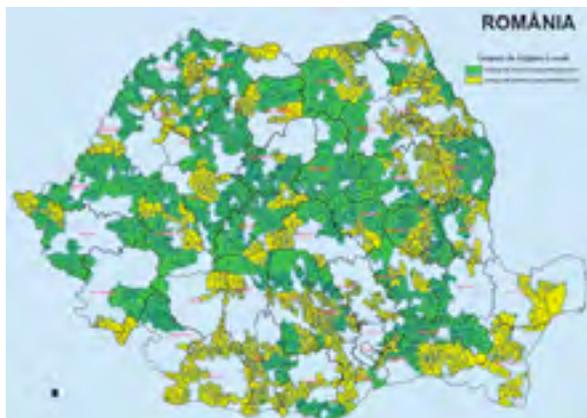
⁵⁰⁹ Marin (2015).

⁵¹⁰ Details of the implemented projects can be found on www.acor.ro or www.aor.ro.

BOX 47**Local Action Groups in Romania**

The Progress Report on the National Rural Development Program for 2013 (MARD, 2014: 105-109) presents the most recent data on the authorized local action groups (LAGs) approved for financing under the LEADER component.

At the end of 2013, 163 LAGs with local development plans were selected for financing, over twice as many as in 2011 (81 LAGs). These 163 LAGS covered a total surface of 142,267 square kilometers, or 78.3 percent of the provisioned target area and a total population of over 6.77 million inhabitants compared with the target of 9.36 million. A total of 1,781 communes and 77 small towns were involved in these partnerships, as well as 5,103 private partners and NGOs. The LAGs had received financial assistance to implement a total of 2,040 local projects compared with the target of 9,502. Most projects, and the largest grants, went to LAGs from three regions: North-East (nearly €16 million for 518 projects), South (over €15.1 million for 354 projects), and Center (more than €12.1 million for 301 projects).

Romanian LAGs Selected for Funding, end of 2013

Source: Ministry of Agricultural and Rural Development, <http://www.pndr.ro/content.aspx?item=2243&lang=RO>.

The map shows that the municipalities that are members in LAGs are spread all over the country but are much more common in the North-East and Center regions. The proportion of localities participating in LAGs declines among small towns from 35 percent in the North-East region and 32 percent in the Center region

to 18 to 26 percent in the other regions. The participation in LAGs by rural communes declines from nearly 80 percent in the Center region to 69 percent in the North-East, 62 to 65 percent in the West and North-West, 57 to 60 percent in the South-East and South, and less than 48 percent in the South-West, respectively 13% in Bucharest-Ilfov.

The larger the city and the higher its capacity, the more likely it will be able to access European funds on its own, instead of in partnership with the neighboring rural communities. The small towns most likely to participate in LAGs in order to access European funds are the recently designated ones, those with 5,000 to 7,500 inhabitants, those with a relatively low level of community development, and those with a low level of economic potential (small self-generated revenues at local budget). Because population size is one criterion, the rate of participation in LAGs is 52 percent for towns with 5,000 to 7,500 inhabitants, 37 to 39 percent for very small towns with fewer than 5,000 inhabitants and those with 7,500 to 10,000 inhabitants, and 22 percent of towns with 10,000 to 15,000 inhabitants, while only one town with more than 15,000 inhabitants participates in a LAG. Among the recently designated small towns the rate of participation in LAGs is 43 percent compared with 32 percent of cities officially designated before 2002. These towns access European funds as partners in LAGs not only due to the eligibility criterion related to population size but also due to their limited capacity to co-finance and manage large projects. In fact, among small towns with fewer than 20,000 inhabitants, the rate of participation in LAGs declines from 46 percent of the least developed towns (those in the lowest quintile of LHD12011) to 25 percent of the most developed ones.

Communes of all types participate in LAGs. However, it appears that communes with the lowest self-generated revenues in their local budgets and most extensive poverty are more likely to be partners in LAGs. At the same time, small remote communes (with fewer than 2,000 inhabitants) find it difficult to take part in local partnerships. Thus, the rate of participation is 54 percent among the small and remote communes compared with 63 percent of small non-remote communes, 69 percent of remote communes with more than 2,000 inhabitants, and 62 percent of the other communes.



Small towns appear to have fewer sources of extra-budgetary funds than communes, so their access to European funding strongly depends on their capacity to build and participate in partnerships, particularly IDAs or LAGs (Box 47). A partnership enlarges the number of potential beneficiaries and thus makes small towns eligible for funding from these extra-budgetary sources. An analysis is needed at both the municipality and program levels of the volume of funds available to small towns as well as of their capacity to absorb these funds. The investment projects covered by European funds largely correspond with the development needs of communes and small towns. A good example is the NRDP's Measure 322, which is by far the most popular program (in terms of volume of funds requested in applications). Measure 322 supports investments in road, water, and social and cultural infrastructure, but most of the funds are spent on improving road and water infrastructure in rural areas. In urban areas, more or less the same types of investment are financed by the Regional Operational Program and the Sectoral Operational Program for the Environment. The state budget also finances capital expenditures in these areas. In 2013, the various water and wastewater system programs funded by the government budget⁵¹¹ were brought under one umbrella - the National Local Development Program (PNDL). The PNDL has a large portfolio of infrastructure

investments in rural areas, the total value of which was around 14 billion RON, with around 50 percent of this funding going to communal and county roads and around 50 percent to water and wastewater projects.

In recent years, the significance of European funds in funding local authorities has increased because the volume of investment resources available from the government budget has diminished with the exception of the PNDL.⁵¹² The Romanian Association of Communes has concluded that: "most arrears at the level of communes are caused by the lack of predictability by the government and ministries in funding development projects through national investment programs. The dominant practice of these national programs is to approve thousands of investments projects but to transfer only small amounts for their implementation, without a clear timeframe for allocation of funds until the completion of the project."⁵¹³ In this context, the large amount of financing available through European funds can be a better financing solution for local authorities, especially given the low level of self-generated revenues that poor communes and small towns can access. However, as a general rule, local authorities are concerned about the lack of predictability of European funds and the growing complexity involved in dealing with them in terms of required documentation, related legislation, and number of control institutions.⁵¹⁴

⁵¹¹ Mainly managed by the Ministry of Regional Development and Tourism, which is currently known as the Ministry of Regional Development and Public Administration.

⁵¹² ExpertForum (2014).

⁵¹³ Romanian Association of Communes (2012: 5).

⁵¹⁴ Marin (2015).

3

AREA-BASED POLICIES



3.2. Integrating Marginalized Communities

The government should address economic and financial inequalities among different geographic areas by implementing integrated community-based social, health, and educational services and promoting partnerships with specialist or grassroots NGOs.





Main Objectives

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3.2. Integrating Marginalized Communities

Segregation is again at the top of the European agenda as it affects almost all European cities, prosperous, growing, and shrinking cities alike. Residential segregation refers to how people are separated in terms of where they live, but segregation can also occur in terms of schools, jobs, or public services and can affect people in all social and demographic dimensions, including age, ethnicity, religion, income, or social class (the rich in one place, the poor in another) or in combination. In the context of urban development, residential segregation is the main frame of reference. Segregation is closely related to concentration, which implies that there is a statistical over-representation of one group and an under-representation of one or more other groups in a certain space. It is also related to the fragmentation of urban spaces into areas with visible differences. “If these fragments become inaccessible, then we encounter segregation into ghettos, gated communities, and other manifestations of hyper-segregation. The most extreme examples of segregation might take the form of polarization, in which different parts of the city fight against each other.”⁵¹⁵

Segregation can be a deliberate choice, such as when better-off groups choose to self-segregate into gentrified areas or gated communities, or can be a separation forced on people by outside factors, such as when marginalized populations are concentrated in poor areas. A ghetto is the most extreme form of forced segregation. “There are no universal rules to determine what is ‘still acceptable’ and what is ‘an extreme’ level of segregation, but it is clear that both extreme forms of self-segregation by the rich and coerced forms of segregation of the poor are part of the problem of an unequal society and ‘unjust’ urban development.”⁵¹⁶

The most common type of segregation in Romania is related to economic and financial inequalities. This aspect has received little attention in the segregation literature compared with the racial-ethnic dimension. The factors that have led to Romania’s segregation issues include the structural changes involved in the country’s transition to a market economy, unemployment, growing economic precariousness, and weaker welfare systems as well as the

housing and urban planning policies promoted during the communist period and the first post-communist decade.

There is currently little measuring and monitoring of segregation in European cities. However, some local authorities in Germany and the Netherlands have developed sophisticated early warning systems to monitor segregation (for example, in Berlin in 1998), and a multitude of studies has examined these efforts.⁵¹⁷ A useful guide to monitoring urban development was produced by the German Federal Ministry of Transport, Construction, and Urban Development in 2009 as an input into integrated local development plans. The guide includes a variety of indicators related to the physical environment (for example, the age, tenure, and quality of the housing stock), social context and demographic data (such as population age groups, ethnicity, and dependents), and quality of life and existence of social opportunities (for example, income, employment, educational attainment levels, and health status). However, the interpretation of such data is critical and sensitive since such analysis often designates some areas as “problematic,” and this interpretation is then used to inform policy. Given the importance of local context, qualitative research is an important complement to statistical analysis for developing a well-rounded understanding of any area. However, while a solid knowledge base is key for informing policymakers, it cannot replace political will to implement change.

Typically, the policies that are in place at the EU level and at the national and local levels in Romania encourage area-based interventions in areas that policymakers consider to be “problematic.” Area-based interventions are usually divided into “hard” and “soft” measures⁵¹⁸ as follows:

- Hard interventions often consist of physical restructuring programs in which buildings are demolished and new infrastructure and housing developments are built or the housing stock is refurbished, new public facilities are created (such as social or cultural facilities and parks), and public transport is improved.

⁵¹⁵ Cotini et al (2013: 10).

⁵¹⁶ Cotini et al (2013: 11).

⁵¹⁷ RegGov (2011).

⁵¹⁸ Cotini et al (2013: 29).

- Soft interventions strengthen networks and interactions between people in the area (for example, through work integration and training programs in specific areas, field work to find solutions for the immediate problems of the homeless or other types of people in extreme situations, and local festivals where the community can gather) and help individuals to access the labor market through training, work experience, and job placement.

However, these initiatives often do not address the driving forces behind segregation such as the deregulation of housing markets or the shrinking welfare state. Instead, neighborhood regeneration projects tend to focus on buildings and infrastructure rather than people and do not challenge the rising land values and house prices that force the relocation of less affluent inhabitants. Regeneration projects, at least in theory, have yet to find a balance between social inclusion and economic competitiveness and need to be supported by a broad range of public and private actors (public agencies, landlords, residents, and businesses) to be effective. While politicians often favor quick and visible interventions that have immediate visible results, neighborhood change takes time and often softer, incremental measures would be more effective in the long term. Also, at least in Romania, many marginalized communities and deprived neighborhoods have a bad reputation with the general population, so local administrators and politicians who attempt to regenerate them can often lose political support.

Both area-based and people-based interventions are crucial for fighting segregation in marginalized areas. Both sectoral (people-based) and spatial (area-based) interventions must be integrated within the strategy. The relevant policies and programs should be coordinated among all levels of governance (vertical policy integration) and across sectors (horizontal policy integration):

- Vertical policy integration can be initiated in many ways. One way is for national policymakers to make strong national policies, selecting the areas of intervention and requiring the cooperation of the regional and local authorities. This model prevails in England, France, the Netherlands, and Sweden. In other countries such as Hungary or Spain, the rules and conditions for deprived areas are selected at the national or regional level, but local authorities decide

which areas are in need of these interventions.

- Horizontal policy integration means coordinating all policies that are relevant for the development of an area. Other than physical interventions, key sectoral policy areas are housing, public transport, education, employment, culture, and the provision of social services. Horizontal policy integration requires adapting existing services and organizations to the specific needs of the area and increasing coordination between the different service providers. To strengthen horizontal integration, URBACT, an EU program promoting sustainable urban development, has suggested, "...the creation of multi-purpose amenities and collaborative projects with different partners as a way of creating a concrete action around which partners at the horizontal level could collaborate."⁵¹⁹

At the European level, the segregation and integration of marginalized or deprived neighborhoods has so far mainly been discussed, analyzed, and acted on in relation to urban areas in the context of urban regeneration and development policies. However, in Romania a large share of the population lives in rural areas. Out of the 3,181 administrative units within the country, only 320 are urban settlements, while 2,861 are rural communes. Segregated and marginalized communities are emerging, especially in urban areas, consisting of concentrations of people who have fallen into extreme poverty as a result of the structural changes associated with Romania's transition to a market economy that resulted in unemployment, growing precariousness, and weaker welfare systems. Nevertheless, marginalized communities can also be found in rural areas, although to a lesser extent than in cities.

In the Romanian context, the "problematic" marginalized communities can be defined as areas characterized by low human capital, limited formal employment, and inadequate housing. This definition applies to both for rural and urban areas, but we devised two identification methodologies based on different indicators in order to reflect the specific circumstances of each type of area (see Annex Table 10.21). We used the Atlas of Urban Marginalized Areas⁵²⁰ to identify urban marginalized areas, and we identified rural marginalized areas by means of a methodology developed as part of this background study that will be further developed as an Atlas of Rural Marginalized Areas under the Flagship Initiative #6.

⁵¹⁹ URBACT (2011: 54) in Colini et al (2013: 33).

⁵²⁰ World Bank (Swinkels et al, 2014a).

BOX 48**Examples of Good Practice in Interventions to Tackle Segregation in Europe**

There are several good practice examples in from different European countries of both area-based and people-based interventions.

AREA-BASED INTERVENTIONS

England: New Deal for Communities

The New Deal for Communities Programme was initiated by the Blair government to help some of England's most deprived neighborhoods. It ran from 1999 to 2008. The goal was to "close the gap" between 39 deprived urban areas and the rest of the country through investments of an average of €50 million in each area over 10 years. The method was to achieve holistic change in relation to three area-based outcomes – crime, community, and housing and the physical environment – and three people-based outcomes – education, health, and joblessness. Local partnerships were established in each regeneration area to ensure that the change was community-led.

SECTORAL (PEOPLE-BASED) INTERVENTIONS

France: Social mix and urban regeneration

In 2000 a law called Solidarité et Renouvellement Urbains (urban solidarity and renewal) came into force in France. The main goal of the program, which is still in operation, is to tackle urban segregation and to strengthen solidarity among citizens in urban areas. It promotes a housing tenure mix through the use of

legal requirements. In urban areas, every municipality is required to achieve a minimum of 20 percent of social housing in its housing stock by 2020. (For more information, see www.aurg.org/sru/sru.htm.)

Germany: Soziale Stadt (Socially Integrative City)

This program is targeted to "neighborhoods with special development needs." It was launched by the federal government in 1999 as a legacy of the first URBAN Community Initiative. It is part of a scheme jointly financed by the federal government and the states (Länder), which covers cities all over Germany. By 2012 more than 500 neighborhoods had participated in the scheme.

The Soziale Stadt program focuses on upgrading and stabilizing critical urban areas and preventing the downward spiral of social exclusion and segregation by inviting the neighborhood's inhabitants to participate in the development, prioritization, and implementation of locally based bottom-up actions.

Soziale Stadt in North Rhein-Westphalia was one of the first area-based initiatives and was part of the urban development funding started in that Land in 1993. Its approach is one of the most comprehensive examples of integrated urban regeneration at the neighborhood level in Europe. Eighty city neighborhoods in North Rhein-Westphalia have created and implemented local action plans under this program.

Source: Colini et al (2013: 28-30).



In the case of both methodologies, we used 2011 Census data, and our analyses were done at the census sector level (see Annex Table 10.22) using three broad sets of indicators: (i) human capital; (ii) formal employment; and (iii) housing conditions. By definition, marginalized areas (census sectors) were those that had disadvantages in all three respects.

In the next three sections we discuss the marginalized communities in rural and urban areas including both Roma and non-Roma communities. The final section presents the multi-sectoral integrated area-based approach that is the most appropriate for ensuring the reintegration of these marginalized communities and discusses lessons learned from previous interventions that have been piloted by various local authorities or NGOs.

3.2.1. Integrating Rural Marginalized Communities

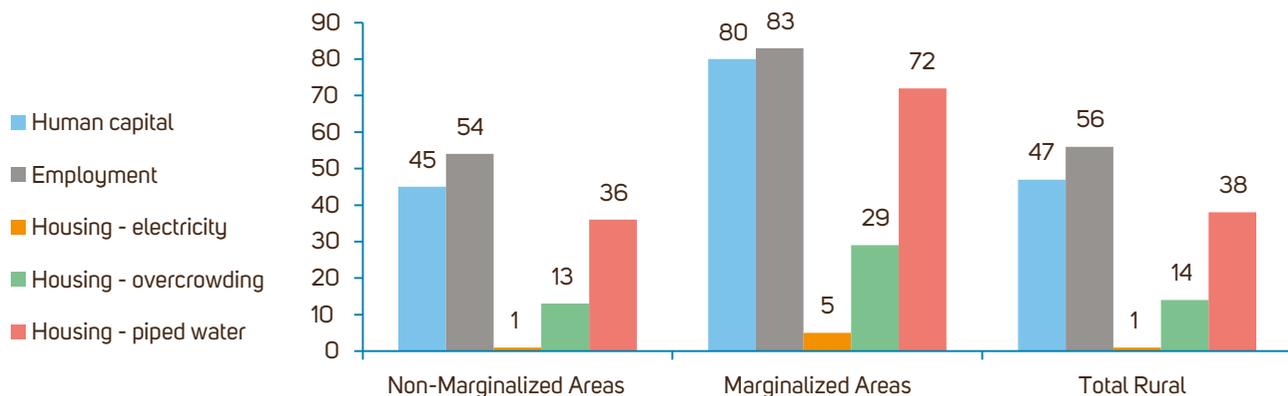
In Romania, the majority of people at risk of poverty or social exclusion live in rural areas (see Chapter 2). However, rural poverty is diverse, from the poverty of small villages and those with aging populations to marginalized communities characterized by low human capital, low formal employment, and inadequate housing.

At the national level, 6.2 percent of the rural population, 5.3 percent of all households, and 5.2 percent of all dwellings are located in rural marginalized areas.

These rural areas are severely deprived census sectors in which most of the population have completed only lower secondary education at most, make a living in the informal sector (especially agriculture), and live in housing conditions that are precarious even by the usual low standard for rural areas that generally have little basic infrastructure or utilities (in other words, they live in overcrowded houses and/or have no access to running water or electricity). These marginalized areas are considered to be “problematic” specifically because they are characterized by low-income households, populations with low levels of education and skills relevant to the labor market, a preponderance of single mothers, large numbers of children, and a high rate of petty crime. Even more than the other rural communities, the marginalized areas have dirt streets and bad housing, are exposed to environmental hazard (such as floods and landslides), and have poor quality or no public services. Table 43 and Figure 51 compare the profile of rural marginalized areas with that of non-marginalized areas.

In 42 percent of the rural marginalized sectors, high proportions of residents belong to the Roma ethnic minority. Self-identified Roma people represent, on average, 27 percent of all residents, which appears to indicate an estimated⁵²¹ proportion of Roma identified by the authorities (or hetero-identified) of about 42 percent. Qualitative research⁵²² has shown that rural marginalized communities include two broad types of communities, namely Roma hamlets and communities of *venetici* (in-migrants). Roma hamlets are popularly called *tiganie* and are usually located at the periphery of villages. The *venetici* communities were formed by in-migrants who came before 1989 and settled in a village because cities were near. The state provided them with an apartment in the block areas built in the 1980s or in former state-owned farms or workers’ colonies, and they worked either in the village agricultural enterprise or in a state-owned industrial enterprise in a nearby town. After 1990, many of them were made redundant. Being in-migrants, they were not granted any reinstated land although they remained in the village. Accordingly, large numbers of these households fell into poverty.

FIGURE 51: Rural Marginalized Areas by Key Indicators, 2011



⁵²¹ According to the National Survey on Roma conducted by the Research Institute for Quality of Life in 1998 in the rural areas of Romania (Zamfir and Preda, coord., 2002), out of every 100 individuals identified by the authorities as being Roma, 64 people self-identify as Roma.

⁵²² See, for example, Stănculescu and Berevoescu, (coord., 2004); Sandu (2005); Berescu et al (2007); and Stănculescu et al (2010). More recent research on the topic is not available. As part of the planned Atlas of Rural Marginalized Areas, a qualitative study was developed in May–June 2015 to identify the main subtypes and characteristics of rural marginalized communities.

TABLE 43: Rural Marginalized Areas by Key Indicators, 2011

Criteria/ Dimension	Key indicators	Rural Non-marginalized Areas	Rural Marginalized Areas	Total Rural
Human capital	Proportion of people aged 15-64 years old who completed 8 grades or less	45	80	47
Employment	Proportion of people aged 15-64 years old who are neither in education nor have ever been in formal employment (employees, employers, or pensioners)	54	83	56
Housing	Proportion of dwellings not connected to electricity	1	5	1
	Proportion of overcrowded dwellings	13	29	14
	Proportion of dwellings not connected to piped water	36	72	38

Source: World Bank calculations using the 2011 Population and Housing Census.

Overall, in Romanian communes, 2,244 census sectors⁵²³ meet the criteria for being rural marginalized areas, and over 564,000 people live in those sectors. Children (between 0 and 17 years old) represent more than one-third (34 percent) of the total population in rural marginalized areas, while the elderly account for only 13 percent (for comparison, the average shares for rural non-marginalized areas are 22 percent for children and 19 percent for people aged 65 or older). One in every four households in rural marginalized areas has five members or more compared with only 15 percent in non-marginalized areas, while 16 percent of households have three children or more compared with only 5 in non-marginalized areas. The proportion of teenage mothers is more than three times higher in rural marginalized communities than in non-marginalized ones (4.6 percent of girls aged between 13 and 17 years old compared with 1.3 percent). Rates of marginalization for the key groups in rural areas are shown in Annex Table 10.23:

While as much as 80 percent of the adult residents of the rural marginalized communities have completed less than eight years of school, of whom 35 percent have only a primary education, in the non-marginalized communities the proportions drop to 45 percent and 8 percent respectively (Annex Table 10.24). The percentage of people neither working as employees nor in education or training is twice as high among youths aged between

15 and 19 years old living in rural marginalized areas compared to those in non-marginalized ones (51 percent as opposed to a 23 percent in non-marginalized areas). The proportion of people neither working as employees nor in education among people aged between 20 and 64 years old is almost 64 percent in rural non-marginalized areas, but this increases to 88 percent in rural marginalized areas; the indicator is highest for Roma women living in rural marginalized areas (95 percent).

Rural marginalized communities are spread across 992 communes (or 35 percent of all communes in the country), with significant regional differences (see Annex Table 10.26). The marginalized census sectors are located in 1,605 villages (14 percent of all villages) in all counties and regions of the country. The proportion of the population living in rural marginalized areas (census sectors) is over twice as high as the national rural average in the North East region (6.2%). While most villages have no marginalized areas, in 663 villages more than half of their populations live in such areas.⁵²⁴ As regards the communes, in 157 communes (representing 5.5 percent of the total number of communes),⁵²⁵ more than one-third of the populations live in marginalized communities.⁵²⁶

⁵²³ Out of all 46,547 census sectors in rural areas at the time of the 2011 census. A number of 2,523 census sectors were not included in the analysis either because they have fewer than 50 inhabitants (2,473) or because they were not sectors of households.

⁵²⁴ In 197 villages 40 to 49 percent of the population live in marginalized areas, and in 209 villages 30 to 39 percent live in such areas.

⁵²⁵ The five communes with the highest shares of marginalized populations are: Bărbulești (Ialomița county), Lipovu (Dolj county), Ibănești (Vaslui county), Voinești (Vaslui county), and Jorăști (Galați county).

⁵²⁶ In 298 communes (10.4 percent) 10 to 19 percent of the population lives in marginalized areas, and in 155 communes (5.4 percent) 20 to 29 percent live in such areas.

3.2.2. Integrating Urban Marginalized Communities

In recent decades, geographically concentrations of extreme poverty have emerged in Romania's urban areas.⁵²⁷ Pockets of poverty have developed within cities where residents fail to benefit from all types of basic services. In comparative terms, poverty is distributed more evenly in rural areas. Where there are small and remote rural localities and those with aging populations that are equally in need of social inclusion policies. Nevertheless, in rural areas, the proportion of children and vulnerable groups affected rarely reaches the same level as in these urban pockets of extreme poverty.

At the national level, 3.2 percent of the population, 2.6 percent of households, and 2.5 percent of dwellings are located in urban marginalized areas. These are severely deprived areas that combine low human capital (little education, poor health, and/or a high number of children) with low formal employment and inadequate housing conditions.⁵²⁸ On the one hand, urban marginalized areas often consist of socially isolated poor areas within cities and towns in Romania and, as such, are not always well reflected in aggregated poverty statistics at the local or county level. On the other hand, they represent "problematic" areas as described in various studies and thus are targeted by urban regeneration programs and policies against segregation. These marginalized areas are deemed to be "problematic" as a result of a combination of bad housing, dirty and decrepit streets, a concentration of low-income households, low levels of education and skills relevant to the labor market, overall poor health, a preponderance of single mothers, large numbers of children, poor quality and/or segregated schools, and a high rate of petty crime. In addition, such areas are physically inaccessible and are exposed to environmental degradation, with only low-quality or no public services. Thus, the market value of the land and dwellings in these areas is much lower than in other areas of the same city. Living

in "problematic" areas can become an additional burden for already marginalized groups because of geographical stigma, leaving them with few opportunities to acquire a proper education, find a good job, or move upward in socioeconomically. As a rule, these areas tend to be underrepresented on local political decision-making bodies.

Urban marginalized areas are often seen as discriminated against from a human rights perspective, particularly as Roma constitute significant percentages of the population in about 46 percent of these marginalized areas. However, according to the National Survey on Roma conducted in 1998, self-identified Roma people represented, on average, 20.7 percent of total residents of the marginalized urban areas of Romania, which indicates that the actual proportion of Roma may be twice as high at about 40 percent.⁵²⁹ Thus, 60 to 80 percent of the residents of marginalized urban areas belong to other ethnic groups than Roma (most being ethnic Romanians).

Overall, 1,139 of the 50,299 urban census sectors in the 2011 Census met the criteria for being marginalized areas, and nearly 342,000 people live in those areas. These were located in 264 cities in all counties and in the capital city, Bucharest (see Map 11). The census data show that 342,933 people lived in marginalized urban areas as of 2011. Children (aged between 0 and 17 years old) represent almost one-third (31.3 percent) of the total population in marginalized urban areas, while the elderly account for only 4.1 percent. One in every five households in marginalized urban areas has five members or more, and 11.9 percent of households have three children or more. Almost half (48.9 percent) of all adult residents of urban marginalized areas have completed fewer than eight years of school. The percentage of people who are neither in employment nor in education or training (NEET) is almost three times higher among youths aged between 15 and 19 years living in marginalized areas than the urban average (28 percent versus 10 percent). The proportion of people aged between 20 and 64 years old who are employed is almost 63 percent at the national urban level, but this decreases to about 48 percent in marginalized areas and drops further to 35 percent among women. For Roma, less than 31 percent who live in such areas are employed, and this

⁵²⁷ Stănculescu and Berevoescu (coord., 2004); Sandu (2005); Berescu et al (2006); Berescu et al (2007); Preda (coord., 2009); Stănculescu et al (2010); Botonogu (2011); and World Bank (Swinkels et al, 2014a).

⁵²⁸ The methodology for identifying urban marginalized areas was developed in a World Bank study (Swinkels et al, 2014a) using 2011 Population and Housing Census data. It identifies three broad criteria: (i) human capital; (ii) formal employment; and (iii) housing conditions. The analysis was done at the level of the census sectors. Marginalized areas (or census sectors) were defined as those that were disadvantaged in all three respects. In addition, the study identified three other types of urban areas that were disadvantaged on terms of one or two of the three criteria. The majority of the total urban population (67.8 percent) lives in non-disadvantaged areas, while 11.7 percent live in areas disadvantaged in terms of human capital, 9.9 percent live in areas affected by unemployment, 5.2 percent live in areas disadvantaged in terms of housing, and 2.3 percent live in other urban areas.

