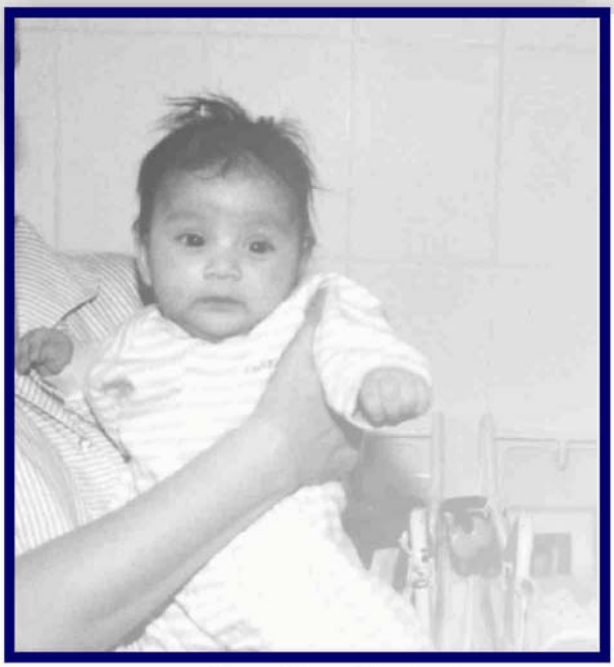
MINISTRY OF LABOUR,
SOCIAL SOLIDARITY AND FAMILY
National Authority
for Child Rights Protection

unicef

IOMC
Mother and Child Care Institute
"Alfred Rusescu"

The Situation of Child Abandonment in Romania



2005

The Situation of Child Abandonment in Romania

2005

CONTRIBUTIONS

UNICEF Romania supported this project, based on an institutional partnership built with government and non-governmental institutions, which included: the Ministry of Health / Mother and Child Care Institute "Alfred Rusescu", the Ministry of Labor, Social Solidarity and Family / the National Authority for Child Protection and Adoption, the International Foundation for the Child and Family, the "Community Supporting the Child" Association, the Center for Education and Professional Development "Step by Step" Association, and the "Youth" Association.

The team of experts leading the study:

Project coordinator: ECATERINA STATIVĂ

Project assistant: TATIANA POPA

Coordinators for the qualitative data: CARMEN ANGHELESCU, RODICA MITULESCU, MIHAELA NANU

Consultative experts: DR. ALIN STĂNESCU, DR. ALEXANDRA ZUGRĂVESCU

Consultants for analyzing and processing data: NINA STANCIU, DAN TURCU

Consultants for data base, graphs and tables: IOANA MARIN, RALUCA GRAUR

Field operators: MIRCEA ANGHELESCU, CORINA BACALEAROS, BOTONOGU FLORIN, MARIA CONSUELA CIOBANU, DANIEL CHIRILA, OANA CLOCOTICI, ALINA COTAN, EFTIHITA CRACIUN, VASILE DESPAN, DANIELA GHEORGHE, MIHAELA GHERGHELI, RALUCA GHINEA, ELENA IONITA, OANA MANTA, IOANA MARIN, IOLANDA MOROŞAN, GABRIELA OPROIU, ARIANA POPA, SANDA FRANCESCA RUSSU, MARIA SÂRBU, FLORENTINA SARGU, GRATIELA SION, DRAGOS STANCIU, DAN-OVIDIU STATIVA, MARIA VOLINTIRU

Authors of Report: ECATERINA STATIVĂ, CARMEN ANGHELESCU, RODICA MITULESCU, MIHAELA NANU, NINA STANCIU

THANKS

This research would not have been possible without the friendly assistance of all individuals devoted to their profession who were contacted for valuable input for the study.

We hereby convey our gratitude for the cordial assistance offered by the directors of the County Public Health Directorates, directors of hospitals, chief of wards, family doctors, professionals from the medical sector.

We would also like to address our thanks to all directors of the County Child Protection Directorates, members of the Child Protection Commisions, professionals involved in child protection services for their special support.

We equally extend our gratitude to the mayors and secretaries of Local Councils, who kindly allocated time and shared valuable information for the qualitative analysis.

Our special thanks is addressed also to all mothers who expressed their availability and openness for sharing useful information for this study.

We also benefited from useful advice and observations from the UNICEF Romania team. Special thanks go to Mrs. Voica Pop, Child Protection Officer and Mrs. Lorita Constantinescu, Child Protection Consultant for efficient coordination of the working group, for valuable ideas and constant support provided during the implementation of activities.

Warning on the findings related to national minorities in the study

This research study had as a main goal the assessment of child abandonment phenomena in hospitals, and the manner in which social care and medical services respond to the identified needs in connection with the issue of child abandonment. Unfortunately, during the research excercise, various forms of racist and discriminator rethoric directed against Roma minority (either from the part of the social actors or from the part of the staff in the social care or medical services) have been encountered and documented. We deliberately wanted to document these expressions by the actors in the field of social services in order to shed light on the magnitude and manifestation of the phenomena not only among the public but also among the service providers and possibly decision-makers. It is hoped that such exposure will stimulate the adoption of firm measures for the elimination of such racist attitudes and discourses from within the social services sector, as well as to contribute to the promotion of democratic and inclusive attitudes in the Romanian society at large.

Within this study a series of findings have been drawn and many conclusions were generated related to the ethnic origin of the mothers who were part of the study sample. By so doing we would like to warn from the very beginning that these data must not be generalized for the whole ethnic community at national level (be it the Romanian, Roma, or any other ethnic group). Such a generalization would not have a scientific justification and could lead to erroneous conclusions. The data and the findings presented in the study refer exclusively to the group of mothers involved in the sample for the child abandonment phenomena investigated.

ACRONYMES

ANPCA	National Agency For Child Protection and Adoption
DJPDC	County Child Rights Protection Department
NGO	Non-Governmental Organization
IOMC	Institute for Mother and Child Care
IUD	Intra-Uterine Disposal
SPSS	**S**tatistical Package for the Social Sciences
FICF	International Foundation for Child and Family
CNP	Personal numeric code

CONTENT

EXECUTIVE SUMMARY

1. Context

Much progress has been made in Romania in the past eight years in the area of the protection of child rights. New central and local institutional structures have been created, as have services for children and families in difficulty, and the prevention of their ending up in difficulty.

In spite of these significant achievements, the problem of child abandonment, which still persists in Romania, is an issue which appeared and worsened prior to 1990. More or less successful, child protection reforms did not act in this regard, leading to the spreading and increasing complexity of this phenomenon.

Even in 2004 unwanted children are abandoned at birth in maternity wards, hospitals and pediatric wards, or simply "left" by their parents for indefinite periods of time in these medical units.

The following conditions lead to these actions, at such a scale, to be classified as a phenomenon: the absence of community services for the prevention of child abandonment, and the consent, tolerance, and indifference on the part of institutions in which these events take place or those directly responsible for child protection.

The abandonment of children in health care institutions results in some of the most perverse effects, including a variety that affect the development of the child at a time considered to be the most important in his life.

The separation of the child from his mother soon after birth or at a very early age in a health care institution exposes the child for long and significant periods of time to an existence in which his development needs are ignored. Likewise the child is often moved to various unsatisfactory locations until temporary measures are taken and stable protection measures are enforced.

2. Justification

The persistence of this phenomenon in all its forms, and the direct long-term effects on the chances of the child to a normal development have justified the initiation of a project which aims to understand what and who makes this possible, and what can be done to decrease this phenomenon.

It is necessary to understand the magnitude of this phenomenon in order to assign a measure of urgency and have a reference point to evaluate the possible programs for intervention.

The objectives of this study also include the understanding of the prevalence of the child abandonment phenomenon by more rigorous conceptual delimitations, and the diagnosis of the most important dimensions of this phenomenon.

3. Methodology

A retrospective transversal study was conducted over a period of three months in 2003 and 2004 to carry out these objectives, and the reference population was made up of children less than five years of age temporarily or definitely abandoned/left, and their mothers.

A cluster sampling technique was used to obtain a representative random group of abandoned children and their mothers, based on their total number in the reference period. The following selection method was used:

Of the eight Romanian development areas (one of which is the area of Bucharest and Ilfov county) two counties (and two sectors, respectively) were selected at random. All health care institutions in these counties and sectors were studied (70 maternity wards, 89 hospitals/pediatric and recovery wards) and 25 emergency placement centers.

Some 2,000 patient charts of under-five children were selected, based on criteria adopted by each institution in part to define an abandoned child.

The working definition of the concept of an *abandoned child* refers to a child whose biological parents have relinquished their responsibility to care for and satisfy his/her basic development needs, and who have physically separated themselves from him/her before this responsibility was taken over by an authorized institution.

This methodology was based on the fact that it would be possible to identify all children who had been exposed for any length of time to abandonment, on condition that a record thereof existed.

Source of information

In addition to studying the medical records and, where appropriate, the files of the children, investigations/interviews were conducted with the mothers of the children selected in the sample.

Focus groups were set up among health care and social welfare institution professionals to verify, supplement and study the findings based on the quantitative data; detailed interviews were conducted with key individuals at various representation and decision-making levels; case studies on child abandonment were carried out.

Tools

Questionnaires, nine different forms, and interview and focus group guides were used to record the data obtained from the documents and the above-mentioned individuals.

Data collection

The collection of quantitative data took place between August–September 2004, while that of qualitative data took place between October–November 2004.

Data processing

The data was processed using the Statistical Package for the Social Sciences (SPSS).

4. Summary of the participants in the evaluation process

The UNICEF Office in Romania supported this project, based on an institutional partnership, whose mission is considered to be just at the beginning. This partnership includes government and non-governmental institutions, of which we would like to mention the following: the Mother and Child Protection Institute “Alfred Rusescu”, the National Authority for Child Protection and Adoption, the International Foundation for the Child and Family, the “Community Supporting the Child” Association, the Center for Education and Professional Development “Step by Step” Association, and the “Youth” Association.

5. Conclusions, lessons learned, recommendations, use made of the evaluation to make timely adjustments in program design and improvements in program performance, possible wider relevance of the evaluation

Lessons learned

Although improperly considered as lessons learned, it is worth pointing out that the data collection teams faced a number of difficulties resulting from a lack of or disregard for archival regulations for medical records, or the incoherence of regulations on the safekeeping of the files of children by County Child Protection Departments.

In some counties the filing of charts is based on admission date, while in others it is according to date of discharge. Some Child Protection Departments keep the files of children in their own headquarters, while in other counties such files are scattered among the various protection units. These inconsistencies impeded the planning of work time and material resources for data collection, although the working methodology had been pre-tested in two counties.

This study led to the establishment of a comprehensive database containing factors relating to the medical and social welfare systems, other institutional factors, as well as to the human and social behavior of the players directly or indirectly involved in the occurrence of the phenomenon of abandonment. Much of this information exceeds the delimitations strictly set by the objectives of the study.

CONCLUSIONS

Child abandonment in 2003 and 2004 was no different from that occurring 10, 20, or 30 years ago.

The magnitude of the phenomenon was determined by the rate of child abandonment (the number of abandoned children per 100 births/hospital admissions).

The rate of child abandonment in maternity wards was 1.8% in 2003 and 2004, translated to an estimated number of 4,000 children, while in hospitals and pediatric wards the child abandonment rate was 1.5% and 1.4% in 2003 and 2004, respectively, or 5,000 children per year at national level.

The percentage of abandoned babies who are born underweight (34%) is four times higher than the norm for Romania (9%).

A striking number of abandoned children have no identity when discharged from hospital. According to data included in this study, the percentage of such children can reach 64% at discharge from maternity wards, 30% from pediatric hospitals, and 10% for children from in emergency placement centers.

Regarding various aspects relating to the organization and operation of maternity wards, which could encourage the observance of the rights of the child, it was found that most maternity wards follow traditional patterns (no rooming-in/mother and child wards), which encourages the separation of the mother from the child.

More than half of the institutions do not respect the rules applicable to them by the Joint Ordinance of the Ministry of Health and the National Authority for Child Protection and Adoption 2003, for the hiring of a social worker, and the reporting/recording of newborn on family physician lists.

The succession of institutions the child has been in and the protection measures it has had access to indicate that two thirds of the children abandoned in maternity wards are transferred at least once to pediatric/recovery wards before any protection measures are taken.

A mere third of all children abandoned in 2003 and in the first three months of 2004 were benefiting by the end of August 2004 from a final protection measure (with their biological or foster family), which shows that the child is subject to various temporary protection measures for a prolonged period. Furthermore, it was found that the hospital/pediatric ward is the most available substitute for accessible social welfare service, both for the parents who want to abandon their child "temporarily" or "definitively," and paradoxically for the child protection services that use such institutions to host children in difficulty while they look for and find protection measures.

An analysis of the characteristics of mothers who have abandoned their children revealed that 42.2% are illiterate, and 27% have not completed Junior High School (grades 5-8); some 80% are low socio-economic level mothers, 85% of mothers have unsure income; 28% were under 20 years old at the birth of the child.

The rejection of the child is much more pronounced in the case of mothers who resort to abandonment in maternity wards, as they have already firmly made up their mind to put their child up for adoption. Rejection is less severe in mothers who abandon their children in pediatric hospitals, as they consider these to be better alternatives for the upbringing of the child, believing that their presence with the child is facultative.

Mothers who abandon their children in pediatric hospitals are poorer and less educated than those who abandon them in maternity wards. They perceive the hospital as a place for the upbringing of their child rather than for the child's abandonment. Thus, they "choose" the hospital as an alternative for the upbringing of their child, not necessarily as a form of abandonment. Often both parents are convinced that the child will be better off in hospital and that their presence there is less important.. Usually they come to see their child only at the insistence of child protection services.

And last, but not least, more than half of the mothers have heard of at least one modern method of birth control to prevent unwanted pregnancies. The pill, the intra-uterine device (IUD), and injectable contraceptives are the most widely known methods (in that order). However, the use of contraceptive methods is desultory.

RECOMMENDATIONS

In the definition adopted in this study for the *abandoned child*, the status of abandonment was not conditional upon its duration. If the systematic and unitary reporting of child abandonment cases will be considered necessary and useful, this will require the acceptance of a single term for abandonment.

➔ In this sense, it is felt that the systematic and unitary reporting of abandonment cases is necessary and useful, and that there is a need to have acceptance on a single term for abandonment and abandoned child. The immediate and strict implementation of the new child rights legislation could lead to the statistical reporting of cases at the level of maternity wards.

The observance and implementation of legislative regulations is supported by scientific arguments of child development theories, which can be debated and assimilated by the staff in the course of continuing education and training.

➔ As such, the initiation of professional and institutional capacity development is recommended in relation to the effective and efficient enforcement of new legislative regulations.

Children's files are incomplete and difficult to locate in child protection departments. There are fewer social investigations than established protection measures, which raises numerous questions on the way in which protection measures are periodically re-evaluated.

- ➔ In this context, there is a need to come up with an operational computerized management system of cases subject to child protection social services, so that all children can be located at any time based on up-to-date information.

The prolonged retention of low birth-weight children without their mothers in health care institutions is not in the best interest of the child. It is highly unlikely that these children will grow up at a normal rate in health care institutions, without the presence of their mothers.

- ➔ It is thus recommended that a low birth rate prevention program be initiated and supported; such a program would decrease the risk of early separation of the mother and child and, implicitly, of child abandonment.

One of the reasons given for leaving healthy children in health care institutions was their lack of identity papers.

- ➔ In this sense, it would be desirable to make mandatory the declaring of the personal numeric code of the child to the maternity ward in which the child is born, and the registration of this code on the child's chart. Only after the child's identity has been established can the chart be filed.
- ➔ In connection with the identity of the child, there is a need to strictly regulate the complete filling out of all columns in the chart, especially in case of the names, address, and identity papers of the parents.

The current organization of maternity and pediatric wards offers insufficient opportunity for the development of an early bond between mother and child, which is necessary for establishing in the child the basic mental health and a normal socio-affective development.

- ➔ The sustained promotion of the rooming-in system is recommended, but the mother is unlikely to instantly change her mind about abandoning her child, because this decision is often made before she is admitted to the maternity ward. The rooming-in system should be coupled with new practices and attitudes for the mother and child to encourage constant contact, support breastfeeding, and help the new twosome to identify ways of forming attachment and mutual support.
- ➔ It is also recommended to initiate and support contact with the mother or both parents, as this is a more flexible approach than the old practices which are today scientifically invalidated.

In the case of children abandoned in or brought into medical units for social protection reasons, it is essential that the staff understand that admission to hospital is not in the child's best interests.

- ➔ The competency of professionals at various decision-making levels must be increased, to shorten the periods of transfer abandoned children are submitted to before reaching stable and final protection measures.
- ➔ It is recommended that new, integrated services be developed to guide mothers to choose alternative protection measures, and eliminate the habit of believing that the hospital is an emergency shelter for any type of difficulty the child may encounter. The acceptance and perpetuation of such situations constitutes not only a violation of the law, but also an acute lack of understanding of the child's developmental needs.
- ➔ This calls for the recommendation to provide support to community services that can focus their efforts on sustaining the retaining of the child in his family environment.
- ➔ The diversification of various mother and family support services is recommended, aimed at meeting the needs of children. Existing day-care centers (now unavailable in rural areas) could also develop services for disabled children, to prevent their separation from their families, justified on the basis of such services not existing in the community. In rural areas, kindergartens (and even schools) not presently used to their full capacity because of the drop in birth rate, could extend their activities by providing services needed to keep children in the family.

- And not least, an important method for the prevention of child abandonment is the promotion of family planning programs, to reach high-risk populations, including those with special health issues: alcohol, mental problems, disabilities.

According to Law 272/2004 on the Protection and Promotion of the Rights of the Child, which stipulates the obligations of local administration authorities to guarantee and promote the rights of the child, it is recommended to support the strengthening of professional capacities:

- of staff working in the local institutions and services, through whom the importance of early childhood and necessary child development conditions can be transmitted;
- of the specialists working in the Child Protection Commission, about the values of childhood and the child, the recognition of the rights of the child, to make them responsible for issuing protection measure proposals, to enforce the law in a specific and favorable manner for every child, so that the law in fact supports the child to offer optimal satisfaction in terms of his developmental needs, instead of regulations which complicate his evolution.

In accordance with the law, the following should be functional, rather than merely formal:

- the individual child protection plan by which individualized and personalized care for each child is ensured; and
- the service plan to prevent the separation of the child from his family.

Under such circumstances, the UNICEF Office in Romania is prepared to provide the technical and financial support needed to strengthen those institutional capacities responsible for the implementation of this new approach legislated not only by Law 272, but also by the Convention on the Rights of the Child. UNICEF is also ready to ensure the monitoring process of the rights of the child, including the evolution of this phenomenon in time, and to promptly sound an alarm when needed.