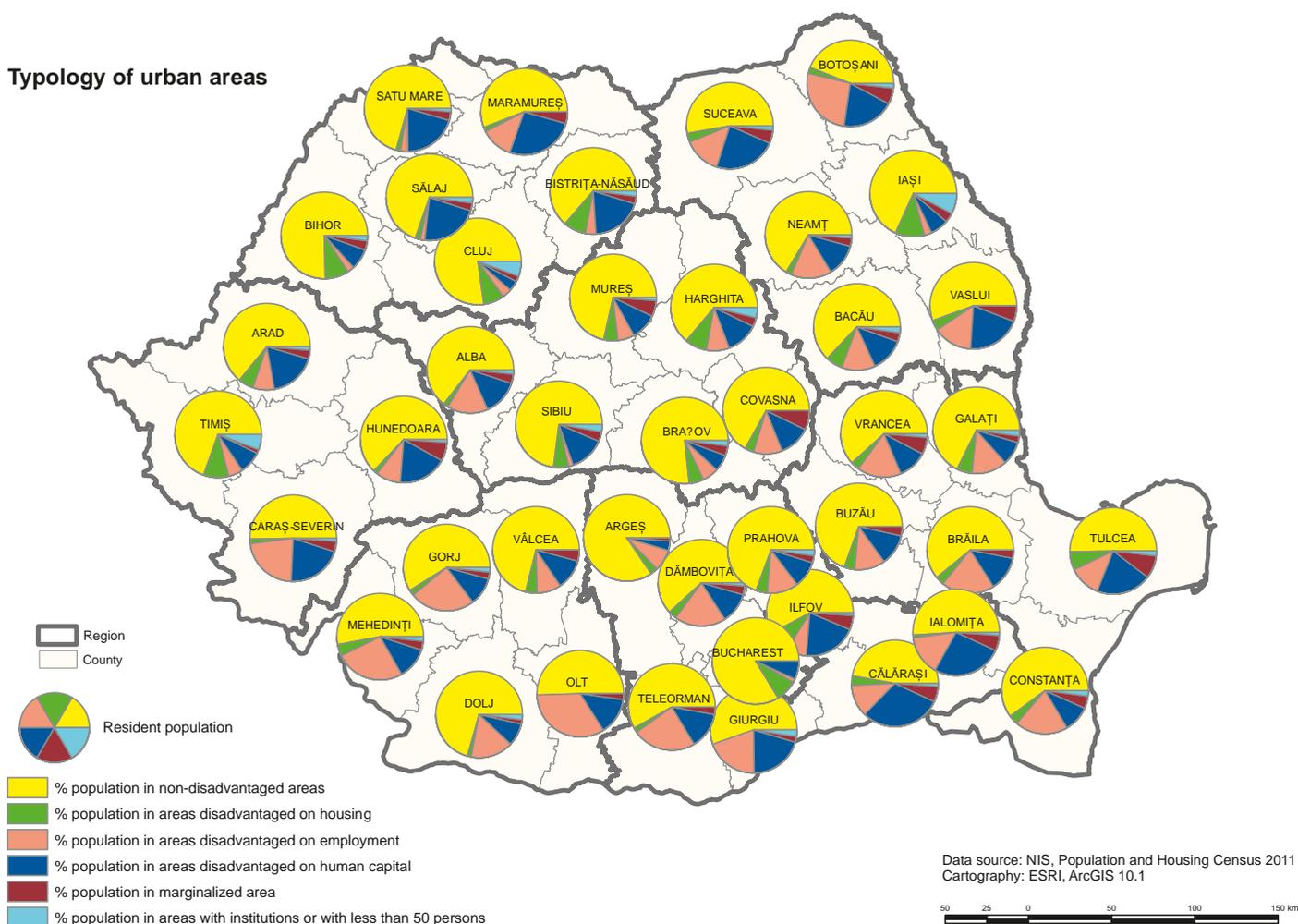
⁵²⁹ According to the National Survey on Roma conducted by the Research Institute for Quality of Life in 1998 (Zamfir and Preda, coord., 2002), the hetero-identification/self-identification ratio, in the case of the Roma, is as follows: for every 100 individuals hetero-identified by the authorities as Roma, 56 people in urban areas and 64 people in rural areas self-identify as Roma.

drops down to only 14 percent among Roma women. Rates of marginalization for these key groups in urban areas are shown in Annex Table 10.23.

Urban marginalized communities are found in most cities of the country but with significant regional differences (see Annex Table 10.26). The marginalized urban census sectors are located in 264 cities in all counties and in the capital city, Bucharest (see Map 11). The proportion of the population living in marginalized urban census sectors is over ten times higher in very small cities (with fewer than 10,000 inhabitants) than in Bucharest. Furthermore, small

towns (those with less than 20,000 inhabitants) contain the largest number of residents of urban marginalized areas, with almost 153,000 people living in these cities. While 56 cities have no marginalized areas, in five cities⁵³⁰ more than one-third of the population (up to 47 percent) live in such areas. There are also regional discrepancies. The percentages of the population living in marginalized areas are 4.3 percent in the North-East and Central regions, 4.2 percent in the South-East, and 3.7 percent in the West, while the other regions have rates equal to or smaller than the national average of 3.2 percent.

MAP 11: Proportion of the Urban Population Living in Each Type of Disadvantaged Area or in Marginalized Areas in Each of the 42 Counties



Source: World Bank (Swinkels et al, 2014a: 14).

⁵³⁰ These cities are: Aninoasa (Hunedoara county), Podu Iloaiei (Iași county), Budești (Călărași county), Băneasa (Constanța county), and Ștefănești (Botoșani county).

The recently published Atlas of Urban Marginalized Areas used qualitative research methods to identify four broad subtypes of marginalized urban areas that partially overlap with each other:⁵³¹

(1) Ghetto areas of low-quality apartment blocks or former workers colonies.⁵³²



These marginalized areas consist of low-quality housing facilities built before 1990 for workers employed by large enterprises during the socialist regime. Most often, these are small to medium-sized buildings (housing 150 to 500 residents) concentrated in one or more low-quality apartment blocks with a desolate appearance. The main problems include massive overcrowding, which puts serious pressure on the block's utilities (electricity, water, sewerage, and garbage collection).

In addition to very poor living conditions, ghetto residents face three major problems: (i) being unable to pay for utilities; (ii) fear of being evicted because of overdue debts (for tenants of social housing); and (iii) weak support networks and low social capital because of the negative reputation of the area. Paying for utilities is a challenge for a large part of the Romanian population, but it is especially difficult for ghetto residents. In most ghettos, the majority of the population has some overdue debt related to utility payments, some of which was built up by previous tenants of their apartments. In order to avoid attaching overdue debt to the rent in social housing, some municipalities evict tenants when they cannot pay their utility bills.

Ghetto communities are fragmented between owners and tenants, between the "bad" and the "well-behaved" (*cuminti*), and between the "self-declared leaders" and the "weak" ones characterized by low self-esteem, a lack of confidence in other people, and a lack of trust in institutions (public or private). These communities are also characterized by helplessness, which is accentuated by the constant shame of living in a disreputable area and is associated with a strong feeling of being belittled and discriminated against by most of society. In fact, many residents of ghetto areas hide their address in order to try to maintain their respectability.

(2) Slum areas of houses and/ or improvised shelters.⁵³³



These areas comprise old neighborhoods on the outskirts of cities with very poor populations that include both Roma and non-Roma. Most have expanded in size since 1990. In addition to low-quality houses made of adobe, many additional improvised shelters have been put together over time, either within the courtyards of old houses or in public areas. These shelters are often made of plastic and cardboard with some wooden frames.

In these slums, the community tends to be spread over a large area, which makes their problems much more difficult to tackle. In some slums, there is virtually no infrastructure or, for example, only one tap that supplies water for the entire area. In other areas, the infrastructure is developed along the main street but is not available in the rest of the area (not even electricity). As a result, many of these areas are insanitary and are greatly exposed to natural hazards such as heavy rain or floods.

⁵³¹ World Bank (Swinkels et al, 2014a). Note that these subtypes cannot be distinguished in the census data.

⁵³² Photo: World Bank (Swinkels et al, 2014a). Aleea Romanilor, Călan, Hunedoara county.

⁵³³ Photo: Berescu (2010). Pata Rat, Cluj, Cluj county.

The main problem for the people in these areas, in addition to extreme poverty and miserable housing conditions, is the lack of identity papers and property documents, even in places where the local authorities have declared this issue to have been resolved. This problem is common to all slum areas. Even more difficult is the situation of those who live in plastic and cardboard shelters situated on public land. Current legislation does not allow municipalities to make them legal owners of this land or give them legal rights of possession. This problem can only be solved through national legislation.

In some areas, especially those that contain improvised shelters, the actual number of inhabitants is unknown, and the census enumerators were only able to obtain data from part of the population. Therefore, the inhabitants of these areas are at least partly invisible in the official figures except for those residents who apply for social benefits. Consequently, residents claim that they are highly exposed to the discretionary actions of the powerful leaders of competing gangs that are active in the area. While some slums can be peaceful and quiet, particularly the older neighborhoods, others are unsafe.

The main issues in the slums will require significant investments in infrastructure and urban planning and/or a change in legislation (in the case of slums on public land). Low school attendance and high school dropout rates need to be addressed by local authorities, schools, Roma leaders, Roma experts, education experts, and civil society organizations. Addressing the situation in these often-expanding communities will require the development of a national framework for well-coordinated actions in the medium and long terms along with considerable investment. The European Commission has recommended that a land-use and housing strategy should cover an entire functional urban area - the de facto city - to prevent segregation.⁵³⁴

(3) Modernized social housing.⁵³⁵



Modernized social housing in urban areas was often developed as part of integrated projects that combined substantial investment in new buildings with a series of social interventions. These areas are well-served with infrastructure and utility services (sometimes better served than the rest of the urban area), but they are often not affordable. Also, they are often located on the outskirts of the city from where the residents have been relocated from slums or other marginalized urban areas. Thus, paying for utilities still represents a major problem for the residents of social housing who tend to be poor people in difficult social situations. This often results in the rapid deterioration of their dwellings and can lead to forced evictions.

In the case of many areas of modernized social housing, the designers of the modernization did not pay enough attention to: (i) the geographical location of the social housing complex within the city; (ii) holding an information and consultation process before any relocation; and (iii) the ethnic composition of the relocated population. If an area is torn out of the context of the city and offers only housing with no other services, is inhabited by a single group defined in ethnic, social, economic, or cultural terms (for example, Roma or the poor), has little development potential, and is dependent on public transportation for accessing basic services such as schools, then that area is segregated regardless of how modern the housing conditions are. This problem is exacerbated when an imposed relocation was carried out in a very short time and without adequate notice to the residents involved. Consequently, some areas of modernized social housing have deepened segregation instead of promoting integration. Furthermore, local authorities in various cities are planning to demolish the pockets of poverty that have grown within the city

⁵³⁴ European Commission (2011b).

⁵³⁵ Photo: World Bank (Swinkels et al, 2014a). Drochia area, Dorohoi, Botosani County.

and to relocate the residents, mostly the poor and Roma communities, to “nicer” and well-serviced compact complexes of buildings outside the city, for example, “on a hill” or “next to a forest.” These plans, however well-meaning, are also likely to exacerbate segregation.

(4) Social housing buildings in historical areas in the city center.⁵³⁶



Marginalized areas of social housing buildings in “historical city centers” or “historical urban areas” are effectively areas of individual houses - often in an advanced state of dilapidation - that were nationalized during the communist period and, after 1990, used as social housing. Local authorities assigned most of these houses to poor families, either before 1989 or in the early 1990s. Some, especially those in a very poor condition, were illegally occupied by homeless people. These are old neighborhoods where people have often lived for 30 years or more.

Except for the fact of being located in city centers, the living conditions of these communities to a large extent resemble those that prevail in slum areas. Because the location of such houses is extremely attractive to investors, these buildings have a potentially high market value, which means that the former owners of these houses (or their inheritors) have made great efforts to repossess them. In accordance with Law 10 passed in 2001, the rights of the former owners (or their successors) were reinstated, and the tenants were given five years to find new housing. A number of people were allowed to stay in some ruined buildings but were not given any identity papers as tenants living at that address, given that the building had been administratively registered as “destroyed.” As a result, many people who have lived in an area for 10 to 15 years or even longer often have only provisional identity papers that state that they are “without dwelling.” This means that the person in question cannot get a job, has no right to medical care or social benefits, and may suffer other deprivations.

All over Europe, the argument that concentrations of poor people tend to lead to crime in a given area has been dangerously misused to justify dispersing communities with no proper resettlement of the displaced people.⁵³⁷ International evidence shows that policies of dispersal often have significant human costs. When demolition is also involved, it represents a policy failure with enormous cost implications, and there are many examples of such interventions that have had controversial outcomes (see Box 49).

BOX 49

Displacement Interventions in Romania

The most worrying interventions that local authorities have taken in marginalized urban areas in Romania are those involving the wholesale displacement of the inhabitants. In most marginalized areas, the buildings are decrepit (some on the verge of collapse), sanitation is appalling (due to a lack of running water and of a sewerage system), and various forms of violence and small crime are widespread (aggravated by overcrowding). In response, local authorities have often decided to take a radical approach and have evicted the inhabitants from the area, making no effort to resettle them elsewhere. These evictions have usually been hasty and forceful and have often involved

the destruction of the few goods that the occupants own. This kind of action reinforces social exclusion and denies children who already live and grow up in misery any chance of escaping poverty and marginalization. Unfortunately, very few local authorities have so far chosen to react to the problems of urban marginalized areas by cooperating with institutions or NGOs in the fields of health, education, culture, or religion or with the residents themselves to come up with better solutions.

Sources: Stănculescu and Berevoescu (coord., 2004), Berescu (2010), and World Bank (Swinkels et al, 2014a).



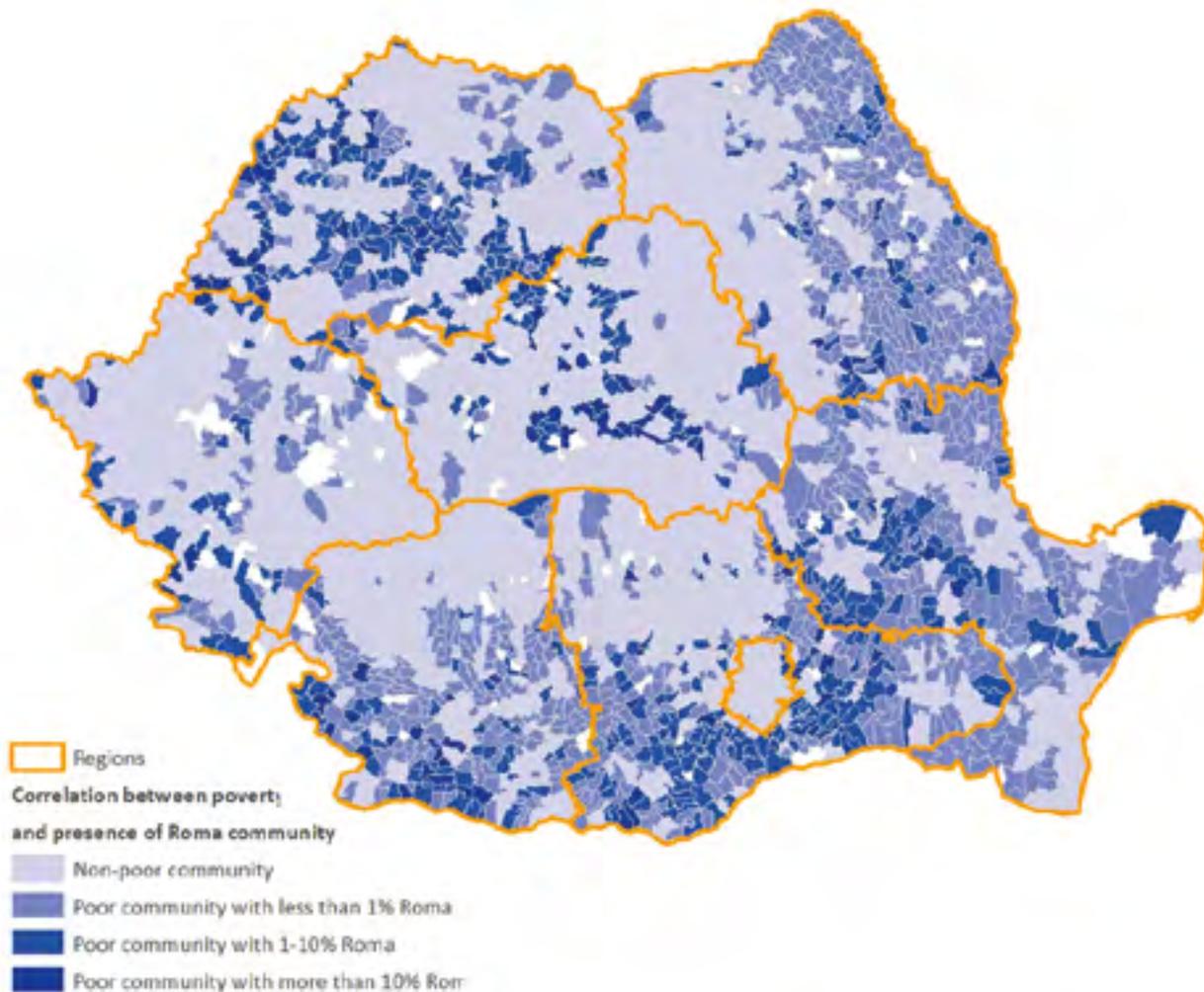
⁵³⁶ Photo: World Bank (Swinkels et al, 2014a). Historical center Uranus, Bucharest.
⁵³⁷ Colini et al (2013: 29).

3.2.3. Integrating Roma Communities

The Roma population does not always overlap with the poorest regions in Romania, as a recent World Bank study has shown.⁵³⁸ According to the 2011 Population and Housing Census, the self-identified Roma population is mainly located in clusters around the western border of Romania, in the heart of Transylvania (usually around large urban centers like Timișoara, Arad, Oradea, Cluj-Napoca,

Târgu Mureș, and Sibiu) and in the southwest between Craiova and Drobeta-Turnu Severin close to the border with Bulgaria and Serbia. Poverty maps estimated using data from the 2011 Census indicate that the population at risk of poverty or social exclusion tends to be clustered in the East and South of the country in areas that contain a relatively low concentration of Roma. Consequently, policymakers should keep in mind that measures aimed at addressing the challenges faced by poor and marginalized groups in general may not have a direct impact on large segments of the Roma minority because these two populations do not overlap geographically.

MAP 12: The Correlation between Local Human Development (LHDI) and the Presence of Roma



Source: World Bank (Ionescu-Heroiu et al, 2013a: 169).

⁵³⁸ World Bank (Ionescu-Heroiu et al, 2013a: 167).

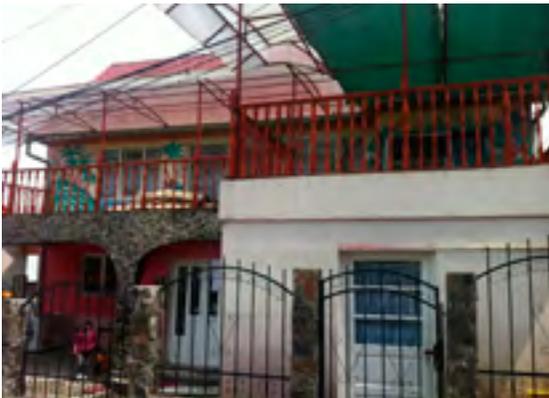
Nonetheless, there seems to be a large number of poor localities to the South and East of Bucharest that also happen to contain a relatively high concentration of Roma. This key insight, which appeared in the same study,⁵³⁹ emerged from comparing the LHDI⁵⁴⁰ with the presence of Roma communities (see Map 12). The fact that these rural communities are so close to the country's capital city and premier economic engine but still fail to benefit from spillover effects once again underscores the need to target measures specifically to Roma communities.

Evidence indicates that most Romanian Roma live in segregated communities. The recent World Bank study on Roma integration⁵⁴¹ found that 56 percent of Roma households live in settlements where the dominant ethnicity is Roma, indicating a high level of segregation. Segregation is highly correlated with lower health status, early school leaving, low labor market attachment, and costly access to other services (such as public transport or healthcare facilities). About half (51 percent) of Roma households living in segregated communities live in dilapidated houses or slum conditions.

A key issue with direct policy implications for designing targeted interventions is whether Roma communities and the marginalized communities discussed in the previous sections overlap or not. The methodology for identifying marginalized communities (in both rural and urban areas) can be used to identify and target resources to people

in need (including Roma). However, the question is whether this instrument captures the specific problems of communities with high proportions of Roma residents and whether it excludes parts of the Roma population living in difficult situations. The current background study conducted for preparing the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 indicated the following:

(1) When the methodology for identifying marginalized communities was applied to the 2011 Census data, this confirmed that the population who self-identified as Roma⁵⁴² was very much territorially concentrated (Annex Table 10.23). In rural areas, nearly 39 percent of all self-identified Roma live in marginalized communities (which are characterized by a combination of low human capital, low formal employment, and poor housing conditions) as opposed to less than 5 percent of non-Roma. In urban areas, almost 31 percent of the self-identified Roma live in marginalized areas, while the share of non-Roma is only 2.6 percent. Furthermore, the Atlas of Urban Marginalized Areas⁵⁴³ showed that an additional 40 percent of self-identified Roma live in areas disadvantaged in terms of human capital,⁵⁴⁴ which by definition differ from the marginalized areas only with regard to housing conditions. This does not mean that Roma who live in areas with low human capital have good housing conditions, but they are not as bad as the dwellings in marginalized areas. This difference can be seen in the following photographs.



A Roma dwelling in an urban area with low human capital

Photo: World Bank (Swinkels et al, 2014a).

Valea Rece, A typical villas area, Targu Mures, Mures county.



A Roma dwelling in an urban marginalized area

Photo: World Bank (Swinkels et al, 2014a).

Poligon area, Aiud, Alba county.

⁵³⁹ World Bank (Ionescu-Heroiu et al, 2013a).

⁵⁴⁰ See the definition of the LHDI in footnote 472, at the beginning of chapter 3.1.

⁵⁴¹ World Bank (Anan et al, 2014). Based on data from the 2011 UNDP/World Bank/EC Regional Roma Survey.

⁵⁴² In the 2011 Population and Housing Census, 621,573 people self-declared as Roma in the entire country, of whom 230,670 were in urban areas.

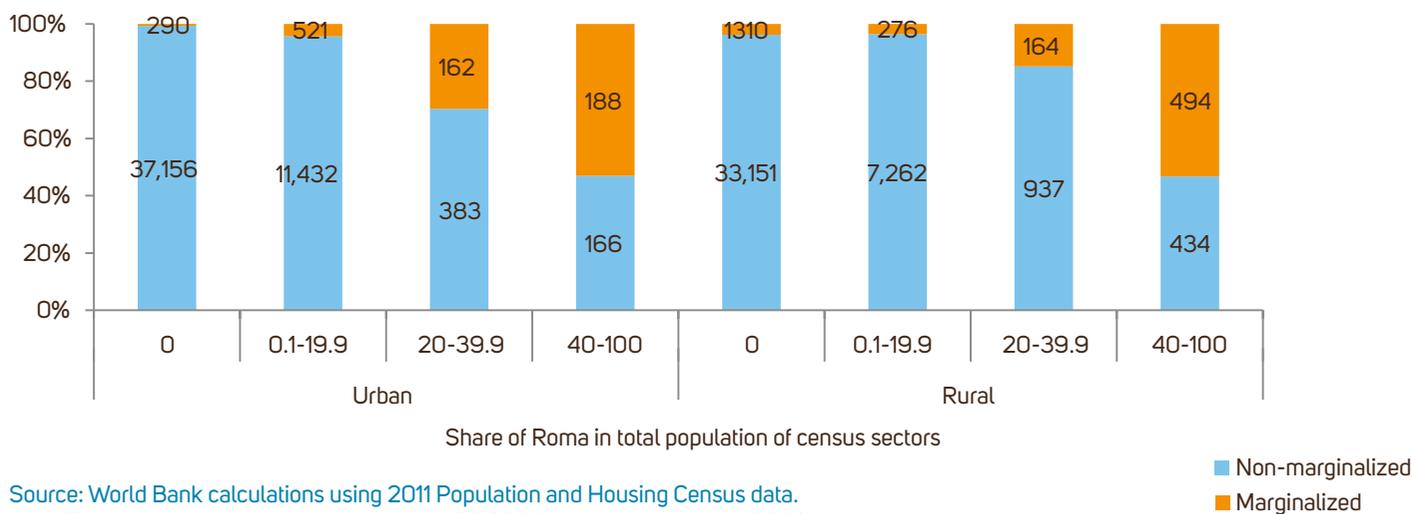
⁵⁴³ World Bank (Swinkels et al, 2014a).

⁵⁴⁴ The proportion of self-identified Roma living in non-disadvantaged areas is extremely low, at only 16.1 percent. For comparison, the majority (67.8 percent) of the total urban population lives in non-disadvantaged areas, while only 11.7 percent live in areas disadvantaged in terms of human capital and 3.2 percent in marginalized areas.

(2) The larger the share of Roma residents in a community, the higher the probability of that community being marginalized (Figure 52). In urban areas, while only 1 percent of communities with no self-declared Roma are marginalized, 47 percent of communities with large shares of Roma are disadvantaged in all three dimensions (human capital, employment and housing). Of the 1,139 census sectors identified as marginalized in the Atlas of Urban Marginalized Areas, 29 percent have more than 20

percent Roma, and only 25 percent have no Roma at all (in comparison only 1.8 percent of all census tracts have more than 20 percent self-declared Roma). Similarly, in rural areas, the probability of being marginalized increases from 4 percent of communities with no self-declared Roma to 53 percent of communities with large shares of Roma. Also, out of the 2,244 Census sectors identified as marginalized, 29 percent have more than 20 percent Roma compared to only 5 percent of all rural census tracts.

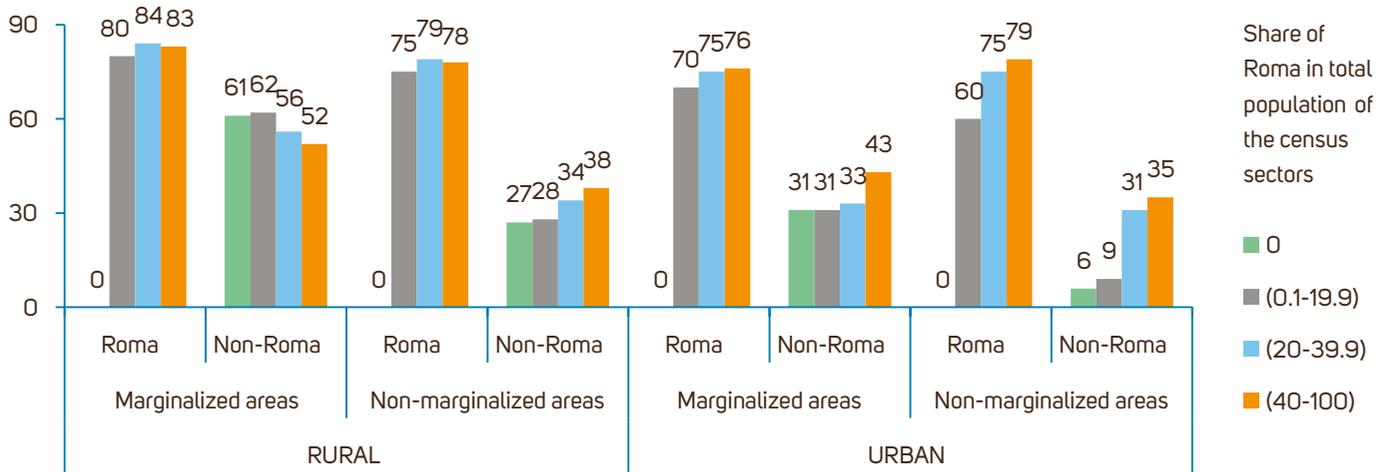
FIGURE 52: Distribution of Census Sectors in Marginalized and Non-marginalized, by the Share of Roma in the Total Population in Urban and Rural Areas in Romania, 2011



(3) Within the same types of communities (rural or urban, marginalized or not marginalized) with similar percentages of Roma within the community, Roma are much more often socially excluded from education and employment as can be seen in Figure 53 and Figure 54. For example, in rural marginalized communities with a large concentration of Roma, the proportion of young people aged between 16 and 24 years old who completed no more than the gymnasium level of education is 83 percent among Roma

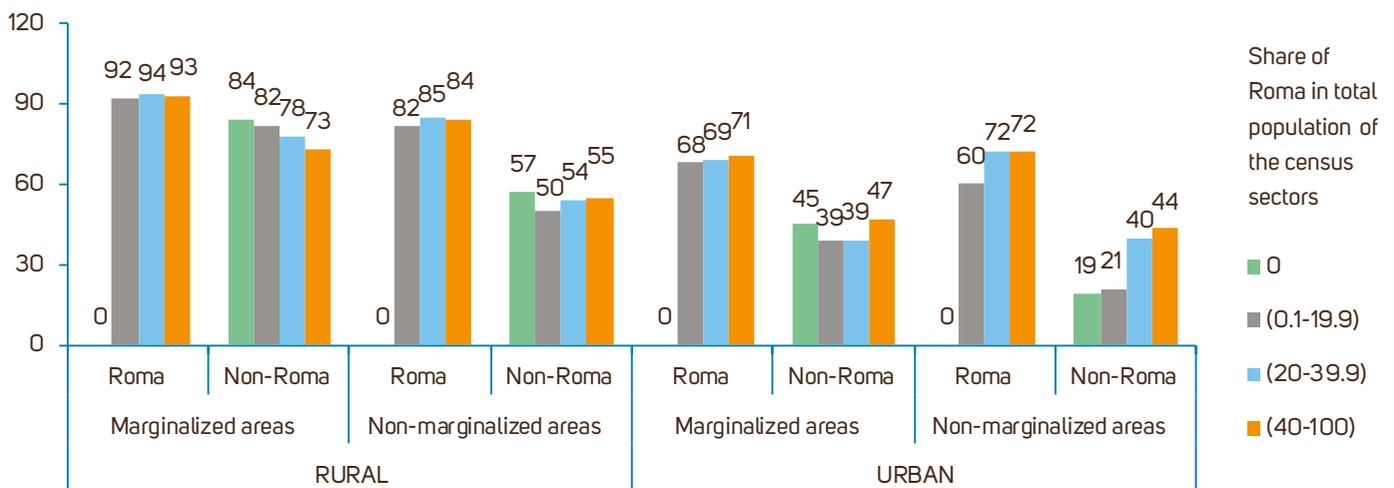
and decreases to 52 percent for non-Roma. In urban marginalized communities with less than 20 percent Roma population, 68 percent of Roma of working age who are not in school are not working or retired, while the percentage is only 39 for non-Roma who are not in school living in the same communities. As a rule, the gap between Roma and non-Roma is more accentuated in urban areas, especially in non-marginalized communities and in areas with lower shares of Roma.

FIGURE 53: Proportions of Youths Aged 16–24 Years Old with a Lower Secondary Education at Most and Not in School by Ethnicity, Type of Area, and Different Percentages of Roma (%)



Source: World Bank calculations using 2011 Population and Housing Census data.

FIGURE 54: People Not Retired or Employees among Not-in-School 15–64 Year-Olds by Ethnicity, Type of Area, and Different Percentages of Roma (%)



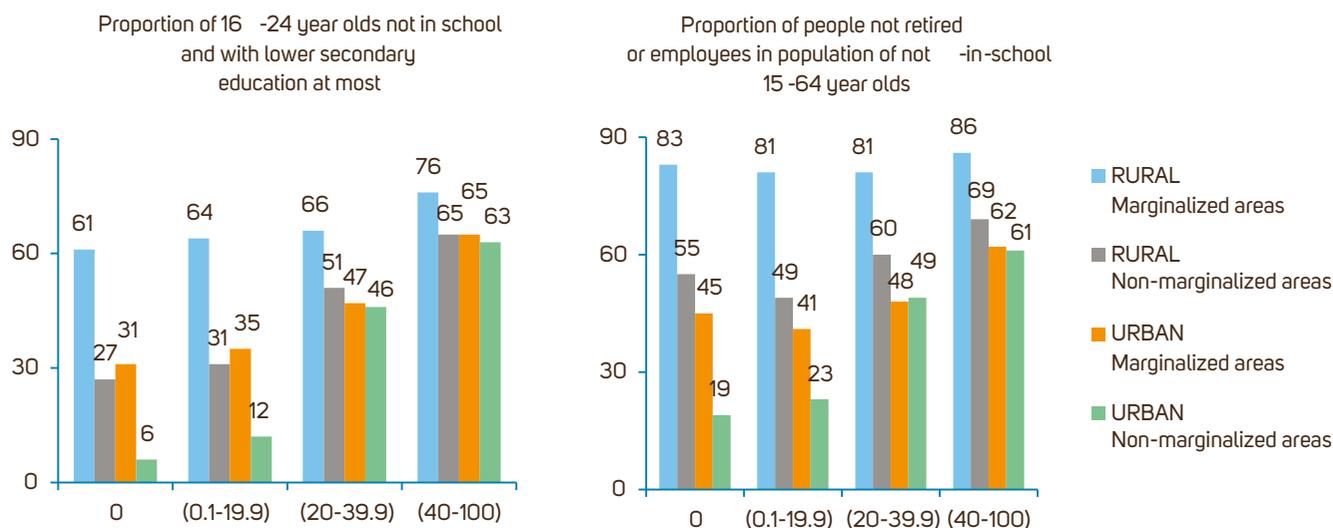
Source: World Bank calculations using 2011 Population and Housing Census data.

(4) The exclusion of Roma from decent housing is specific to urban areas, while in rural areas limited access to utilities tends to be common to all residents. Annex Table 10.27 shows the substantial gap between urban and rural dwellings in terms of basic utilities. The dwellings in marginalized areas are less endowed with utilities than those from non-marginalized communities, but the gap is considerably wider in urban areas. For example, the share of people living in dwellings with no piped water varies in urban areas from 8 percent in non-marginalized communities to 34 percent in the marginalized ones, while in rural areas the share is 66 percent in non-marginalized areas and 86 percent in marginalized communities. In rural areas, the gap is much narrower with respect to other services than in urban areas given that 99 percent of the rural population live in dwellings with no hot water from a public network, 94 percent with no connection to a sewage disposal system, and 90 percent with no gas for cooking. Similarly, there is little variation according to the share of Roma in total population in rural areas,⁵⁴⁵ whereas in urban areas it is significant, particularly in the non-marginalized communities (see Annex Table 10.28). Therefore, with regard to housing, Roma are more disadvantaged than

non-Roma, especially if they live in urban areas either in communities with a high concentration of Roma or in marginalized areas.

(5) In general, the higher the share of Roma in a marginalized community, the worse the values of all social exclusion indicators are. Although in all marginalized communities the situation is by far worse than in other areas, the share of Roma continues to be a good predictor of the severity of the problems for everyone in these areas. If, for example, in marginalized areas with no self-declared Roma, 31 percent of youths aged between 16 and 24 years old are not in school and have attained a lower secondary education at most, whereas in marginalized communities with more than 40 percent of the population being Roma, the equivalent figure is 65 percent (Figure 55). The share of Roma is a good predictor of the severity of exclusion within non-marginalized areas as well. For instance, the same indicator (the proportion of young people who have completed gymnasium at most) varies between only 6 percent in urban non-marginalized areas with no self-declared Roma and 63 percent in non-marginalized communities with high concentrations of Roma (which is a value close to that in urban marginalized areas).

FIGURE 55: Differences in Terms of Education and Employment between Areas with Different Shares of Roma for Both Marginalized and Non-marginalized Communities in Urban and Rural Areas (%)



Source: World Bank calculations using 2011 Population and Housing Census data.

⁵⁴⁵ With the exception of electricity connection.

(6) Most importantly, with regard to human capital, formal employment, and even to access to utilities (in urban areas), living in a marginalized or non-marginalized urban area makes little or no difference to the situation of Roma; what matters is the proportion of Roma in the total population of the area. Regardless of whether they live in a marginalized or non-marginalized urban area, Roma have significantly lower scores on all human capital and employment indicators than other ethnic groups. The gap between Roma living in marginalized areas and those living in non-marginalized areas is much narrower than the gap between non-Roma in these two types of areas. In all types of areas (marginalized or not), the larger the proportion of (self-identified) Roma, the lower the human capital and formal employment of its Roma residents (but not necessarily of the non-Roma ones). With regard to housing indicators, no matter whether Roma live in marginalized areas or in communities with high concentration of Roma, they are likely to have limited access to potable water and connections to sewage disposal systems or electricity.

In conclusion, interventions that target marginalized areas do not benefit all Roma. Measures are needed that are specifically targeted to Roma communities, particularly those with higher proportions of Roma, based on the EU's "explicit, but not exclusive" principle on Roma inclusion⁵⁴⁶ and that strongly focus on human capital (education, skills and healthcare), formal employment, and access to basic utilities (water, sewage, and electricity). At the moment, Roma are often not explicitly targeted by social inclusion programs. Also, specific social policies, programs, and investment projects often target disadvantaged population groups but without specific methodologies for measuring the extent of their disadvantage. While there is not always a need to target Roma exclusively, the absence of specific criteria for identifying target groups and the lack of a clear methodology by which to measure these criteria makes it difficult to target social programs at the local level. Targeting Roma communities is hampered by a lack of data on ethnicity, which are not collected systematically. Collecting these data on a regular basis would make it possible to track social outcomes for Roma and non-Roma communities and to carry out much deeper analysis of the determinants of poverty.

The lack of capacity within local communities to design and implement projects compounded by inadequate central-level support is undermining the ability of many disadvantaged communities to benefit from EU funds.⁵⁴⁷ In particular, the EU Structural Funds, the Cohesion Fund, and the European Agricultural Fund for Rural Development are not reaching enough marginalized Roma communities. The overall absorption rate of EU Structural and Cohesion Funds during the 2007 to 2013 period was also low in Romania. This is due to a number of key factors: (i) a lack of alignment between the legislation regulating the implementation of structural instruments and other relevant national laws; (ii) the complexity of administrative procedures; (iii) a lack of administrative capacity both within management authorities and among beneficiaries; (iv) the absence of adequate accountability mechanisms requiring local authorities to address issues faced by Roma and other disadvantaged communities; (v) a lack of co-financing capability on the part of local authorities; and (vi) the unclear distribution of tasks among ministries and other public entities at the national level.

3.2.4. An Integrated, Cross-sectoral, Area-based Approach to Marginalized Areas

Integrated, cross-sectoral regeneration projects that balance social inclusion with economic competitiveness are the best way to reduce geographically concentrated poverty in marginalized urban areas, in Roma communities, and in certain remote rural areas. These interventions need to be supported by a broad range of public and private players (public agencies, landlords, residents, and businesses) in order to be effective. Policies against segregation can relate to a particular geographical area (area-based interventions) or to specific policy sectors (people-based policies). "Problematic" areas need high-quality, accessible services – affordable housing, education, employment, childcare, healthcare services, and public

⁵⁴⁶ The European Union's 10 Common Basic Principles on Roma Inclusion recommend "explicit but not exclusive" targeting of measures, "focusing on Roma people as a target group but not to the exclusion of other people who share similar socio-economic circumstances" (Principle No. 3). "Policies and projects should be geared towards 'vulnerable groups', 'groups at the margins of the labor market', 'disadvantaged groups', or 'groups living in deprived areas' with a clear mention that these groups include the Roma" (Principle No. 2). http://www.coe.int/t/dg4/youth/Source/Resources/Documents/2011_10_Common_Basic_Principles_Roma_Inclusion.pdf.

⁵⁴⁷ A study was conducted by the World Bank (Anan et al, 2014) in the context of the Assessment of the Communication and Collaboration between the Managing Authority and Intermediate Bodies of the Regional Operational Programs and Facilitation of Proactive and Direct Support for Beneficiaries. It indicated that, while many local communities are capable of submitting funding proposals, they often lack the capacity to design and implement projects. The report identified several capacity gaps including the inability to define or verify the technical specifications of investment projects and to undertake procurement procedures in line with the regulations on EU funds.

transport – in order to achieve levels of integration on a par with other parts of the same city. To this end, policymakers should consider adopting sectoral or people-based policies that are tailored to improving the circumstances of individuals or households with low incomes and specific needs in these “problematic” areas.

These policies might include:

- A land use and housing strategy that applies to the whole functional urban area in order to prevent extreme segregation.
- Specific efforts to provide public services in “problematic” areas.
- Education and school policies that aim to improve the quality of education across the board and to achieve an ethnic and socioeconomic mix of students in all schools.
- Economic interventions to increase employment, support start-ups, and enhance training opportunities.
- A social housing policy that makes affordable housing available in all parts of a given city.
- Planning regulations that prevent the development of gated communities.
- A mobility policy that guarantees equal opportunity of access to job centers and major facilities by public transport from all parts of the city.

Area-based and people-based interventions must be integrated in a framework of participative community development in order to fight segregation effectively. For the 2014 to 2020 programming period, the European Union has proposed an approach called community-led local development (CLLD) in which local people are invited to form local partnerships to design and implement integrated multi-sectoral area-based strategies to tackle segregation

and poverty in marginalized areas. Similar to the role played by LEADER in rural areas, CLLD is expected to be an effective method for reducing the segregation of the urban poor and marginalized areas. LEADER and the EMFF will provide Romania with CLLD funds for rural areas and very small cities, and the ERDF and the ESF will provide funds for urban areas. This support will increase the total budget available for local development and will enable local authorities to consider a broader range of interventions. Nonetheless, programs that are financed from several different sources are complex to design and implement and require experience in the area of urban development, while the relevant local partners need to have already established working relationships with each other. They “could prove difficult to implement for groups experimenting with local development for the first time. It will therefore be crucial to analyze the capacity of LAGs [local action groups] and to choose an appropriate division of tasks between the LAGs and the authorities responsible for the design and implementation of the program... Solid preparation and capacity-building actions should be organized to enhance their administrative capacity.”⁵⁴⁸

Local and central capacity to develop and implement integrated projects is vital for improving the living conditions of Roma and of marginalized communities. To date, Romanian policymakers have had no incentives to tackle urban decline and target funding to segregated neighborhoods, and the general provisions associated with EU funding have offered very limited opportunities to do so. Also, there has been no attempt to take an integrated approach to the design of interventions. Although several different approaches to reducing the segregation of disadvantaged communities have been tried in Romania, no comprehensive review has been done of the success or failure of these approaches. As a result, there is only limited data on how the limited number of integration policies and programs in Romania have actually performed in the field, what practices seem particularly successful and why, and what ways exist to circumvent the often overly rigid government systems in order to ensure that integration programs are delivered responsively and effectively.

⁵⁴⁸ European Commission (2013a: 29).

BOX 50**Lessons Learned From Previous Integration Interventions in Romania**

Various lessons have emerged from previous integration interventions that have been implemented in Romania.

1. There is a need for a national legislative framework to govern policies related to marginalized communities. This framework should provide regulations related to:

- A national housing policy (which has yet to be developed).
- Regulations related to properties in slum areas.
- The enforcement of Law 15/2003 (according to which mayoralties may lease public land to local people for construction purposes with proposals selected on the basis of a set of criteria).
- Investment in buildings owned partly by the municipality and partly by the residents.
- Changes in the fiscal rules for calculating the interest and penalties for unpaid taxes owed to state or local budgets by social tenants.
- The settlement of historical debts related to social housing services.

In addition, at the city level, land use and housing regulations need to be developed that apply to entire functional urban areas in order not to perpetuate extreme segregation (European Commission, 2011b).

2. Interventions in marginalized areas should be integrated in order to combine investment projects in housing and infrastructure with projects related to employment, the education of children and adults, sanitation services, parental education courses, family planning, the provision of hot meals for children, life skills development (for teenagers), the fight against discrimination, community empowerment, and other social, medical, or cultural activities. A national scheme of vocational training needs to be developed for adults who have little or no formal education (eight grades of schooling at most) and who live in marginalized areas.

3. Policymakers must search for innovative solutions to the problems of marginalized areas that are affordable for the poor but that also aim to raise family incomes within the community. Only in this way can an intervention be sustainable and the quality of life enhanced.

4. In order to make the community accountable, the intervention must have clear, predictable, and transparent rules and procedures that are publicly debated, agreed on by all stakeholders, and put into action. For example, an explicit and widely disseminated local policy to regulate social housing would improve the relationship between tenants and the local authority. A clear set of penalties and rewards should be formulated so that desirable behavior by tenants is acknowledged and thus rewarded, while undesirable behavior is discouraged. It would be useful to provide information on both positive and negative examples to tenants to ensure that they understand what is expected of them.

5. Interventions in marginalized areas need to be medium-term or long-term, with a preparatory phase of one to two years during which both the local authority and the marginalized community learn to communicate, build an equal partnership, and create a participatory environment with a well-defined, predictable, and transparent set of rules.

6. Interventions in marginalized areas should include components targeted to neighboring non-marginalized areas to foster social integration and increase the odds of the project being acceptable to all citizens.

7. Interventions should be designed to take into account differences in:

- Infrastructure (apartment blocks as opposed to slum areas as opposed to social housing).
- Property (owners as opposed to tenants of social housing as opposed to people living in improvised shelters).
- Community participation (communities concentrated in apartment blocks as opposed to communities spread over large areas).
- Leadership (communities with strong informal leaders as opposed to communities with no strong leaders).
- The history of the area (old-traditional neighborhoods as opposed to new neighborhoods).

8. Interventions targeted to children are likely to have positive spillovers at the community level and thus to increase support from residents who do not benefit directly from the project.

Source: World Bank (Swinkels et al, 2014b: 32).



Limited consultation between central policymakers and local communities can limit the relevance and sustainability of policies and initiatives aimed at increasing the social inclusion of Roma and marginalized communities by failing to take account of local needs and opportunities. Moreover, the discriminatory attitudes of some officials toward Roma can deter them from participating in the design and implementation of inclusion programs.

Therefore, local communities should be involved in the design and delivery of interventions. To support this, local authorities could offer training to community members in areas such as participatory decision-making, accounting, and basic financial literacy. In addition, involving local populations in efforts to upgrade local infrastructure could increase their sense of ownership, while providing them opportunities to work and develop skills. It is important to ensure that these improvements to local infrastructure and housing will not lead to increased concentration or further physical isolation and segregation of marginalized groups. This non-segregation principle is reflected in Article 7 of the European Regional Development Fund (ERDF) Regulation, which was amended in May 2010 to encourage the use of ERDF funds for housing interventions as long as these

interventions promote integration and prevent the isolation and exclusion of marginalized communities.

Having well-coordinated institutional mechanisms is a prerequisite for developing effective policies, implementing priority interventions, and reducing service delivery gaps. We recommend that the government of Romania clarify the responsibilities of the various institutions involved in the effort to reduce geographically concentrated poverty. This can be done through both legislation and the establishment of cooperative working arrangements at the local level. The government should enact a framework law that sets out the functional relationships between various bodies as well as their budgetary sources. It should also support the building of capacity at the local authority level, which will be essential to make the most effective use of EU funds. Policymakers should also formulate a methodology for gathering stakeholder feedback, encouraging local participation in the design and operation of interventions, and developing partnerships with Roma and marginalized communities. Finally, simplifying the procedures for local communities to apply for EU funds is likely to increase demand and foster local initiatives.

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4. STRENGTHENING
INSTITUTIONAL
CAPACITY TO
REDUCE POVERTY
AND PROMOTE
SOCIAL INCLUSION

4

STRENGTHENING INSTITUTIONAL CAPACITY TO REDUCE POVERTY AND PROMOTE SOCIAL INCLUSION

Strengthening Institutional Capacity To Reduce Poverty And Promote Social Inclusion

The government should aim to enhance the capacity of the public system at all levels to enable all parties to work together in order to develop and implement policies to combat poverty and social exclusion.

The main priorities should be: (i) upgrading the current IT system to implement a strong e-social assistance system; (ii) strengthening coordination mechanisms and developing an integrated monitoring and evaluation system; and (iii) developing a modern payment system.

Each chapter dedicated to people-based (sectoral) policies presented in detail the priority measures recommended to increase and strengthen Romania's institutional capacity to reduce poverty and promote social inclusion. Specifically, each chapter included a sectoral analysis of development needs in the areas of human, legal, financial resources and monitoring and evaluation mechanisms and went on to describe the best practice solutions to meet these needs. This chapter presents the main recommendations in each of these areas.





Main Objectives

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4.1. Enhancing Capacity for Policy Formulation and Management at all Levels

Planning and management activities still represent a challenge at all system levels and in all sectors. Policies, programs, and services still fail to take into account existing research and rarely benefit from special needs assessments, and because of this their efficiency can be only partially estimated. Furthermore, there are few mechanisms for monitoring and evaluating their outcomes. The lack of systematic, evidence-based planning in Romania hinders interventions at all stages of their implementation, making it difficult to set clear objectives

and targets and to prioritize and standardize management and implementation procedures.

Building capacity for policy formulation, planning, and managing services is a prerequisite at all levels and in all relevant sectors for developing anti-poverty and social inclusion policies. Legislation is required to establish the key elements and procedures involved in designing, managing, and implementing social programs.

A summary of the changes needed in the current legal provisions is presented in Table 44 below.

TABLE 44: Changes in the Current Legal Provisions by Sector

Employment	Create labor market regulations and promote social dialogue to support the ability of workers to negotiate for wages commensurate with their productivity.
Social Protection	<p>Enact a new legislative and regulatory framework to consolidate the three current means-tested programs (the GMI, the FSA, and the HB) into a single program - the Minimum Social Insertion Income (MSII) program, soon to become the key anti-poverty program in Romania.</p> <p>Ensure longer contribution periods and higher contribution levels in order to achieve adequate pensions in the future.</p> <p>Review social pension policy to address the low coverage of the pension system of the working age population, especially in rural areas.</p> <p>Review legislation regarding anticipated pensions and the future pension age to address the problems involved in reducing the number of anticipated retirees and raising the pension age.</p> <p>Develop secondary legislation to enforce the government's comprehensive law on social assistance (292/2011).</p> <p>Unify the medical criteria for assessing the degree of disability for people with disabilities and create a single delivery channel to serve all people with disabilities (currently two separate systems exist to certify an applicant's disability, one for pensions and one for allowances).</p> <p>Develop comprehensive regulations for occupational therapy covering funding and evaluation methodologies and the inclusion of newly trained professionals in all public and private services that deal with people with disabilities.</p>
Education	<p>Ensure effective law enforcement mechanisms for ensuring free compulsory education for all children.</p> <p>Draft and pass a specific all-inclusive education law in accordance with the recommendations of the Office of the High Commissioner for Human Rights of the United Nations.</p> <p>Ensure enforcement mechanisms in accordance with the national legislation to ensure that children and young people with disabilities can receive their education in mainstream schools, in special schools, or in special classes integrated into mainstream schools. Develop a coherent framework for a real and constructive partnership between teachers and the parents of their students with special educational needs.</p> <p>Redesign current IVET programs by setting up apprenticeships, redesigning the curricula, developing national sponsorship programs with large companies, and focusing on students most at risk of dropping out.</p>

Health	<p>Change the paradigm of public health policy by increased budget allocations to evidence-based preventive and health promotion services, while building programmatic capacity at all levels.</p> <p>Review all national health programs as of 2014 including the national mother-and-child healthcare program. Develop a national plan for healthcare services, followed by prudent investments in infrastructure and human resources.</p> <p>Consider developing local, regional, and national plans for reducing the incidence of unhealthy kinds of behavior and for preventing chronic diseases.</p> <p>Consider changing legislative provisions in order to allow local authorities to hire GPs with funds from the National Health Insurance Fund.</p> <p>Revise, update, and endorse the tasks and job descriptions of community health workers.</p> <p>Review and diversify the interventions included in the minimum and basic benefits packages delivered by family doctors and increase the share of services that proved to be effective (evidence-based services) in reaching the poor.</p> <p>Redesign the National Plan to Prevent and Control M/XDR-TB 2012-2015. Reinforce, through regulatory measures and county-based mapping of resources, the Direct Observed Treatment Strategy and develop procedures and guidelines for HIV/TB detection and care based on international recommendations and protocols.</p> <p>Issue legislation on private health insurance for those who can afford this option.</p>
Housing	<p>Elaborate a housing policy and a housing strategy to address the excessively high housing cost rate on the poor and to prevent homelessness, especially due to evictions.</p> <p>Ensure the pro-poor focus of the large infrastructure programs aimed at rehabilitating and modernizing the housing and utility stock.</p> <p>Ensure that improvements to local infrastructure and housing will not lead to increased concentration or to the further physical isolation and segregation of marginalized groups.</p> <p>Increase the capacity of shelters, strengthen the capacity for carrying out emergency interventions in the street, adopt regeneration programs to tackle the problem of illegal settlements, cease illegal evictions, and adopt prevention policies for people at risk of ending up in the streets.</p>
Social Participation	<p>Change the current legislative framework governing volunteering in order to encourage social participation.</p>

In terms of human resources, more and better trained staff are greatly needed in all social sectors. Thus, the previous chapters highlighted the following list of main development needs:

- Increase the management and operational staff of the National Employment Agency devoted to developing specialized local employment services (ALOFM) and create local partnerships for the implementation of ALPMs and the sub-contracting of some of its services.
- Develop a national program to strengthen social assistance services at the community level for the 2015 to 2020 period, accompanied by investment in community-based services such as daycare and other support services for independent or supported living (such as transportation, personal assistants, assistive devices, and interpreters).
- Increase the number of professionals in strategic planning and monitoring and evaluation, as well as case management within the County Directorates for Social Assistance and Child Protection (DGASPCs) to strengthen strategic planning, methodological coordination, and support for the local-level SPAS as well as in monitoring and evaluating service providers within the county.
- Develop a continuous training system for professionals working in social services, including professionals dealing with the social services regulatory system. There is still no dedicated mechanism for evaluating social services or for training evaluators of social services.
- Strengthen the capacity of Social Inspection to evaluate and control social services as well as cash transfer programs.

- Invest in and increase the number of professionals available within the County Resources and Educational Assistance Centers (CJRAEs) to enable them to become real resource centers for inclusive education.
- Provide systematic training for teachers and care providers in how to provide ECEC to children from poor and vulnerable families.
- Enhance the capacity of teaching staff to ensure the effective delivery of inclusive education to Roma children.
- Introduce a national program for young specialists in agriculture.
- Enhance the role and the capacity of the County Directorates for Public Health to provide professional support and supervision to community health workers (both CHNS and RHM).
- Develop an effective health workforce strategy, particularly for attracting and retaining staff in rural areas.
- Extend and strengthen the community-based nursing system as the most powerful equalizer in the health system. Develop community-based healthcare services in villages with no permanent family doctor's practice.
- Train or retrain community healthcare providers (family doctors, community nurses, and Roma health mediators) in how to deliver quality pre- and postnatal care and childcare.
- Invest in continuous medical education programs, tailored to the health needs of the most disadvantaged for family doctors and their nurses.
- Extend the number of professionals specializing in the early diagnosis of children with disabilities.
- Create traineeships, internships, and placement programs in administrative positions at the central, regional, and local levels, especially for young Roma women.
- Develop training for community members in areas such as participatory decision-making, accounting, and basic financial literacy.
- Train community representatives in the use of the LEADER program and the LAG (local action group) framework.

Besides legal changes and human resources, adequate government funding should be secured, in parallel with the funding received from various European bodies, for the reduction of poverty and promotion of social inclusion. As shown in the previous chapters, increased overall financing together with improved financial management is required in all social sectors. The main aspects of the issue of funding, as discussed in previous chapters, are presented in Table 45.

TABLE 45: Changes in the Current Legal Provisions by Sector

Employment	Increase resource allocations to - and improve the management of – labor market institutions and activation policies for socially vulnerable groups and the in-work poor.
Social Protection	<p>Increase the budget of means-tested programs and their share in the overall social assistance budget.</p> <p>Increase the budget of the forthcoming MSII compared to the combined budgets of the current programs to ensure that social assistance funds cover most of the poor.</p> <p>Earmark a budget within the state budget for social assistance services at the community level and develop mechanisms for monitoring the efficient use of this budget by supporting the salary of a full-time employee as well as the costs related to the national monitoring system.</p> <p>Increase the budget allocated to the development of social services for vulnerable groups.</p> <p>Improve the financing framework to ensure the sustainability of financing for social services by developing funding mechanisms and procedures, promoting coordination and harmonization between financing mechanisms in different sectors (such as healthcare, education, housing, and employment), increasing transparency and the dissemination information on the procedures for contracting out social services, and improving costing methodology and procedures for social services.</p>

Education	<p>Increase overall financing for the education sector.</p> <p>Continue the program of investment in essential infrastructure in order to ensure that students can access all public educational institutions at all levels. This investment might come from the Structural and Cohesion Funds.</p> <p>Increase investments in disadvantaged schools in marginalized urban and rural areas.</p> <p>Review the system of Supplementary Funding, which is currently based on a weighted funding formula for children in vulnerable situations, and ensure that it is properly delivered to all mainstream schools where such children are enrolled.</p> <p>Revamp the whole series of cash programs implemented through schools, acknowledging that they are in reality social assistance, and merging the national cash programs into the MLFSPE's Family Allowance (soon to be the MSII) program, which has low application costs and considerable monitoring and oversight capacity.</p>
Health	<p>Increase overall financing for the health sector, especially the budgetary allocations to primary healthcare and ensure adequate funding for the development of community-based healthcare services.</p> <p>Review and revise the existing financial and non-financial incentives designed to attract and retain physicians in rural and remote areas.</p> <p>Design, implement, and budget for a clear policy on informal payments in the public healthcare system nationwide.</p> <p>Ensure adequate funding for targeted measures addressing the health of the poor and vulnerable population and for social support and interventions targeted to the poor, such as vouchers for transportation to medical facilities and subsidies to MDR-TB patients or adequate budgets for specific interventions for vulnerable groups such as IDUs, street children, the homeless, prisoners, and Roma.</p> <p>Increase budgetary allocations for preventive services in the field of reproductive health.</p> <p>Provide adequate funding for redesigning the National Plan to Prevent and Control M/XDR-TB 2012-2015.</p> <p>Invest in health infrastructure and technology in a cost-effective way in accordance with the requirements of the national plan for health services and based on documented evidence.</p>
Housing	<p>Increase the budgetary allocations for social housing.</p> <p>Invest in the infrastructure of villages incorporated within cities in order to improve the quality of life of the population in small towns.</p>
Social participation	<p>Increase the access of all vulnerable groups to information and knowledge in a wide range of formats.</p>
Marginalized communities	<p>Finance a package of integrated interventions in marginalized communities (in rural development, regional development and human capital) from the national budget, EU funds or loans to significantly reduce or eradicate the incidence of deep, concentrated, and persistent poverty in Romania by 2020.</p>

Institutional reforms should be carefully planned and assessed, given that they could result in the loss of

experienced staff, which could negatively affect the service delivery capacity of the institutions.