The UNICEF Office in Romania wishes to initiate and support programs which are adapted to the Romanian reality in terms of the development of certain indices, the promotion of the monitoring system, and the support of evaluations for continuous improvement of basic services for child and family. This initiative also includes a program focusing on the registration of the birth of all children, thus fulfilling the rights of a child to acquire a name, a citizenship, and to know and be cared for by his parents.

The new program of the UNICEF Office in Romania for the period 2005-2009 has as its basis the principle of ensuring and promoting a protective environment for the child and his family, which requires a global and comprehensive approach of all issues. As such, the program proposes the general framework for stage two in the child protection system reform process.

CHAPTER 1

CONTEXT AND JUSTIFICATION

1.1. Historical Background

Child abandonment (at birth) is a rudimentary method of managing unwanted or unaccepted pregnancies, for cultural and/or economic reasons. Its existence or persistence in modern societies comes from the lack of certain services, functionality of some institutions, and a culture relating to their use.

As of 1967 Romania recorded a sudden rise in the number of abandoned children, especially at birth. The abandonment phenomenon, condemned by all governments, has been poorly managed, as its magnitude has not decreased for over 35 years.

While there has always been some child abandonment in Romania, as there has been in other cultures, there was no significant magnitude in time and space for this to become a part of tradition or to define a cultural specific of the Romanian people.

A pro-natalist demographic policy decree was issued in November 1966, and as of June 1967, children began being abandoned in maternity wards and hospitals/pediatric wards. As a result, child abandonment was perceived as a direct outcome of the pro-natalist decree, and remained as such in the collective consciousness until 1990.

There has been insufficient study of this phenomenon that started in 1967, in the sense that to attribute the appearance of abandoned children to the prohibition of abortion would imply that their mothers would have obviously resorted to abortion to avoid giving birth to unwanted children they would later abandon.

For some mothers the resorting to abortion is considered a rather *responsible* attitude to reproduction, within certain parameters (in terms of values of the respective timeframe). Based on such logic, however, it is difficult to believe that a sub-category of women came into being who replaced fertility control by abortion with child abandonment from this category of mothers who use abortion to limit fertility.

While one can *presently* find numerous similarities between abandonment and abortion, their association in 1967 was hardly acceptable in terms of the values of those times, especially as concerns abortion.

Therefore one feels certain about the undoubted existence of other determinants or phenomena that strangely combined with the pro-natalist decree to generate that particular segment of the population that resorted to abortion. These may include the displacement of large segments of the population due to industrialization, the failure to morally condemn such behavior, or the encouragement, for one reason or another, of the breach between mother and child, that overlapped and crossed to produce such a brutal social level effect on children, especially in terms of unwanted ones.

Furthermore, it is believed that child abandonment at that time did not necessarily (or merely) constitute a means for controlling fertility, but rather represented a means for collective reaction to certain pressures aggressively promoted by a very harsh dictatorial political regime.

The imposition of the pro-natalist policy brought with it increasing repressive measures against doctors because of infant deaths, with excessive (and exclusive) blame being heaped on the medical sector, in lieu of attributing the responsibility of such casualties to parents.

This ill-fated balance initially resulted mainly in the acceptance of abandoned children being kept in health institutions to prevent their possible death at home. Enquiries into the deaths in hospitals were (obviously) less terrifying for medical staff in such institutions than that in the territory, where cases were attributed to negligence on the part of medical staff, and resulted in the punishment of physicians.

This resulted in a trend to forcibly send children from the territory to hospitals for minor afflictions.

The staff responsible for announcing the arrival of the child from the hospital to the territory recalls the refusal of medical staff to accept the child if its family did not offer sufficient guarant*ees for risk-free care of the child.*

The doubling of the number of births in a short period of time (for which the medical infrastructure was unprepared) theoretically also meant a doubling in the number of "*normally*" abandoned children, to which were added other problems that come with the increase of the number of such children. The management of these problems by the medical staff, in the complete absence of social welfare services, generated a series of anomalies which, perpetuated over the years, have taken a semblance of "normality" and "acceptability".

It was quite common for a mother to claim a lack of proper living conditions at home in order to abandon her child in a health institution, and be subject to no consequences. The saying that "the government wanted them, so the government should raise them" was deeply entrenched in the public consciousness, and became a cynical means for legitimizing such acts.

It was equally common for the medical staff to encourage mothers to leave their children in the care of health institutions, claiming that this was best for those children, especially when there were any suspicions of risky home care. According to various studies, some 85% of children placed in shelters and dystrophic wards in 1990 had been sent there on the basis of a physician's recommendation for institutionalization (*The Causes of Child Institutionalization in Romania, 1991*).

This "complicity" between the mother and the institutions, fostered by the belief that this is in the child's best interests, also contributed to the rise in, perpetuation and acceptance of the child abandonment phenomenon in Romania, especially in health institutions.

The pro-natal policy was mainly implemented by Decree 770/1966, prohibiting abortion upon request, and progressively limiting the access of the population to any kind of contraceptives, including condoms. The demographic policy was politically justified, and the outlawing of contraceptives was justified "scientifically". Politicians and major part of the medical community engaged in aggressive propaganda against family planning. Such counter-propaganda was only possible due to the limited circulation of scientific information during the communist dictatorship, including at academic level.

The unprecedented human development recorded in the '80s in most European countries remained unmatched in Romania. Important progress in understanding child development resulted in new approaches for the child, focussing on increased capitalization for early childhood. Such progress was unknown in Romania, because of its isolation behind the Iron Curtain, and due to the discontinuation of socio-human academic education at the end of the '70s.

The more than 20 year tolerance of the abandonment phenomenon and the simultaneous and progressive development by the communist government of an institutional child protection infrastructure (for unwanted, abandoned and neglected children), entirely inadequate in terms of the needs of the child, confirm the consequences of Romania's isolation as concerns such knowledge, especially in the socio-human field.

A "natural" drop in the child abandonment phenomenon was expected in the 1990-91 period, after the fall of communism, following the liberalization of abortion and free access to contraceptives.

But this did not happen. In the 14 years since 1989, ever more complex justification was assigned to abandonment, which hindered the identification of solutions for decreasing the number of abandoned children. The communist government had developed a system of values for 25 years that undermined family ties, encouraged dependence on the state, weakened the capacity of families to care for their children, and generally promoted the neglect by parents of their parental responsibilities and, sometimes, even of their own lives.

Against the backdrop of such a crisis of values, large segments of the population sank into deep poverty. At the same time, the new social policies for the child in difficulty carried the mark of old mentalities linked to institutional protection values, which were developed outside and with no consideration for the importance of the family and the satisfying of the needs of the child.

Children abandoned in hospitals were left for long periods in these institutions. Their separation from families, by setting up a severe protection measure, could last from several months to 4-5 years. Their normal development was jeopardized not only by illnesses, but especially by the fact that their developmental needs were ignored. The delayed implementation of protection measures was circumstantially "justified" at various political moments. Initially, it was thought that hospitals had no qualified/designated staff to handle such problems, and the medical staff was limited in terms of ability to make any intervention.

Since 1989, many large child protection institutions have closed down. Due to the fact that the magnitude of the abandonment phenomenon remained unchanged, children continued to stay for long periods in maternity wards and pediatric hospitals because they had no another place to go to.

The subsequent closure of such institutions resulted in similar blockages, even while alternative protection measures (foster parents, maternal centers) were being developed, because these could not meet all the needs. Blockages are perpetuated, because few children leave the child protection system. The children stay with their foster parents for periods comparable to those spent in placement centers. Therefore, new cases require the creation of new placement (new foster parents).

The Literature of the child abandonment phenomenon

The magnitude of the child abandonment phenomenon was unknown prior to 1989, mostly due to the fact that abandonment was not officially acknowledged.

A first study conducted in 1990 by the Institute for Mother and Child Care (IOMC) and UNICEF, entitled ***The Causes of Child Institutionalization in Shelters and Dystrophic Wards***, drew attention to the fact that of the some 9,000 children aged 0-3 years who had been institutionalized in shelters throughout the country, 83% were coming directly from maternity wards and hospitals, pediatric and dystrophic wards. These children had been institutionalized based on a physician's recommendations.

Most children suffered from chronic medical problems or disabilities, which they developed during their stay in the respective institution due to a lack of proper attention, stimulation, exposure to sunshine and adequate food. Few of them were legally declared abandoned, although they had been deserted.

The causes for institutionalization were numerous, from a lack of social and material support (single or teenage mothers, absence of fathers or the extended family) to problems related to extreme poverty (large families, mothers with no babysitting support during work hours, alcoholism, prostitution etc.).

UNICEF, the International Foundation for Child and Family (FICF), and IOMC carried out a second study in 1996 entitled ***The Causes of Child Institutionalization in Romania***, which indicated that some 70% of the children aged 0-3 years who had been institutionalized in shelters were coming directly from maternities and pediatric hospitals/wards.

The survey showed that child abandonment (in maternity and pediatric hospitals/wards) was the main cause of institutionalization in the case of 51% of these children. It further evidenced that child abandonment was considered to be the sole cause for institutionalization in only 10% of the cases, while the remainder pointed to other socio-economic factors.

Another study carried out in 1997 in seven maternity wards throughout the country and three in Bucharest emphasized an average 1.61% rate of child abandonment between the limits of 0.75-2.7% (I.M. Dambeanu, Petronela Stoian and others: *Child Abandonment as a Form of Negligence*, in the book entitled *The Mistreated Child*, 2001). The characteristics of the mother who abandons her child were defined as being related to marital status (single mothers), age (teenagers), and level of education (low).

In 2000 Iuliana Dombici, Minerva Ghinescu and others conducted a study entitled *Maternal Abandonment*, which draws attention to a prevalence rate of child abandonment in maternity wards of 0.7-2.5%, based on the number of inhabitants of the communities in which the maternity is located.

The prevalence of child abandonment in **maternity wards** is similar in the above-mentioned studies. There are no exact figures on the abandonment of under-five children in pediatric hospitals and wards, although their presence is regularly reported in the hospital environment.

Most of these studies were conducted based on the analysis of documents and the interviewing of maternity professionals. None made any attempt to understand the child abandonment phenomenon from the perspective of the mother.

Although these studies have certain limitations because methodologies were used that do not allow for the generalization of country-level results, they are valuable as case studies.

Similarly, it should be mentioned that while the last two studies deal specifically with "child abandonment," one cannot find a definition of the notion or concept of child abandonment. As such it is unclear what exactly the prevalence contained therein refers to.

The present study makes use of at least four approaches for understanding the context which generates and determines the persistence of the child abandonment phenomenon in Romania: the health of the abandoned child, the socio-cultural and economic condition of the mother, the care practices in health institutions, and the appropriateness and accessibility of social and medical services for the mother and child.

The child abandonment concept: A historical and legal perspective

The rise in the number of abandoned children and the long periods they spend in health institutions has led to the issuing of a law that should provide solutions in terms of the newly created situation.

Law 3/1970 regulated "*the protection of certain categories of minors*", and formed the basis for the institutionalization of all these children in health care institutions. The decision for institutionalization was made by a commission, usually upon the recommendation of a physician, and was based on the argument that the children's development would have been "*jeopardized within the family.*" According to this Law, the destination of such children was a *closed* medical institution, known as a *shelter* (if the child had identity documents) or a *dystrophic ward* (for children without identity documents).

The notion of an *abandoned child* was entirely absent from this law, because the law "stipulated" the separation of the child from his family and parents and his admission to an institution as one of a series of opportunities ensuring that the child benefited from additional resources for its proper development.

As such, these children were not considered to be *in difficulty*, nor was it felt that their rights were being violated, but rather that their needs were being fully met within a *collective* guaranteed by the state. The collective and the state were perceived as guarantors.

The provisions of this law illustrate the limited perspective of the development of the child, which entirely ignored its relationship with its mother/parents. The meeting of its needs was extremely limited, only in terms of food and shelter, as it was believed that its educational needs would "appear only after age 3". This perspective was similarly fostered among parents.

This is how a law, aimed at saving children whose *development was jeopardized within the family*, led to the development of a *culture of institutional child abandonment, irreversibly affecting their normal development*, without this being acknowledged as such.

The actions and behavior of those professionals who came in contact with these children, left parentless in medical institutions or in the care of social services, will be closely associated with this culture for a long time to come.

Law 3/1970 was in effect until June 1997, at which time Emergency Ordinance 26/1997 was passed, mainly to regulate the protection of various categories of neglected or abandoned children, either temporarily or permanently, known generically as *children in difficulty*. This law refrains from using the expression *abandoned child* due to the existence of another law (Law 47/1993), already in effect at that time. This earlier law aims at clarifying the legal status of *the child that has been abandoned by parents* in an institution.

According to the provisions of this law, the court could declare such a child *abandoned* on the basis of previously established criteria and conditions, to ensure that the child could benefit from certain protection measures, such as foster parents or adoption.

When the above-mentioned law went into effect, many child protection system professionals felt that only children *declared legally abandoned* could be considered *abandoned*, and recommended that other abandoned children be assigned the less scientific appellation of *deserted* children.

The perspective that currently drives to the designation of a child as either *abandoned* or *deserted* relates only to the mother/parent's point of view. This perspective ignores and fails to legally and morally sanction those practices that perpetuate the status of complete abandonment of children (for long periods and at highly significant ages) in medical institutions in which their normal development is seriously jeopardized because their fundamental needs are not being met.

The authors of this study believe that children under the age of two, and especially newborns, left without their mother, constitute an emergency segment that requires right away measures. Immediate protection for such children must not be delayed for bureaucratic procedural reasons, because their normal development can be irreversibly harmed.

Law 272/2004 on *the protection and promotion of the rights of the child*, entered into force as of 1 January 2005, uses the appellations of *deserted child, foundling* or *child abandoned by mother* strictly from the same perspective and without defining them.

Working definition of the abandonment concept

An abandoned child is one whose biological parents have relinquished the responsibilities of caring for and meeting its fundamental development needs, severing physical ties with the child prior to the time an authorized institution has been able to take over the responsibility.

The designation "abandoned" may be neither conditioned nor amended by the duration for which the parents have relinquished their responsibility or the location of the child at the time its mother/parents resorted to such relinquishing.

What is important is that all children suffering the (sometimes irreversible) consequences of maternal deprivation in all its forms be included, regardless of the duration of the separation.

1.2. Purpose of the Project

The research was aimed at:

- acquiring knowledge on the prevalence of the child abandonment phenomenon by means of more rigorous conceptual delimitations;
- carrying out an evaluation of the most important features of the child abandonment phenomenon;
- developing strategies and programmes, based on the assembled data, which may contribute to the decrease of the child abandonment phenomenon in Romania.

The objectives were:

1. To record and describe the various forms of abandonment;
2. To identify the causes which lead to the temporary/permanent abandonment of the child;
3. To identify certain characteristics of the children selected for this study, specifically in terms of their health;
4. To identify various medical and socio-cultural risk factors among mothers who have abandoned their children;
5. To identify certain perceptions concerning the importance of the mother–child relationship among mothers, and professionals and health care and mother-and-child social protection sector decision-makers;
6. To evaluate various mother-and-child care practices in medical institutions, and the accessibility of medical and social services for women.

1.3. Methodology

A transversal retrospective study was carried out, within a three-month period (January-February-March) in 2003 and 2004, in order meet the objectives.

The reference population is made up of under-five years old children, abandoned/deserted temporarily or permanently in 2003 and 2004, and their mothers. Such children can be found in Romania in hospitals, maternity, pediatric and recovery wards, and in emergency service centers. The latter may accept and shelter children that have been "found" parentless or that have been reported by institutions or individuals as being in danger, because their parents/legal guardians have abandoned them.

The study covered two years to capture differences or possible progress in terms of child abandonment prevention due to the adoption of legal measures in this regard.

Sample

The study was conducted on a representative national sample, initially estimated at some 400–780 children, and on an equal number of mothers.

Sampling process

The cluster sampling technique was used for this study, in order to obtain a random group of children and mothers, compared to their total number within the reference time frame. The following process was employed for the selection of institutions:

Of the 8 Romanian development regions (one of which is the Bucharest and Ilfov region) two counties (and two sectors, respectively) were selected at random.

The study involved all medical institutions (maternity and newborn wards, pediatric and recovery hospitals/wards) and the emergency service centers in these counties and sectors.

All under-five children from the above institutions were selected from the January–March 2003 and January–March 2004 periods, based on the following criteria:

Eligibility criteria for children from newborn wards:

- ✓ Newborn whose chart indicates "abandoned child", "social case", "runaway mother", etc.;
- ✓ Newborn with normal birthweight (>2,500 g), who did not leave the maternity ward within seven days, and is in hospital without his mother;
- ✓ Healthy newborn with normal birthweight (>2500 g), who is transferred without his mother to another pediatric/recovery hospital/ward;
- ✓ Newborn with low birthweight who, upon reaching normal weight, is not discharged and continues to be in hospital without his mother;
- ✓ Newborn with non-life-threatening medical problems/malformations or disabilities, who can be cared for at home, has not been claimed by the family, and is in hospital without his mother.

Eligibility criteria for children in pediatric hospitals/wards*:*

- ✓ Children who have been transferred directly from a maternity ward, without their mother and/or who are not visited by their legal guardians;
- ✓ Children under five in hospital, without their mother, with no justifiable medical diagnosis;
- ✓ Children under five in pediatric hospitals/wards, without their mother, and with no justifiable medical diagnosis.

Eligibility criteria for children in recovery wards*:*

- ✓ Children who have been transferred directly from maternity wards, pediatric hospitals/wards, without their mothers, and/or have not been visited by their mothers/legal guardians;
- ✓ Children under five who are in hospital without their mothers/legal guardians, are not visited by the latter, and/or are in hospital with no justifiable medical diagnosis.

Eligibility criteria for children deserted in other public and private places, other than medical institutions:

- ✓ Children under five who have been brought in without their parents/mothers to emergency service centers, children who have accidentally "gone missing", whose parents have reported them missing to the police, and are being searched for, have been excluded.

Eligibility criteria for mothers:

- ✓ The mothers of the children selected for the study, regardless of whether or not they were living with their children at the time of data collection.

Identification of cases included in the study sample was made as following:

- Children were identified on the basis of on-the-spot study of all observation charts available in the maternity/newborn wards, pediatric hospitals/wards, and recovery/dystrophic wards in the January–March periods of 2003 and 2004, respectively, etc.
- Children enrolled in emergency service centers or identified with the help of the County Child Rights Protection Departments (DJPDC) following a study of files and of other existing records for the reference period of the study;
- Mothers were identified on the basis of a study of observation charts and documents held by the County Child Rights Protection Departments. The latter assisted with the contacting of mothers and the surveys were carried out in their homes.