4.2. Developing an Integrated Approach in the Field of Social Policy Development

Adopting an integrated approach in policy development, service provision, and the use of local resources can be expected to improve the way in which national and local authorities plan and use existing resources for reducing poverty and social exclusion. Interventions based on an integrated approach would be the product of cross-sectoral cooperation and would take into account all aspects of the wellbeing of the targeted groups.

Several conditions will be key to making this integrated approach happen. It is recommended that the government: (i) set up an inter-sectoral Social Inclusion Commission with a technical secretariat to be in charge of the implementation of the Social Inclusion and Poverty Reduction Action Plan for 2015-2020 and a social inclusion monitoring and evaluation system; (ii) develop specific legislation, quality standards, and a comprehensive regulatory system for vulnerable groups; (iii) train social service workers, education professionals, community mediators, and other relevant professionals in the integrated approach to service provision; (iv) establish multi-disciplinary teams of community workers (integrated intervention community teams) at the local level and multi-agency cross-sectoral cooperation at all levels, especially for children with high

dependency needs and complex medical conditions and those in rural or isolated areas, as a first step towards the full integration of service delivery in the long term; (v) encourage vulnerable groups to be more active in decision-making at all levels from local service provision to national policymaking; (vi) enhance local and central capacity to develop and implement integrated projects as a key factor for improving the living conditions of Roma and of marginalized communities; (vii) improve horizontal coordination within and between ministries and the vertical coordination of social service delivery between the central, county, and local levels; and (viii) make a proper budget allocation available from local and national sources for all of these activities.

Area-based and people-based interventions are crucial for fighting segregation in marginalized areas. Relevant policies and programs should be coordinated among all levels of governance (vertical policy integration) and across sectors (horizontal policy integration). Integrated, cross-sectoral regeneration projects that balance social inclusion with economic competitiveness are the best way to reduce geographically concentrated poverty in marginalized urban areas, in Roma communities, and in certain remote rural areas.

4.3. Developing an Integrated Approach in the Field of Social Policy Development

The government needs to develop a national social inclusion monitoring and evaluation (M&E) system and establish specific indicators of poverty and social inclusion to track progress towards the goals set out in the National Strategy on Social Inclusion and Poverty Reduction 2015-2020. The system is needed to ensure that the results of the interventions included in this National Strategy can be measured and monitored during the 2015 to 2020 period and to ensure that the key elements of poverty reduction, social inclusion and participation, and an integrated approach to social services are reflected in national and local policies.

Developing such a system would also increase accountability and efficiency in the allocation of public resources and thus more effectively meet the real needs of poor and vulnerable people. In order to adequately plan the development of the social inclusion M&E system, the government with input from the World Bank should prepare an M&E plan that will set out the logical sequence of implementing and monitoring interventions.

In the context of limited resources and numerous needs (which need to be prioritized and dealt with in the most effective way possible), the government should continue to invest in strengthening its M&E capacity by: (i) improving mechanisms for collecting both administrative and survey data on a regular basis; (ii) building the capacity of staff at different levels (central, county, and local) to analyze quantitative and qualitative data in the areas of poverty and social exclusion; (iii) increasing the skills of the line ministries' staff responsible for implementing the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 in carrying out different types of evaluations (such as needs

assessments, process and impact evaluations, and cost-benefit analyses); and (iv) strengthening cooperation and coordination between different institutions in carrying out activities in the areas of poverty reduction and social inclusion.

To track the results of the flagship initiatives in reducing poverty, the government is advised to strengthen the monitoring capabilities of the EU-SILC survey for Romania by: (i) adding an additional module to the questionnaire to track some of these initiatives and (ii) expanding the survey's representative subsamples of beneficiaries of these initiatives. These improvements in the survey's design would enable the government to track: (i) the level of poverty among the beneficiaries of the MSII program and their labor market attachment; (ii) the use of ALMPs and training activities by the MSII and Youth Guarantee beneficiaries; and (iii) the level of poverty in marginalized communities.

Several evaluations will be needed to inform the policy reforms in the coming period: (i) an impact evaluation of the various elements of the Minimum Social Insertion Income program;⁵⁴⁹ (ii) impact evaluations of active labor market programs for the poor and vulnerable (including the Youth Guarantee program), (iii) a process and impact evaluation of the EU-funded social economy projects; (iv) an impact evaluation and cost-benefit analyses of integrated social services at the community level; (v) impact evaluations of means-tested benefits aimed at increasing school attendance and improving the academic performance of disadvantaged children; (vi) process evaluations of social services prioritizing child protection social services; and (vii) needs assessments of specialized social services at the local, regional, and national levels.

⁵⁴⁹ The elements of the design of the MSII that should be evaluated are the impact of the size of the labor earnings of the families that are exempt from the income test on the activation of working age poor and the success or failure of the conditionalities related to school attendance and performance and to health interventions.

4.4. Improving Service Delivery with Information and Communication Technologies

The use of information and communication technologies (ICT) varies in various ministries and agencies responsible for employment, social protection, health, and education policies. In general, they operate in silos, with few opportunities to share and exchange information about their beneficiaries. Most management information systems (MISs) were developed seven to ten years ago, and both their hardware and software is becoming technically obsolete.

While there is a need to update or upgrade most of the sectoral MISs, in relation with the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, expanding the coverage and functionality of the social assistance MIS is absolutely necessary. This MIS is expected to play – when the MSII program implemented – the important role of a registry and a targeting tool for programs for the poor. The goal is to develop an MIS that will: (i) enable local social assistance workers to devote more time and resources to social work activities; (ii) enable the tracking, monitoring, and case management of the poor and vulnerable, leading to better policymaking and improved targeting of resources; and (iii) strengthen the referral function of the local social workers to specialized services (such as employment, health, education, disability, child protection, and long-term care).

The present processing system for social assistance benefits encompasses means-tested, categorical, and universal benefits. In most cases the local authority is the institution to which potential beneficiaries must submit their benefit applications. This has the advantage of being close to the applicant, of providing them with locally based assistance in completing the forms, and finding any local information that the applicant needs for the means-test process. However, in some cases the local authority is burdened with handling applications that could instead be submitted directly (via a web portal) by the applicant, and the new MIS will offer this facility.

The current social assistance system is unnecessary complex and inefficient and suffers from significant governance problems related to the ICT system:

- The social assistance processing system relies heavily on paper documents, and various eligibility

and processing rules involve a range of private, public, and compliance costs, all of which contribute to making the system cumbersome and inefficient. This weakness is exacerbated by the lack of ICT technology support within most local authorities. At the county level – which is where the local authorities send the benefit applications – the County Agencies for Payments and Social Inspection use a central MIS system (SAFIR) to administer the majority of benefits. However, the SAFIR system is outdated and inflexible, has limited functionality, and does not have adequate ex-ante data verification capacity. Overall, SAFIR is not capable of sustaining the future system requirements as recommended in the National Strategy on Social Inclusion and Poverty Reduction 2015-2020.

- The prime responsibility for the governance of the present social assistance system rests with the National Agency for Payments and Social Inspection (ANPIS). However, ANPIS has extremely limited internal resources and capacity to manage or develop ICT systems, and at present it relies on another governmental institution – the Special Telecommunications Service – and a private sector contractor to operate and maintain the SAFIR system. This governance gap poses a serious risk to the implementation of the recommendations of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 in the field of social assistance, while also negatively affecting the ongoing operation of the SAFIR system.

We recommend that the government should respond these issues by simplifying benefit eligibility conditions, streamlining the processing system, rationalizing the number of decision-making centers, strengthening the inspection system, and developing a new social assistance MIS to automate processing and to carry out validations (both ex-ante and ex-post). This new MIS should include automated payment processing and auditing as well as case management and prioritization tools to support service staff in local authorities, in the county Agencies for Payments and Social Inspection (AJPIS), and in partner

institutions.

We recommend that the social assistance MIS strategy focus on four main areas: (i) ICT governance; (ii) a business operations model; (iii) MIS development; and (iv) the reform of payment services. This will require significant institutional strengthening, the centralizing of decision-making, and the reforming of business processes. It will also involve a major ICT development program over a five-year timeframe. At the local authority level, we recommend further development of local customer relationship management solutions to enable local authorities to maximize the automation of all local social assistance processes so that they can link all local databases with the social assistance MIS.

The core of the new MIS will be: (i) the electronic transfer of data on means-tested programs from local authorities; (ii) government-to-citizens web interfaces (G2C) for universal and categorical programs; (iii) a centralized data processing center within the National Agency for Payments and Social Inspection (ANPIS); (iv) the electronic transfer of data between the MIS and other government organizations; (v) a centralized payments system for all types of social assistance benefits – means-tested, categorical, and universal; (vi) the centralized management of social assistance service providers; (vii) government-to-business web interfaces (G2B) enabling the social assistance MIS to be accessed by authorized social assistance service providers; (viii) an accounting (general ledger) interface; and (ix) advance reporting and analytics, including risk profiling to prevent and detect possible errors or cases of fraud.

The proposed e-social assistance system will also facilitate better coordination between the social benefits and social

services systems, which will make both systems more effective in meeting the needs of their clients. By providing a clear picture of each recipient and all of the cash benefits that he or she receives, it will also enable social workers to develop a comprehensive planning system for support services, to make informed referrals to specialized services (when needed), and to observe and evaluate a client's progress and the impact of all of the different kinds of support provided to him or her.

We recommend that the social assistance MIS be implemented in three stages. Between 2015 and 2017, the government will: (i) develop additional ICT support for the new unified MSII benefit; (ii) move the current MIS to the Oracle 12 database version; (iii) deliver ICT support to local authorities; and (iv) reform the governance of the entire social assistance system, especially at the central level. Between 2016 and 2018, it will be necessary to: (i) develop the new social assistance business operations model and (ii) start modernizing the payments system. From 2018 to 2020, the government will: (i) develop and implement the social assistance MIS and (ii) finish modernizing the payments system.

The new MIS will significantly automate benefit processing. This will free up staff at the grassroots to focus on the most vulnerable clients and, using the case management approach, target interventions and priority actions to those clients. Other key benefits that will flow from the new MIS will include: (i) the reduced costs of the application and qualification process and the payments system; (ii) greater accuracy of decision-making; (iii) less fiscal leakage as a result of reduced levels of error and fraud; and (iv) improved targeting of key interventions and support services.

4.5. Modernizing Payment Systems

The current payment system for social assistance benefits involves a complex set of (mostly manual) procedures and fails to take advantage of modern technologies. Most social assistance benefits are calculated by the SAFIR MIS system. However, all subsequent tasks – from obtaining the funds from the Treasury to making payments to the beneficiaries – are undertaken outside the SAFIR platform. The existing system by which authorities at different levels request, obtain, and distribute the funds needed to make benefit payments is inefficient, fragmented, and overly complex. The existing payment modalities are outdated, are not secure, and involve moving large amounts of cash to post offices to be distributed to beneficiaries. In addition, the audit and reconciliation functions are inadequate.

To remedy the inefficiencies and weaknesses in the current system, we recommend that the government implement a payments modernization program as a result of which payment of benefits will be automated using the electronic transfer of funds. The new central funds distribution and payment processing system will be managed at the central level rather than by the 42 county-level AJPIS offices.

The payments modernization program will have two main pillars: (i) reforming the system of requesting and distributing funds to pay social assistance benefits by replacing the present fragmented and multi-layered system with a single centralized funds transfer and distribution system and (ii) reforming the methods used to pay beneficiaries by strategically moving to an electronic benefit payments platform and using modes of payment that are more secure, less costly, and more easily accessible to beneficiaries.

The overall objectives of the program will be to: (i) rationalize and automate the funds transfer function between ANPIS and the Treasury; (ii) phase out insecure cash-in-hand payments; (iii) ensure that beneficiaries receive their payments conveniently, safely, and securely; (iv) use the most cost-effective, secure, reliable, and sustainable technologies to make benefit payments; and (v) make all benefits payable directly to the beneficiary (including the Heating Benefit and the Disability Benefit).

The strategic advantages to be gained by adopting this new system are: (i) a significant reduction in administration complexity and workload; (ii) the freeing up of scarce resources to be reallocated to other critical support services; (iii) the elimination of costs associated with printing and distributing payment receipts; (iv) reduced scope for fiscal leakage by minimizing cash-only transactions; (v) an increase in the beneficiaries' options for making purchases and payments; (vi) the automatic audit and reconciliation of payments; (vii) a reduction in security costs associated with transporting large volumes of cash to and from post offices; and (viii) less financial exclusion for vulnerable groups.

We recommend that the transition to electronic payments should take place in stages over a period of five years and should involve specific groups of beneficiaries at each stage. Many beneficiaries will require support to move from cash-in-hand payments to e-payments, and special measures, such as help with opening bank accounts, will have to be put in place. A comprehensive communications plan will also be required to explain the new system to the public and build their confidence in it.

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Annex 1: Research Activities Underpinning this background study

1. Qualitative research:

- Case studies in Arad and Botoșani counties (over 150 interviews)
- Interviews with representatives of central governmental bodies (over 20 interviews)
- Interviews with recipients /eligible potential beneficiaries of means-tested benefits and with social workers.

2. Quantitative data collection and analysis:

- Census of the urban mayoralities on social housing
- Census of the SPAS social workers (more than 3,100 questionnaires from local authorities)
- Consolidated database of physicians, representatives of the pharmacies, community nurses/health mediators
- Administrative dataset on social services for the elderly
- Administrative dataset on social services for people with disabilities
- Administrative dataset on child protection services
- Identification of the “source communities” (rural/urban) for children in special protection services based on administrative data from the Child Monitoring and Tracking Informational System (CMTIS) managed by the National Authority for the Protection of Child’s Rights and Adoption (NAPCRA)
- Research in cooperation with UNICEF and NAPCRA on the children in the special protection services and the source-communities
- Analysis of poverty and material deprivation for vulnerable groups – 2008/2012 (EU-SILC)
- Prognosis of poverty dynamics in 2013/2020 (EU-SILC)
- Simulation of the impact of different policies on poverty (EU-SILC)

- Segmentation of NEETD for the target group of means-tested benefits (EU-SILC)
- Profiles of vulnerable groups – teenage mothers, children with parents left abroad, persons with disabilities, lonely elderly, rural, children out of school, homeless (2011 Population and Housing Census)
- Diagnosis of the housing problems for the overall population (2011 Population and Housing Census)
- Diagnosis of the problems in small/recently declared urban localities (2011 Population and Housing Census and administrative data)
- Identification of poor villages (2011 Population and Housing Census)
- Identification of rural marginalized communities (2011 Population and Housing Census)
- Analysis of the overlap between Roma communities and urban/rural marginalized communities
- Analysis of the conditions and types of social participation.

3. Other analyses (case studies, focused desk research, and background notes):

- Functional analysis of the role of the National Agency for Employment in reducing poverty and social exclusion
- Analysis of the microcredit sector and of the shelter workshops for persons with disabilities
- Analysis of special education for children with disabilities
- Analysis of the nutrition-related programs in schools
- Analysis of the means-tested programs in schools (school supplies, High School Money, and social scholarships administered at the local level)
- Stock taking of the European funds for small urban localities.

Annex 2: Poor and Vulnerable Groups

I. Statistical Data

ANNEX TABLE 2.1: Percentage of the Population and Relative Poverty Rates by Age and Area, 2012

	Population structure		Relative poverty rate	
	Rural*	Urban**	Rural*	Urban**
0-15 year olds	16.6	13.8	52.1	16.5
16-64 year olds	62.5	70.9	39.2	11.2
65+ year olds	21.0	15.3	23.5	6.3
Total	100	100	38.1	11.2

Source: World Bank calculations using data from the 2012 EU-SILC.

Note: *Rural = thinly populated areas. **Urban = densely populated areas and intermediate areas.

ANNEX TABLE 2.2: Percentage of the Population and Relative Poverty Rates by Occupational Status and Area, 2012

	Population structure		Relative poverty rate		
	Rural*	Urban**	Rural*	Urban**	Total
<16 year olds	16.9	14.0	52.1	16.5	33.3
Employees	18.2	39.0	11.6	3.5	5.6
Self-employed (including family workers) with employees	0.1	0.4	0.0	6.6	5.5
Self-employed without employees, skilled or unskilled workers in agriculture, forestry or fishery	15.8	2.3	57.4	54.0	56.8
Self-employed without employees, other occupations	5.6	2.4	49.7	22.7	39.8
Unemployed	2.0	2.4	62.9	45.6	52.1
Pupil, student, further training, unpaid work experience	5.8	8.8	44.1	15.8	25.1
In retirement	24.6	24.3	20.7	5.1	11.8
Permanently disabled or/and unfit to work	1.0	0.6	49.3	38.6	44.7
Fulfilling domestic tasks and care responsibilities	9.4	5.0	55.7	29.8	44.8
Other inactive person	0.6	1.0	63.9	23.6	36.3

Source: World Bank calculations using data from the 2012 EU-SILC.

Note: *Rural = thinly populated areas. **Urban = densely populated areas and intermediate areas.

ANNEX TABLE 2.3: Poverty Rates for Children (0-17) and Youths (18-24) by Area of Residence, 2012

	Children	Youth
Urban*	17.0	18.4
Rural**	52.6	47.1
Total	34.0	31.4

Source: World Bank calculations using data from the 2012 EU-SILC.

Note: *Urban = densely populated areas and intermediate areas. **Rural = thinly populated areas.

ANNEX TABLE 2.4: Poverty Rate for Households with Different Numbers of Children, 2012 (%)

Households with...	Total	Urban*	Rural**
0 children	16.5	8.2	29.0
1 child	22.6	12.3	41.8
2 children	33.8	16.1	52.0
3+ children	56.6	39.2	65.2

Source: World Bank calculations using data from the 2012 EU-SILC.

Note: *Rural = thinly populated areas. **Urban = densely populated areas and intermediate areas.

ANNEX TABLE 2.5: The Percentage of Children Living in Households with Different Numbers of Children, 2012

Households with...	Total	Urban**	Rural*
0 children	0	0	0
1 child	36	24	13
2 children	45	23	22
3+ children	19	6	13
Total	100	52	48

Source: World Bank calculations using data from 2012 EU-SILC.

Note: * Urban = densely populated areas and intermediate areas. ** Rural = thinly populated areas.

ANNEX TABLE 2.6: Average Real Pension Indices of State Social Insurance Pensioners, including Pensions from Ministry of Defense, Ministry of Internal Affairs, and Romanian Information Service (base year 2000)

2000	2001	2002	2003	2004	2005	2006
100	105.9	109.5	117.4	131.2	141.8	154.8
2007	2008	2009	2010	2011	2012	2013
190.1	255.1	285.8	278.9	265.7	265.9	266

Source: Tempo Online, the National Institute of Statistics.

ANNEX TABLE 2.7: Relative Poverty Rate by Gender, 2012 (%)

Age	Females	Males
0-17	34.9	33.1
18-24	30.4	32.4
25-49	22.3	21.2
50-64	15.1	17.6
65-79	16.6	7.8
80+	26.5	14
65+	19.3	9.2
Total	23.1	21.9

Source: World Bank calculations using data from the 2012 EU-SILC.

ANNEX TABLE 2.8: Relative Poverty Rate by Gender, 2012 (%)

	% of elderly (aged 65+)	% of poor elderly (aged 65+)
Lone elderly (65+), of whom...	22	33
Men	6	5
Women	16	28
Couple of elderly (both 65+ and married)	23	8
Other types of HHs with elderly	34	26
Households without elderly	0	0
Total	100	100

Source: World Bank calculations using data from the 2012 EU-SILC.

ANNEX TABLE 2.9: Relative Poverty Rate by Gender, 2012 (%)

	2008	2009	2010	2011	2012
Primary education	42.1	37.4	36.4	35.1	35.3
Lower secondary education	33.6	30.2	31.7	34.5	34.4
Upper secondary education	14.8	11.9	13.3	15.2	15.2
Post-secondary non-tertiary education	3.3	2.1	4.6	5.1	5.6
First stage of tertiary education	0.7	1.2	1.1	2	3.1
Age<=16	32.4	31.4	31.3	32.4	34
Total	23.4	20.8	21.1	22.2	22.6

Source: World Bank calculations using data from the 2012 EU-SILC.

ANNEX TABLE 2.10: Relative Poverty Rates for the Working Age Population (between 15 and 64) by Occupational Status and Area, 2012

	Relative poverty rate			% of population
	Rural*	Urban**	Total	
Employees	11.6	3.5	5.6	44.2
Self-employed (including family workers) with employees	0.0	6.7	5.6	0.4
Self-employed without employees, skilled or unskilled workers in agriculture, forestry or fishery	61.8	54.5	60.6	10.4
Self-employed without employees, other occupations	52.7	21.9	41.0	5.2
Unemployed	62.9	45.6	52.1	3.2
Pupil, student, further training, unpaid work experience	46.7	16.0	27.0	12.9
In retirement	15.0	5.3	8.4	12.3
Permanently disabled or/and unfit to work	48.6	34.5	42.5	1.0
Fulfilling domestic tasks and care responsibilities	56.7	30.9	45.9	9.4
Other inactive person	63.8	24.6	37.0	1.2
Total	39.6	11.3	22.5	100.0

Source: World Bank calculations using data from the 2012 EU-SILC.

Notes: *Rural = thinly populated areas. ** Urban = densely populated areas and intermediate areas.

ANNEX TABLE 2.11: Relative Poverty Rates for the Working Age Population (between 15 and 64) by Occupational Status, 2008-2012

	2008	2009	2010	2011	2012
Employees	5.5	5.1	5.0	5.9	5.6
Self-employed (including family workers) with employees	3.5	2.2	0.0	2.1	5.6
Self-employed without employees, skilled or unskilled workers in agriculture, forestry or fishery	62.0	66.0	58.7	63.0	60.6
Self-employed without employees, other occupations	34.5	39.0	35.8	41.3	41.0
Unemployed	41.5	40.4	42.0	45.3	52.1
Pupil, student, further training, unpaid work experience	23.6	21.8	20.6	23.5	27.0
In retirement	12.5	10.7	8.5	9.3	8.4
Permanently disabled or/and unfit to work	39.0	35.8	33.2	35.5	42.5
Fulfilling domestic tasks and care responsibilities	43.4	40.4	41.7	45.8	45.9
Other inactive person	33.2	44.2	39.0	36.1	37.0
Total	21.2	20.9	20.2	22.0	22.5

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

ANNEX TABLE 2.12: Poverty Rate by Ethnicity and Residential Area, 2013 (%)

	Non-Roma	Roma
Rural	5.6	37.0
Urban	1.6	28.0

Source: World Bank calculations using data from the 2013 HBS.

ANNEX TABLE 2.13: Percentage of People under 60 years old Living in Households with Very Low Work Intensity in Different Kinds of Geographical Areas, 2012

	2012
Densely populated areas	5.5
Intermediate areas	7.4
Thinly populated areas	9.0
Total	7.4

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

ANNEX TABLE 2.14: Percentage of People Aged 16 to 59 Living in Households with Very Low Work Intensity by Education, 2008-2012

	2008	2009	2010	2011	2012
Primary education	20.0	21.7	18.9	17.8	18.0
Lower secondary education	11.0	9.8	9.2	9.8	9.6
Upper secondary education	7.1	6.4	5.8	5.5	6.6
Post-secondary non-tertiary education	8.6	8.6	8.1	9.0	9.2
Tertiary education	2.0	2.2	2.2	2.1	3.8
Age<=16	5.6	6.7	3.7	3.0	4.6
Total	8.2	7.6	6.8	6.6	7.3

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

ANNEX TABLE 2.15: Percentage of People Suffering from Severe Material Deprivation, 2008-2012

Cannot afford to ...	2008	2009	2010	2011	2012
... go on holiday	75.7	75.6	77.1	76.1	75.2
... run a car	48.8	46.6	43.6	41.3	39.6
... eat meat or other protein regularly	19.5	23.7	21.4	21.9	23.7
... face unexpected expenses	41.9	41.8	44.7	50.5	53.2
... pay their rent, mortgage, or utility bills	0.4	0.6	0.4	0.6	0.6
... keep their home adequately warm	13.9	14.9	16.1	17.3	18.1
... purchase a washing machine	20.2	17.8	15.5	13.7	12.9
... have a telephone	12.4	9.4	7.2	6.6	5.8
... purchase a color television set	2.6	2.2	1.8	1.4	1.5

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

ANNEX TABLE 2.16: Percentage of People Suffering from Severe Material Deprivation by Residential Area, 2012

Cannot afford to ...	Thinly populated areas	Densely populated areas/intermediate areas
... go on holiday	86.2	67.1
... run a car	46.8	34.3
... eat meat or other protein regularly	29.1	19.8
... face unexpected expenses	59.5	48.6
... pay their rent, mortgage, or utility bills	0.2	0.8
... keep their home adequately warm	17.5	18.6
... purchase a washing machine	22.4	5.9
... have a telephone	9.8	2.9
... purchase a color television set	2.7	0.6

Source: World Bank calculations using data from the 2012 EU-SILC.

ANNEX TABLE 2.17: Percentage of People Suffering from Severe Multiple Deprivation by Education Level, 2008-2012

	2008	2009	2010	2011	2012
Primary education	52.9	50.9	51.0	47.2	46.9
Lower secondary education	43.2	41.4	40.7	38.9	38.0
Upper secondary education	25.7	25.5	24.9	24.3	25.3
Post-secondary non-tertiary education	15.9	15.0	13.1	11.1	11.7
First stage of tertiary education	6.6	8.1	9.0	9.0	8.8
Age<=16	39.3	40.1	36.7	36.0	38.6
Total	32.9	32.2	31.0	29.4	29.9

Source: World Bank calculations using data from the 2008-2012 EU-SILC.

ANNEX TABLE 2.18: Percentage of Population at Risk of Poverty or Social Exclusion, 2008-2013

	2008	2009	2010	2011	2012	2013
People at risk of poverty or social exclusion (AROPE)	44.2	43.1	41.4	40.3	41.7	40.4
People at risk of relative poverty after social transfers (AROP)	23.4	22.4	21.1	22.2	22.6	22.4
People severely materially deprived	32.9	32.2	31	29.4	29.9	28.5
People living in households with very low work intensity (population aged 0 to 59 years)	8.3	7.7	6.9	6.7	7.4	6.4

Source: Eurostat.

ANNEX TABLE 2.19: Projected Relative and Anchored Poverty Rates, 2012-2020

	Relative poverty rate			Anchored poverty rate (poverty line anchored in 2012)		
	Low Growth	Moderate Growth	High Growth	Low Growth	Moderate Growth	High Growth
2012	22.5	22.5	22.5	22.5	22.5	22.5
2013	23.1	23.1	22.8	21	21	21
2014	22.9	22.8	22.3	20.3	19.9	19.6
2015	22.9	22.4	22.5	19.4	18.7	18.7
2016	22.7	22.3	22.3	18.8	18.1	17.6
2017	22.9	22.5	22.2	18.2	17.1	16.3
2018	22.9	22.5	22.1	17.4	15.5	14.5
2019	23	22.7	22.2	16.7	14.4	13
2020	23.1	22.7	21.6	15.9	13.4	11.2

Source: World Bank estimations using data from the EU-SILC in three main scenarios.

ANNEX TABLE 2.20: Reduction in the Number of Poor in the Best Case Scenario, 2012-2020

	2012	2013	2014	2015	2016	2017	2018	2019	2020	Diff 2020- 2012
Predicted population 2012-2020 (thousands)	20,071	20,020	19,988	19,964	19,935	19,904	19,873	19,842	19,810	
Projected poverty rate	22.5	23	22	23	22.3	22.2	22.1	22.2	21.6	
Projected number of poor if population size does not change (thousands)	4,516	4,576	4,476	4,516	4,476	4,456	4,436	4,456	4,335	-181
Projected number of poor if population size changes (thousands)	4,516	4,565	4,457	4,492	4,445	4,419	4,392	4,405	4,279	-237

Source: World Bank estimations using data from the EU-SILC in three main scenarios.

II. Assumptions of the Poverty Forecasting Model

Our poverty forecasting model relies on a macro-demographic labor force-micro model to quantify the likely reduction in relative income poverty between 2014 and 2020. The model was used to assess under what conditions Romania will achieve the poverty target and what combination of economic growth, employment and wage growth, and policies designed to increase the earnings and transfer income of the poor would ensure the achievement of the target. The model uses 2012 EU-SILC data to simulate the 2014-2020 at-risk-of-poverty (AROP) indicator and anchored poverty indicators.

The poverty forecasting model relies on a set of macroeconomic, labor force, and demographic assumptions:

- Three possible economic growth scenarios were modeled - a low, base, and a high economic growth scenario (Annex Table 2.21, middle panel). The forecasts used in the scenarios were those of the IMF, the World Bank, and the EU as of September 2014. Under the low economic growth scenario, Romania's GDP per capita is expected to grow by 2.2 to 2.5 percent per annum over the forecasting period. Under the high economic growth scenario, per capita GDP is expected to increase gradually from 3 percent in 2014 to 5 percent in the period 2018 to 2020.
- Corresponding to each economic growth scenario, there are three employment growth scenarios (Annex Table 2.21, first panel). Under the low scenario, the share of employed people in the cohort of those aged between 20 and 64 years old is expected to grow from 63.8 percent in 2012 to 64.9 percent by 2020 or by 1 percentage point over the period. This forecast is consistent with the weak employment growth achieved during the previous decade. Under the base scenario, employment is expected to grow by 3.6 percentage points. Under the high (rather optimistic) growth scenario, the employment rate is expected to increase gradually to reach 70 percent by 2020, which is the Romania's EU 2020 employment target (an increase of 6.2 percentage points over eight years).
- Labor productivity was assumed to follow the same path in all cases, while education trends were derived on the assumption that Romania will meet its EU 2020 national education targets by 2020.

ANNEX TABLE 2.21: Growth Scenarios for Romania

	Employment rate (20-64 years old)			GDP Growth rate			Labor productivity (growth rate, per hour)	% of 18-24 with at most lower secondary education	Tertiary educational attainment in 30-34 age group
	Low	Base	High	Low	Base	High			
2012	63.8	63.8	63.8						
2013	63.6	64.1	64.5	3.5	3.5	3.5	1.5	14.8	20.2
2014	64.0	64.6	65.2	2.5	2.7	3.0	1.7	14.3	21.3
2015	64.4	65.1	65.9	2.6	3.1	3.5	2.0	13.8	22.1
2016	64.6	65.6	66.7	2.5	3.7	4.0	2.4	13.3	23.0
2017	64.7	66.1	67.4	2.5	3.9	4.5	2.7	12.8	24.0
2018	64.8	66.5	68.1	2.5	4.0	5.0	2.7	12.3	25.0
2019	64.8	66.8	68.9	2.2	4.1	5.0	2.7	11.8	26.0
2020	64.9	67.4	70.0	2.2	4.1	5.0	2.7	11.3	26.7

The assumed changes in economic growth, employment, labor productivity and education achievement that are presented in Annex Table 2.21 were then incorporated into a microeconomic model based on data from Romania's 2012 EU-SILC survey, the same survey that was used to track progress toward the relative income poverty target (AROP) and the anchored poverty rate.⁵⁵⁰

The model was also calibrated with the predicted change in demographics and labor market participation.⁵⁵¹ Between 2012 and 2020, Romania is likely to experience a significant change in the level and structure of its population (see

Annex Table 2.22). The total population is expected to fall by 177,000 people. This change will be distributed differently across age groups. While the old age cohort (people aged 65 years old and older) is expected to increase by 436,000 people, the working age population (those aged 20 to 64 inclusive) will shrink by 557,000 people, and the number of children (up to 20 years old) by 56,000. Over time, the working age population will fall while the elderly population will increase, putting further strains on government revenues derived from income taxes and increasing demand for pensions, healthcare, and elder care.

ANNEX TABLE 2.22: Main Demographic Changes, 2014–2020 (in thousand people)

Age groups	Year							Change 2014-2020
	2014	2015	2016	2017	2018	2019	2020	
0-14	3,133	3,127	3,117	3,116	3,117	3,113	3,110	-24
15-19	1,093	1,088	1,092	1,090	1,081	1,071	1,061	-32
20-64	12,464	12,368	12,270	12,174	12,083	12,002	11,907	-557
65+	3,297	3,381	3,457	3,524	3,592	3,656	3,733	436
Total	19,987	19,964	19,935	19,904	19,873	19,842	19,810	-177

Source: World Bank's PROST model for Romania.

In the micro model, the employed population was derived from the predicted working age population (Annex Table 2.22) and the low, base, and high employment rates (Annex Table 2.21). Further assumptions about the rate of unemployment were used to estimate the number of unemployed over the forecasting period. The sum of the employed and the unemployed represents the total active population of each year.

Finally, the model incorporated the predicted changes in the coverage of the old age pension (assumed to be stable)

and its real value as forecasted by the PROST model. The ratio of the average pension to the average wage, however, is predicted to fall by about 10 percent between 2014 and 2020 as a result of the Swiss indexation formula used in the first pillar of the pension system in Romania. This change was incorporated into the model.

Changes in the size of different population groups and of the employed and the unemployed were introduced into the micro model by altering the weights of the respective categories.

⁵⁵⁰ For each of the forecast years, the income of the households in the survey sample was changed using the assumed changes in education distribution, employment, labor productivity, and expected GDP growth. The model adjusted education distribution in such a way that it mimics the supposed education distribution in that particular year; this adjustment affected only individuals in the 20 to 34 age group. Employment was also adjusted to take account of the employment rates of the 20 to 64 age group in each year. The unemployed/inactive individuals with the highest probability of being employment were "switched" to employed status until the total number of the employed reached the assumed employment level of that year. These individuals who are predicted to move from inactivity to employment were imputed earnings based on their level of education, sector of activity, work experience, and other variables known from the survey. All individuals who were employed (or were predicted to move from inactivity to employment) received a flat increase in their earnings equal with the assumed increase in labor productivity. The social protection transfers to households were assumed to remain at the same level in real terms (in other words, they increased only with the expected inflation rate). The incomes of the households were changed according to these assumptions, and the model generated a new, simulated income distribution for each year of the forecast period.

⁵⁵¹ The demographic forecast was taken from the National Institute for Statistics. Other demographic changes, such as changes in formal employment, informal employment, the number of pensioners, and the real value of their pension, were simulated using the World Bank's PROST model.

Annex 3: Employment

I. Statistical Data

ANNEX TABLE 3.1: Key Characteristics of the NEETD Groups from the Bottom Quintile

Group	Size	Short description	Males (%)	Urban (%)	Modal Age	High School or More (%)	Single (%)	Kids<15 (Average)	Kids<16 (Average)
1	24	Educated urban unemployed men	75	74	35-44	65	39	0.53	0.15
2	18	Married middle-aged rural women	12	31	35-44	62	0	0.81	0.27
3	17	Uneducated idle youths	28	67	15-24	25	49	0.1	0.0
4	11	Young rural women with families	4	6	25-34	9	0	2.45	0.74
5	10	Single Roma youths	38	35	15-24	0	70	1.26	0.19
6	8	Educated rural unemployed	67	1	25-34	91	71	0.15	0.15
7	7	Urban Roma women with families	0	100	25-34	0	0	2.84	1.78
8	5	Young urban couples	47	97	25-34	52	0	2.28	0.85

Source: Bachas (2013).

ANNEX TABLE 3.2: Activation Policies

Vulnerable Group	Activation Policies
Educated urban unemployed	Job counseling and assistance
Educated rural unemployed	Additional barrier might be low local demand ->information and job search assistance
Educated inactive women	Provide opportunity to work by developing child care facilities
Young and middle-aged urban couples	Second chance education, targeted retraining linked to new employment
Young unemployed early school leavers	Build human capital early on (through CCTs), vocational education
Inactive women with little work experience and many children	Address barriers to employment

Increasing barriers
↓

Source: Bachas (2013).

II. Profiling of Job Seekers

In Romania, there is no nationwide systematic model of job seeker profiling to distinguish different types of job seekers as is practiced in some countries such as Australia, Germany, Ireland, Denmark, France, and Serbia.

One benefit of such profiling systems is that they can reduce the costs involved in making clients job-ready and thus enable employment services to allocate more resources to serving disadvantaged groups who are hard to activate. An extension of the current self-service approach

would be to allow job seekers to complete a “profiling” tool either online or using pen and paper for those who have no access to ICT. This would make it possible to categorize self-registered clients and to prioritize interviews with those most in need. The clients whose self-assessment indicates that they do not need an in-depth interview can be encouraged to use the self-service approach to pursuing jobs and registering themselves for vocational training courses or internships online.

ANNEX TABLE 3.3: Profiling in the Serbian Public Employment System

Profiling Levels	Service Provided
1 st Level Clients who are easily employable on the open labor market and are offered basic mediation services by PES.	Information and job-matching Job fairs
2 nd Level Clients who are employable on the open labor market but who need to be supported with active job-search PES services.	Information and job-matching CV preparation and interview techniques – active job search Job clubs
3 rd Level Clients who need intensive support from the PES	“Self-efficiency” training Pre-job-club workshops to help this category of clients to participate in the job club Employment subsidies Public works Programs of additional education
4 th Level Clients for whom short-term mediation is not possible without intensive support for their reintegration into the labor market	Intensive individual counseling Assessment of working ability “Self-efficiency” training Social and professional rehabilitation

Source: Communication from Serbian Public Employment Service, 2010.

Profiling is currently one of the key areas of experimentation and study in Europe (there is already a strong history of using profiling in the US). Profiling is basically a way of identifying those clients most in need when they register with the PES so that PES resources are properly and cost-effectively targeted (see the Serbian model described above). The idea is that there is less need to engage with clients who can help themselves than to concentrate on the

ones who do need help. This approach supports the concept of a dual internal pricing system as is used by some PES in EU and OECD countries so that more financial resources can be allocated to clients who need extensive support and are hard to place in jobs.

There are a number of approaches that can be used to carry out profiling, with the econometric approach generating the most interest among professionals at present.

The characteristics of each approach can be described as follows:

- Assessment by Counselor

In this approach, which is currently used in the Romania NEA, the clients' risk of long-term unemployment is assessed by employment service staff solely on the basis of interviews. The risk assessment can be either more or less formal in terms of using questionnaires and checklists. The main advantage of this approach is that it captures risk factors specific to the individual and thus makes it easy to prepare a needs assessment. As to the disadvantages, the approach is costly, and the accuracy of the assessment can vary substantially between individual employment mediators.

- Group Screening

In this approach, a client's risk of long-term unemployment is determined on the basis of whether he or she belongs to one or more at-risk target groups, which is typically ascertained by employment service staff using statistical analysis. The main advantages of this approach are its low costs and its objectivity as the assessment does not require the input of counselors. The disadvantage of the approach is that it does not take into account characteristics and risk factors specific to each individual as the assessment is based on group characteristics only.

- Econometric (Statistical) Model

In the econometric approach, the characteristics of individual clients are fed into a mathematical model based on statistical indicators and knowledge of causal relationships. The model then calculates a risk measure for each client. The main advantages of this method include its low costs, its objectivity, and its combination of theory and empirical data. The disadvantages of the model include its inflexibility, the complexity of building the model, and the need for statistical data on job seekers' characteristics and outcomes that must be regularly updated. Adopting the econometric approach is more time-consuming than other methods because it must be preceded by research to establish the econometric factors to be used in profiling. The time needed to introduce the econometric model is approximately two years.

The Australian Job Seeker Classification Instrument (JSCI) is based on the econometric model and computes the risk of

becoming long-term unemployed on the basis of a number of individual characteristics. Based on their JSCI results, job seekers are referred to Job Services Australia to receive whatever level of assistance best suits their needs. Where the JSCI indicates that a client may need the most intensive assistance from Job Services Australia or the support provided by the Disability Employment Services (DES), the job seeker will undertake an additional comprehensive Job Capacity Assessment (JCA) before being referred to the most suitable specialized service.

The JSCI computes the risk of becoming long-term unemployed on the basis of 14 individual characteristics as follows:

- Age
- Gender
- Language and literacy
- Disability or medical condition
- Recent work experience or lack thereof
- Stability of residence
- Educational attainment
- Disclosed ex-offender
- Personal characteristics requiring professional or specialist judgment
- Indigenous/Australian born/South Sea Islander status
- Country of birth
- Geographic location
- Vocational qualifications
- Family status/living arrangements
- Contactability (access to a telephone)

Only job seekers at high risk are counseled immediately by their case managers, whereas low-risk job seekers are eligible for job search training only after a few months. Considering the extensive datasets now available to the National Employment Agency in Romania, it is recommended that this approach be considered.

III. Evaluation of the Outcomes of ALMPs

A sustainable system for measuring the outcomes of active labor market programs (ALMPs) is presented in the OECD Employment Outlook for 2005.⁵⁵² This system depends on having inter-connected databases such as those that are or will be available to the NEA. The authors of the OECD report proposed that the PES should track off-benefit, employment, and earnings outcomes for program participants for up to five years in order to assess which programs have had a genuinely beneficial long-term impact. They suggested that a robust measure of long-term outcomes can be assessed in terms of a “B + tW” formula, where B is the benefit payments saved, t is the tax rate, and W is total participant earnings (the product of the employment rate and the wage rate). They go on to say that “when impacts are measured over long periods, the earnings component in this formula can be relatively large. Effective performance management with outcomes valued according to the (B + tW) formula would not only reduce total unemployment but also increase the delivery of substantive employment services which improve long-term employment and earnings outcomes. It would improve

government’s net financial balance, because the (B + tW) criterion means that programs are selected when the benefit savings and increased tax receipts that they generate exceed their cost.”

How benefit savings, the tax rate, and wage savings can be calculated can be seen by applying this system to the measurement of the outcomes of Job Clubs in Ireland. The current cost of an immediate job club placement⁵⁵³ in Ireland is €800 when all job club capital and staff costs are taken into account. The employment taxation rate for that one person over the first six months of employment (€600 to €1000 in total depending on the job) can exceed the cost of the job club intervention. The saving on unemployment benefit (say €720 per month multiplied by six) is additional to the tax gain. If the placed job seeker is tracked over a long period, the saving to the government is in many cases even more substantial using the B+ tW formula. It is, therefore, clear that the Job Clubs’ simple active job search interventions in a normal labor market can be one of the most cost-effective and efficient proactive employment measures available to governments.

IV. Youth Guarantee Program in Romania, 2014–2015

Twenty-two Youth Guarantee Centers will be established in Romania over the next year, and 10 have recently begun operating. They will operate as joint information and employment centers using many of the existing NEA tools and services. They are designed to provide a more comprehensive overall package of services than the range of services provided by local employment agencies, including educational and training opportunities as well as employment mediation. Part of the logic of establishing such centers is the perceived reluctance of many young job seekers to use the existing PES services beyond meeting the conditionalities associated with any monetary benefits that they may be receiving. Having a service that operates in parallel with yet connected to the NEA may have implications for how the management of labor market

provision for young people is delivered in the future.

The services planned for delivery through the Youth Guarantee Initiative in 2014 and 2015 include:

1. Early intervention and activation measures:

- An integrated database of youth unemployment
- Information campaigns in schools
- Scaling up self-service systems and implementing them at the local level, especially in rural areas
- Continuation of the programs “Second Chance for a Primary and Lower Secondary Education” and “High-school Money.”

⁵⁵² OECD (2005).

⁵⁵³ The placement rate averages 70 percent for job-ready clients.

2. Labor market integration measures:

- Activation measures for self-employment and entrepreneurship
- Professional counseling and guidance
- Professional training
- Mobility allowances
- Incentive payments for employers
- Pilot youth guarantee schemes.

V. A Staff Training Initiative to Professionalize the Work of NEA Advisers and Mediators

The approach envisaged is for the NEA to enter into an agreement with a university (either the psychology department or the adult education/counseling department) in order to jointly deliver a two-level training program for employment advisers and mediators and other front-line employment staff. The first level (part-time over six months) would be delivered to all the relevant staff and would consist of an introduction to professional vocational guidance in the PES. The second level (see Annex Box 3.1. below) would initially be delivered to a selected number of graduates from the first level, with the second level taking two years to complete on a part-time basis. Ultimately the aim would be to have most front-line staff who wish to take part trained at the second level. The courses described in Annex Box 3.1. were developed in Ireland by the National University of Ireland, Maynooth,⁵⁵⁴ and any such initiatives in Romania would need to be developed from scratch taking into account local conditions and a training needs analysis.

Given the right conditions, the first level of training could be put in place quickly. In Ireland it is delivered in an open learning format incorporating home-based learning materials and workshops. The methodology of the workshops would be based on an experiential approach, which encourages people to engage in a critically reflective process of learning. The course would explore the models and approaches to guidance and counseling as well as

client case reviews, reflections on good practice, and applied guidance skills. Workshop themes might include:

- Adult Development and the Guidance Process
- Models of Adult Guidance
- Applied Guidance Skills
- Support Systems, Contracts, and Boundaries
- Change, Transition, and Loss
- Understanding Aggression and Conflict
- Developing a Quality of Work Life
- Endings and Evaluation.

Assessment procedures might include on-the-job skills applications and case presentations, learning journals, and interviews by the trainer. The training would teach the skills and strategies used in advising, informing, and guidance, assessing information and contacts in the labor market context, working effectively with others in teams and networks, managing relationships and boundaries with clients, and defining roles in different situations and settings.

⁵⁵⁴ This model is based on the Certificate in Guidance and Counseling course developed by the Adult Education Department of the National University of Ireland-Maynooth in conjunction with the Irish PES (FAS).

ANNEX BOX 3.1

Second-level professional adult guidance programme for employment advisers/mediators

The course aims to develop the critical awareness of participants about their professional role by:

Developing participants' knowledge on adult guidance and counselling;

Facilitating the exploration of issues of marginalisation and exclusion as they relate to employment and unemployment;

Enabling participants to develop the key skills and competencies involved in working with clients.

The Diploma would extend over two academic years on a part-time basis and would be delivered in an open learning format, incorporating e-learning materials, and workshops.

Course hours include 212 hours of home-based learning and 216 hours of workshop (total 428 hours)

The workshops are to be provided over 2 x 3 day and 6 x 2 day sessions each year and one week-long psychometric testing workshop in the first year. Participants are expected to attend on average one workshop per month.

Introductory module

- Unit I: Course guide
- Unit II Study skills for adults returning to learning
- Unit III Learning as a way of being

1. Psychology of human development

- Unit I Transition to adulthood
- Unit II Developmental stages in adulthood
- Unit III Development and change in the context of social exclusion

2. Sociological perspectives on work, employment and everyday life

- Unit I Work, employment and everyday life
- Unit II Work and unemployment
- Unit III Historical overview

3. Vocational Guidance

- Unit I Career information and Information Technology
- Unit II Theory and practice of career development and behavior

- Unit III Theory and application of psychometric testing

4. Group work

- Unit I Group facilitation: skills and styles
- Unit II Experiential approaches to group dynamics and process
- Unit III Theoretical perspectives on group work

5. Theory and Practice of guidance and counselling

- Unit I Applied guidance skills
- Unit II Applied counselling skills
- Unit III Theoretical perspectives on counselling

6. Research and evaluation methodologies

- Unit I Quantitative approaches to research
- Unit II Qualitative approaches to research
- Unit III Applied research techniques

7. Psychology of work and working life

- Unit I Organization systems and dynamics
- Unit II Human resource management
- Unit III Occupational psychology

8. Professional issues in adult guidance and counseling

- Unit I Working with difference
- Unit II Working with disability

Skills Application: twice a year, participants are required to submit a taped interview together with a written commentary. This would be completed in the light of both the theoretical and practical aspects of the course. The case studies will assess participants' capacity to demonstrate a competent use of skills.

A portfolio of home based learning activities is to be completed by each participant and assessed to gauge the understanding of the material.

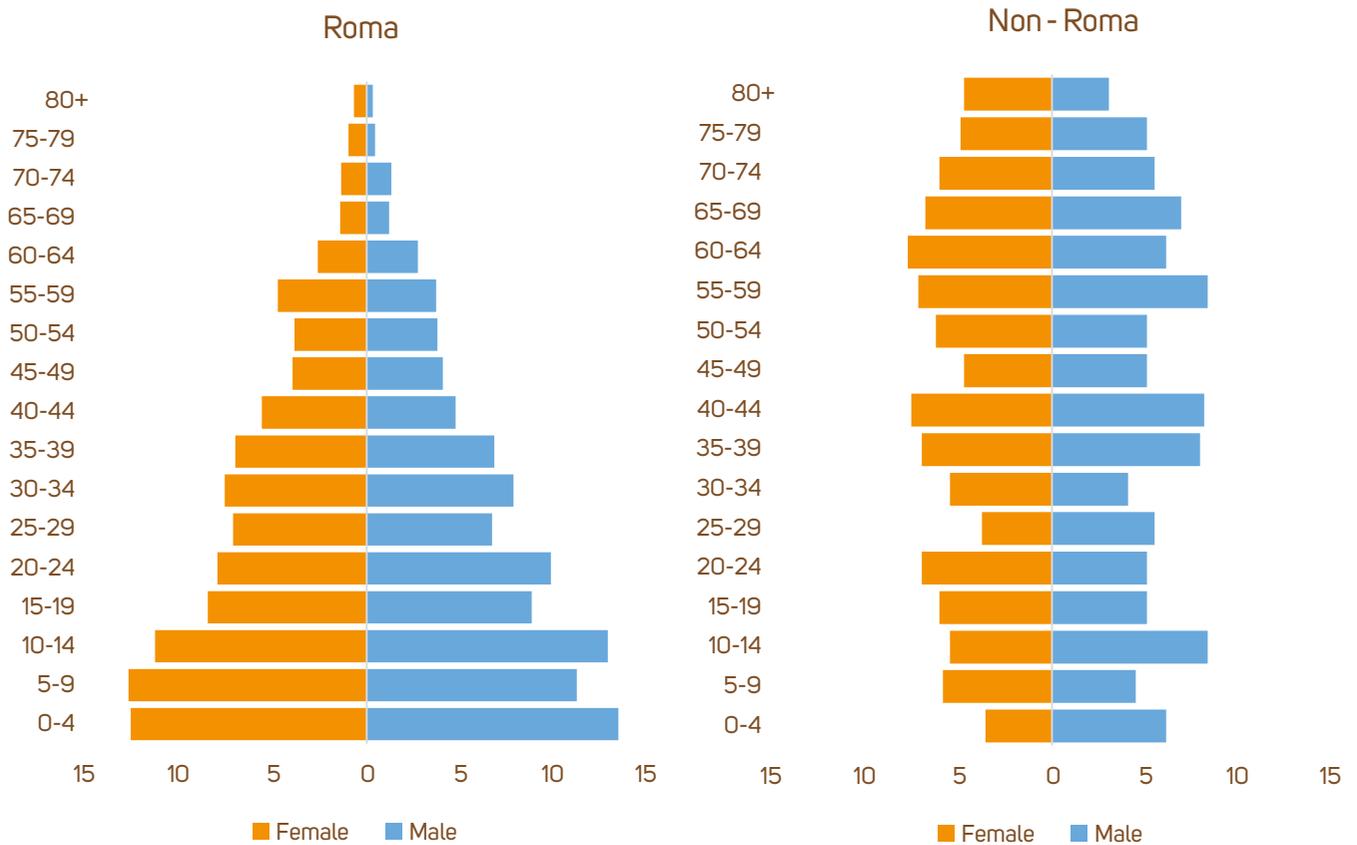
Essay/Research: Participants are required to submit two essays throughout the course. One of the essay must be completed from the module Theory and Practice of Guidance and Counselling. Participants will also complete a research project integrating perspectives from various modules.

Self- and Peer Assessment: Twice during the course participants will submit a learning statement on their personal development and learning progress



Annex 4: Social Transfers

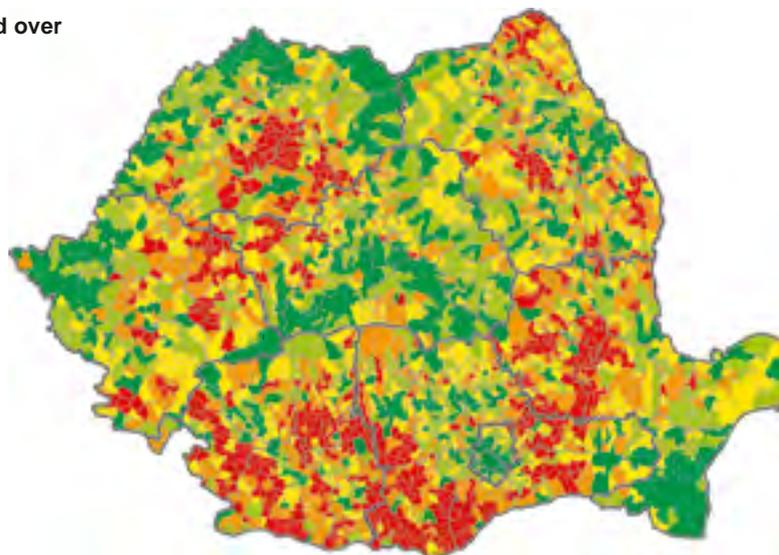
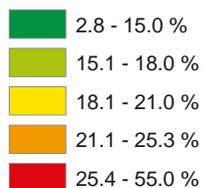
ANNEX FIGURE 4.1: Contrasting Population Pyramids: Roma and Non-Roma Population in Romania



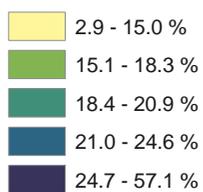
Source: Based on the 2011 UNDP/World Bank/EC regional Roma survey and United Nations (2013).

ANNEX FIGURE 4.2: Share of the Population Aged 65 and Over in the Total Population (left side) and Share of Pensioners in the Total Population (right side)

Share of the population aged 65 and over in total population

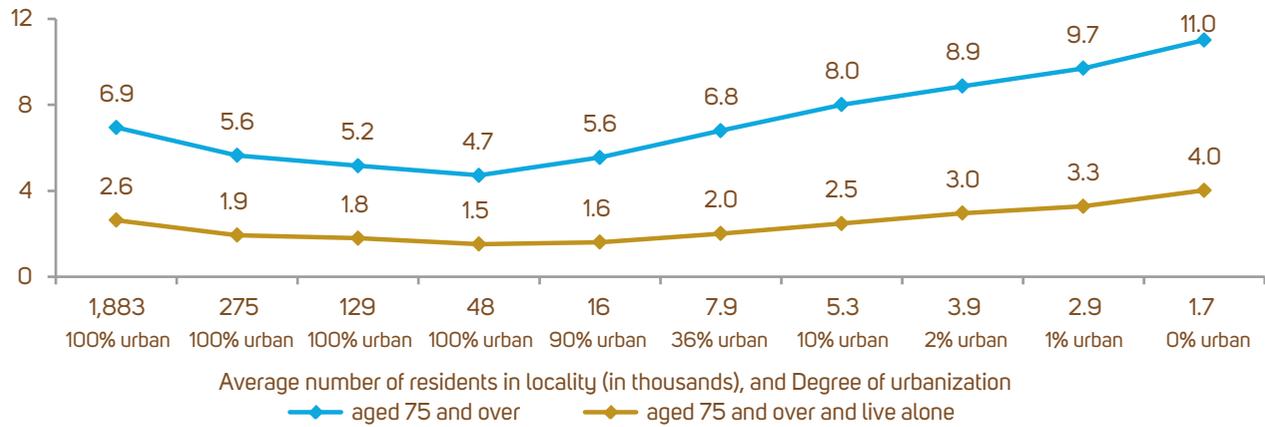


Share of pensioners in total population



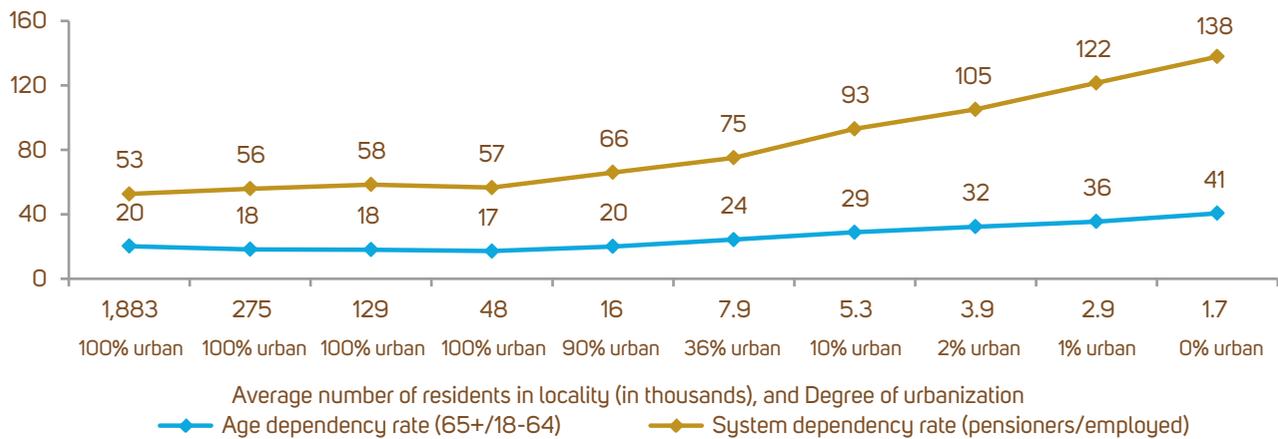
The intervals represent quintiles calculated at locality level.
Data source: NIS, Population and Housing Census 2011
Cartography: ESRI, ArcGIS 10.1

ANNEX FIGURE 4.3: Proportion of Population Aged Over 75 and Living Alone by the Degree of Urbanization in Population Deciles



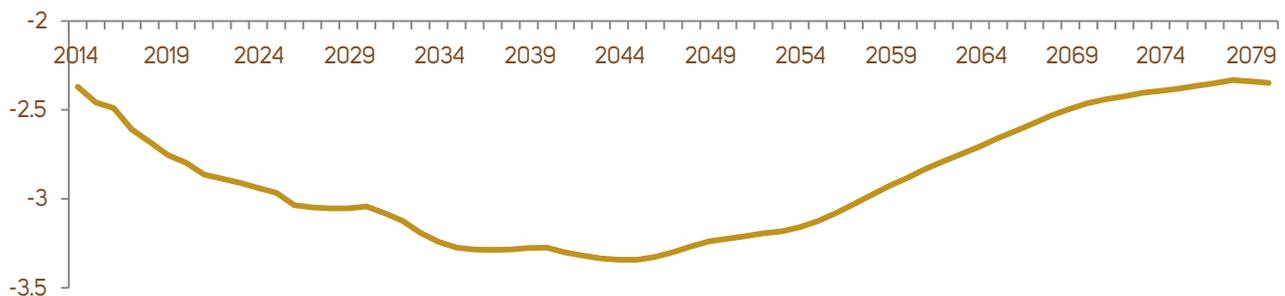
Source: 2011 Population and Housing Census data.