Sources of information

1. Medical records of the children from the above-mentioned medical institutions and social protection services;
2. Inquiries/interviews with the mothers of the children from the target group. Findings from the quantitative data were verified, completed, and studied;
3. Focus-groups with professionals from medical and social protection institutions;
4. In-depth interviews with key individuals at various representation and decision-making levels;
5. Case studies based on child abandonment cases.

Tools

Questionnaires, forms, and interview and focus group guides were used to collect the information from the above-mentioned documents and individuals.

The working tools for the collection of quantitative data are as following:

Chart 1 ***Data on the maternity ward –*** the tool for recording information on the location, organization and operation of the maternity wards included in the study.

Chart 1.1 ***Data on the newborn*** – the tool for recording information extracted from the observation charts of the newborns selected for the study.

Chart 2 ***Data on the pediatric hospital/ward*** – the tool for recording information on the location, organization and operation etc. of the institutions selected for the study.

Chart 2.1 ***Data on the child in pediatric/recovery hospitals/wards*** – the tool for recording information included in the observation charts of the children selected for the study.

Chart 3 ***Data on the emergency child reception services*** – the tool for recording the location, organization and number of cases who have received such services during the reference period.

Chart 3.1 ***Data on the child that has had to have emergency child reception services*** – the tool for recording information extracted from the file of the child who received such services.

Chart 4 ***Data from the County Child Rights Protection Department (DJPDC)*** – the tool for recording the number of reports, who made these reports, and the type of protection measures taken during the reference periods.

Chart on the child's route – the tool for recording the information on the places the child has been, the duration of his/her stay in each of these places, and the protection measures taken for the child from birth until the moment the study was conducted.

Questionnaire for mothers – the tool used during interviews with mothers of the children selected for the study.

Synthetic chart – summarizes the activity of the teams in each county.

Tools for the collection of qualitative data were as following:

- Guide for focus group discussions with health care professionals;
- Guide for group discussions with child protection professionals;
- Guide for in-depth interviews with significant decision-making professionals;
- Guide for conducting case studies with mothers who abandoned their children.

All data collection tools were pre-tested in counties that were not included in the sample, thus being subjected to several changes before their final form.

Data collection

Data was collected by teams made up of two individuals. Staff was selected on the basis of profession (social workers, psychologists, sociologists, and physicians), relevant experience, knowledge and interest in the specifics of the project.

Each team was assigned one county.

The teams participated in a specialized two-day training session, before the data collection activities were initiated. The training was intended to teach integrated skills for interpreting and collecting data from medical records and from DJPDC documents, and skills in terms of interview techniques with the mothers of children from the target group.

Data collection activities were supervised by the members of the technical group.

The collection of the quantitative data was carried out from August–September 2004, while that of qualitative data from October–November 2004.

Data processing

The data was processed with the use of the the Statistical Package for the Social Sciences (SPSS).

RESULTS

Identification and description of the various types of child abandonment

The methodology employed to meet the objective was based on the premise that all children exposed to abandonment would be identified, regardless of its duration, but on the condition that **records** thereof existed.

The locations for searching/identifying abandoned children were *maternity wards, pediatric and recovery hospitals/wards, and emergency child reception service centers*. For each of these locations the *data sources* and *selection criteria* by which *abandoned* children could be delimited had been defined.

In order to identify under-five years old children who were abandoned in the January–March periods of 2003 and 2004, investigators studied all *observation charts* of children in maternity wards, hospitals/pediatric and recovery wards, located on the territory of counties/sectors included in the sample. For the identification of children abandoned in places other than medical institutions, files were studied of children who were received by emergency reception service centers of the DJPDCs/organized private bodies (OPA), during this same reference period.

CHAPTER 2

CHILDREN ABANDONED IN MATERNITY WARDS

The eligibility criteria used to select cases were the following:

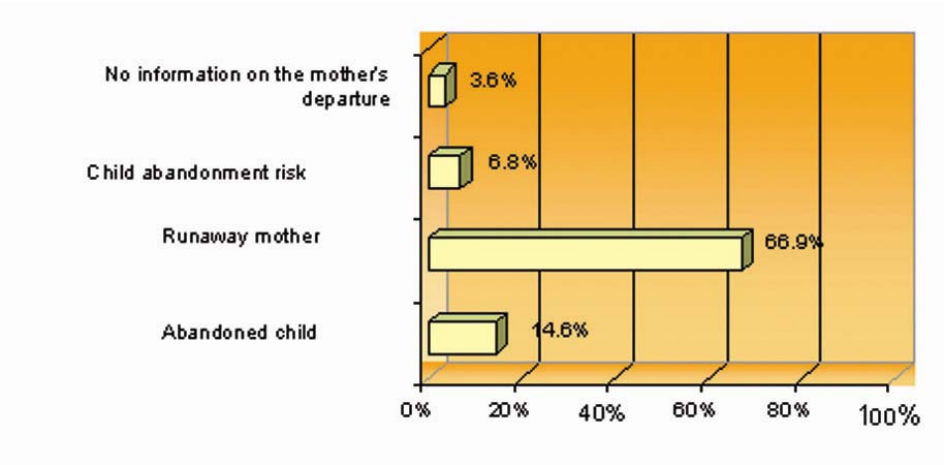
- ✓ Newborn whose chart indicates “abandoned child”, “social case”, “runaway mother”, etc.;
- ✓ Newborn with normal birthweight (>2,500 g), who did not leave the maternity ward within seven days, and is in hospital without his mother;
- ✓ Healthy newborn with normal birthweight (>2,500 g), who is transferred without his mother to another pediatric/recovery hospital/ward;
- ✓ Newborn with low birthweight who, upon reaching normal weight, is not discharged and continues to be in hospital without his mother;
- ✓ Newborn with non-life-threatening medical problems/malformations or disabilities, who can be cared for at home, has not been claimed by the family, and is in hospital without his mother.

The investigations resulted in the identification of **617 abandoned children**, of which **322 in 2003** and **295 in 2004**.

The risk that any given abandoned child should not be selected was rather low owing to the fact that, in addition to the respecting of selection criteria, investigators consulted both maternity ward staff and social workers, wherever these existed.

As a rule, records of children selected on the basis of the defined criteria included a notation “runaway mother”, “abandoned child”, or “abandonment – social case” on the unannounced departure of the mother from the maternity ward.

Figure 1: **Notations on observation charts regarding abandonment (n=617)**



There were also cases at several county maternity wards where the departure of the mother was in no way recorded on the child’s observation chart. In such cases investigators looked for notations on the changes in the child’s nutrition (the introduction of formula due to the departure of the mother).

2.1. The rate of child abandonment in maternity wards

The rate of child abandonment was calculated by dividing the total number of *abandoned children* in the reference period by the total number of children born alive.

- ⇒ Total number of abandoned children in 2003: 322
- ⇒ Total born alive in 2003: 17,904
- ⇒ Total number of abandoned children in 2004: 295
- ⇒ Total born alive in 2004: 16,246

According to this calculation, the 2003 and 2004 child abandonment rates were 1.8.

The rate of child abandonment in maternity wards differs according to the size of the cities/communities in which these are operating. **Table 1** shows the distribution of abandoned children according to community size of the of maternity wards.

Table 1

	% (n=617)
County capital	75.0
Municipality	12.6
Towns	8.4
Communes	3.9

2.2. General features of children abandoned in maternity wards

Following the selection of observation charts on the basis of defined criteria, information on the newborn and his/her parents was extracted.

a) Health condition

The children's health was monitored on the basis of several indicators.

Table 2

Child's condition at birth	**% (n=601)**
Normal health at birth	86
Requires intensive care	14

Observation charts record a dichotomous description of the child's condition at birth: "normal health at birth" and "requires intensive care".

In addition, 9% of the children were born with congenital malformations.

> *"A child with malformations is more frequently abandoned, because the mother is ashamed, fears of being judged by society and the child might not be accepted by society. Roma families no longer abandon their disabled children, because they can get money and other incentives.*
>
> *There are insufficient institutions for children with disabilities. The law going into effect as of 1 January 2005 calls for emergency training for professional maternal assistants (AMP) for newborns up to the age of two.*
>
> *While there are enough institutions, there is insufficient specialized staff for disabled children."*
>
> Interviews with directors of DJPDC

b) Birthweight

As shown also by other studies, birthweight is one of the relevant determinants for abandoning a child. In the study sample, a mere 66.6% of children were born with normal birthweight – 2,500 g and above. The percentage of low birthweight of children is 34% which is very warring because for the general population this percentage is about 9%. Also, the average weight at birth is only 2,700 g, compared to 3,200 g indicated by studies conducted on the general population.

Table 3

Birthweight	% (n=617)
Up to 1,000 g	3.9
1,000-1,500 g	3.5
1,500-2,000 g	10.5
2,000-2,450 g	19.4
2,500 g and over	66.6

This increased prevalence of low birthweight children may be explained from several perspectives. Specialized literature supports the idea that unwanted children are born with a lower weight than that considered normal at birth. The mother's failure to avail herself of prenatal services, adopt a proper diet and an adequate lifestyle for the benefit of the child's development may contribute to this defect. The high percentage of low birthweight children might suggest that their mothers neglect them as early as the intra-uterine phase.

"The risk of abandonment is higher for the premature baby, especially if the mother has other children at home; mothers run away from hospital, some returning after a certain period (2-3 weeks).

In other cases, the child is abandoned by its mother who fears not being able to cope with a premature baby requiring special care.

We have a 19.3% premature birth index – many old mothers give birth to premature babies."

Interviews with neo-natologists physicians

c) The Apgar[1] score

Most of the babies had a good or very good score at birth. Some 87% of babies had an Apgar score of 8 and higher. It is to be mentioned that these high scores are not incompatible with the data on low birthweight, as the score represents the general health of the child at birth. There is no Apgar score recorded in the observation charts of 16.4% of the children, although a "mere" 10.7% of these were born at home.

Table 4

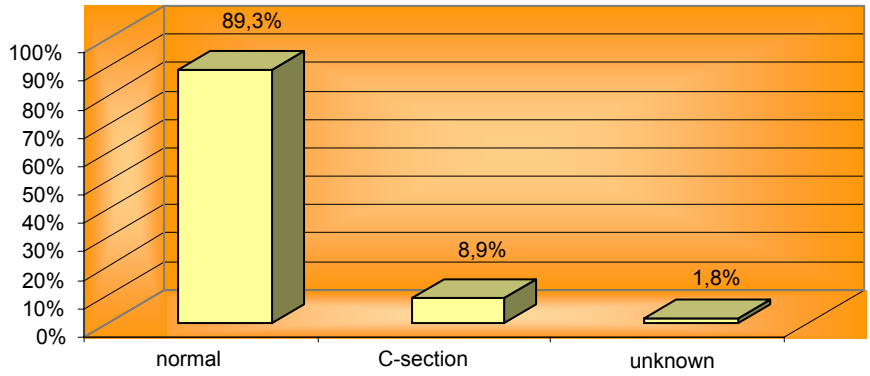
The Apgar score	% (n=516)
3	2%
4	1%
5	2%
6	3%
7	5%
8	23%
9	53%
10	11%

[1] The Apgar Score is a number from zero to ten representing the sum of evaluation scores of five clinical indicators (coulor of teguments, breath, reflex of iritation, musle tonus and motility, heart pulse) and reflecting the quality of new-born adaptation to extrauterine life.

d) The birthing method

Some 90% of the children were delivered by natural childbirth, 9% were born by C-section, and relevant information is missing for 1.8% of the births.

Figure 2: **Birthing method (n=617)**



e) Gender

The table below shows the distribution of children included in the study sample by gender. There is a slight over-representation of boys in the study sample (50.9%). This may be attributable to the vulnerability of the health of boys at birth since, as health has also been revealed by other studies as constituting a reason for abandoning a child in Romania[2]. Qualitative studies have also given rise to other explanations. Several single mothers indicated that they would have taken the child home if it had been a girl: "*I would have felt bad if she had experienced the kind of difficulties I had.*"

Table 5

The child's gender	% (n=617)
Male	50.9%
Female	49.1%

f) Parity (rank)

The table below shows that almost half of the children in the study sample are ranked 1 or 2. It is worth pointing out that in 5.2% of cases the observation chart contained no information on such rank.

Table 6

The child's rank	% (n=585)
rank 1	34%
rank 2	18%
rank 3	17%
rank 4	12%
rank 5	6%
Above rank 5	13%

[2] Infant Mortality in Romania, Ministry of Health, 2002, page 7.

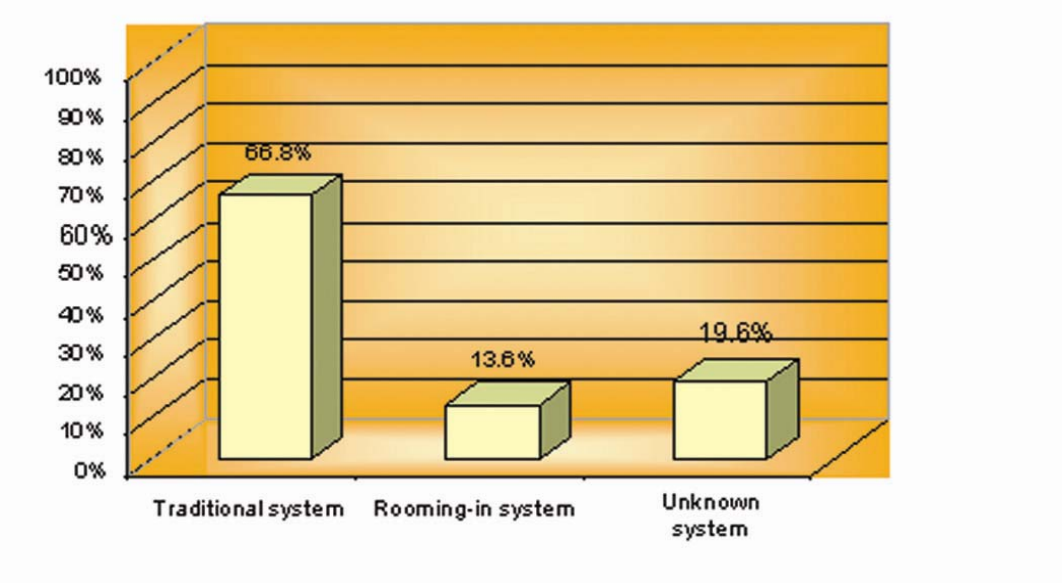
Despite the assumption that Romanian families with many children tend to abandon their children, this study shows that more than 50% of families which abandoned babies come from the ones with one and two babies (rank 1 and rank 2, 52%).

e) Models of care

Early bonds between mother and child are important to discourage intentions of child abandonment. As such, it was interesting to look for the models of care these children enjoyed after birth. ***Figure 3*** shows that only 13.6% of the children benefited from the rooming-in system.

> *The rooming-in system is very useful for preventing abandonment, as close bonding between the mother and child is promoted from the very first moments of the child's life.*
>
> Interview with neo-natologists physicians

Figure 3: **Child benefiting from different models of care (n=617)**

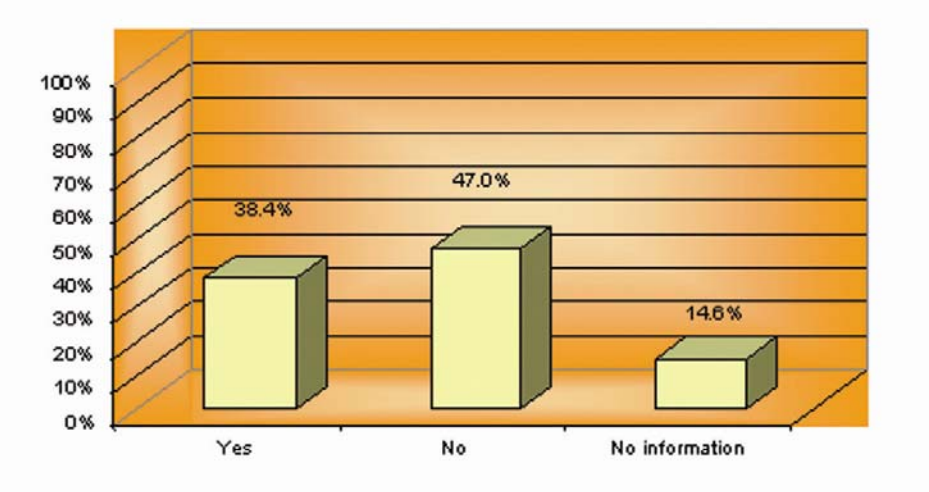


f) Breastfeeding

A mere 38.4% of children were breastfed by their mothers till they were abandoned (Figure 4) and unfortunately, medical charts do not contain information regarding the reason for which breastfeeding was not occurring.

> *"We suspect that a mother who avoids breastfeeding her child or does not show up for all the scheduled breastfeeding sessions is planning to abandon her child. In any case, mothers who want to desert their child neither hold nor demonstrate any joy about the child. The physician who assists the mother at birth should insist that she sees her child immediately at birth."*
>
> Neo-natologist physicians

Figure 4: **Was the child breastfed? (n=617)**



g) Identity of the child

Respect for the right of identity begins with the recording of the child's birth, which subsequently leads to the issuing of its birth certificate. The existence of the birth certificate is confirmed by the child's personal numeric code (CNP) which, in for the selected cases, was recorded on only 36% of observation charts, meaning that same number of these children also had birth certificates (Figure 5).

This is a very serious matter, because without a birth certificate a person "does not exist". There was needed also to look for other sources to ensure that the information is correct. As such, the teams of investigators made inquiries at the *birth registration office* within the maternity wards to ascertain whether certificates acknowledging their birth had been issued for the selected children, and to whom these certificates were issued (Figure 6).

The information obtained confirmed that 36% of children had a birth certificate. The Department for Child Protection (DPC) undertook the necessary steps to obtain identity documents for a further 21% of the children, while for the remaining 43% of the children such steps were not started.

Figure 5: **Was a numeric personal code (CNP) recorded on the child's observation chart? n=617**

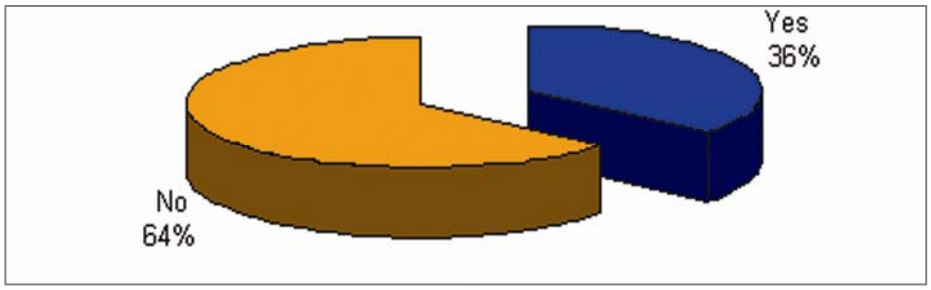
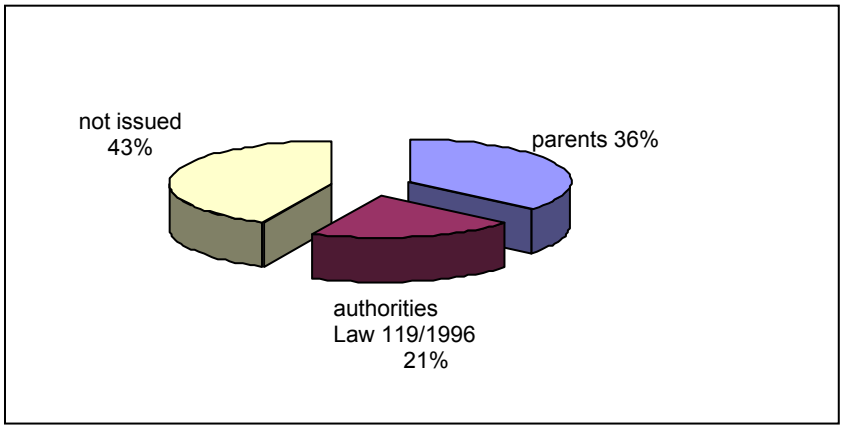


Figure 6: **To whom was the certificate acknowledging the birth issued? (n=617)**



2.3. General features of parents of the children abandoned in maternity wards

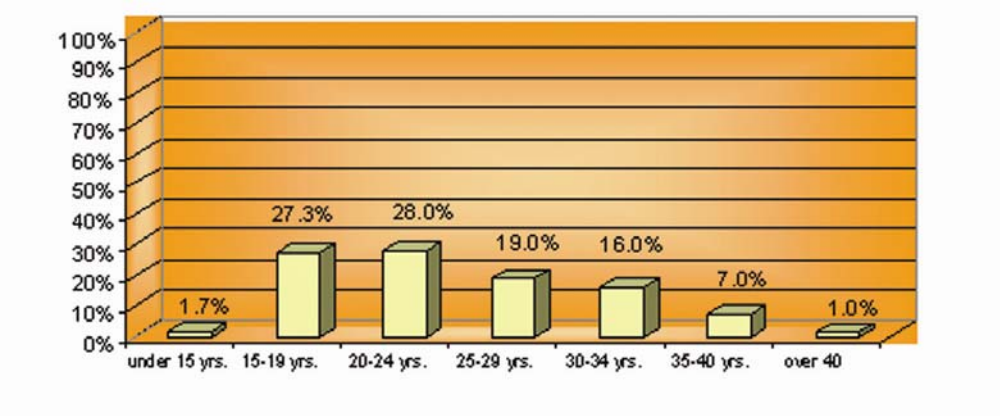
Information on the parents is important for identifying a child. The observation charts contained limited information on the parents, and more data referred to the mothers than to fathers. The lack of information was due, to a greater extent, to the negligence with which these charts were filled in.

a) Age of the mother

Observation charts indicated that most mothers who had abandoned their children in maternity wards were under age 20 at the time the child was born (29%), followed closely by those aged 20–24 years (Figure 7), while the average age was 22. Health care system professionals associate child abandonment with teenage mothers, aged 14-15, or very young.

This perception was only partially confirmed in the study. It is to be mentioned that some 8% of observation charts indicated no age for the mother.

Figure 7: **Age of the mother (n=570)**



b) The mother's residence

Knowing where the mother lives and having her exact address is essential information to be able to contact the mother/parents of the child. In the study, the residence was recorded in 85.1% of the cases.

c) The mother's marital status

Information on marital status was available for only 83.6% of the mothers who have abandoned their children; such information was unavailable for the remainder of mothers. ***Table 7*** presents the distribution of mothers by marital status. The high percentage (63%) of single mothers is significant. It is possible that this figure includes mothers who live in consensual union, and did not properly declare their status on entering the hospital. Another issue is that many mothers, who were part of a union before getting pregnant, are left by their partners when they find out about the pregnancy or about the time of the child's birth.

Table 7

The mother's marital status	% n=516
Married	18.2%
Consensual union	17.6%
Divorced/separated	0.7%
Widowed	0.3%
Single (unmarried)	63.9%

d) The mother's occupation

This is recorded in only 85.7% of the cases. Only 5.8% of mothers are employed, 3.8% of these are high school or university students, and 90.4% of them are either housewives or unemployed. (***Table 8***).

"Abandonment is more common among women who do not have a job, especially in the case of single mothers."

"Some mothers who have abandoned their children are high school or university students. In these cases, the causes for abandonment are the psycho-emotional immaturity of the mother, pressure from the family who does not accept the child, and the mother's wish to continue her studies without the responsibility of a child."

Obstetrician/gynecologist

Table 8

The mother's occupation	% n=529
Employed	6.6%
Housewife	56.1%
Unemployed	0.3%
Retired	0.9%
No occupation	31.0%
High school/university student	4.3%
Other	0.8%

e) Father of the child

Almost half of the observation charts do not contain any information about the child's father. On charts containing this information, there was found that a mere 34% of the children were acknowledged by their fathers.

2.4. Information on the request of child protection measures

A child who has been abandoned in a maternity ward is a case of extreme urgency from the moment it is deserted, and the child protection services must take immediate action. The most recent regulations attribute the responsibility of maternity ward staff to the heads of wards and social workers to prevent a prolonged stay of the child in that ward. The first step is to notify the child protection services within 24 hours of ascertaining that the child has been abandoned.

According to the Joint Ordinance of the Minister of Health and the State Secretary for the National Authority for Child Protection on the prevention of situations of children in difficulty, the head physician of the ward is responsible for immediately notifying and reporting in writing to the specialized public child protection service.

This enables the service to decide on the placement measure within 24 hours in the event the child was *deserted* in the maternity ward by his mother, provided the newborn qualifies for hospital discharge from a medical standpoint.

Although almost all children identified fell into this category, few observation charts contained any record of requests by the mother or persons responsible for the maternity ward for child protection measures.

Table 9

Requests for protection measure	%
The mother requests a protection measure (n=617)	8.9%
The Maternity Ward notifies the DPC to enforce a protection measure (n=617)	10.5%

Furthermore, instructions/decisions by DJPDC were found in 13% of the observation charts studied, based on reported cases of child abandonment.

2.5. Duration of the stay of children in Maternity Ward

When analyzing *the duration of the stay in the Maternity Ward*, the study took into account cases which involved children without a mother and/or justified medical diagnosis; this duration was also one of the criteria for selecting the children in the study sample.

As can be seen from this data, the duration of the stay continues to be significant; thus, 46% of the children selected in 2003 and 39% of the children selected in 2004 spent more than 20 days in the Maternity Ward. Also, almost a third of the children in 2003 and a quarter in 2004 “unjustifiably” spent more than one month in the Maternity Ward.

The ratio of children who stayed for a few days (4-5) in the Maternity Ward without their mother and with no medical justification rose by some 5% in 2004, as compared to the same period in 2003.

Table 10

How many days did the child spend in the Maternity Ward?	Year 2003	Year 2004
4-5 days	14%	18.6%
5-10 days	17.4%	16.9%
10-20 days	21.4%	24.2%
20-30 days	19.3%	15.4%
Over 1 month	27.9%	24.8%
Total	100%	100%

Such progress, while modest, might be linked to the regulation that Maternity Wards have a social worker or another person assigned to carry out certain duties to shorten the duration of the stay of children in the Maternity Ward.

> *"Abandoned children spend a lot of time in the Maternity Ward, first due to human considerations, to give mothers the chance to revise their decision to abandon their children. Then there are administrative considerations resulting from the birth recording and preparation procedures for the child to be taken over by the DPC. In many cases, there are also medical considerations."*
>
> Physician, OB-GYN Clinic and Maternity Ward
>
> *"There is not always a chance for integration with the biological or extended family; many of the children have psycho-locomotor deficiencies which require care in a specialized institution."*
>
> Deputy Director, DPDC

2.6. Discharge from the Maternity Ward

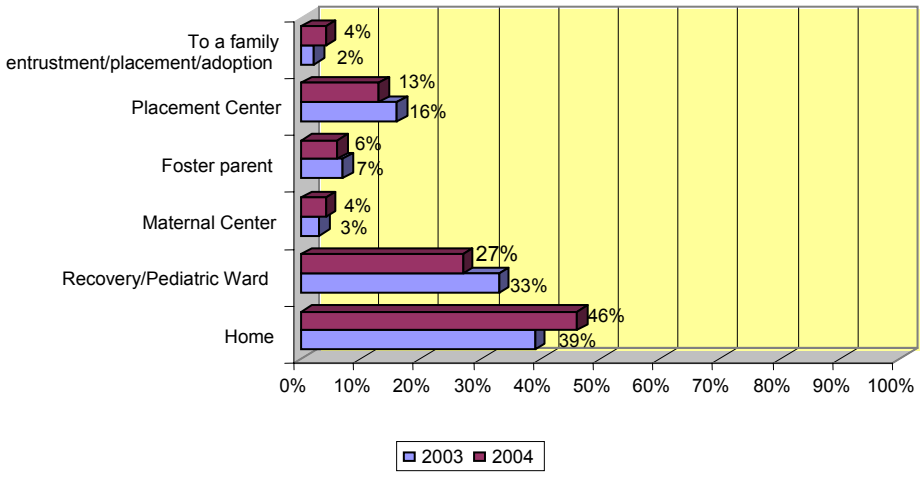
Where did the children go after being discharged from the Maternity Ward?

Overall, such information was available only in the case of 88.9% of the selected children, because in 11.1% of cases this data, which is believed to be very important, is missing from the observation charts of the children from the Maternity Wards.

Possible destinations for the children are:

1. Home, with both their biological parents or with only one of them;
2. Transfer to a Pediatric/Recovery ward;
3. Placement Center ;
4. Foster parent ;
5. Placement or entrustment with a family with a view towards adoption;
6. Maternal Center.

Figure 8: **Where did the child go after being discharged from the Maternity Ward? by reference years: 2003 n= 294, 2004 n= 255**



a) Home with the biological family

The information collected indicated that 39% of the children were "integrated" into the family in 2003, directly from the Maternity Ward. This percentage increased to 46% in 2004. Therefore, the percentage of children integrated into the family in 2004 was higher by 7% than in 2003 (***Figure 8***). The word "integrated" is in quotes, because most of the children are "delivered" home to their parents with no previous preparation for such integration.

The collected data indicated that the "integration" is not always preceded by an evaluation of the situation, as stipulated by law. Many of the children are taken directly by ambulance to the door of the house where the mother resides, a few days after birth, sometimes in the company of a social worker. The very notion of integration is improper in such cases.

With regard to the discharge of these children directly to the family, investigators noted that most cases are exclusively solved by the Maternity Ward staff, sometimes also by the social worker, but without notifying the child protection department. It us unknown whether these children are subsequently monitored by the various protection institutions or by the family physician, especially since most of them do not have any identity documents.

The Joint Ordinance of the Ministry of Health and the National Authority for Child Protection and Adoption of 28 July 2003 stipulates that within 48 hours the County Child Rights Protection Department should be notified about the above-mentioned cases of children in Maternity Wards. The study of observation charts reveals that DJPDC was notified of only 10.5% of the cases.

> *"Several years ago this is what I used to do as well. I would take the children by ambulance to their mothers, who usually protested our "leaving" the children, and then we would rush away for fear that she would give him back to us. In time, we understood that this was not a solution, because the mother would bring the child back to the Pediatric Ward and would (re)abandon it there. A few months would pass until a protection measure was taken. We had to assist in the issuing of identity documents for most of the children, so that they could be placed in the care of the child protection services. After the closure of shelters/Placement Centers for small children, there were very limited places for such children, and we would keep them in the pediatric or recovery wards."*
>
> Social Worker

It was also found that taking the children to the mothers is often a process which involves negotiations and threats. This takes place in the presence of the other children in the family and the respective baby is perceived as an object that can be given, taken or refused.

Because of the way they are transported and handled, and wrapped in diapers so that their little hands and feet are not visible, the image is far from that of a child. The staff transporting these babies from the Maternity Wards to the homes of their mothers refers to them as "little loaves of bread."

b) Transfer to pediatric and recovery wards

It is known that, in many counties, and especially in Bucharest, Pediatric Wards and particularly recovery wards take on the children who have been abandoned in Maternity Wards, until such time as a protection solution can be identified.

> *"Children who have been abandoned in Maternity Wards are taken over by the Department of Child Protection if they have identity documents, and they end up in protection institutions. Those without identity documents are taken over, two weeks to one month later, by the Pediatric Ward, where they may stay until they are 3 years old. There are special rooms for abandoned children in some Maternity Wards, where they stay for months, until their identity documents are issued and they are taken over by a protection institution."*
>
> Physician

It was noted that in 2003, the percentage of abandoned children **who were transferred from Maternity Wards to pediatric/recovery wards** was 27.5%, and 33.5% in 2004, up by 6%.

Placement centers for children below the age of 3 have been closed down in many counties, to prevent the serious consequences of institutional protection at a very young age. This process has been progressively intensified. The reward for closing down such institutions came from intensified efforts to integrate children into their family and to create a network of foster parents.

Demand cannot be met for want of foster parents, and as such pediatric/recovery wards become the "intermediate stops" for children who have been discharged from Maternity Wards, until such time as a new slot becomes available or is created within the protection system. This also explains the increase of transfers to pediatric and recovery wards in 2004. The fact that residential institutions for very young children have been replaced with pediatric/recovery wards, is considered a step backwards, because these are even worse than the shelters. This anomaly is confirmed by the fact that there are no beds for mothers in recovery wards (as is the case in Pediatric Wards), so the destination of such children is very clear (***Box 3***).

"Why are they left in hospital without any protection measure?

The Director of Child Protection Services told us he has nowhere to place them. There are no more shelters, and foster parents do not want to take on dystrophic children. Look at him, he weighs just 3 kilograms at 6 months.

Do you think their development would be better if someone were to hold and love them?

Certainly. The poor things cry all day and even all night. We have already become used to this and no longer hear them.

Have the parents ever come?

Yes, some Gypsy parents have come, but they don't want to take them home because they don't like how the child looks."

Discussion between a field investigator and a pediatrician

c) Discharge to Placement Centers

In spite of pressures to avoid placing under-three children in residential protection institutions, this has not been fully observed. The percentage of children who are discharged from Maternity Wards directly into **Placement Centers** is still quite high, namely 13% in 2003 and 16% in 2004.

d) Discharge to a foster parent

A small percentage of children go directly to a **foster parent**, 7% in 2003 and 6% in 2004. In some counties the protection services and foster parents have reservations about the placement/reception of children who are only a few days old.

e) Placement with families

A very small percentage of children, 2% in 2003 and 4% in 2004 were **placed with families**, sometimes in view of adoption. As of 2005, when Law 272/21.06.2004 goes into effect, this protection measure and that of placement with a foster parent will become the only ones possible for neglected and abandoned children under the age of 2.

f) Maternal Center

Some 3% and 4% of children were placed in Maternal Centers with their mothers in 2003 and 2004, respectively.

The destination of the child also depends on the following factors: identity documents, duration of stay in maternity, mother's appeal for a child protection measure, heath of the child.

2.6.1. Destination of the child at the time of discharge, depending on the existence of identity documents

Because a large number of children did not have any identity documents at the time of discharge, their destination was identified after discharge based on this criterion. Most children without birth certificates went to their biological families (45.3%). There is real danger in discharging a child without identity documents, as they can be sold, trafficked, neglected and, in extreme situations, killed, without any such act being legally reported. It should be underlined these dangers, as there were no available information on children who were transferred to their families, and because the DJPDCs and family physicians were not notified about this transfer.

Table 11

Where did the child go after discharge	Has a birth certificate % (n=161)	Has no birth certificate % (n=252)
To the family	37.9	45.3
To the Pediatric/Recovery ward	25.4	28.9
To a Maternal Center	5.1	3.5
To a foster parent	8.1	5.5
To a Placement Center	19.8	14.6
Placed with a family	3.7	1.5
Placed in view of adoption	-----	0.7

2.6.2. Destination of children at the time of discharge, according to the duration of stay in a Maternity Ward

It was noticed that most children end up with their biological families, provided their stay in Maternity Wards does not exceed 1 month, and depending on the first destination following discharge. However, there is a slight drop in the percentage of children who go to their families based on the length of their stay in Maternity Wards. In the case of periods extending beyond 1 month, the situation changes, as most of those children are discharged to Placement Centers.

Table 12

Days in the Maternity Ward	Biological Family	Pediatric/ Recovery ward	Maternal Center	Professional foster parent	Placement Center	Placement with a family	Placement in view of adoption
4-5 days (n=81)	56.7%	37.1%	1.2%	2.6%	1.2%	----	1.2%
5-10 days (n=81)	59.2%	23.4%	7.5%	3.7%	4.9%	1.3%	---
10-20 days (n=99)	46.3%	31.3%	1.1%	3.1%	17.1%	1.1%	---
20-30 days (n=84)	39.2%	26.3%	3.6%	9.6%	15.4%	4.7%	1.2%
1 month (n=26)	34.6%	23.1%	7.6%	3.9%	26.9%	3.9%	---
Over 1 month (n=97)	23.7%	24.7%	5.2%	13.2%	28.9%	4.1%	---

2.6.3. Destination of children at the time of discharge if their mothers appeal for a child protection measure

The most frequent destination of children whose mothers appeal for a child protection measure is a maternal center, followed by a Placement Center.

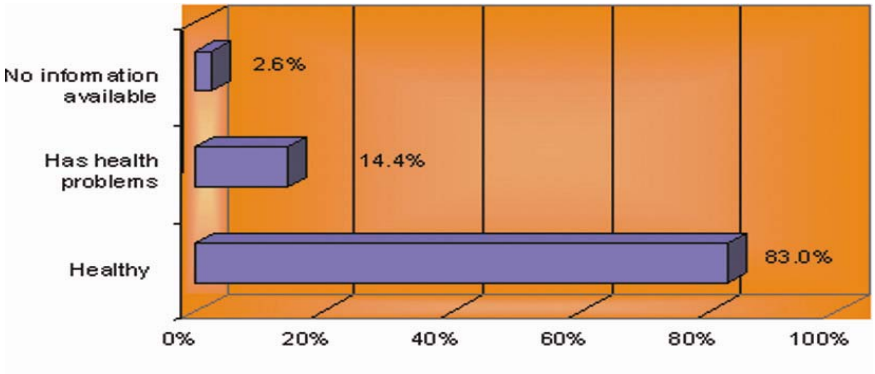
Table 13

Destination of children	% (n=30)
To the family	13.3
To the pediatric/recovery ward	3.3
To a maternal center	30.1
To a foster parent	13.3
To a Placement Center	20.1
Entrustment/placement to a family	13.3
Entrustment in view of adoption	6.6

2.6.4. Where did the children with health problems go when discharged?

As determined from the records, at the time of discharge, some 83% of the children were healthy and 14.4% were reported as having a variety of health problems.