ANNEX FIGURE 4.4: Old Age Dependency Rates by the Degree of Urbanization in Population Deciles



Source: 2011 Population and Housing Census data.

ANNEX FIGURE 4.5: Projected PAYG Pension System Deficit as a Percentage of GDP



Source: World Bank calculation using PROST, 2013 input data provided by Ministry of Public Finance.

Annex 5: Social Services

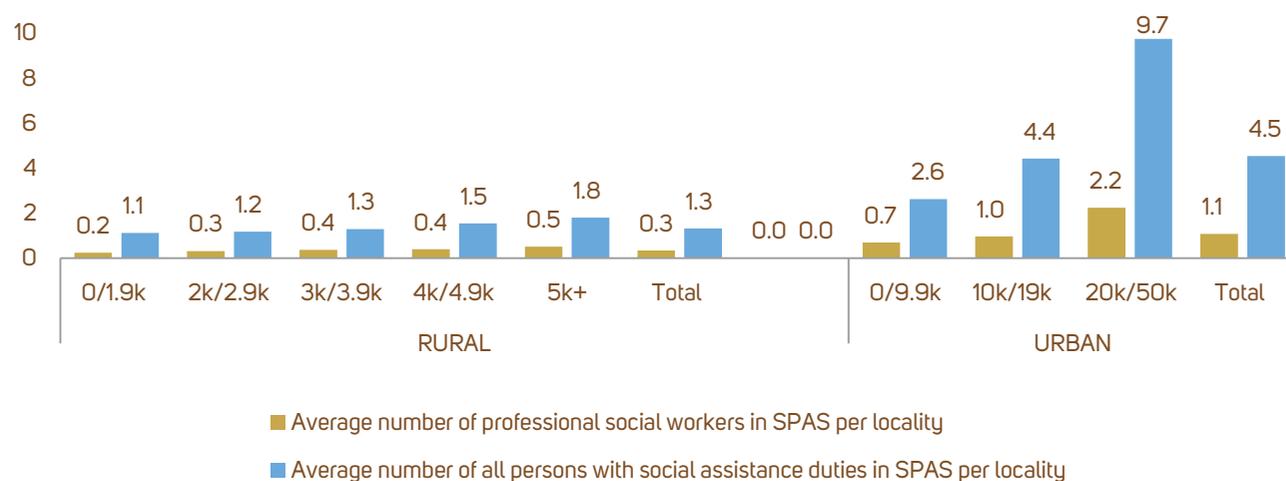
I. Statistical Data

ANNEX TABLE 5.1: Administrative Organization of the SPAS at the Community Level (%)

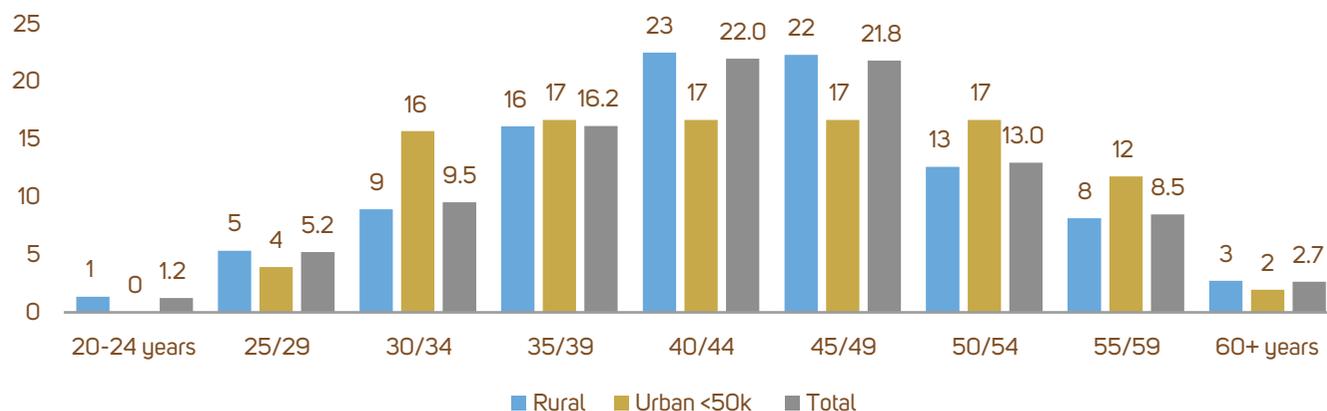
	Direction	Service	Compartment	Office	No specialized structure	Total	Number of localities
Rural							
0-1,999 inh,		4	46	3	47	100	751
2,000-2,999		6	54	3	38	100	782
3,000-3,999		10	57	4	29	100	603
4,000-4,999		13	60	3	24	100	326
5,000+ inh,		11	66	5	18	100	399
Total		8	55	3	34	100	2,861
Urban							
<10,000 inh,	2	33	48	9	8	100	134
10,000 & <20,000	7	46	41	7	0	100	91
20,000 & <50,000 inh,	29	63	6	2	0	100	54
Total	8	43	38	7	4	100	279

Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.

ANNEX FIGURE 5.1: Human Resources at the SPAS Level



Source: World Bank "Social Assistance Services at the Community Level" Survey, May 2014.
Note: k = thousand inhabitants.

ANNEX FIGURE 5.2: Distribution by Age Group of Staff with Social Assistance Responsibilities at the SPAS Level (%)

Source: World Bank, "Social Assistance Services at the Community Level" Survey, May 2014.

Note: Urban localities = those with fewer than 50,000 inhabitants

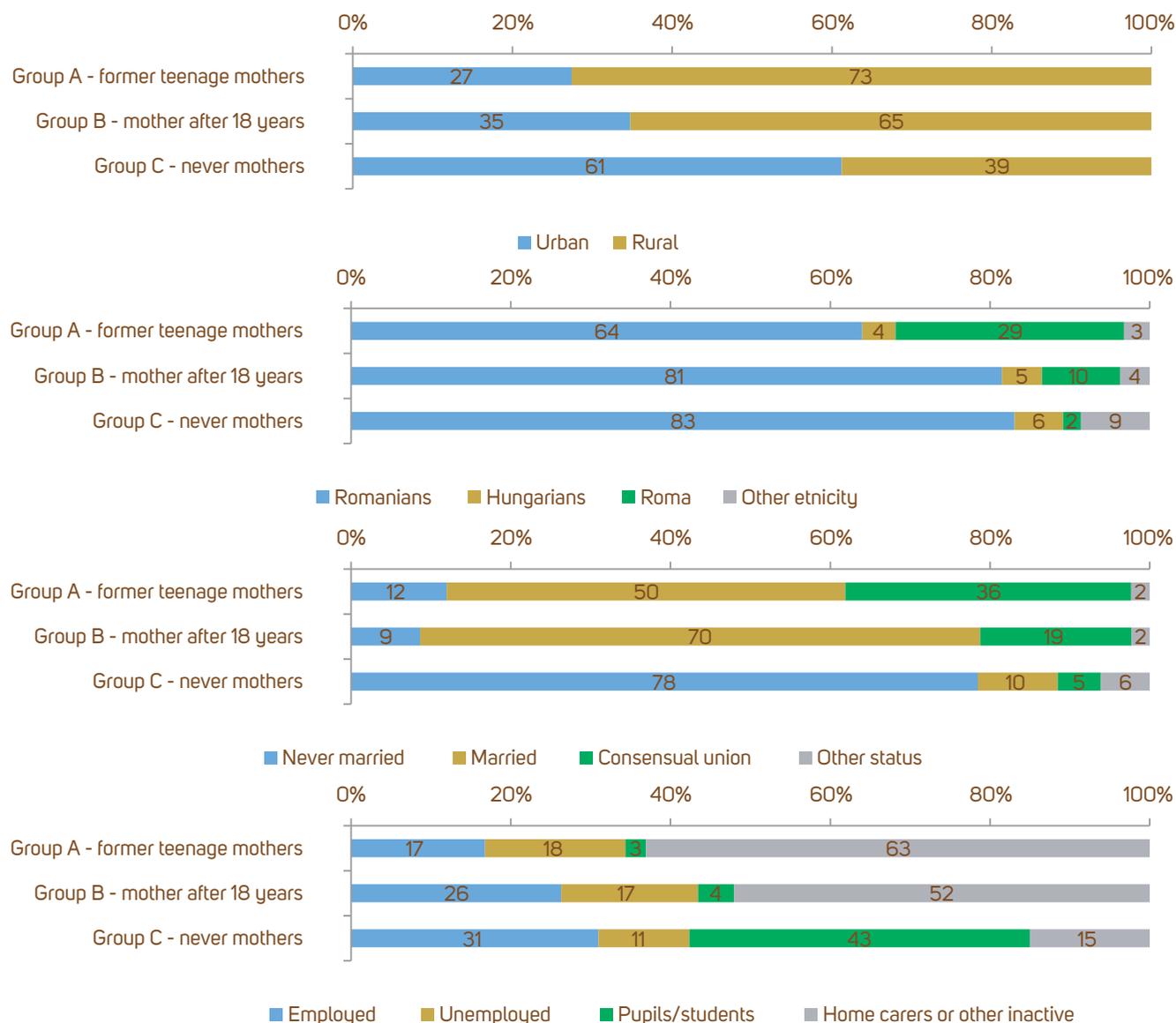
ANNEX TABLE 5.2: Participation in Education of Children with Migrant Parents (%)

	% of 6-9 year-olds in education	% of 10-14 year-olds in education	% of 15-17 year-olds in education
Children with both parents at home	75.5	97.3	92.8
Children with one parent at home and the other having migrated abroad	77.1	97.9	91.3
Children with both parents having migrated abroad	60.3	87.0	73.3
Children with one parent at home and the other having migrated within the country	77.2	97.5	92.1
Children with both parents having migrated within the country	65.3	89.4	86.8
Children with one parent having migrated abroad and one parent having migrated within the country	67.1	93.8	89.9

Source: Authors' calculations using 2011 Population and Housing Census data.

Note: Migrant parents are those who have migrated abroad or within the country for work or studies who are absent from the household for less than 12 months.

ANNEX FIGURE 5.3: Comparisons between Young Women (18-24) Who Were Teenage Mothers, Who Had their First Child after the Age of 18, and Who have No Children (%)



Source: Authors' calculations using 2011 Population and Housing Census data.

II. Methodology of Census of Public Social Assistance Services at the Community Level

The World Bank carried out a census of Public Social Assistance Services (SPAS) in cities and rural communities in Romania in May 2014 as an input to the National Strategy on Social Inclusion and Poverty Reduction 2015-2020.

The aim of the census was to map all people working for local authorities with responsibilities in the area of social work. The questionnaire gathered information on the number of people with responsibilities in the area of social work, the type of contract that they had, their education level and qualifications, and their positions within the organization. The

questionnaire was filled in by 3,014 localities out of the total of 3,180, a completion rate of 95 percent.

Because of its special characteristics, Bucharest was not included in the analysis. Due to partial non-responses, the 40 cities with 50,000 or more inhabitants were also excluded from the analysis. Thus, the analysis presented in this volume covers all 279 cities with population of fewer than 50,000 inhabitants and all 2,861 communes, a total of 3,140 local authorities. The data are not weighted.

ANNEX TABLE 5.3: Census Completion Rates by Urban and Rural Area and Population Size

	Population size	No. of localities in Romania	No. of localities that responded	Completion rate (%)
Romania	Total	3,180	3,014	95
Urban	0/4,999	29	27	93
	5,000/9,999	105	103	98
	10,000/14,999	64	61	95
	15,000/19,999	27	25	93
	20,000/49,999	54	50	93
	50,000/99,999	21	21	100
	100,000/500,000	19	14	74
	Total	319	301	94
Rural	0/1,999	751	704	94
	2,000/2,999	782	739	95
	3,000/3,999	603	577	96
	4,000/4,999	326	315	97
	5,000+	399	378	95
	Total	2,861	2,713	95

Source: World Bank, "Social Assistance Services at the Community Level" Survey May 2014.

III. Medical Rehabilitation Services for People with Disabilities

In Romania, medical rehabilitation services for people with disabilities used to be delivered in institutionalized settings, but the growing trend is for local authorities or accredited NGOs to provide these services within the community.

Physical medical rehabilitation for children is provided in designated centers under the management of the Ministry of Health, either at rehabilitation hospitals in Bușteni (Prahova), Gura Ocnitei (Dâmbovița), Dezna (Arad), Băile Felix (Bihor), and Mangalia (Constanta) or at rehabilitation centers at the county and municipal levels. These centers are relatively well equipped and are run by qualified professionals. The current trend is moving towards having a larger number of smaller rehabilitation services located in municipalities and managed by the DGASPCs. NGOs have also been developing medical rehabilitation services since the 1990s, either in specialized centers (for example, in Cluj, Iasi, and Timisoara) or as specific services within day centers or small group homes.

Medical rehabilitation for adults is provided in public hospitals and mainstream rehabilitation units, as well as in specialized centers and spas, depending on which type of intervention and disability is involved. However, there are reports that adults with disabilities find it more difficult to access rehabilitation services than children. Law 448/2006 gives them the right to access rehabilitation programs and medical devices free of charge based on the Framework Agreement of the National Health Insurance (Contractul Cadru al Casei de Asigurari de Sanatate or NHI). Personal assistants are required to accompany severely and noticeably disabled individuals free of charge to these medical or rehabilitation units. However, in practice, a large majority of families claim that they are obliged to pay for these personal assistants, as well as for a significant amount of medical consumables, medicines, and equipment because of the limited annual budget of the NHI.

Residential rehabilitation facilities are organized under the methodological coordination of the National Directorate for Protection of Persons with Disabilities (DPPD) and are administered by the county DGASPCs (funded by the state budget). Other medical rehabilitation centers are administered by the Ministry of Health. Since 2007 new

medical rehabilitation facilities have been established regularly to provide ambulatory care for people with disabilities who are not institutionalized. All of these services, including freelance professionals, must currently submit to an accreditation process to ensure that a precise inventory exists at the administrative level of each county (within the Directorate of Health). For-profit services including small, multi-disciplinary rehabilitation centers and physiotherapy centers are also expanding very rapidly, especially in the larger cities.

Some examples of medical (re)habilitation services that are currently provided in Romania are the following:

Mainstream (re)habilitation services, including physical medical rehabilitation services in hospitals and spas (such as physiotherapy, electrotherapy, and hydrotherapy)

Specialized (re)habilitation services for people with disabilities (within day care centers, residential centers, or specific rehabilitation centers for disabled). These services address the specific medical rehabilitation needs of various groups of people with disabilities (such as cerebral palsy, rare diseases, and agenesis). The DGASPCs provide rehabilitation services at the county level for children with disabilities (through residential and daycare services) and for adults with disabilities in the following facilities:

- Pilot Centers for the (Re)habilitation of People with Disabilities (CPRRPH)
- Centers for the (Re)habilitation of People with Disabilities (CRRPH)
- Centers for Neuro-Psychiatric Rehabilitation (CRRN)
- Support services for daily activities including:
- The production of orthoprosthetic devices and other medical equipment that increase the person's ability to function and carry out daily activities
- The provision of medical consumables for people with disabilities (such as incontinence items, liquid nutrition, and wound care).

IV. Support Services for People with Disabilities

Increasing access for people with disabilities to programs, facilities, and support services for independent or supported living is critical to ensuring their full inclusion in society. Independent or supported living is the domain in which the role of support services is key. So far, the Romanian social services system supports for the following services:

Mainstream services:

- Social housing – The allocation of a rent-free social house to people with disabilities should be a priority for social service providers. There should be one additional room for the family of a person with disabilities. State-owned apartments can be used to accommodate people with disabilities (Law 448/2006).
- Elderly residential settings
- Foster care for children with disabilities without parental care.

Specific services for people with disabilities:

- Public Centers for Care and Assistance (CIA/DPPD)
- Public sheltered homes or group homes for adults (DPPD)
- Residential centers for children with disabilities (National Authority for Child Protection)

- Private residential services for people with disabilities, usually in family-like settings or group homes but also in larger residential settings.

Support services for independent living or for in-home care:

- Subsidized interest on bank loans taken out by people with disabilities to buy or renovate/adapt a house or apartment
- Personal assistant
- Supported housing in apartments or homes that are located in the community
- In-home support for daily routines and activities
- Respite centers for families
- Interpreters for sign language and for easy-to-understand communication
- ICT and assistive devices
- Adapted means of transport
- Counselor for independent living/case manager for people with disabilities.

V. Organization and Provision Principles of Services for Drug Users in Romania

According to the national standards developed by the National Anti-Drug Agency,⁵⁵⁵ three levels of services are provided to drug users in Romania.

Level 1 services are provided both by public institutions and NGOs on a small scale and at the local level. Thus, they do not have national coverage. These services identify drug users, persuade them to seek treatment, refer them to specialized services, address their basic social and medical needs, and coordinate with providers of level 2 and 3 services. Specifically, the main services provided by level 1 are: (i) providing substitute treatment; (ii) quick testing for HIV and hepatitis (B and C); (iii) distributing condoms; (iv) pre- and post-testing counseling; (v) hepatitis A and B vaccinations; (vi) general medical care; and (vii) promoting harm reduction services related to drug use problems.

Level 2 services are provided by specialized units in the public health system and in drug prevention, assessment, and counseling centers (CPECA). They provide specialized care and monitoring and refer users to level 3 services. Specifically, the main services provided by level 2 are: (i) providing substitute treatment; (ii) abstinence continuation treatment; (iii) outpatient rehab; (iv) drug tests in body fluids; (v) quick HIV and hepatitis testing; (vi) distribution

of condoms; (vii) pre- and post-testing counseling; (viii) hepatitis A and B vaccination; (ix) general medical care; (x) occupational therapy (ergo therapy); (xi) psychiatric medical care; (xii) individual, group, and family psychotherapy; (xiii) standardized testing for psychological assessment; and (xiv) promoting services provided by the Integrated Care for Addictions Center (CAIA).

Level 3 services consist of social reintegration services and are provided by post-treatment centers and therapy communities.

The principles underlying the standards that govern services for drug users in Romania are as follows: (i) all levels of services must be available in all regions of the country (possibly in each county); (ii) the treatment of the drug user should not just focus on treating the addiction but also in addressing the health, social, legal, and vocational problems related to drug use; (iii) the necessary medication involved in addiction treatment must be provided in combination with psychological counseling and behavioral psychotherapy; and (iv) the recovery of a drug addict is a lengthy process that must be monitored by specialists and adjusted when needed.

⁵⁵⁵ ANA (2005b).

VI. Organization and Types of Services for Victims of Human Trafficking in Romania

According to national legislation and policy, the victims of human trafficking are entitled to free services provided mostly through: (i) victims' assistance centers; (ii) victims' protection services and services for the social reintegration of offenders; and (iii) NGOs.

Assistance centers are established and organized as per Law 678/2001 in each county and district. They exist within the County Directorates for Social Assistance and Child Protection and are financed by the County Council, including transit centers for adults and unaccompanied minors.

Victims' protection services and services for the social reintegration of offenders are established and organized as per Law 2011/2004 in each county as part of the courts. Both types of services serve both victims of human trafficking and victims of domestic violence.

NGOs can organize separate services for human trafficking or in partnership with public authorities (for example, the centers and services mentioned above or local councils). However, NGO services for trafficking victims are organized separately from NGO services for the victims of domestic violence.

Several institutions play a role in referring victims of human trafficking to specialized services. These include the Border Police, the Office for Combating Organized Crime, the Directorate for Social Assistance and Child Protection,

the National Agency against Trafficking in Human Beings (ANITP), local authorities, the International Social Service, the International Organization for Migration, and other international organizations active in the field.

Victims of domestic violence are referred mostly by the police, by the Directorate for Social Assistance and Child Protection, by local authorities, and by NGOs.

Moreover, if a victim of human trafficking is involved in a criminal proceeding filed by the authorities against the traffickers, she can ask for physical protection and/or to be placed in an Assistance Center or in a witness protection program. In addition, as per Law 211/2004, victims can receive financial compensation.

Providers in the field are also involved in actions to prevent human trafficking such as seminars, workshops, prevention campaigns, and the Helpline managed by ANITP. Furthermore, they help to monitor the phenomenon by reporting data on service beneficiaries to the regional centers of ANITP or to other institutions responsible for preventing and counteracting human trafficking.

Apart from services provided in specialized units as described above, according to the law (292/2011), victims can also receive community services consisting of social assistance, emotional support, psychological counseling, legal advice, professional guidance, and help with social reintegration.

ANNEX TABLE 5.4: Types of Services Provided to Victims of Human Trafficking in Romania

Name/Category of Services	Types of Action	Assistance Centers	Protection Services	NGOs
Information (on rights and available services)	Distribution of informative materials Face-to-face information	Yes	Yes	Yes
Psychological assistance	Psychological assessment Individual psychotherapy Group psychotherapy Couples or family therapy Art therapy	Yes	Yes	Yes
Social assistance	Help with acquiring identity documents Mediating the victims' relations with the authorities, with their family, and with other social assistance services Counseling to aid the victims' social and professional reintegration	Yes		Yes
Material assistance	Provision of food supplements, hygiene and cleaning products, clothes, and footwear			Yes
Housing assistance	Temporary accommodation (10 days to 3 months) in a victims' reception center Assistance in finding a permanent home	Yes		Yes
Legal aid	Legal advice	Yes	Yes	Yes
Medical care	Referral of victims to specialized medical services if they are in need of medical care	Yes		Yes
Support for school reintegration	Provided by cooperation with the County School Inspectorate	Yes	Yes	Yes
Support for professional reintegration	Vocational counseling and guidance (As per Law 678/2001, victims of human trafficking receive "priority" services from the County Employment and Vocational Training Agencies.	Yes	Yes	Yes

VII. Organization of Services for Victims of Domestic Violence in Romania

Measures to prevent and counteract domestic violence in Romania are described in the most recent policy document, *the National Strategy for the Prevention of and Fight against Domestic Violence for 2013-2018*.⁵⁵⁶

The approach to combating domestic violence is a cross-cutting effort under the coordination of the MLFSPE in partnership with the Ministry of the Internal Affairs, the Ministry of Health, and the Ministry of Justice.

ANNEX TABLE 5.5: Social Services for Victims of Domestic Violence and Attackers in Romania, 2012

Type of unit	Description	Number of units/ coverage in territory
Shelters (reception centers for emergencies)		26/ not in all counties
Recovery centers for victims of domestic violence	Social assistance units with or without legal structure providing accommodation, care, and social rehabilitation and reintegration of victims	15/ not in all counties
Centers for preventing and counteracting domestic violence		12/ not in all counties
Information and public awareness centers		8/ not in all counties
Offices for preventing and counteracting domestic violence		3/ not in all counties
Assistance centers for attackers	Social assistance units with or without legal structure that provide a residential or half-residential system for the rehabilitation and social reintegration of attackers, education, counseling, and family mediation, as well as psychiatric or detox treatments (in cooperation with specialized hospitals/clinics)	2/ not in all counties
Emergency reception centers for minors		11/ not in all counties
Foster centers		4/ not in all counties
Social assistance units that also provide services to victims of domestic violence		22/ not in all counties
Restraining order (measure as per Law 25/2012) as a tool to assist victims of domestic violence and to aid the recovery/rehabilitation of the attacker		Country-wide
Primary social services provided within the community		Country-wide

⁵⁵⁶ MLFSPE (2012).

Annex 6: Education

I. Statistical Data

ANNEX TABLE 6.1: Explanatory Model of Early School Leaving among Adolescents aged 15–18 Years Old

	Odds Ratio		
	Model 1	Model 2	Model 3
Rural v. Urban	1.8***	3.3***	2.0***
Men v. Women	1.5***	1.2***	1.5***
Mothers' education: Primary at best v. High school or over		49.4***	23.8***
Mothers' education: Gymnasium v. High school or over		10.7***	6.7***
Mothers' education: Lower secondary v. High school or over		3.7***	2.7***
1st Decile v. 5th decile or higher			4.0***
2nd decile v. 5th decile or higher			2.4***
3rd-4th decile v. 5th decile or higher			1.5***
Constant	0.08***	0.5***	0.01***
Pseudo R ²	0.04	0.21	0.23
Log likelihood	-4193	-2570	-2485
LR chi ² ; df, prob>chi ²	375; 2; 0.0	1326; 5; 0.0	1497; 8; 0.0

Source: World Bank calculations using pooled data from the 2009-2012 HBS.

II. Legislative Framework and Education Network for People with Disabilities

The legislative framework that regulates access to education for people with disabilities is extensive and covers all aspects of education from preschool to tertiary education and vocational training.

- The Constitution of Romania (article 16, Equality in rights).
- Law 221/2010 on the ratification of the UN Convention on the Rights of Persons with Disabilities.
- Law 18/1990 on the ratification of the UN Convention on the Rights of the Child, republished in the Official Gazette no 314/2001.
- Law on Education, no. 1/ 5.01.2011 (see mostly chapter 2, sections 13 and 16).
- Law 448/2006 on the protection and promotion of rights of people with disabilities.
- Law 272/2004 on the protection and promotion of children's rights.
- Ordinance 137/2000, approved by Law no. 48/2002 regarding the prevention and sanctioning of all forms of discrimination, with all modifications and updates (published in the Official Gazette no.69, January 2002).

- Law 107/2004 amending Law 76/2002 on unemployment insurance (with reference to free-of-charge training for unemployed adults).

Plus the following:

- Decision no.1251/2005 of the Ministry of Education on measures related to the improvement of education, compensation, rehabilitation, and social protection of children/pupils/young people with special educational needs, within the special and special integrated system of education (<http://lege5.ro/Gratuit/haydgojw/hotararea-nr-1251-2005-privind-unele-masuri-de-imbunatatire-a-activitatii-de-invatare-instruire-compensare-recuperare-si-protectie-speciala-a-copiiilor-elevilor-tinerilor-cu-cerinte-educative-speciale->)
- Order no.6552/2011 of the Ministry of Education, regarding the functioning of the Evaluation and School Orientation Commission, for children with special educational needs, within the County Center for Resources and Educational Assistance (CJRAE).
- Order 5555/2011 regarding the functioning of CJRAE/CMBRAE.
- Order of the Minister of Education no. 3414/16.03.2009 regarding the organization of special technological high schools (grades IX to XI).
- Ministerial Order no. 4928/8.09.2005 regarding the organization of classes/groups/or special schools that enroll children with severe, accentuated, or associated disabilities (grades I to X).
- Ministerial Order no. 4927/08.09.2005 regarding the organization of classes/groups in mainstream and special schools that enroll children with light and medium disabilities.
- Ministerial Order 5379/25.11.2004 regarding the methodology for educational support services for children with special educational needs who are enrolled in mainstream education (support teachers/mobile teachers).
- Decision 522/8.05.2003 regarding the methodology for implementing Ordinance 129/2000 on the professional training of adults.