Figure 9: **The child's health at the time of discharge (n=617)**



Children with health problems were most often transferred to pediatric/recovery wards. Over 10% joined their biological family and some 7% were absorbed into the child protection system.

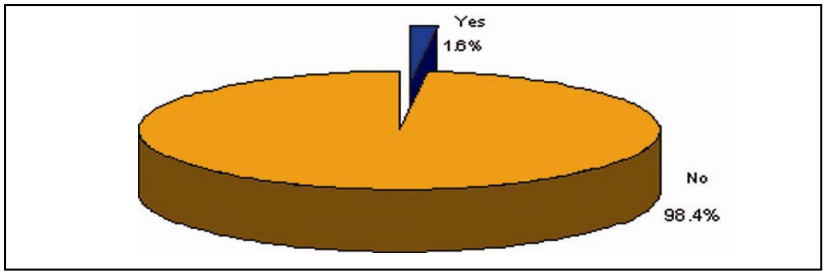
> *"Medical practices in some hospitals may stimulate child abandonment. It is possible that pediatricians encourage the abandonment of the child by frequently hospitalizing young children without their mothers, or even by advocating hospitalization in cases which do not require such a measure (based on the child's health)."*
>
> Pediatrician

Table 14

Where did the children with health problems go when discharged from the Maternity Ward?	% (n=67)
To the family	16.4
To the Recovery/Pediatric ward	74.8
To a foster parent	5.9
To a Placement Center	2.9

Some 1.6% of abandoned children died in maternity/newborn wards.

Figure10: **Did the child die? (n=617)**



2.7. Aspects relating to the organization and operation of Maternity Wards

The study includes 70 Maternity Wards, operating in county capitals, cities, towns and communes, as follows:

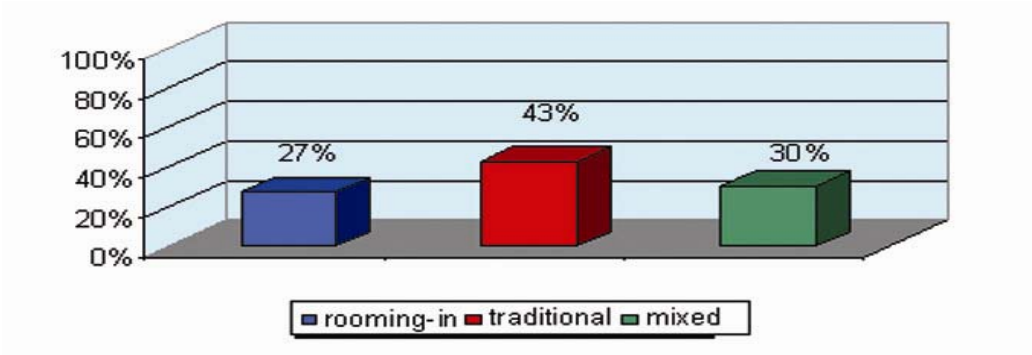
Table 15

	% (n=70)
County capitals	18.6
Municipality/town	80.0
Commune	1.4

Information was collected from the Directors of the medical institutions visited during the study and from the heads of Maternity and Pediatric Wards.

The information focused on the organization and operation of Maternity Wards, as it is believed this may influence the child abandonment phenomenon. Some of this refers to the organization of the Maternity Wards in the **rooming-in** system. Figure 11 presents the organization of newborn wards in the 70 institutions that were included in the study. Thus, 27% are organized according to the rooming-in system, 42.9% according to the traditional system and 30% have a dual system.

Figure 11: **In what kind of system is the newborn ward organized? (n=70)**



Discussions with newborn ward staff demonstrated that the rooming-in system is not sufficiently known, and that the idea that it might contribute significantly to discouraging child abandonment is not accepted.

"The mothers make up their minds early on in their pregnancy, deciding to leave their child in the Maternity Ward, although not necessarily with the intention to abandon it… because many of them leave convinced that they will return for taking the child, but then they just forget to come back."

Neo-natologist physician

In many Maternity Wards that are organized according to a mixed system, mothers at risk of abandoning their children are hospitalized, particularly in the traditional section, where the separation of the mother and child is more pronounced because of continuous physical distancing. In such a system, the child is "given" to the mother periodically and for a very short period of time, only for breastfeeding. There are many Maternity Wards in which newborns and their mothers are kept on different floors.

"I had a baby in this Maternity Ward 26 years ago. I cannot believe that in such an important city, where so many children have died in maternity/newborn wards, there is no rooming-in system. In this hospital, the baby, tightly wrapped in diapers, is given to the mother in a ward three floors down from that of the newborns, only to allow strictly scheduled breastfeeding, as was the case 50 years ago".

Story told by a field investigator

Some staff monitor the risk of child abandonment to promote the advantages of the rooming-in system, and discourage the mother from resorting to abandonment.

"We have organized the rooming-in system especially for mothers at risk of abandoning their children.

Although we are unable to organize a rooming-in system, we have set up something intermediary, namely a room for children between two wards for mothers. The children's room has large windows to allow mothers to see their children at all times, and the latter are cared for by both the mothers and the Maternity Ward staff."

Neo-natologist physician

Another interesting aspect is the observance of the Joint Ordinance of the Minister of Health and the National Authority for Child Protection and Adoption dated 28 July 2003. The ordinance stipulates that it is compulsory to notify, in writing and within 48 hours from the child's birth, the family physician whose patient list includes the mother, in order that the newborn may be included on this same list.

The ordinance further stipulates that the County Health Insurance Office and City Hall must be notified in the case of a child born by a mother who is not on a family physician list, so that the child can be included on such a list. The heads of the

Maternity Wards indicated that only 67.1% of the institutions included in the study notify the family physician at the time the child is discharged from the Maternity Ward.

Table 16

Has the departure of the children in the field been reported to the family physician?	**%**
Yes	67.1
No	32.9

"The mothers go home with a newborn baby in all kinds of weather and sometimes without any money. These are mothers we have identified as being at risk for abandoning their children, and whom we have managed to get to reconsider leaving their children in the Maternity Ward.

How do they get home?

By bus, this only comes once a day. Our county is mostly rural, and many villages are located dozens of kilometers from us. Travel is very difficult as the roads are in a precarious condition.

How do you know that the mother will not leave the child out on the street?

We don't. There is no one we can notify about the child's arrival. In many communities there is no family physician or telephone system, while in others, a physician visits only once or twice a week because (s)he is not a local resident. You probably find that hard to believe.

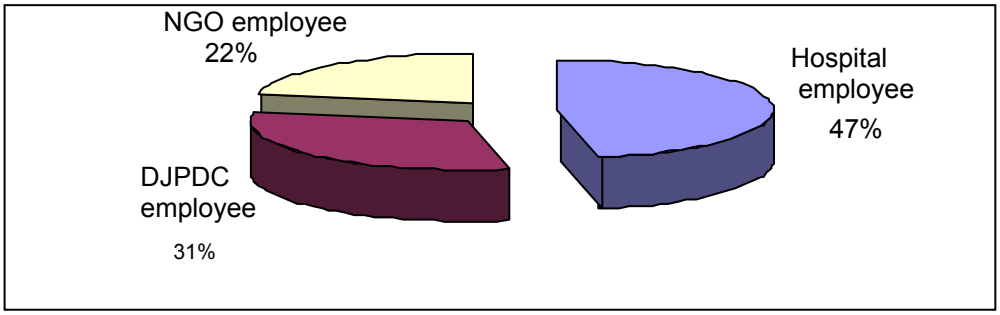
Do you discharge them even without a birth certificate?

Mostly we don't. We explain to the mothers that without any identity documents they cannot receive any allowances or additional assistance for the child."

County hospital social worker

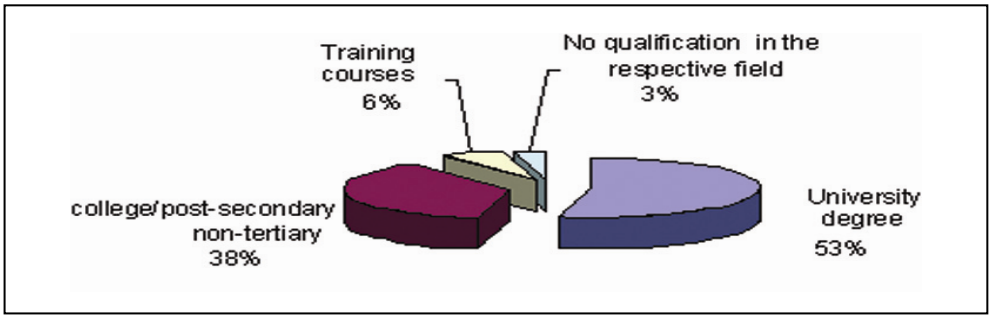
Of the 70 Maternity Wards included in the study, only 45.7% had a social worker or an individual responsible for such duties, even though the above-mentioned Ordinance stipulates that it is compulsory to employ a social worker or a person with similar responsibilities in all Maternity Wards. Some 47% of currently employed personnel were hospital employees, 31% were employees of the County Child Rights Protection Department (DJPDC) and 22% were employees of non-governmental organizations (NGO).

Figure 12: **The social worker is (n=32)**



More than half of the Maternity Ward social workers have a university degree, 38% have post-secondary non-tertiary degrees, 6% have undergone some training courses, and 3% have no specialized qualifications in this field.

***Figure 13*:** **Education of the social worker (n=32)**



Even though the work of social workers requires a distinctive space, only 55% of Maternity Wards have set up such an area. The ability of social workers to prevent child abandonment or decrease the stay of a child in medical institutions is not always best used. In most Maternity Wards the social worker is notified about an abandoned child by the ward staff without having "his own" right to identify child abandonment cases. Some of them informed us that they are not notified immediately after a mother runs away, and at times they are forced to take the child home by ambulance to make room in the ward.

In the selected counties there are also community nurses who play an important role in managing the cases of families and children in difficulty. According to the statements of the Directors and heads of wards, only 44% of community nurses are notified by the Maternity Wards in the counties where such a network of community nurses exists.

"There are no laws to prevent child abandonment or to compel Maternity Wards to get involved in the prevention of abandonment. Nevertheless, we are sensitive to child abandonment. We must provide conditions which discourage mothers from deserting their children. Despite the lack of legislation in this area, we take care of mothers who are at risk of abandoning their children, looking for solutions and answers to their problems. We tend to keep the children longer in cases where the mothers claim to lack conditions for caring for the children, help them record their children with the population records office, and offer solutions for the children to be cared for in the child protection system. Recently, we initiated two child abandonment prevention programs. We have accepted several NGO professionals into our institution, who are working to bring down the number of abandoned children. While results are good, they are insufficient".

Physician – OB-GYN clinic and Maternity Ward

"Current child protection legislation is not explicit about the way in which we should act to prevent child abandonment in medical institutions. We initially involved ourselves in child abandonment prevention in order to decrease the number of young, institutionalized children.

The legislation does not include any responsibility for our institution in terms of 'mother and child' care practices. However, we became directly or indirectly involved in training programs for Maternity Ward and pediatric hospital staff to ensure greater efficiency in child abandonment prevention. We never miss an opportunity in our contacts with medical staff to discuss bonding, fostering the relationship of mother and child, family care of the child, and other such issues."

Director DJPDC

CHAPTER 3

CHILDREN IN HOSPITALS/PEDIATRIC AND RECOVERY WARDS

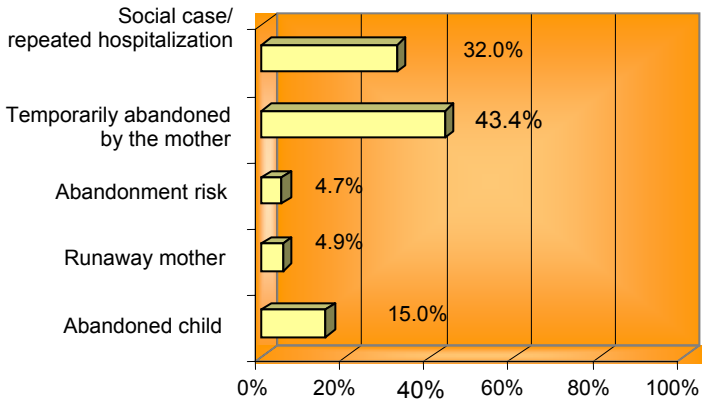
The following criteria were used for the selection of cases from Pediatric and Recovery Wards:

- ✓ Children who have been transferred directly from the Maternity Ward, without their mothers and/or who are not visited by their legal guardians;
- ✓ Children under age five, in hospital without their mothers and a justified medical diagnosis;
- ✓ Children under five, who are in pediatric hospitals/wards without their mothers and a justified medical diagnosis.
- ✓ Children who have been transferred directly from Maternity Wards, pediatric hospitals/wards, without their mothers and/or who are not visited by their mothers/legal guardians;
- ✓ Children under five, who are in hospital without their mothers/legal guardians, are not visited by them, and are in such an institution without a justified medical diagnosis.

The investigations indicated **a total of 986 children**, **of which 508 in 2003** and **478 in 2004**.

The observation charts of children who have been selected from hospitals/pediatric and recovery wards included notations such as: *social case, abandoned child, runaway mother, child abandonment risk, temporarily deserted by the mother*.

Figure 14: **Notes concerning abandonment on the child's observation chart (n=986)**



Unlike the Maternity Ward, where the risk of missing a child for the study sample was rather limited, in pediatric and recovery wards such risk was highly probable. Therefore, there were included in the selection criteria children who were repeatedly hospitalized for short periods of time, many of whom were hospitalized and discharged on the same day (a practice "agreed upon" with the health insurance office to ensure that a certain number of hospitalization days are not exceeded), with no justified medical diagnosis.

The investigators had to monitor the child's identity in order to avoid including the same child in the study more than once, which would have led to an artificial increase in the rate of abandoned children. A single *chart 2* was filled out for any child hospitalized more than once.

In some counties, if parents earn only a minimum guaranteed income the child's observation chart contains a "social case" notation, and such children were selected only if they also met the remaining selection criteria.

The investigators indicated that it was sometimes difficult to decide whether a child qualified for the selection criteria, mostly because some hospitals cover up cases of child abandonment claiming palliative or borderline treatment for a sick or healthy child.

Some counties use recovery wards as genuine social protection services for healthy children under the ages of 2-3, without reporting such cases to the specialized child protection services.

> *"Dystrophic recovery wards take in children shortly after their discharge from Maternity Wards, due to low birth-weight and/or slow evolution in recovery of weight gain at home. Children remain in these wards for several months, without being in adequate contact with their families. Parents inquire about their children by telephone, sometimes take them home for a week, and then re-hospitalize them for a month.*
>
> *These children are not considered in need, abandoned/deserted and thus the protection services are not even informed. As such, the hospitalization syndrome results in major changes in both the physical and mental development of these children.*
>
> *Similar situations were also reported by the investigators involved in this study.*
>
> *In one of the surveyed counties, the DJPDC management "justified" their non-involvement attitude by the fact that they had received no official report from a medical institution or from the Public Health Authority.*
>
> *Although the Child Protection Commission includes a representative of the Public Health Authority, some Commissions do not even have a single medical system representative among their members.*
>
> *Children who have spent long periods in pediatric hospitals are subject to similar situations.*
>
> Observations on the field by a psychologist

Staff working in these wards justifies such an anomaly by claiming that the parents who request that their children be admitted to recovery wards do not have proper conditions to raise them safely while they are still very young. The children mostly stay in hospital for several months, with very rare visits from the parents, or they are taken home for short periods of time. Discussions with County Child Protection Services representatives revealed that they believe such a compromise to be the best alternative, because limiting access to such services would determine the parents to take their children home, and expose them to even greater health risks.

> *"Such a situation was reported in a recovery ward where there were over 230 children under the age of one, obviously without their mothers. The children had been brought by their mothers who claimed they did not have proper conditions to raise them at home (other older children). These mothers did not inform Child Protection Services so as not to lose the allowance allocated for the child (in case a protection measure was implemented).*
>
> *The medical staff sincerely believed that what they were doing was in the best interest of the child. They never thought that keeping the children for months in beds in white wards, day in and day out, could be cause psychological damage.*
>
> *Such children, whom we considered to be borderline, were not included in the category of abandoned children, because there was some uncertainty about whether or not they should be included in our study."*
>
> Observations on the field by a psychologist

3.1. The rate of child abandonment in hospitals, pediatric/recovery wards

The average rate of child abandonment in pediatric medical institutions was calculated by reporting the number of abandon children to the total number of children entries in the hospital.

Total number of abandoned children in 2003: 508
Total number of hospitalizations in 2003: 33,411
Total number of abandoned children in 2004: 478
Total number of hospitalizations in 2004: 33,354

The 2003 rate was 1.5%, while that in 2004 was 1.4%, with limits ranging between 0.2% and 3.7% in 2003 and 0.1% and 4% in 2004.

This is the minimum value, since a child was counted only once, regardless of the number of hospitalizations.

Note: if the study had included 230 children previously reported in the total number of children recorded in 2004, the rate of child abandonment would have been higher (2.1%).

As in the case of Maternity Wards, the highest percentage of abandoned children comes from hospitals and Pediatric Wards operating in large cities.

More than half, i.e. 55.7% of the children in the sample, come from hospitals located in county capitals, 24.1% from municipalities, 14.3% from cities and 5.9% from villages.

Table 17

	% (n=986)
County capital	55.7
Municipality	24.1
Town	14.3
Commune	5.9

3.2. Circumstances leading to the hospitalization of children in Pediatric Wards/ hospitals

After selecting the observation charts based on the above-mentioned criteria, information on children abandoned in these institutions and on their parents was extracted. The data processing led provided data on circumstances of hospitalization and characteristics of the abandoned children.

Who brought the child in for hospitalization?

46.9% of the children were brought in by their parents, 41.1% by an ambulance, 7.3% by other persons, 4.5% by representatives of the DJPDC, and 0.2% by the police. This information illustrates that more than half of the children came from their families.

Table 18

Who brought in the child?	% (n=986)
The mother	31.0
The father	2.4
Another member of the family	3.9
Strangers	0.9
DPDC representatives	3.1
The Police	0.2
The ambulance	29.3
Neighbors	0.4
Transfer from the Maternity Ward	23.3
No information available	5.4

Most of them were probably sick because they were hospitalized either as emergency cases (42%) or they had a written recommendation from a physician (28.2%). Some 21.7% of the children were hospitalized as a result of an inter-hospital transfer. Information is missing on the person/institution who hospitalized 28.7% of the children (***Table 19***).

"Mothers who intend to abandon their children refuse to be hospitalized with them, invoking family responsibilities, the existence of other children who need to be taken care of at home, and the need to earn money in this period.

These mothers are either negligent, or they do this on purpose, but they never have any identity documents with them. They are poorly dressed and have precarious hygiene.

We noticed that mothers who intend to abandon their children show up at the Emergency Room with no written physician's recommendation, and their children usually in critical medical condition."

Pediatric Physician

Table 19

Type of hospitalization	% (n=986)
Emergency	42.1
Recommendation from family physician	20.2
Recommendation from ambulatory specialist physician	8.0
Inter-hospital transfer	21.7
Upon request of the family	3.8
Other	4.3

43.5% of the cases that come recommended by a physician include the *"social case"* notation.

The fact that 89% of the children had a medical diagnosis at the time of hospitalization and 11% were hospitalized with no medical diagnosis confirms that children with exclusively social problems can be hospitalized in pediatric/recovery hospitals (**Table 20**). This is all the more obvious since over 40% of them also had a "social case" notation on their recommendation.

Table 20

Reason why the child was brought in?	% (n=986)
Medical diagnosis	89.0
Abused/mistreated by parents	1.2
Neglected by parents	1.3
Left at home without supervision	0.5
Left in a public place	1.0
Abandoned in the Maternity Ward	7.0

3.3. General features of children abandoned in hospitals, pediatric/recovery wards

a) Birthweight – it is to be pointed out that this information is missing in the case of 41.3% of the observation charts studied. The percentage of low birthweight children is 34.2%, a value extremely close to that of children abandoned in Maternity Wards.

Table 21

Birth weight	% (n=578)
Under 2,500 g.	34.2
Over 2,500 g.	63.8

b) Congenital malformations

8.8% of the children have congenital malformations.

Table 22

Does the child have any congenital malformations?	% (n=986)
Yes	8.8
No	90.3
Not recorded on file	0.9

c) The children's age

Table 23 presents the distribution of the children selected by age groups. Most of the children are aged 13-24 months, followed by children under 12 months old. The number of abandoned children decreases as the age increases.

Table 23

Age	% (n=986)
Up to 12 months	24.3
13-24 months	40.6
25-36 months	18.6
37-48 months	11.3
49-59 months	5.2

d) Gender

51.8% of the children are boys, and 48.2% are girls. It can be noticed the same over-representation of male children, as in the case of the Maternity Wards (***Table 24***).

Table 24

The child's gender	% (n=332)
Male	51.8
Female	48.2

e) Parity (rank)

Over 50% of the children are ranked 1 and 2. It is worth pointing out that in 27.7% of the cases the child's rank is not recorded in the observation charts.

Table 25

The child's rank	% (n=714)
rank 1	27.5
rank 2	24
rank 3	17.6
rank 4	11.3
rank 5 and higher	19.6

f) The residential environment

50.1% of the children reside in urban areas, while 49.9% are in rural areas. There is no information available for 4.3% of the children.

e) The child's identity

Almost one third of the children identified in the sample do not have birth certificates.

Table 26

Does the child have a birth certificate?	% (n=986)
Yes	**68.2**
No	**31.8**

3.4. General features of parents of the children abandoned in hospitals, pediatric/recovery wards

The data presented on the parents is merely informative, since for some 40% of the cases no information is recorded in the children's observation charts. The name of the mother is recorded in only 78.9% of the cases.

Table 27

Is the mother's name recorded on file?	% (n=986)
Yes	78.9
No	21.1

a) The mother's age

Regarding the **age**, it was observed that almost one fourth of the mothers are under 20 years of age. Compared to mothers who abandon their children in Maternity Wards, the percentage of mothers under 20 is smaller. There is a lack of information regarding the mother's age in the case of one fourth of the mothers of children identified in the study.

Table 28

Mother's age	% (n=723)
Under 20	24.3
20-24	29.4
25-29	20.4
30-34	17.2
35-40	7.0
Over 40	1.7

b) Marital status

With regard to marital status, over half of the mothers are married or live in consensual unions (***Table 29***). As compared to the mothers in the Maternity Wards, the percentage of mothers living in stable and unstable consensual unions is much higher, namely over 50%.

Such information is recorded in only 57.8% of the cases.

Table 29

Marital status	% (n=587)
Married	24.3
Consensual union	29.4
Divorced/separated	20.4
Widowed	17.2
Single (unmarried)	7.0

c) The mother's occupation

Over 90% of mothers have no occupation (they are unemployed). Information is available on in 58.7% of the cases.

Table 30

Mother's occupation	% (n=579)
Employed	5.0
Housewife	49.1
Unemployed	0.5
Retired	0.5
No occupation	44.5
High school/university student	0.5
Prostitution	0.6

d) Residence recorded

The mother's residence is recorded in 90.6% of the studied cases.

Table 31

Is the residence recorded in file?	% (n=986)
Yes	90.6
No	9.4

e) Information on the father

Almost 40% of the observation charts contained no information on the child's father.

Table 32

Is there any information on the father recorded on file?	% (n=986)
Yes	60.6
No	39.4

3.5. Information on the request for child protection measures

As in the case of children who have been abandoned in Maternity Wards, there were atempts to establish if there is any information on the reports made to the competent authorities regarding the abandonment of the children and/or a request that they provide child protection measures.

A small number of observation charts contained a request for child protection measures recorded, both with regard to the mother, as well as the authorities within the Maternity Ward).

Table 33

	%
The mother requests a protection measure (n=986)	1.7
The Maternity Ward notifies the DPC to take a protection measure (n=986)	2.6

2.7% of the observation files studied contained decisions/requests by the DJPDC.

3.6. Duration of the children's stay in the pediatric/recovery wards

The duration of the children's hospitalization in pediatric/recovery wards is presented in **Table 34** for the two years included in the study. It is noted that the situation was better in 2004, compared to 2003, in the sense that the percentage of children who are in pediatric/recovery wards for less than 10 days is higher in 2004 and the percentage of children who are there for 20-30 days or over 1 month is lower.

Table 34

How much time did the child spend in the Pediatric/Recovery Ward?	Year 2003 (n=508)	Year 2004 (n=478)
4-10 days	32.2%	43.2%
10-20 days	17.2%	14.4%
20-30 days	10.9%	11.2%
Over 1 month	38.9%	28.8%
Until present	0.9%	2%

There are no explanations regarding the decrease of the length of hospitalization for those children who meet the selection criteria requirements. The association of such improvement with the activity of certain social workers is unlikely as only 20% of these institutions employed social workers.

> *"The children have no identity documents, the procedures for placing them in families or in institutions are lengthy and bureaucratic."*
>
> Pediatric Physician

3.7. The relationship between parents and children during the hospitalization period

The hospitalization of the mother with the child

8.4% of the mothers were hospitalized with their child, but only for a short period of time, because they left the medical institution without notifying the medical staff.

Parental visits to the children during the hospitalization period

It is to be mentioned that only 5% of the children were visited at least once by their parents.

3.8. Discharge from the pediatric/recovery wards

3.8.1. The children's health at the time of discharge

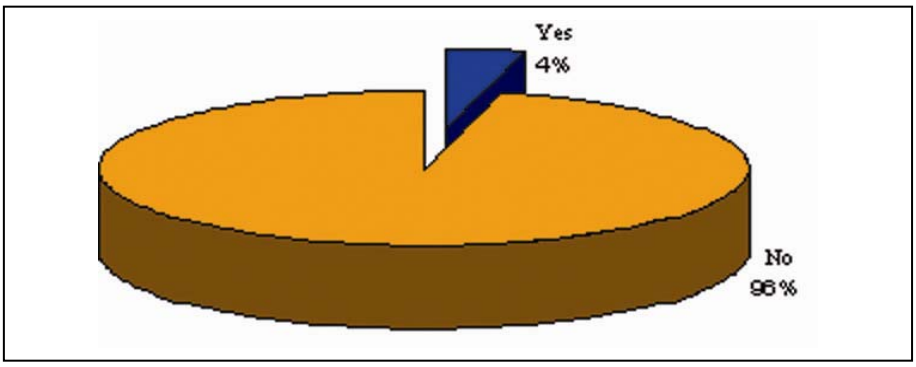
In the case of 74.5% of the children, the observation charts include notes that the child was healthy at the time of discharge from the hospital, while 25.5% of the children showed various health problems.

Table 35

The child's health at the time of discharge	% (n=986)
Clinically healthy	74.5
Has health problems	25.5

4% of the abandoned children died in hospitals/ pediatric wards.

Figure 15: **Abandoned children who died in pediatric/recovery wards (n=986)**



3.8.2. Where did the children go after being discharged from Pediatric/Recovery Wards

Table 36 presents the destination of the children after being discharged from the pediatric/recovery wards.

Almost half of the children went home after being discharged from the hospital, both in 2003 and 2004. As in the case of children who were discharged from Maternity Wards directly to their families, most of the children from the pediatric/recovery wards were taken home to their parents by hospital staff, without notification to the child protection services.

This can be dangerous because 95% of the children were never visited during their stay in hospital. There was no information with regards to their monitoring after discharge. One thing is certain: most of them are brought back to the Pediatric Ward.

Almost 30% of the children selected in the study sample did not have birth certificates at the time of discharge from the hospital, and regardless of their destination, these children can get lost or be declared lost.

Some 25% are taken to Placement Centers after being discharged from hospital.

"The children who are included in the child protection system are perceived as being "suited for this process", as they are unwanted, have an unknown father, are the product of rape, are HIV-infected, and have physical or mental disabilities. Some are Roma or Roma-Turkish children from large families."

Professional DJPDC

13.4% of the cases in 2003 and 18.3% in 2004 were transferred to other medical institutions or to recovery wards within the same hospital.

Some 4% of the children were given for placement with a foster parent, and a small percentage went to relatives and other families, for placement in view of adoption.

Table 36

Where did the children go at the time of discharge from the pediatric/recovery wards?	Year 2003 (n=352)	Year 2004 (n=298)
Home	49.7	49.2
Pediatric/recovery wards	13.4	18.1
4th degree relatives	1.2	0.2
Maternal center	1.2	2.1
Foster parent	3.9	3.3
Placement Center	27.9	24.1
Placement/adoption with a family	1.9	1.0
Still in that ward	0.8	2.0

When comparing the situation of cases discharged from Pediatric Wards in 2003 and 2004, one can see that the difference is not significant enough to determine whether progress has been made in the area of child protection.

Some observation charts contain a notation of *social case* or *social problem* added to the secondary discharge diagnosis (48.4%).

The destination of these children was no different from that of children for whom there was no such mention (the data is not presented).

3.9. Aspects relating to the organization and operation of hospital and Pediatric Wards

89 hospitals/Pediatric Wards were included in the study. 22.2% of these institutions are located in county capitals, 76.4% in municipalities and cities, and 3.4% in communes.

Table 37

	% (n=89)
County capitals	20.2%
Municipality	76.4%
Commune	3.4%

The data collected on hospitals and Pediatric Wards revealed that up to 90% of these institutions allow the hospitalization of mothers together with under-five years old children.

However, there are conditions in certain hospitals in terms of the mother being allowed to stay with her child, namely the seriousness of the child's condition, severe disabilities, payment of a fee, or the availability of beds for mothers.

It is surprising that 37.1% of the hospitals/Pediatric Wards never allow mothers to visit their children.

"We have no responsibilities related to abandonment according to the organization and operating regulations of the hospital; rather we assume human, unwritten responsibilities.

Once we solve the child's health problems, we notify the Child Protection Department of the presence of an abandoned child in the hospital. This institution takes the appropriate steps and moves the child to a Placement Center. At first, we provided the Child Protection Department staff with all the information on the child and the mother, to regulate the child's legal status.

Our Ministry assigned us a series of responsibilities in this area; we are unable to fulfill these because we have too many responsibilities in our own health sector. Often, the received recommendations are left in a drawer, among other unresolved papers. We don't have time to do it all.
Recently, we hired a social worker and he started taking care of social cases. He is trying to make the mother aware; he is encouraging her to breastfeed the baby in order to create a bond."

Pediatric Physician

3.10. Quantitative and qualitative information in observation charts of hospitalized children

With regard to the source of information on children in Pediatric Wards/hospitals, investigators noticed the scarceness of information on the child's situation, due either to a lack of interest on the part of the person filling in the chart or a lack of cooperation between the various hospital services. The number of observation charts which do not indicate where the child is going after being discharged is unacceptably high, especially since there is extremely limited information to identify the child and the family's residence. This situation is aggravated by the fact that almost 30% of the children do not have birth certificates, thus being in effect "non-existent", and subject to become possible future victims no one would ever find out about.

Also, there are no standard country-level pediatric observation charts. Sometimes, the use of files not specifically designed for children allows for the omission of certain essential information that could be used to track the child, because there are no specific fields for such information.

CHAPTER 4

CHILDREN WHO HAVE BEEN ABANDONED IN PLACES OTHER THAN MEDICAL INSTITUTIONS

It was considered that those children who were abandoned by their parents in places other than medical institutions could be found in emergency service centers. However, it was difficult to assess how inclusive this service is for the "absorption" of abandoned children, or to know how many of them never received such services and are truly abandoned.

For the **selection** of abandoned children in the emergency service centers, all the names of children under five who received such services during the two reference periods were listed. Subsequently, the information was extracted from their files and thus, able to identify the following: children under five who were brought without their parents/mother to the emergency service center (children who were accidentally "lost" by their parents, whose disappearance was reported to the police, and who were being looked for, were excluded).

During the reference periods **140 children in 2003** and **192 in 2004** were identified.

4. 1. Circumstances in which the child ended up in an emergency service center

Where did the child come from?

More than half of the children, namely 59%, were abandoned in medical institutions. A significant percentage, namely 27.1%, were children brought from home due to serious neglect. Some 10.5% of children were brought in off the street or public transportation.

Table 38

Where was the child found?	% (n=322)
Abandoned in medical institutions	59
Home of the biological family	27.1
On the street	8.4
On public transportation	0.3
Other	5.1

Who brought in the child?

42.8% of the children were brought in by DJPDC representatives, 21.7% by an ambulance, 13.3% by parents/legal guardians, 11% by other authorities (physicians, mayors, etc.), 2.1% by the police/public guards, 2.1% by strangers, and 1.5% by relatives**.**

Table 39

Who brought in the child?	% (n=322)
DJPDC representatives	48.2
Ambulance	21.7
Parents/legal guardians	13.3
Other authorities (mayor, physician, etc.)	11.0
Police/Public guards	2.1
Strangers	2.1
Relatives	1.5

Reason for which the children were brought to the emergency services center

Most children were brought in from the Maternity Ward in which they had been abandoned (44.6%).

About half of the children had either been neglected by their parents, or the parents did not have the necessary means to raise them.

Table 40

The reason the child was brought in	% (n=322)
Abused/maltreated by parents	6.3
Neglected by parents	22.3
Left in a public place	1.8
Parents arrested	2.1
Parents did not have necessary means to raise him	22.9
Abandoned in a medical institution	44.6

4.2. General features of children in emergency service centers

a) Health

The study of the documents in the children's files indicated that more than 17% of them displayed symptoms of inter-current diseases, 2.1% showed signs of physical abuse, and 0.8% were in shock**.** 7.2% of the children had various forms of disabilities.

Table 41

The child's health	% (n=322)
Displays symptoms of inter-current diseases	17.8
Shows signs of physical abuse	2.1
Is in shock	0.6

b)The child's identity

Over 90% of the children hospitalized in emergency service centers had identity documents.

Authorities had not initiated any procedures to establish the identity of 8.7% of the children who were without any form of identification.

Table 42

Does the child have a birth certificate?	% (n=332)
Yes	91.3
No	8.7

c) Gender

It was noticed an over-representation of boys compared to girls in the case of children who were abandoned and brought to emergency service centers, and this over-representation is highest when compared to the situation in maternity and Pediatric Wards.

Table 43

The child's gender	% (n=332)
Male	55.7
Female	44.3

d) Age

Among under-five years old children, most abandoned children in emergency service centers are under 12 months (Table 44). This can be explained by the fact that over 59% were children who had been abandoned in medical institutions.

Table 44

Age	% (n=332)
Up to 12 months	48.5
12-24 months	32.2
24-36 months	10.2
36-48 months	3.2
48-59 months	5.9

e) Information on the parents

What is surprising is the fact that the parents of over 95.5% of the children are known, since 59% of these come from maternity wards where an emergency measure was undertaken.

Table 45

The parents are:	% (n=332)
known	95.5
unknown	4.5

4.3. Duration of the children's stay in emergency service centers

The data collected showed that most children spend at least two months in these emergency service centers, but there are children who stay there for a year or more (**Table 46**). This is in direct contravention with the provisions of currently enforced legislation. The law stipulates that the child's stay in this type of service should not exceed 15 days and, in exceptional cases, 30 days.

Table 46

How long did the child receive this service?	% (n=332)
Up to 1 month	34.0
Between 1-3 months	28.0
Between 3-6 months	12.3
Between 6-12 months	4.2
Between12-24 months	1.2
To this day	20.2

4.4. Discharge from the emergency service centers

Unlike the other two groups of abandoned children, most children from the emergency service centers go into the child protection system, either to a foster parent (43.7%) or a Placement Center (23.2%).

Their return to their biological family is much less frequent than in the case of the children who have been abandoned in medical institutions. The intention to abandon the child is probably less masked than in the other cases (Table 47), although 30.7% of them have been visited during their emergency placement, especially by their mothers (Table 48).

Table 47

Where did the children go at the time of discharge from Emergency Service Centers?	(n=332)
Home	17.5
Relations to the fourth degree	0.9
Maternal center	0.6
Foster parent	43.7
Placement center	23.2
Placement for adoption with a family	7.2
Adoption	0.9
Still at the Center	6.0

Table 48

Who visited the child?	% (n=93)
The mother	77.4
The father	12.9
Relatives to the fourth degree	6.4
Other people	3.3

4.5. Information on emergency service centers

Emergency service centers may operate either at (traditional) locations which have distinctive staff and responsibilities, on the premises of Placement Centers, or through the foster parent institution.