Annex 7: Health

ANNEX TABLE 7.1: The Minimum Package of Primary Healthcare Services for the Uninsured Population, 2014

Service	Frequency of visits	No. points per visit	Monetary value of points (RON)	GPs fee (RON)	Senior GP fee (RON)
1. Medical services for medical/surgical emergencies	1 visit per person per episode	5.5	1.83	10	12
2. Surveillance and detection - infectious diseases with endemic/epidemic risk - suspected and confirmed	1 visit per person per disease	5.5	1.83	10	12
3. Pre- and post-natal care					
3.a. Pregnancy registration - first quarter	1 visit	5.5	1.83	10	12
3.b. Monthly monitoring (months 3-6)	1 visit per month	5.5	1.83	10	12
3.c. Bi-monthly monitoring (months 7-9)	2 visits per month	5.5	1.83	20	24
3.d. Postpartum care - home visit after discharge	1 home visit	15	1.83	27	33
3.e. Mother check-up 4 weeks after delivery	1 visit	5.5	1.83	10	12
4. Family planning services	2 visits per person per year	5.5	1.83	20	24
5. Release of death certificate	1 home visit	15	1.83	27	33

Source: Data from the Framework Contract and its application norms regarding the 2014-2015 service delivery within the Health Insurance System (Gov. Decision 400/2014; Ministry of Health-Health Insurance House Ordinance 619-360, May 2014).

Annex 8: Housing

I. Statistical Data

ANNEX TABLE 8.1: Private Ownership of Housing Stock in EU-28: the Five Countries with the Highest Percentage and Those with the Lowest, 2000 and 2012

	2000		2012	
	Total	Poor	Total	Poor
EU27			70.4	52.6
Romania	97	95	96.6	96.0
Lithuania	95	92	91.9	85.6
Hungary	94	86	90.5	82.9
Slovakia			90.4	82.3
Croatia			89.5	87.3
Denmark			64.3	29.1
France	70	52	63.7	35.2
Austria	69	68	57.5	30.5
Germany	56	36	53.3	24.9
Switzerland			43.8	31.7

Source: Eurostat.

ANNEX TABLE 8.2: Percentage of Young Adults Aged 18-34 Living with Their Parents

	2007	2008	2009	2010	2011	2012
EU-28	47.1	47.5	47.7	47.4	48.2	48
Romania	57.2	57.1	58.3	58.9	60	61.7
Lithuania	54.7	54.8	55.4	55.7	54	56.6
Hungary	51.5	53.2	58.2	60.6	61.9	63.1
Croatia				68.7	70.5	71.3
Bulgaria	59.7	62.7	62.8	66	66.7	64.5
Italy	60.7	60.5	61.1	60.5	62.6	64
Poland	59.4	58.5	58.2	58.4	60.5	60.2

Source: Eurostat.

ANNEX TABLE 8.3: Number of People per Lived-in Room, 2012

Income deciles	ROMANIA				URBAN				RURAL			
	Mean	Std. dev.	Min	Max	Mean	Std. dev.	Min	Max	Mean	Std. dev.	Min	Max
D1	1.44	0.91	0.13	7	1.76	1.11	0.13	7	1.37	0.84	0.20	7
D2	1.02	0.64	0.13	7	1.35	0.80	0.25	6	0.92	0.54	0.13	7
D3	0.92	0.57	0.13	4	1.22	0.68	0.14	4	0.80	0.48	0.13	4
D4	0.91	0.56	0.17	5	1.17	0.65	0.17	4	0.77	0.45	0.17	5
D5	0.88	0.52	0.14	6	1.06	0.58	0.20	4	0.73	0.43	0.14	6
D6	0.83	0.48	0.13	4	0.96	0.52	0.25	4	0.67	0.35	0.13	4
D7	0.81	0.44	0.14	4	0.90	0.46	0.17	4	0.65	0.34	0.14	2
D8	0.79	0.40	0.14	4	0.85	0.40	0.14	3	0.66	0.36	0.14	4
D9	0.79	0.39	0.17	3	0.84	0.40	0.17	3	0.61	0.29	0.17	2
D10	0.73	0.37	0.13	3	0.76	0.38	0.13	3	0.55	0.28	0.17	2

Source: National Institute of Statistics, 2012 Household Budget Survey.

Note: Income deciles based on the total monthly household cash income per capita (without self-consumption).

ANNEX TABLE 8.4: Surface of Lived-in Rooms (Square Meters) per Person, 2012

Income deciles	ROMANIA				URBAN				RURAL			
	Mean	Std. dev.	Min	Max	Mean	Std. dev.	Min	Max	Mean	Std. dev.	Min	Max
D1	14.79	10.98	1.17	200.0	12.93	12.45	1.17	200	15.25	10.54	1.50	95
D2	20.64	13.39	2.29	130.0	16.41	11.07	2.29	88	22.00	13.79	2.29	130
D3	23.36	14.92	3.43	147.0	18.03	12.81	3.50	87	25.42	15.17	3.43	147
D4	23.66	15.29	3.00	130.0	18.72	12.31	3.00	120	26.34	16.06	3.00	130
D5	24.59	14.73	3.50	180.0	20.94	12.95	3.50	100	27.49	15.39	3.50	180
D6	26.42	16.10	3.13	170.0	22.91	13.43	3.33	96	30.74	17.95	3.13	170
D7	26.46	14.79	3.00	120.0	23.45	12.86	3.00	100	31.62	16.39	6.00	120
D8	27.00	15.36	3.00	150.0	24.91	13.74	4.80	112	32.05	17.73	3.00	150
D9	26.81	14.29	4.14	135.0	25.08	13.22	4.14	120	32.33	16.07	6.00	135
D10	29.40	15.27	4.67	140.0	28.10	14.33	4.67	140	35.76	17.95	7.00	128

Source: National Institute of Statistics, 2012 Household Budget Survey.

Note: Income deciles based on the total monthly household cash income per capita (without self-consumption).

ANNEX TABLE 8.5: Severe Housing Deprivation by Poverty Risk and Age (Children), 2007-2012, (%)

	Romania		EU-28	
	2007	2012	2007	2012
Total population	31.8	22.8	7.2	5.0
Population at risk of poverty	52.6	49.2	15.6	12.6
Children	46.1	36.9	10.0	7.5
Children at risk of poverty	71.4	63.6	21.8	18.1

Source: Eurostat.

ANNEX TABLE 8.6: Proportion of Population Suffering From Different Types of Housing Deprivation (%)

		2007	2008	2009	2010	2011	2012
Lacking a bath or a shower inside the dwelling	EU-28	3.6	3.4	3.1	2.9	2.8	2.7
	Romania	41.8	41.7	41.2	38.9	36.8	35.4
Lacking indoor flushing toilet for the sole use of the household	EU-28	4.1	3.7	3.5	3.4	3.1	3
	Romania	44	41.2	42.5	40.8	38.7	37
Leaking roof, damp walls, floors, or foundation, or rot in window frames or floor	EU-28	28.2	26.4	25.8	25.7	24.3	23.5
	Romania	44.9	37.7	34.9	33.2	35.1	30
The dwelling is considered too dark	EU-28	8.2	7.2	7.3	6.8	6.8	6.1
	Romania	7.6	8.2	8.7	7.6	7.7	6.4

Source: Eurostat.

II. Situation of Social Housing (SSH) Survey

In October 2014 as part of the preparation of the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, the World Bank⁵⁵⁷ in collaboration with the Ministry of Regional Development and Public Administration (MRDPA)⁵⁵⁸ carried out a Situation of Social Housing (SSH) survey in all urban municipalities. The survey was conducted as a collaboration between two teams working on two different World Bank projects: (i) Support for the Preparation of a National Strategy and Action Plan on Social Inclusion and Poverty Reduction 2015-2020 and (ii) Assisting in Housing and Infrastructure Development Strategy (Regional Development Program 2, Harmonizing Public Investments).

Data were collected between September and November 2014. The sample consisted of all Romanian urban administrative units - 319 cities and six Bucharest sectors. The aim of the SSH survey was to provide an overview of publicly owned housing units in Romania. The questionnaire gathered information on the following topics:

1. Social Housing

- Stock of Social Housing
- Supply and Demand
- Beneficiaries and Occupancy of Social Housing
- Quality of the Social Housing Stock
- Overdue Debts to Utilities and Rent in Social Housing

⁵⁵⁷ Research team included Corad Bogdan, Cătălina Iamandi-Cioinaru, Monica Marin, Georgiana Necutau and Andreea Trocea, with the support of Alexandra Călin.

⁵⁵⁸ The World Bank team's counterparts in the MRDPA were Mr. Teofil Ghercă and Mr. Bogdan Ghinea.

2. Housing Programs

- Housing Units for the Mobility of Specialists
- Emergency Houses
- Youth Housing Program
- Land Plots for Young Families
- Other Types of Rental Housing Units Owned by Local Public Authorities
- Shelters for Homeless People

3. Local Housing Policies and Management

- Local Strategies and Local Budgets Allocated to Social Housing
- Budgets for Building, Renovating, and Maintaining Social Housing in 2012-2013
 - Main Problems in Managing the Housing Stock Owned by the Local Public Authorities
 - Main Problems in Developing the Housing Stock Owned by the Local Public Authorities

In accordance with current legislation, the SSH survey used the following definitions for social housing:

- **Social housing** is defined under the Housing Law 114/1996 as a dwelling that is allocated by a public authority for a small rent (subvention) to individuals or families who cannot otherwise afford to buy or rent a house from the free housing market. This definition does not include housing services for vulnerable groups such as shelters for the homeless.
- **Housing units with a social character** (named also “affordable houses” by local public authorities) represent the housing stock owned and managed by the local public authority that are rented to the poor population. This fund is not “social housing” as it does not comply with the legal requirements. Most often this stock consists of nationalized or low-quality houses that have been neglected in the past few years and are located in unattractive, difficult to access, and poorly endowed urban areas, with a low market price.

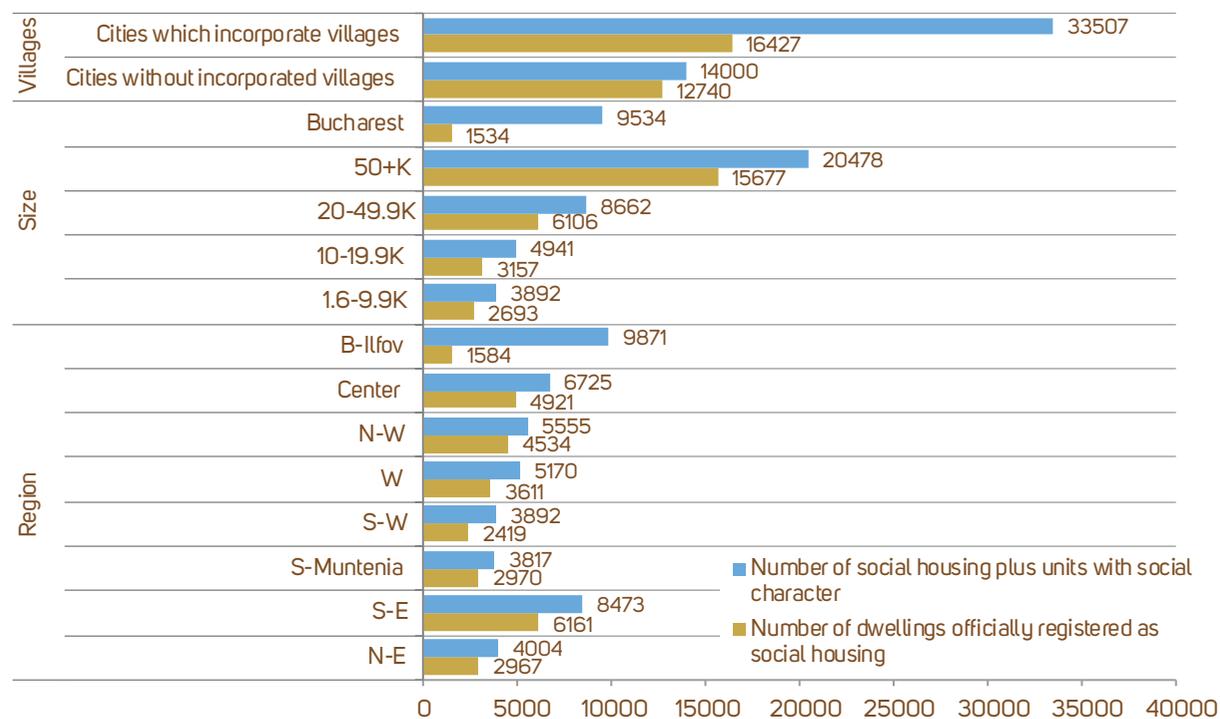
The questionnaire was filled in by the staff of 300 urban municipalities and three sectors of Bucharest, a total response rate of 93 percent. The highest response rates were registered in the South-East (97 percent) and Center (96 percent) regions, while the lowest rates were in the Bucharest-Ilfov (79 percent) and North-East (89 percent) regions. Also, there was a low response rate from the new small towns designated between 2002 and 2006.

ANNEX TABLE 8.7: SSH Survey Response Rates by Region, Population Size, City Composition, and History

		Non- response (number)	Responses (number)	Total (number)	Response rates (percent)
TOTAL		22	303	325	93.2
Development Region	1 North East	5	41	46	89.1
	2 South East	1	34	35	97.1
	3 South Muntenia	3	45	48	93.8
	4 South West	4	36	40	90.0
	5 West	2	40	42	95.2
	6 North West	2	41	43	95.3
	7 Center	2	55	57	96.5
	8 Bucharest-Ilfov	3	11	14	78.6
Population Size (2011 Census)	1.6-9.9K	7	127	134	94.8
	10-19.9K	8	83	91	91.2
	20-49.9K	2	52	54	96.3
	50+K	2	38	40	95.0
	Bucharest	3	3	6	50.0
City Composition	Cities without incorporated villages	4	76	80	95.0
	Cities that incorporate villages	18	227	245	92.7
City History	Old small cities (with fewer than 20,000 residents) designated before 2002	9	165	174	94.8
	New small cities (with fewer than 20,000 residents) designated after 2002	6	45	51	88.2
	Medium and large cities (with more than 20,000 residents)	7	93	100	93.0

Source: MRDPA and the World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

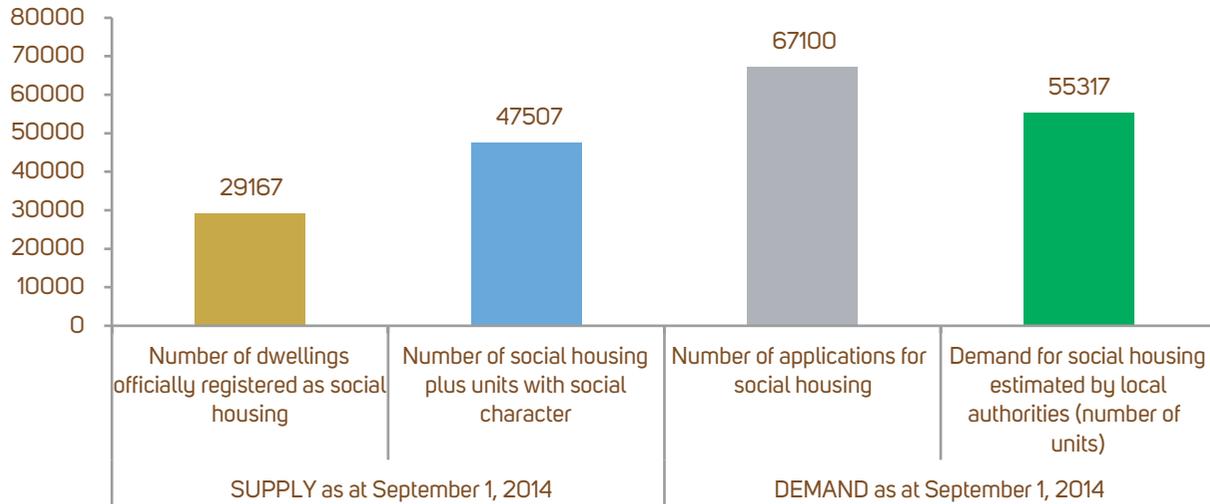
Notes: N=300 cities and 3 Bucharest sectors. Data from the questionnaires were supplemented by information provided by the Bucharest General Mayorality (PGMB) at the Stakeholders' Meeting organized by the World Bank within the project Regulatory Impact Assessment (RIA) Framework in Romania, held in Bucharest on February 12, 2015. Three sectors of Bucharest (sectors 1, 2, and 6) responded to the survey while the PGMB provided additional data on the other three sectors (sectors 3, 4, and 5).

ANNEX FIGURE 8.1: Profile of the Stock of Social Housing in Urban Romania as at September 1, 2014

Source: MRDPA and the World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

Notes: N=300 cities and 3 Bucharest sectors, completed with data from the General Mayoralty of Bucharest regarding sectors 3, 4 and 5, as of February 2015. Total number of social housing = 29,167 units. Total number of social housing plus units with social character = 47,507 units.

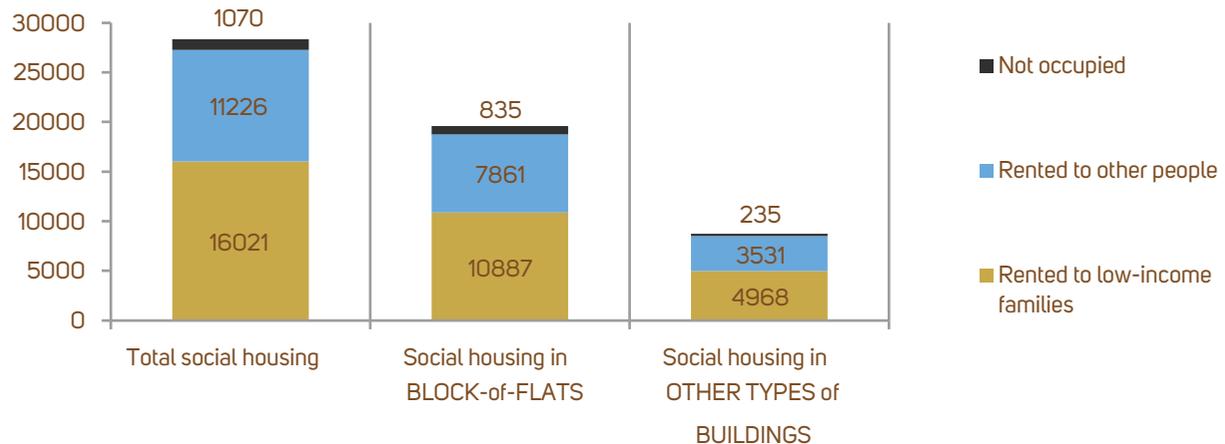
ANNEX FIGURE 8.2: Supply and Demand for Social Housing in Urban Romania as of September 1, 2014



Source: MRDPA and the World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

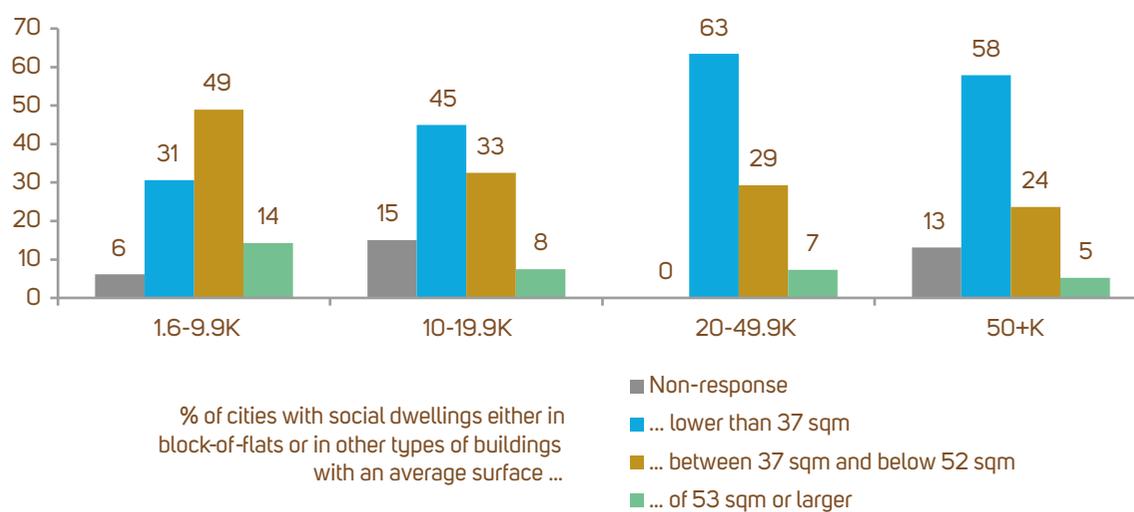
Notes: N=300 cities and 3 Bucharest sectors, completed with data from the General Mayorality of Bucharest regarding sectors 3, 4 and 5, as of February 2015.

ANNEX FIGURE 8.3: Beneficiaries and Occupancy Rates of Social Housing in Urban Romania as of September 1, 2014



Source: MRDPA and the World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

Notes: N=168 cities and 3 Bucharest sectors, with state-owned dwellings officially registered as social housing; N=154 cities and 3 Bucharest sectors, with social housing in blocks of flats; and N=102 cities with social housing in other types of buildings. Rented to low-income families according to art.42 in the Law no. 114/1996.

ANNEX FIGURE 8.4: Quality of Social Housing in Urban Romania as of September 1, 201

Source: MRDPA and World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

Notes: N=168 cities (Bucharest sectors not included) with state-owned dwellings officially registered as social housing.

ANNEX TABLE 8.8: Social Dwellings with Debts to Utilities and/or Rent Payments

		Number of dwellings officially registered as social housing that responded to SSH	Number of social dwellings without debts	Number of social dwellings with debts
Utility Payments				
	TOTAL	20,399	14,365	6,034
Development Region	1 North East	2,829	1,542	1,287
	2 South East	2,272	1,426	846
	3 South Muntenia	2,832	2,081	751
	4 South West	1,491	971	520
	5 West	3,312	2,502	810
	6 North West	3,961	3,026	935
	7 Center	2,968	2,300	668
	8 Bucharest-Ilfov	734	517	217
Population Size (2011 Census)	1.6-9.9K	2,205	1,480	725
	10-19.9K	2,806	1,986	820
	20-49.9K	4,439	3,243	1,196
	50+K	10,265	7,168	3,097
	Bucharest	684	488	196
Subsidized Rent				
	TOTAL	26,559	17,032	9,527
Development Region	1 North East	2,925	1,530	1,395
	2 South East	4,999	3,249	1,750
	3 South Muntenia	2,950	2,147	803
	4 South West	2,053	1,477	576
	5 West	3,611	2,073	1,538
	6 North West	4,374	2,368	2,006
	7 Center	4,913	3,633	1,280
	8 Bucharest-Ilfov	734	555	179
Population Size (2011 Census)	1.6-9.9K	2,534	1,521	1,013
	10-19.9K	3,068	2,102	966
	20-49.9K	6,106	3,382	2,724
	50+K	14,167	9,506	4,661
	Bucharest	684	521	163

Source: MRDPA and the World Bank, Survey on Situation of Social Housing (SSH), September-November 2014.

Notes: N=168 cities (Bucharest sectors not included) with state-owned dwellings officially registered as social housing.

Annex 9: Social Participation

ANNEX TABLE 9.1: Social Dwellings with Debts to Utilities and/or Rent Payments

	Heavy drinkers	Drug addicts	Criminal record	Homosexuals	Gypsies	People with AIDS	Muslims	Different race	Immigrants	Jews
Gender										
Male	62%	64%	58%	60%	47%	43%	22%	21%	21%	18%
Female	70%	66%	61%	59%	45%	43%	24%	20%	21%	19%
Age										
18 - 49 years old	66%	63%	57%	56%	44%	42%	21%	22%	21%	20%
50 - 64 years old	65%	67%	60%	60%	47%	42%	22%	18%	20%	18%
65 and over	73%	69%	68%	68%	49%	50%	28%	22%	21%	17%
Education										
Primary	69%	68%	67%	65%	51%	53%	32%	28%	28%	19%
Secondary	64%	66%	63%	64%	45%	47%	25%	21%	20%	20%
High school	67%	63%	56%	54%	46%	39%	20%	20%	20%	19%
Tertiary	70%	66%	52%	54%	36%	29%	12%	11%	14%	9%
Activity status										
Working	65%	64%	57%	55%	43%	39%	20%	21%	20%	18%
Unemployed	66%	74%	46%	70%	42%	47%	21%	9%	9%	12%
Retired	71%	68%	66%	66%	53%	48%	27%	21%	22%	18%
Other inactive	65%	64%	58%	58%	39%	46%	22%	20%	22%	21%
Size of community										
Under 5k	67%	69%	64%	66%	48%	48%	29%	29%	27%	25%
5k - 20k	64%	60%	61%	58%	41%	49%	25%	18%	19%	18%
20k - 100k	64%	66%	51%	60%	42%	37%	17%	17%	17%	18%
100k - 500k	70%	62%	61%	52%	52%	36%	20%	17%	19%	11%
Over 500k	67%	71%	53%	55%	39%	38%	13%	12%	14%	15%
Region										
North-East	65%	63%	66%	62%	52%	56%	33%	30%	33%	26%
South-East	53%	47%	47%	44%	40%	23%	29%	28%	25%	17%
South-Muntenia	67%	67%	42%	68%	54%	45%	16%	21%	18%	23%
South-West Oltenia	74%	65%	68%	57%	48%	44%	22%	21%	20%	17%
West	75%	65%	82%	70%	45%	45%	15%	10%	17%	12%
North-West	79%	81%	64%	65%	59%	54%	20%	16%	15%	17%
Center	60%	63%	60%	52%	26%	37%	22%	12%	11%	11%
Bucharest – Ilfov	68%	74%	57%	58%	41%	40%	18%	19%	19%	20%
TOTAL	67%	65%	60%	59%	46%	43%	23%	21%	21%	19%

Source: 2008 European Values Study.

Note: Data in cells represent the percentage of the population who would not like to have the corresponding group as neighbors.

ANNEX TABLE 9.2: Targets of Intolerance among High School Students in Romania, 2011

	Homosexuals	Gypsies	People with AIDS	Muslims	Jews	Different race
HH Education Stock						
Without high school	82%	65%	74%	52%	45%	33%
High school	78%	70%	65%	47%	36%	29%
College	66%	74%	59%	40%	30%	20%
Post-graduate	56%	79%	55%	32%	27%	18%
Self-assessed poverty						
Poor	72%	63%	55%	46%	35%	30%
Average	75%	69%	66%	45%	35%	26%
Rather wealthy	74%	76%	64%	48%	39%	26%
Wealthy	72%	80%	69%	47%	41%	37%
Rural/ Urban						
Rural	82%	70%	70%	52%	46%	36%
Urban	68%	72%	60%	40%	29%	21%
TOTAL	74%	71%	65%	45%	36%	27%

Source: Open Society Foundation (2011).⁵⁵⁹

Note: Data in cells represent the percentage of the high school students who would not like to have the corresponding group as neighbors.

⁵⁵⁹ Survey on Religion and Religious Behavior carried out in June 2011 on a sample of 1,204 persons aged 18 years or over, <http://www.fundatia.ro/romanii-devin-mai-toleranti-religios>. Calculations done by Claudiu Tufiş.