In the counties included in the study 25 such services were identified. Few counties have more than a single such service on their territory (with the exception of those counties in which these services are operated through a foster parent).

Most are located in county capitals. As a rule these services are being run on the premises of Placement Centers.

Table 49

The service is located in	% (n=25)
County capital	80.0
Municipality/town	16.0
Commune	4.0

Such services are created both by the specialized public services and by authorized private bodies, and are developed as modules within Placement Centers and with foster parents.

Table 50

The emergency child protection institution is located at	% (n=332)
Emergency Placement Center	30.1
Social Protection Service – Placement Center with an Emergency Placement Center module	50.0
Authorized private body – Placement Center with an Emergency Placement module	6.0
Social Protection Service – Foster parent	10.8
Authorized private body – Foster parent	3.0

CHAPTER 5

THE CHILD'S ROUTE

Information was sought in the records of the County Child Protection Services for all the children identified in Maternity Wards, hospitals/pediatric and recovery wards, as well as in emergency service centers. This was done to identify the route the children followed and the type of the protection measures they benefited from. The route is important because it provides information on the quality and appropriateness of protection services for the child's development needs.

The route describes the places the child spent time at from the time it was abandoned by its mother, and the temporary or permanent protection solutions it has been assigned up to date of collecting data. It is worth to point out that information and files were found for a mere 694 of the 1,935 children.

5.1. Types of the routes

48 types of routes were identified for the children in the study sample.

Table 51

The child's route	%
Maternity Ward - Pediatric Ward - Family	6.6
Family - Pediatric Ward - Family	7.2
Maternity Ward - Pediatric Ward - Placement Center	1.6
Family - Pediatric Ward - Placement Center	5.5
Family - Placement Center	8.2
Maternity Ward - Placement Center	13.1
Maternity Ward - Pediatric Ward - Professional Foster Parent	2.7
Family - Pediatric Ward - Professional Foster Parent	8.1
Family - Professional Foster Parent	3.7
Maternity Ward - Professional Foster Parent	12.5
Maternity Ward - Pediatric Ward - Family - Pediatric Ward	0.3
Maternity Ward - Family - Pediatric Ward - Family	1.2
Maternity Ward - Adoptive Family	2.4
Maternity Ward - Pediatric Ward - Death	0.3
Family - Pediatric Ward	1.4
Maternity Ward - Pediatric Ward	1.3
Maternity Ward - Family - Pediatric Ward - Placement Center	0.4

Family - Pediatric Ward - Death	**0.1**
Family - Pediatric Ward - Placement Center - Adoptive Family	**1.7**
Maternity Ward - Family	**6.5**
Family - Placement Center - Professional Foster Parent	**3.3**
Family - Placement Center - Family	**1.7**
Maternity Ward - Pediatric Ward - Adoptive Family	**0.3**
Maternity Ward - Pediatric Ward - Placement Center - Professional Foster Parent	**0.6**
Maternity Ward - Maternal Center	**0.3**
Maternity Ward - Maternal Center - Adoptive Family	**0.3**
Maternity Ward - Maternal Center - Family	**0.1**
Family - Pediatric Ward - Placement Center - Professional Foster Parent	**0.6**
Family - Pediatric Ward - Adoptive Family	**0.7**
Family - Pediatric Ward - Professional Foster Parent - Adoptive Family	**0.1**
Maternity Ward - Placement Center - Professional Foster Parent	**2.3**
Maternity Ward - Family - Pediatric Ward - Placement Center - Professional Foster Parent	**0.4**
Maternity Ward - Family - Pediatric Ward - Professional Foster Parent	**0.1**
Family - Maternity Ward - Placement Center	**0.3**
Maternity Ward - Pediatric Ward - Professional Foster Parent - Family	**0.1**
Maternity Ward - Family - Pediatric Ward	**0.1**
Maternity Ward - Placement Center - Family	**0.3**
Maternity Ward - Family - Professional Foster Parent - Placement Center	**0.1**
Maternity Ward - Family - Placement Center - Professional Foster Parent	**0.1**
Maternity Ward - Placement Center - Professional Foster Parent - Family	**0.1**
Maternity Ward - Maternal Center - Placement Center - Professional Foster Parent	**0.1**
Maternity Ward - Family - Placement Center	**0.4**
Family - Maternity Ward - Placement Center - Professional Foster Parent	**0.1**
Maternity Ward - Pediatric Ward - Placement Center - Family	**0.1**
Maternity Ward - Placement Center - Pediatric Ward	**0.4**
Family - Placement Center - Pediatric Ward - Professional Foster Parent	**0.9**
Family - Placement Center - Pediatric Ward	**0.4**
Maternity Ward - Pediatric Ward - Placement Center - Adoptive Family	**0.1**
Total	**100.0**

The **most frequent** routes were:

- ⇒ Maternity Ward – Placement Center: 13.1%,
- ⇒ Maternity Ward – Professional Foster Parent: 12.5%
- ⇒ Family – Placement Center: 8.2%

None of these routes end with a definitive solution for the child (biological or adoptive family).

The routes of abandoned children in Maternity Wards

The "ideal" route, namely from the Maternity Ward to the family, occurs in only 6.5% of the cases. In 13% of the cases, beginning in the Maternity Ward and ending in the family, there is an intermediate stage in the Pediatric Ward (sometimes also the Placement Center or the Professional Foster Parent).

There are routes which illustrate that the child was subjected to re-abandonment in a Pediatric Ward after it had been integrated into its family upon discharge from the Maternity Ward:

Maternity Ward – Family – Pediatric Ward: 2.3%

The routes of abandoned children in Hospitals/Pediatric Wards

The most frequent routes were:

- Family – Pediatric Ward – Professional Foster Parent: 8.1%,
- Family – Pediatric Ward – Family: 7.2%,
- Family – Pediatric Ward – Placement Center: 5.5%,
- Family – Pediatric Ward: 1.4%

Of these routes, only one ends with a definitive solution for the child.

The routes of the children identified in emergency service centers rarely included periods in medical institutions. Of the total 48 routes, 28 contain a "stop" in the Pediatric Ward.

The analysis of routes highlights the fact that the Hospital/Pediatric Ward is the most handy and accessible service for both the parents who wish to abandon their child "temporarily" or "permanently" and, paradoxically, for the Child Protection Services, which employs the Pediatric Hospital to host children in difficulty until a protection measure is identified.

Eight of the routes include three different locations without reaching a definitive form of protection, another eight routes have four stops before a definitive form of protection is found, and one route has five stops without ever reaching a definitive form of protection.

An analysis of the child's route shows that 28,1% were in their biological family, almost 9% were in adoption, 37,8% were in maternal assistance and 19,6% in a placement center. Other 19% were at their relatives, 0,1% in maternal center or in medical units (3,5%). From the files of the routes was revealed that 9.5% of the children were eligible for adoption, meaning there was parental consent for adoption.

Table 52

Where is the child at present?	% (n=694)
Biological family	28.1
National adoption	8.9
Fourth degree relatives	1.9
Professional Foster Parent	37.8
Placement Center	19.6
Medical institution	3.5
Maternal Center	0.1
Dead	0.1

5.2. Type of protection measures in effect

According to the longer or shorter routes, at the moment of collecting data, the children for whom such routes could be identified were in the following stage in terms of protection measure:

Table 53

Type of protection measure enforced	% (n=460)
Placement	69.3
Entrustment for adoption	12.8
Emergency placement	7.5
Entrustment in view of adoption	10.4

The number of days the children had spent in medical institutions until a protection measure was put in place is very high. Almost half of the children spend more than 50 days in medical institutions without their mother, awaiting a protection measure.

Table 54

Number of days spent by children in medical units	% n=694
1-25	40.1%
26-50	11.3%
51.100	35.2%
101-150	6%
151-200	2.6%
201-300	1.6%
More than 301	3.3%

5.3. Length of the routes

In order to determine the route of the child starting from the place where he/she was abandoned till entering in a final protection measure (biological family or adoptive family), the methodology consisted in several types of "event history analysis". Those techniques are applicable for situations which fulfill several criteria, as follows:

(1) There is a certain number of subjects (in our case the children) which pass through a certain number of situations (maternity wards, medical units, placement centers, maternal assistant, biological gamily, adoptive family etc);

(2) Situations can happen any time;

(3) Time criteria which influence those events (example of children who started their route in maternity wards, whose parents gave their consent for adoption, the number of days spent in hospital wards);

The main non-parametrical methods which can describe longitudinal data are the Kaplan Meier ones and the mortality tables.

ANALYSIS 1

Length according to the starting point, maternities or other places.

The analysis revealed the following conclusions presented in the figures below. The children who begin their route in a Maternity Ward are more likely to end up with a permanent protection measure, as opposed to those who begin their route in other places.

Table 55 **The ratio of children who did not end up in a biological or adoptive family and whose route began in a Maternity Ward or in another place, in accordance with the length of the route (in number of days)**

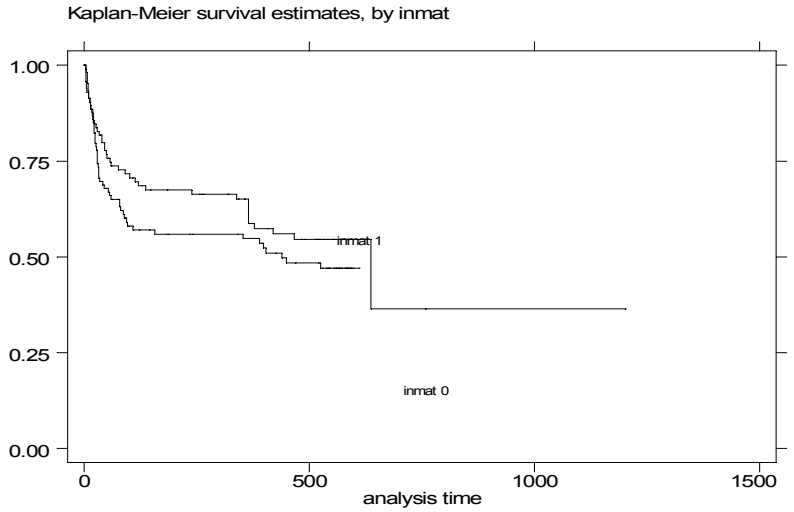
Route's length -in days-	The route started in	
	Maternity Ward %	Other location %
151	57.0	67.4
301	55.9	66.3
451	48.3	55.9
601	47.0	54.5

This data shall be interpreted as follows:

Example 1: 57% of children who began their route in a Maternity Ward did not end up with a permanent form of protection (biological or adoptive family) after 151 days.

Example 2: 47% of children who began their route in a Maternity Ward did not end up with a permanent form of protection after 601 days.

Figure 16



In ***Figure 16*** the representation indicates:

1) on the ax Ox: the time of the entry in the route till the final protection measure or till end of September 2004 (end of collecting data). Once the line is flat – see the extreme right – it means, that all children from this category (those which started their route in maternities) reach a definitive protection measure or it is September 2004 (end of data collection). This is olso showed by the table (see ***Table 55***) by the fact that after 601 days 47% of the children who started their routes in maternities didn't reach a definitive measure of protection.

2) Analysis of the other ax (equivalent of Oy) representing the probability of child existence in the route (can be observed also in the table, as for example after 151 days 56% of the children which started their routes in maternities didn't reach a final measure of protection). At the beginning of the route, when there are all the children, the probability is 1. After 151 days, 57% of children started their route in maternities didn't reached a final protection measured.

ANALYSIS 2

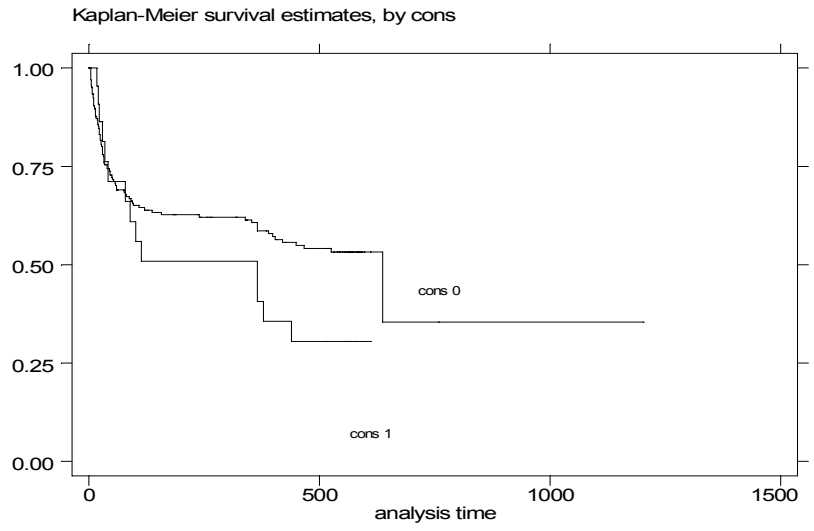
Length of the route according to the consent of the parents.

As can be seen in the ***Figure 17*** below, there is no difference between the two categories of children in the first 100 days. A difference begins to show only after 301 days, in the sense that 50.8% of the children whose mothers gave consent for adoption did not yet end up with a permanent form of protection, while during that same period 63.3% of the children whose mothers did not give consent for adoption had not yet ended up with a permanent form of protection. The difference decreases more significantly after 601 days, when 30.4% of the children whose mothers gave consent for adoption did not end up with a permanent form of protection, as compared to 53% of children whose mothers did not give their consent for adoption (see Table 56).

Table 56

Route's length -in days-	Consent for adoption	
	was given %	was not given %
301	50.8	63.3
600	30.4	53

Figure 17



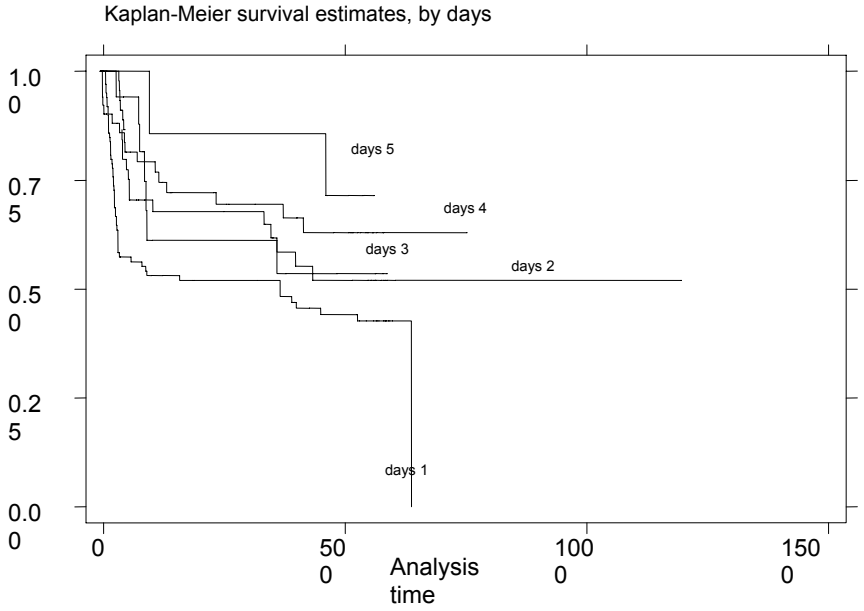
ANALYSIS 3

Length of the route according with the number of days in the medical institutions

(1= <=30 days, 2= 30-60 days, 3= 60-90 days, 4= 90-180 days, 5= >180 days)

As can be seen in the graph, most of the children who end up with a permanent form of protection are those who spend the fewest days in medical institutions (days 1), followed by days 2, days 3, days 4 and days 5. In other words, the less they stay in medical institutions, the higher are their chances of ending up in a permanent form of protection (biological or adoptive family).

Figure 18



CHAPTER 6

MOTHERS WHO HAVE ABANDONED THEIR CHILDREN IN MEDICAL INSTITUTIONS

Following the identification of the children in accordance with their medical observation charts and emergency service center entry records, there was also an attempt to identify their mothers. In comparison to the number of children who were identified as being abandoned, namely 1,935, the number of mothers who were identified and located in order to be interviewed was less than 20%.

For this reason, the level of representation is questionable. The identified sample is outsized in the case of mothers from rural areas, and those who took their children home.

There are several explanations for the fact that only a limited number of mothers were found.

1. Operators identified children who were abandoned by their mothers, either temporarily or permanently, during the observation period, regardless of whether or not these children subsequently ended up with their biological families. In the case of *temporary abandonment*, many of the children in the records cannot be found in the Child Protection Department records, because their abandonment was not reported by the medical institutions.

   As such, it was difficult to identify them on the basis of the address recorded in the observation charts, since a great deal of information was incomplete. The information was found in Department records if during the observation period the mothers *re-abandoned their children* in Hospitals/Pediatric Wards, or if the mothers requested a protection measure.

2. Name changes resulting from marriage also made the identification of the mothers difficult.

3. Some Child Protection Departments keep the files of all the children at their headquarters while others keep them at the Placement Centers where the children are located. This made extracting information from Child Protection Department documents on all institutionalized children (and on their mothers, respectively) impossible, because the deployment of teams to various communities where Placement Centers were located had not been initially planned.

4. Addresses were false or not updated, especially in large cities.

5. Temporary/seasonal absences from the residence locality.

6. Hospitalization or arrest.

7. Serious mental illnesses or disabilities making communication impossible.

8. Refusal of certain Child Protection Department staff to cooperate with the teams.

9. Refusal of certain Child Protection Departments to cooperate for the visit of some categories of mothers who had given their consent for adoption.

> *"Of the 58 cases selected in the given timeframe, I only managed to locate and interview 28 mothers, because 10 mothers were out of town for an extended period of time (nobody knew where), 7 (Roma) mothers had moved abroad with their families, 10 mothers had given the hospital a false address and were not listed in the records of the Child Protection Departments, 1 person, although acknowledged by the Child Protection Department, denied she was the person in question.*
>
> *Of 37 mothers identified, 3 were out of town engaged in begging, 1 had been arrested, 7 were out of town (in Iaşi, Bucharest, Timişoara), 1 was mentally ill, 1 was engaged in prostitution, 3 had moved out of town, and 1 had left for Spain."*
>
> Excerpts from field investigator reports

The questionnaire used to interview mothers is a **modular** one, containing both general and specific questions for various sub-groups of mothers. The idea behind the creation of such modules was the need to understand the context and motivations of the mothers who decide to abandon their children.

Initially, there was an intention to structure the presentation of data according to three categories of mothers, delimited according to the place in which they had abandoned their children. Because there were no distinctive cases for the third category (places other than medical institutions), the presentation of results will be structured only according to two categories of mothers: those who abandoned their children in Maternity Wards and those who abandoned their children for the first time in Hospitals and Pediatric Wards.
Qualitative data will be introduced along with the statistical presentation of quantitative data.