Annex 10: Area-based Policies

I. Statistical Data on Small and Very Small Villages and Those with Aging Populations

ANNEX TABLE 10.1: Distribution of Villages and Rural Population by Village Population Size, 2011

Village population size ...	Number of villages	Share of total number of villages (%)	Total population	Share of total rural population (%)
<50 inhabitants	830	7	20,822	0.2
50-99	780	6	57,746	0.6
100-149	787	6	98,533	1.1
150-199	775	6	134,729	1.5
200-249	686	6	153,920	1.7
250-299	663	5	181,677	2.0
300+ inhabitants	7845	63	8,615,424	93
Total	12,366	100	9,262,851	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.2: Distribution of Small Villages (Fewer than 200 Inhabitants) by Region, 2011

Regions	Number of villages	Share of total number of villages (%)	Small villages	Larger villages	Small villages	Larger villages	Total (%)
			<200 inh. (%)	200+ inh. (%)	<200 inh. (%)	200+ inh. (%)	
North-West	1,744	14	13	14	24	76	100
Center	1,688	14	22	11	41	59	100
North-East	2,332	19	14	21	19	81	100
South-East	1,385	11	10	12	23	77	100
South Muntenia	1,959	16	10	18	17	83	100
Bucharest-Ilfov	89	1	0	1	3	97	100
South-West Oltenia	1,939	16	17	15	27	73	100
West	1,230	10	14	9	36	64	100
Total	12,366	100	100	100	26	74	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.3: Distribution of Very Small Villages (Fewer than 100 Inhabitants) by Region, 2011

Regions	Number of villages	Share of total number of villages (%)	Very small villages		Larger villages		Total (%)
			<100 inh. (%)	100+ inh. (%)	<100 inh. (%)	100+ inh. (%)	
North-West	1,744	14	12	14	11	89	100
Center	1,688	14	29	11	27	73	100
North-East	2,332	19	11	20	8	92	100
South-East	1,385	11	10	11	12	88	100
South Muntenia	1,959	16	8	17	7	93	100
Bucharest-Ilfov	89	1	0	1	1	99	100
South-West Oltenia	1,939	16	14	16	12	88	100
West	1,230	10	16	9	21	79	100
Total	12,366	100	100	100	13	87	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.4: Share of Children and Elderly in the Total Population of Small and Very Small Villages, 2011

Population aged ...	Very small villages		Total (%)	Small villages		Total (%)
	<100 inh. (%)	100+ inh. (%)		<200 inh. (%)	200+ inh. (%)	
<18 years old	16	22	22	18	22	22
50+ years old	50	37	37	47	37	37
55+ years old	45	32	32	41	31	32
60+ years old	38	25	26	35	25	26
65+ years old	29	18	18	26	18	18
70+ years old	24	14	14	21	14	14
75+ years old	16	9	9	14	9	9

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.5: Share of Dwellings Connected to Utilities in Small and Very Small Villages, 2011

	Very small villages	Larger villages	Total	Small villages	Larger villages	Total
Dwellings with...	<100 inh. (%)	100+ inh. (%)	(%)	<200 inh. (%)	200+ inh. (%)	(%)
Piped water from the public network	32	32	32	28	33	32
Sewage disposal system connected to a public sewage disposal plant	4	6	6	4	6	6
Electrical lighting	99	99	99	99	99	99
Gas from public network for cooking	10	10	10	9	10	10

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.6: Share in Total Population of People with Limitations because of Health Problems in Small and Very Small Villages, 2011

People with limitations because of health problems ...	Total number	Share of total population (%)	Very small villages	Larger villages	Small villages	Larger villages
			<100 inh. (%)	100+ inh. (%)	<200 inh. (%)	200+ inh. (%)
... with significant difficulties, of which:	264,416	2.9	4.4	2.8	4.0	2.8
- without aid from someone else	177,083	1.9	3.1	1.9	2.9	1.9
... with complete inabilities, of which:	57,299	0.6	0.8	0.6	0.8	0.6
- without aid from someone else	17,099	0.2	0.3	0.2	0.2	0.2

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.7: Villages with Aging Populations, 2011

Villages with more than 50% of individuals aged ...	Number of villages	Share of total number of villages (%)	Total population	Share in total rural population (%)	Average village size	Children living in these villages*
50+ years old	2,342	18.9	637,760	6.9	272	14
55+ years old	1,288	10.4	238,183	2.6	185	12
60+ years old	625	5.1	70,587	0.8	113	10
65+ years old	208	1.7	8,973	0.1	43	5
70+ years old	108	0.9	2,859	0.03	26	3
75+ years old	32	0.26	270	0	8	0
Total rural population	12,366	100	9,262,851	100	749	

Source: World Bank calculations based on 2011 Population and Housing Census.

Note: * Share of total number of children aged 0 to 17 years living in these villages in total population of these villages.

ANNEX TABLE 10.8: Distribution of Villages with Aging Populations by Region, 2011

Regions	Villages with more than 50% of individuals aged 50+ years old (%)			Villages with more than 50% of individuals aged 55+ years old (%)			Villages with more than 50% of individuals aged 60+ years old (%)		
	No	Yes	Total	No	Yes	Total	No	Yes	Total
North-West	78	22	100	86	14	100	92	8	100
Center	81	19	100	88	12	100	93	7	100
North-East	93	7	100	97	3	100	99	1	100
South-East	82	18	100	90	10	100	96	4	100
South Muntenia	83	17	100	91	9	100	96	4	100
Bucharest-Ilfov	98	2	100	100	0	100	100	0	100
South-West Oltenia	72	28	100	85	15	100	94	6	100
West	72	28	100	86	14	100	93	7	100
Total	81	19	100	90	10	100	95	5	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.9: Share of Dwellings Connected to Utilities in Villages with Aging Populations, 2011

Dwellings with...	Villages with more than 50% of individuals aged 50+ years old (%)			Villages with more than 50% of individuals aged 55+ years old (%)			Villages with more than 50% of individuals aged 60+ years old (%)		
	No	Yes	Total	No	Yes	Total	No	Yes	Total
Piped water from the public network	33	26	32	32	27	32	32	29	32
Sewage disposal system connected to a public sewage disposal plant	6	3	6	6	4	6	6	4	6
Electrical lighting	99	99	99	99	99	99	99	99	99
Gas from public network for cooking	11	6	10	10	7	10	10	6	10

Source: World Bank calculations based on 2011 Population and Housing Census.

II. Statistical Data on Small Communes (with Fewer than 2,000 Inhabitants)

ANNEX TABLE 10.10: Distribution of Communes and Rural Population by Commune Population Size, 2011

Commune population size ...	Number of communes	Share in total number of communes (%)	Total population	Share in total rural population (%)
<1,000 inhabitants	88	3	65,117	1
1,000-1,499	247	9	314,583	3
1,500-1,999	416	15	727,606	8
2,000-2,499	419	15	941,083	10
2,500-2,999	363	13	992,611	11
3,000+ inhabitants	1,328	46	6,221,851	67
Total	2,861	100	9,262,851	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.11: Distribution of Small Communes (Fewer than 2,000 inhabitants) by Region, 2011 (%)

	Communes by population size (number of inhabitants)						Total	Small communes	Larger communes	Total
	<1000	1000- 1499	1500- 1999	2000- 2499	2500- 2999	3000+		<2000 inh.	2000+ inh.	
North-West	6	21	13	15	15	13	14	15	14	14
Center	27	17	16	13	12	9	12	17	11	12
North-East	0	5	13	14	17	24	18	9	21	18
South-East	16	11	12	12	9	13	12	12	12	12
South Muntenia	6	11	13	20	18	21	18	12	20	18
Bucharest-Ilfov	0	0	0	0	0	2	1	0	2	1
South-West Oltenia	15	16	19	18	17	10	14	18	13	14
West	31	18	14	8	12	6	10	17	7	10
Total	100	100	100	100	100	100	100	100	100	100
North-West	1	13	13	16	14	43	100	27	73	100
Center	7	12	18	15	13	35	100	37	63	100
North-East	0	3	11	12	12	63	100	13	87	100
South-East	4	8	14	14	10	50	100	26	74	100
South Muntenia	1	5	11	16	12	55	100	17	83	100
Bucharest-Ilfov	0	0	0	0	0	100	100	0	100	100
South-West Oltenia	3	10	20	19	15	34	100	32	68	100
West	10	16	20	11	15	28	100	46	54	100
Total	3	9	15	15	13	46	100	26	74	100

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.12: Share of Dwellings Connected to Utilities by Commune Population Size, 2011 (%)

Dwellings with...	Communes by population size (number of inhabitants)						Total
	<1000	1000-1499	1500-1999	2000-2499	2500-2999	3000+	
Piped water from the public network	31	28	34	28	29	33	32
Sewage disposal system connected to a public sewage disposal plant	5	4	6	3	4	6	6
Electrical lighting	99	99	99	99	99	99	99
Gas from public network for cooking	12	9	8	7	6	12	10

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.13: Share of Dwellings Connected to Utilities in Small Communes, 2011 (%)

Dwellings with...	Small communes	Larger communes	Total
	<2000 inh.	2000+ inh.	
Piped water from the public network	32	32	32
Sewage disposal system connected to a public sewage disposal plant	5	6	6
Electrical lighting	99	99	99
Gas from public network for cooking	9	11	10

Source: World Bank calculations based on 2011 Population and Housing Census.

III. Statistical Data on Small Urban Towns (fewer than 20,000 inhabitants)

ANNEX TABLE 10.14: Distribution of the Urban Population by City Size and Region (%)

	Small towns	Medium cities	Large cities	Total
	1,641-20,000 inhabitants	20,000-200,000 inhabitants	>200,000 inhabitants	
North-East	2.8	7.2	2.7	12.7
South-East	1.9	5.8	4.9	12.5
South Muntenia	3.2	6.3	1.9	11.4
South-West	2.9	3.5	2.5	8.8
West	2.7	4.8	2.9	10.5
North-West	2.6	7.0	3.0	12.6
Center	2.9	7.4	2.3	12.6
Bucharest-Ilfov	0.5	1.0	17.3	18.9
TOTAL	19.3	43.1	37.6	100.0

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.15: Distribution of Small Towns and Urban Population by Population Size, 2011

Population size ...	Localities (number)			Population (number)		
	Small towns designated before 2002	Small towns recently designated	Small towns total	Small towns designated before 2002	Small towns recently designated	Small towns total
0-4,999 inhabitants	19	10	29	65,175	42,585	107,760
5,000-7,499	42	23	65	270,593	144,109	414,702
7,500-9,999	33	7	40	288,993	61,129	350,122
10,000-14,999	54	10	64	643,044	121,406	764,450
15,000-19,999	26	1	27	444,489	15,329	459,818
Total	174	51	225	1,712,294	384,558	2,096,852

Source: World Bank calculations based on 2011 Population and Housing Census.

ANNEX TABLE 10.16: Average Levels of Local Human Development (LHDI) by Locality Type and Population Size, 2002 and 2011

Population size ...	Larger cities 20,000+ inhabitants		Small towns (fewer than 20,000 inhabitants) declared before 2002		Small towns (fewer than 20,000 inhabitants) recently designated		Rural communes	
	LDHI 2002	LDHI 2011	LDHI 2002	LDHI 2011	LDHI 2002	LDHI 2011	LDHI 2002	LDHI 2011
0-4,999 inhabitants	-	-	41.7	43.9	37.4	41.1	31.9	35.7
5,000-7,499	-	-	40.8	43.7	37.4	41.4	36.0	40.6
7,500-9,999	-	-	42.9	46.0	39.3	43.6	38.0	44.1
10,000-14,999	-	-	44.2	46.9	39.1	43.9	39.9	46.3
15,000-19,999	-	-	46.4	48.3	*	*	-	-
20,000 or over	49.7	52.1	-	-	-	-	*	*
Total	49.7	52.1	43.2	45.9	38.1	42.5	32.6	36.6

Source: The Local Human Development Index (LHDI) developed in World Bank (Ionescu-Heroiu et al, 2013a).

Note: *Only one case.

ANNEX TABLE 10.17: A Comparison of Local Budget Indicators: between Small Towns, Larger Cities, and Rural Communes by Population Size

Population size	Self-generated revenues of localities (annual average per inhabitant, in 2009 constant RON)			Total volume of expenditures on European funded projects, in the period 2009-2012 (Euro per capita)		
	Small towns designated before 2002	Small towns recently designated	Rural communes	Small towns designated before 2002	Small towns recently designated	Rural communes
0-4,999	186	151	54	75	14	143
5,000-7,499	150	84	70	55	55	83
7,500-9,999	158	69	108	79	46	48
10,000-14,999	178	130	113	37	87	41
15,000-19,999	148	*	*	63	*	*
Total	164	107	58	57	51	133

Source: World Bank's calculations using local budget execution data posted by the Ministry of Administration and Interior available at: http://www.dpfb.l.mai.gov.ro/sit_ven_si_chelt_uat.html (date of accession: January 10, 2014) as well as population data from 2011 census (National Institute of Statistics).

Note: * Only one case of 15,000 inhabitants or over.⁵⁶⁰

⁵⁶⁰ At present, the local budget execution data are reported by the Ministry of Finance. The Ministry of Administration and Interior is the Ministry of Internal Affairs.

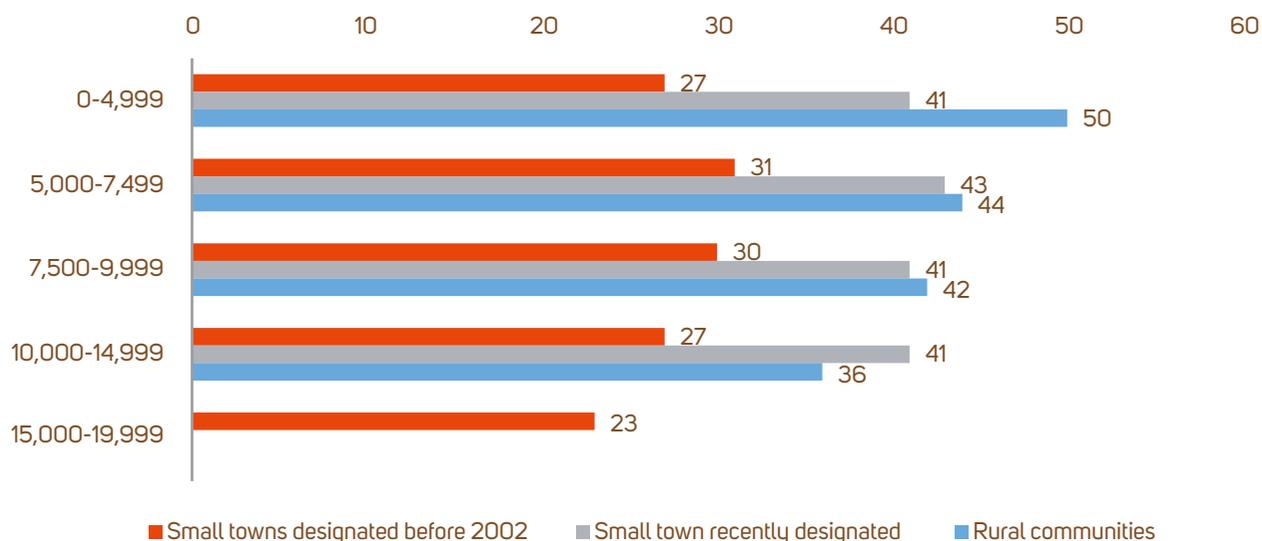
ANNEX TABLE 10.18: Average Shares of Dwellings Connected to Utilities in Small Towns and Communes, 2011 (%)

Population size	Small towns designated before 2002	Small towns recently designated	Rural communes	Small towns designated before 2002	Small towns recently designated	Rural communes
	Piped water from the public network			Sewage disposal system connected to a public sewage disposal plant		
0-4,999	75	48	27	48	23	3
5,000-7,499	70	40	33	42	15	7
7,500-9,999	74	41	44	52	16	13
10,000-14,999	79	45	47	56	21	22
15,000-19,999	81	*	*	63	*	*
Total	75.5	43	28	52	19	4
	Gas from public network for cooking					
0-4,999	36	15	6			
5,000-7,499	25	21	13			
7,500-9,999	37	28	25			
10,000-14,999	47	25	34			
15,000-19,999	51	*	*			
Total	39	23	8			

Source: World Bank calculations based on 2011 Population and Housing Census.

Notes: The size of the locality and the county to which the locality belongs were held constant. In order to compare similar rural and urban localities, the propensity score method was used. * Only one city and one commune of 15,000 inhabitants or over. ** For comparison, the average shares of dwellings connected to utilities in larger cities (20,000 or more inhabitants) are the following: 92 percent piped water from the public network, 85 percent sewage disposal system connected to a public sewage disposal plant, and 75.5 percent gas from public network for cooking.

ANNEX FIGURE 10.1: Distribution of Working Age Population Not in Education or Training by the Highest Level of Education Achieved, in Small Towns and Communes, and by Population Size, 2011 (%)



Source: World Bank's calculations using data from the 2011 Population and Housing Census.

Notes: For recent small towns and communes, the category of 15,000 to 19,999 inhabitants was not included because of the small number of localities in this category (only one city and one commune). Primary education in Romania refers to grades 1-4, while lower secondary education is gymnasium (1-8 grades).

ANNEX TABLE 10.19: Employment of Working Age Population in Small Towns and Communes by Size, 2011 (Average %)

Population size	Small towns designated before 2002	Small towns recently designated	Rural communes	Small towns designated before 2002	Small towns recently designated	Rural communes
	Employee			Self-employed (including family's unpaid helper) in agriculture		
0-4,999	51	43	27	4	11	28
5,000-7,499	48	41	31	5	11	24
7,500-9,999	50	40	36	5	10	17
10,000-14,999	52	44	41	3	10	17
15,000-19,999	52	*	*	3	*	*
Total	51	42	28	4	11	27
	Unemployed			Inactive other than students or pensioners		
0-4,999 inhabitants	7	7	4	14	19	21
5,000-7,499	7	6	4	18	20	20
7,500-9,999	8	6	4	17	22	23
10,000-14,999	7	6	4	16	19	19
15,000-19,999	7	*	*	15	*	*
Total	7	6	4	17	19	21

Source: World Bank calculations using data from the 2011 Population and Housing Census.

Note: * Only one city and one commune.

ANNEX TABLE 10.20: Employment of Working Age Population in Large Towns by Size, 2011 (Average %)

	20,000-199,999	200,000+	Total
Employees	57	60	57
Self-employed (including family's unpaid helper) in agriculture	1.2	0.4	1.1
Unemployed	6	5	6
Inactive other than students or pensioners	12	8	12

Source: World Bank calculations using data from the 2011 Population and Housing Census.

IV. Statistical Data on Marginalized Areas

ANNEX TABLE 10.21: Three Criteria of Marginalization with Key Indicators and their Corresponding National Thresholds in Urban and Rural Areas (%)

Criteria/ Dimension	Key indicators	URBAN		RURAL	
			80th percentile = national urban threshold *)	Key indicators	80th percentile = national rural threshold **)
Human capital	Proportion of population aged 15-64 years old who completed 8 grades or less		22.1	Proportion of population aged 15-64 years old who completed 8 grades or less	59.3
	Proportion of people with disabilities, chronic diseases, or other health conditions that make their daily activities difficult		8	-	
	Proportion of children (0-17 years) in total population		20.5	-	
Employment	Proportion of people aged 15-64 years old neither in formal employment (employees or employers) nor in education		22.2	1: Proportion of people aged 15-64 years old neither in education nor have ever been in formal employment (employees, employers or pensioners)	72.1
	Proportion of dwellings not connected to electricity		0.0***)	Proportion of dwellings not connected to electricity	2.7****)
Housing	Proportion of overcrowded dwellings (<15.33 square meters per person)		54.7	Proportion of overcrowded dwellings (Eurostat indicator*****)	26.1****)
	Insecure tenure: proportion of households that do not own their dwelling		12.3	Proportion of dwellings not connected to piped water	87.9****)

Source: For urban areas, the World Bank (Swinkels et al, 2014a: 9). For rural areas: NIS, 2011 Population and Housing Census.

Notes: * In urban areas, thresholds are calculated using only census sectors of households with between 50 and 500 inhabitants. ** In rural areas, thresholds are calculated using only census sectors of households with 50 or more inhabitants. *** Fewer than 1 percent of the urban dwellings are not connected to electricity and the 80th percentile is therefore 0 percent. Any urban census sector for which at least one dwelling is not connected to electricity (and thus the value is greater than 0 percent) passes this threshold. **** For the housing criterion, the rural national threshold was set at 90th percentile and the criterion is passed if any of the three indicators is higher than its corresponding threshold. ***** Eurostat indicator for overcrowding without the condition referring to a room for the household.

ANNEX TABLE 10.22: Distribution of Census Sectors by Locality Size in Rural and Urban areas, 2011

Locality size Resident population:	Census sectors				
	Number of localities	Total number	Average number per locality	Minimum per locality	Maximum per locality
RURAL:	2,861	46,547	16	2	61
119-499	12	85	7	4	11
500-999	76	615	8	3	21
1,000<2,000	663	6,775	10	2	37
2,000<3,000	782	10,783	14	6	36
3,000<7,500	1,236	25,152	20	7	61
7,500<20,000	91	3,107	34	17	58
20,000<30,000	1	30	30	30	30
URBAN:	320	50,299	157	10	7,573
1,000<2,000	1	12	12	12	12
2,000<3,000	6	80	13	10	16
3,000<7,500	87	2,675	31	12	62
7,500<20,000	131	7,325	56	27	100
20,000 - 149,999	82	19,290	235	67	773
150,000 or more	12	13,344	1,112	739	1,459
Bucharest	1	7,573	7,573	7,573	7,573

Source: World Bank calculations using 2011 Population and Housing Census.

ANNEX TABLE 10.23: Rates of Marginalization of Key Groups in Rural and Urban Areas, 2011

Key indicators	RURAL			URBAN		
	Marginalized Areas	Non-Marginalized Areas	Total	Marginalized Areas	Non-Marginalized Areas	Total
	%	%	%	%	%	%
POPULATION						
(resident population)	6.2	93.9	100	3.2	96.8	100
Roma ethnicity (self-identified)	38.7	61.3	100	30.8	69.2	100
Non-Roma	4.7	95.3	100	2.6	97.4	100
People with disabilities, chronic diseases, or other health conditions	4.9	95.1	100	3.4	96.6	100
Elderly 65+ years	4.1	95.9	100	1.2	98.8	100
Children 0-17 years	9.6	90.4	100	5.8	94.2	100
Population 15-64 years old who completed 4 grades or less	21.0	79.0	100	18.2	81.8	100

Key indicators	RURAL			URBAN		
	Marginalized Areas	Non-Marginalized Areas	Total	Marginalized Areas	Non-Marginalized Areas	Total
	%	%	%	%	%	%
Population 15-64 years old who completed 8 grades or less	9.9	90.1	100	8.8	91.2	100
Working age population (15-64 years old) not in education	5.8	94.2	100	2.9	97.1	100
Proportion of people aged 15-64 years old neither in education nor have ever been in formal employment (employees, employers or pensioners)	21	79	100	6.3	93.7	100
HOUSEHOLDS			100	2.6	97.4	100
Households with 5+ members	8.3	91.7	100	6.4	93.6	100
Households with 3+ children	15.9	84.1	100	14.8	85.2	100
DWELLINGS	5.2	94.8	100	2.5	97.5	100
Dwellings not connected to piped water	9.9	90.1	100	11.9	88.1	100
Dwellings not connected to sewage system	7.8	92.2	100	11.9	88.1	100
Dwellings not connected to electricity	26.6	73.4	100	24.7	75.3	100
Overcrowded dwellings*)	10.7	89.3	100	4.0	96.0	100
Households with insecure tenure	5.9	94.1	100	7.3	92.7	100

Source: Source: World Bank calculations using 2011 Population and Housing Census. For urban areas: Swinkels et al (2014a: 281).

Notes: *) In urban areas, measured against a threshold of <15.33 square meters per person, in rural areas, based on the Eurostat indicator for overcrowding without the condition referring to a room for the household.

ANNEX TABLE 10.24: Percentage of People from Rural Areas Neither Working as Employee Nor in Education by Age, Gender, and Type of Area

		% of people not employed or in school		% of people not employee or in school	
		Marginalized	Non-marginalized	Marginalized	Non-marginalized
15-19	years old	36	17	51	23
20-64	Total	45	36	88	64
	Men	38	33	85	59
	Women	53	40	90	69
	Men, Roma	62	62	92	81
	Men, non-Roma	30	32	83	59
	Women, Roma	69	64	95	88
	Women, non-Roma	47	39	88	69

Source: World Bank calculations using 2011 Population and Housing Census.

ANNEX TABLE 10.25: People from Urban Areas by Key Employment Indicators, 2011 (%)

Key indicators	URBAN		
	Marginalized Areas	Non-Marginalized Areas	Total
Vulnerable workers*) 15-64 years old	8.2	91.8	100
Informal workers**) 15-64 years old	5.1	94.9	100
Housewives and other economically dependants 15-64 years old	7.4	92.6	100
Population 15-19 years old not in employment, education or training (NEET)	13.3	86.7	100
Population 20-64 years old in employment	2.1	97.9	100

Source: Source: Swinkels et al (2014a: 281).

Notes: *) Vulnerable workers include: unpaid family workers, workers in agriculture, day laborers. **) Vulnerable workers plus the self-employed.

ANNEX TABLE 10.26: Rates of Marginalization by Locality Size and by Region in Rural and Urban Areas, 2011 (% of population)

Key indicators	RURAL			URBAN		
	Marginalized Areas	Non-Marginalized Areas	Total	Marginalized Areas	Non-Marginalized Areas	Total
	%	%	%	%	%	%
LOCALITY SIZE						
(resident population)	6.2	93.9	100	3.2	96.8	100
< 2,000			100	11.2	88.8	100
2,000 - 4,999			100	6.9	93.1	100
5,000 - 9,999			100	9.0	91.0	100
10,000 - 19,999			100	6.3	93.7	100
20,000 - 149,999			100	3.6	96.4	100
150,000+	-	-	100	1.1	98.9	100
Bucharest	-	-	100	0.8	99.2	100
DEVELOPMENT REGION						
North-East			100	4.3	95.7	100
South-East			100	4.2	95.8	100
South			100	2.9	97.1	100
South-West			100	2.5	97.5	100
West			100	3.7	96.3	100
North-West			100	3.1	96.9	100
Center			100	4.3	95.7	100
Bucharest-Ilfov			100	1.2	98.8	100

Source: For urban areas, the World Bank (Swinkels et al, 2014a: 13). For rural areas: NIS, 2011 Population and Housing Census. World Bank's calculations.

ANNEX TABLE 10.27: Proportions of Individuals Living in Dwellings without Basic Services by Ethnicity and Type of Area (%)

Individuals		RURAL				URBAN			
		Total	Roma	Non-Roma	Diff (Roma - non-Roma)	Total	Roma	Non-Roma	Diff (Roma - non-Roma)
Piped water from the public network	Non-marginalized	66	75	65	10	8	31	8	23
	Marginalized	86	82	88	-5	34	49	30	19
	Total	67	78	66	11	9	37	8	28
Hot water from the public network	Non-marginalized	99	99	99	1	63	88	63	26
	Marginalized	100	100	100	0	92	96	91	5
	Total	99	100	99	1	64	91	63	27
Sewage disposal system connected to a public sewage-disposal plant	Non-marginalized	94	98	94	4	16	53	15	38
	Marginalized	99	100	99	0	59	77	54	22
	Total	94	98	94	4	17	60	16	44
Electric lighting	Non-marginalized	0.7	3.9	0.6	3	0.1	1.7	0.1	2
	Marginalized	5.3	9.5	3.7	6	3.9	10.3	2.2	8
	Total	1.0	6.1	0.7	5	0.2	4.4	0.2	4
Gas from a public network for cooking	Non-marginalized	89	93	89	4	25	66	24	41
	Marginalized	98	98	98	-1	73	88	69	19
	Total	90	95	89	6	26	73	25	47

Source: World Bank calculations using data from the 2011 Population and Housing Census.

ANNEX TABLE 10.28: Proportions of Individuals Living in Dwellings without Basic Services by Ethnicity, Type of Area, and Different Percentages of Roma (%)

	Share of Roma in total population of the census track	Non-marginalized			Marginalized		
		Total	Roma	Non-Roma	Total	Roma	Non-Roma
URBAN							
Piped water from the public network	0	7	0	7	40	0	40
	(0.1-19.9)	9	23	9	25	34	25
	(20-39.9)	30	40	26	32	46	27
	(40-100)	44	50	37	48	54	37
Hot water from the public network	0	60	0	60	94	0	94
	(0.1-19.9)	68	83	67	90	94	90
	(20-39.9)	93	95	92	91	96	89
	(40-100)	97	98	96	96	97	93
Sewage disposal system connected to a public sewage disposal plant	0	14	0	14	65	0	65
	(0.1-19.9)	18	39	18	48	57	48
	(20-39.9)	57	69	53	57	71	52
	(40-100)	77	82	70	77	84	67
Electrical lighting	0	0	0	0	2	0	2
	(0.1-19.9)	0	2	0	2	7	2
	(20-39.9)	1	2	1	5	9	3
	(40-100)	1	2	1	9	11	5
Gas from public network for cooking	0	23	0	23	80	0	80
	(0.1-19.9)	28	54	27	66	78	65
	(20-39.9)	62	76	56	71	86	64
	(40-100)	85	91	76	82	90	69
RURAL							
Electrical lighting	0	1	0	1	4	0	4
	(0.1-19.9)	1	3	1	4	9	3
	(20-39.9)	2	4	1	6	11	4
	(40-100)	3	5	1	8	9	4

Source: World Bank calculations using data from the 2011 Population and Housing Census.

Programme title: Sectoral Operational Programme Human Resources Development 2007-2013.

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Project title: Provision of Inputs for the Preparation of a Draft National Strategy and Action Plan on Social Inclusion and Poverty Reduction

Editor: The World Bank

Publishing date: October 30, 2015

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