General characteristics of mothers who abandoned their children

CASE STUDY

Child abandoned in a Maternity Ward

My name is A.M. I was born in 1982 in the city of R.V. where I spent my entire childhood. In addition to my mother and father, I have a younger sister.

I am now 22 years old, and have been living for about 6 months with my child in a Maternal Center in the city. The child has not been acknowledged by his father.

When I was young, as late as 8th grade, I had everything I needed. I went to the seaside, to the mountains, would spend my holidays with my grandparents, especially my paternal grandfather, who loved me very much.

I was never beaten. I was rarely punished. My parents made enough money, they both had jobs.

Even now they have a good financial situation. My father works abroad, he comes home every three months. With the money they earn they are building a house in my father's native village, they have enough money.

When I was living with my family, I had a lot of gold, as did my mother and sister.

When I grew up and went to vocational school, my parents, especially my mother, treated me very harshly. They kept me mostly in the house. I was rarely allowed to spend time outdoors with other youngsters my age.

For a while I got along well with my mother, but I never had any discussions with her about boys, or sex…

She loved my sister more than she loved me. My father also noticed and confessed that he too loved my sister more than he loved me. My sister was more the way they wanted. She was nice, obedient, and studied hard. I was more of a rebel, was less obedient, and liked to have fun. I always argued with them about this. Once, a neighbor childhood friend of my mother's witnessed an argument between my mother and I about going out. I heard her stand up for me and telling my mother: "Do you think you're any better?". I don't know what she was trying to hint at. Probably it was one of their secrets from childhood.

I did not meet any boys other than my current partner. He was my first boyfriend, and then he became my life partner. I met him on the street in our city. I was with a school friend who introduced us.

I started my sex life when I was 19; at that time I was a night student at an industrial High School.

After I met my partner, I asked my mother if I could go with him to a disco. That's when I introduced him to my mother, because she always liked to control everything.

She did not like him and forbade me to go out with him again. She insisted that he was older than me, that he is a Roma, that he is "not for me". In spite of my mother's feelings, we continued to meet in the street, go to pubs, have conversations.

What attracted me most to him was the fact that he knew how to listen to me when I had a conflict with my parents and sister, and he never hid any of his problems. He was in the process of divorcing his wife, with whom he had a child, and he was involved in a fairly complicated property settlement trial.

That's when the fights with my mother started, the beatings, the prohibition to leave the house.

One day, when my parents were at work, I decided to leave with him for good. I moved into a rather poor apartment. The apartment, subject to the property settlement trial, was dirty, had no windows, was unpainted, and unfurnished. I did not care about the conditions, for me it was important that I was with the man I loved, the man who understood me. After running away from home, I dropped out of High School because I had found my freedom.

"My husband" criticized me for dropping out of school.

Some two months after I left my parents' home, I called them to ask whether I could stop by to pick up a check and a few things. They let me in, but you could see in their eyes that they did not approve of my behavior, and that they did not care for me.

That's when I realized I did not need their money, their gold, but rather their love.

The partner I live with is 11 years older than I am. What attracted me to him was his seriousness, his maturity, and the confidence he gave me when I told him about the conflicts with my parents.

Although he is a Roma, he is well respected in town, and has relations mostly with Romanians.

He only finished four grades. He has no occupation, but is a good businessman. He used to have a company which made him a lot of money. He was in the scrap metal business, and sold car engines. The company is now experiencing financial difficulties, and is on the verge of bankruptcy. He works on his own, in a makeshift workshop. He makes thermal insulated windows. He does not earn much at present, not enough to support me and the child.

"My husband" is very mature, he taught me a lot of things about sex, about everything else, he is "worldly-wise", he can answer every question I have.

He is emancipated. He speaks nicely. You cannot tell he is a Roma except by his complexion.

After I moved in with him, I became pregnant but terminated that pregnancy because we realized we did not have what it took to raise a child. I found out about the pregnancy after taking a test, and then had an abortion.

When I became pregnant a second time, with the child we are talking about, we were both upset. It was an unwanted child, born at an inappropriate time.

I was certain that I was pregnant at about 2½ - 3 months. I talked about this with "my husband", and he suggested I have an abortion. I was not very lucky because the holidays were coming, I postponed the abortion, time went by, and the child started to kick.

I did not see any physician during my pregnancy. I have a family physician but went to him very rarely. I was told family physicians prescribe medication and I am against this. I have heart and liver problems but am trying to treat these with herbal concoctions.

I have a weak nervous system. When I get angry, my head shakes and I believe this is the result of emotional stress and fear in the family.

I did not prepare anything for the child's birth, no diapers, nothing. I did not pay any attention to this aspect, especially since the money was very limited. During the pregnancy there were days when I would only eat bread. At the time we were trying to survive and could not care for a child.

I did not hide my pregnancy, but when we were going out, I did not feel comfortable when mutual friends or acquaintances looked at me.

I gave birth to the child after 8 ½ months in another county. The birth, which took place in the city of C. was not premeditated. It was unexpected.

Because we had no money, one day "my husband" decided to sell the car we owned at a very large car fair, some 200 km from R.V. Because the roads were very bad, my water broke. That's when I decided to go to the Maternity Ward to avoid having problems.

I was admitted to hospital with only the clothes on my back.

At admission I was asked to present my identity documents. I did not have them on me, and neither did my husband, because he had forgotten them at home, even though he would have needed them in order to sell the car. I told the truth, that I was from out of town, and unmarried. The Maternity Ward suspected that I wanted to provide a fake ID. I gave them my parents' address.

When I was hospitalized, and after putting me in the ward for pregnant women, the nurses spoke to me harshly, even ignoring me. The girls in the ward received attention from the medical staff. For instance, I heard that if they give you an enema the birth is much easier, but they didn't give me one.

The pain started after they gave me an IV to induce labor. An Arab doctor assisted me at birth, and he treated me very well. He encouraged me. When the doctor would leave, the nurses treated me with indifference. After the birth, the child was taken to the nursery. I was not given any information on the child, apart from the fact that it was a boy, that he weighed 2,800 grams, and that he received a "9 Apgar score". I asked whether he had any malformations, because I knew from watching TV that many unwanted children have malformations. No one answered my question, and when I first breastfed him I was not allowed to remove the diaper wrapping.

There were eight women in the Maternity Ward, and the children stayed in the nursery.

After I got better I breastfed him because that was what all women did.

After the delivery, I did not receive enough food, no one paid any attention to me. I asked the other girls in the room for a towel, some cotton, for other things, and even food. They would get these from home, and had plenty of food.

I would eat using the spoon of one of the girls, from the cup of another girl, it was not pleasant. They did not seem too friendly to me, either.

I did not know how to care for the child. I was afraid at the thought of leaving the Maternity Ward because I did not know how to feed him, how to care for him.

On the third day, "my husband" visited me and I ran away from the Waternity Ward, leaving the child behind. When the other girls went to breastfeed their children, I left the ward, and ran into the hospital yard in the robe and slippers the hospital had provided. There were lots of people in the hospital yard. I went out gate, nobody stopped me. It was customary for the girls to go out to shop at a nearby store. They would buy biscuits, candy and others such things. "My husband" was waiting ten meters from the hospital gate in a parked car. We talked in the car for several minutes, and decided to leave the child in hospital and to go home. We left in the car he could not sell. My boyfriend reminded me that we were very short on money and that the apartment where we were leaving was not appropriate for the child. He told me that after his business revived, we would look for him, and take him home.

We went home, and after more than a month somebody came to my apartment door saying they were from the Child Protection Department. We talked and I admitted I have left my child in the Maternity Ward in the city of C. They found me because my mother had given them my address. That's how they found out where I was living. They took care of the child's identity documents. The boy now has a birth certificate. The Maternity Ward staff gave him a name which I don't like. It is too similar to the one of my partner's former wife.

After some time, the social worker told me that the boy was moved to a shelter and that if I wanted, I could visit him. I went there several times, sometimes every day, if there was no quarantine. At the shelter I was encouraged to come as often as possible, to hold my child in my arms.

I do not know much about contraceptives. I've heard about them, I don't know exactly which pills make me put on weight, might deform me, and I have absolutely rejected the idea of using them. We use the calendar method, and other methods known by my boyfriend.

The social services people tried to arrange for me to be reunited with my family.

They told me that my parents would accept me with a child, but without my partner.

I don't want to go back to my parents' home, because they would take me to another county, so that people would not find out I had a baby with a Roma man. They would lock me up in the house they have built in that village. They are saying that I am a woman with poor morals.

I know that my husband is not perfect, but it is "the person" that counts. He is a good thinker, doesn't steal, he's a well-respected man.

My in-laws do not accept me either. They want their boy to marry a Roma woman.

I do not visit them because they live in a gypsy neighborhood. My husband keeps telling me to stay away from some evil gypsies.

The child is very important to me. I am now in a Maternal Center because I visited my child very often at the shelter. When they saw that I love my child, they proposed that I stay with the child in the Maternal Center.

My husband comes to the Maternal Center, but he can't do that all the time, because he travels outside the county.

6.1. Features of the mothers

Age of Mothers

"One of the causes of child abandonment is the fact that mothers are very young. These mothers begin their sex life very early, at about 13-14 years old, when they have no capacity for discernment. It is an age at which they cannot begin living on their own with their child. Other people make decisions for them, usually their parents or life partners. Mothers aged 13-14 do not have maternal instincts and are not averse to advice to leave their child in the care of the state."

Physician

According to the information obtained in interviews with mothers, throughout the study sample, 27.6% are *very young mothers* under 20, with an important variation between the two categories of mothers (36.8% and 16.7%, respectively) (***Table 57***). It is to be mentioned that, throughout the sample, the average age of the mothers was 24, with extreme limits between 14 and 43 years. Some 6.5% of the mothers were under-16 years old at the time of the child's birth (the data are not presented).

Table 57

Mother's Age	Total (n=350)	Mothers who have abandoned their children in Maternity Wards (n=201)	Mothers who have abandoned their children in pediatric/recovery wards (n=149)
Under 20	27.6%	36.8%	16.7%
20-24	26.3%	20.8%	31.6%
25-29	23.3%	21.4%	25.3%
30-34	13.3%	12.3%	13.5%
35-40	7.6%	6.7%	8.4%
Over 40	1.9%	1.9%	4.5%

Ethnic Origin

Throughout the sample, which level of representation is questionable, according to those mentioned at the beginning of this chapter, it can be noted that most of the mothers who have abandoned their children in medical institutions are of Roma ethnic origin (56.7%). The ethnicity was determined by self-identification, using the information in the interviews with the mothers who could be tracked. According to the two categories, one can see that almost half of the mothers in the sample who abandon their children in Maternity Wards are of Roma ethnic origin, and the other half are of Romanian and Hungarian ethnic origins.

Over 66% of the identified mothers who have abandoned their child in Pediatric and Recovery Wards are of Roma ethnic origin (***Table 59***). The over-representation of mothers of Roma ethnic origin abandoning their children is obvious if it is taken into account that this ethnic group makes up less than 10% of the general population.

"Roma women give birth from the age of 14-15 to 40, deliver babies they do not take care of (the children raise each other), and it is not uncommon for the parents to leave them at the door of the hospital.
In fact, Roma children are born to be exploited by their parents . When they grow up, they are sent out to steal. Society is likely to blame because the Roma have been marginalized. They must be helped, because they are human, and must be integrated into society."

Medical assistant

Table 58

Ethnic origin	Total (n=350)	Mothers who have abandoned their children in Maternity Wards (n=201)	Mothers who have abandoned their children in Pediatric/Recovery Wards (n=149)
Romanian	41%	48%	29.5%
Hungarian	1.7%	0.9%	2.6%
Roma	56.7%	51.1%	66.4%
Turkish-Tartar	0.6%	----	1.5%

When matching age and ethnic origin, it is noticeable that most of the under-20 mothers in the sample are of Romanian ethnic origin.

Table 59

Mother's age	Romanian (n=144)	Roma (n=199)
Under 20	29.8%	26.1%
20-24	21.5%	28.1%
25-29	20.8%	25.6%
30-34	13.8%	13.2%
35-40	11.4%	5.5%
Over 40	2.7%	1.5%

The Residential Environment of Mothers

Over 60% of the mothers who could be tracked and interviewed were originally from rural areas.

When comparing this figure to the information from observation charts of the children it is to be noticed that rural area mothers are over-represented in the sample.

The teams who participated in data collection mentioned in their reports that the mothers from large cities were rarely found. Many addresses were either no longer valid, or fake.

Although the percentage of mothers residing in rural areas is larger than that of mothers who have abandoned their child in Pediatric Wards, the differences are not significant (**Table 60**).

"Although statistics do not show a difference between village and city, child abandonment is noted more often in medical institutions in urban areas. This conclusion is often erroneous, and is based on the fact that many mothers from rural areas come to urban hospitals to deliver their babies."

Most women from rural areas, who want to abandon their children, deliver them in Maternity Wards located in large cities, in order to cover their tracks more easily.

Director DJPDC

Table 60

	Total (n=350)	Mothers who have abandoned their children in Maternity Wards (n=201)	Mothers who have abandoned their children in Pediatric/Recovery Wards (n=149)
Urban	38.2%	38.8%	35.5%
Rural	61.8%	61.2%	64.5%

Marital Status

The table below draws attention to the very large percentage of mothers who are living in a consensual union or are single (Table 61). Most single women are included in the category of mothers who have abandoned their children in Maternity Wards.

"Consensual unions are very often accepted in environments where children are abandoned. Short-term consensual unions often result in an unwanted pregnancy and the start of another relationship because the partner does not want to be involved in bringing up a child whose father he is not. The pregnancy between two short-term consensual unions often ends in children being abandoned in Maternity Wards, Pediatric Hospitals, Dystrophic Wards, etc."

Professionals of DJPDC

Table 61

	Total (n=350)	Mothers who have abandoned their children in Maternity Wards (n=201)	Mothers who have abandoned their children in pediatric/recovery wards (n=149)
Married	21.7%	17.4%	28.1%
Consensual union	55.3%	54.2%	57.1%
Divorced	0.6%	0.7%	0.6%
Widow	0.6%	0.9%	---
Single	21.9%	26.8%	14.2%

By comparing the two prevalent ethnic origins, it can be noted that in both cases consensual unions are predominant: over 65% among the Roma, and not exceeding 43% in the case of Romanians (***Table 62***).

Table 62

Mother's marital status	Romanian n=144	Roma n=199
Married	23.7%	20.1%
Consensual union	43%	65.3%
Divorced/separated	0.7%	0.5%
Widow	1.3%	___
Single (unmarried)	31.3%	14.1%

Religion

The distribution of the sample by religion shows that over 63% of mothers declared they were Orthodox; attention was given to the high percentage of mothers who indicated they were agnostics (15.1%), and to the over-representation of Muslim mothers (2.8%), a situation which can be explained by the fact that the sample of counties included the only one in which this religion is better represented.

"No doubt the economic and material situation of mothers contributes to abandonment, but not fundamentally. These become factors towards the end of the process, once the family, school and religion have failed to fulfil their duties."

Statement of a Child Protection Commission Director

Table 63

Mother's Religion	Total (n=350) %
Orthodox	**63.2**
Roman Catholic	**6.6**
Greek Catholic	**2.3**
Protestant	**3.4**
Neo-Protestant	**4.3**
Muslim	**2.8**
Agnostic	**15.1**
Other religion	**0.9**
Did not know/answer	**1.4**

Education/Schooling

The level of a mother's education was perceived by participants in the qualitative studies, professionals and decision-makers, as constituting a synthetic risk factor which has a major impact on child abandonment, because this educational level determines the social and economic status, with all its consequences on all life components. A precarious education, due to the insufficient schooling of mothers, was continuously mentioned as being among the major causes/risk factors in the making of a decision about abandonment.

"The main cause for child abandonment is ignorance.
Contraceptive measures are presented in school, and are a subject as commonly debated as teeth brushing. Unfortunately, this very information on contraceptives does not reach the most vulnerable segment of the population that has not had any form of schooling."

Obstetrical – Gynecologist Physicians

Overall, the percentage of mothers with no education or very little schooling is very high, at 70%.

If considered separately, the mothers in maternity wards are somewhat more educated than those in the pediatric ward (see ***Table 64***).

Table 64

	Total (n=354) %	**Mothers who abandoned their children in maternity wards (n=205) %**	**Mothers who abandoned their children in pediatric/recovery wards (n=149) %**
No education	42.2	38.2	47.6
Primary School incomplete	27.1	24.3	30.3
Completed Primary School	13.4	16.6	8.2
9-10 grades/ Vocational school	14.3	15.8	11.7
High school	2	4.3	1.3
Post-secondary non-tertiary education/ University education	1.2	0.8	1.2

> *"Most mothers who abandon their children are illiterate, and have no skills to raise the children."*
>
> Obstetrical – Gynecologist Physician

According to ethnic origin, the percentage of illiterate Romanian mothers is 16.6%, while that of Roma mothers is over 60%. (***Table 65***)

Table 65

Mother's education	**Romanian (n=144) %**	**Roma (n=199)**
None	16.6	61.4
Primary School incomplete	25	27.6
Primary School completed	23.6	6.0
9-10 grades	19.4	2.5
Vocational School	7.6	2.5
High School	4.8	----
Post-secondary non-tertiary education	1.5	----
University education	1.5	----

Living Conditions

As can be seen in ***Table 66***, most of the mothers live in so-called *dwellings with yards* (42.7%), followed by *shacks* (35.9%).

It was decided to consider a *dwelling with a yard* any small construction intended or adapted as living space, and in rather precarious condition, with a formal or informal yard. By *shack* it is meant a very dilapidated living space, made of clay, and usually with a single room.

Some 8.8% of the mothers live in extremely precarious conditions, in *improvised living spaces,* i.e. a variety of shelters made of cardboard or other materials, in garbage dumps, in metal structures etc. Some 0.6% of the mothers live in houses, classified as larger buildings designed for living, with more than 3 rooms, and in very good condition.

There are also mothers who have no living space at all (1.4%), known as "homeless" and usually mentally retarded, who sleep in parks or in the sewer system, and were former street children. Considered in terms of these two categorizations, the living conditions of mothers who have abandoned their children in maternity wards are better than those who have abandoned them in pediatric wards.

Table 66

	Total (n=350) %	**Mothers who abandoned their children in maternity wards (n=201) %**	**Mothers who abandoned their children in pediatric/ recovery wards (n=149) %**
Apartment	10.5	10.7	11.4
Dwelling with yard	42.7	48.8	35.4
House	0.6	1.3	----
Improvised living space	8.8	7.8	9.3
Shack	35.9	30.3	42
Homeless	1.4	1.1	1.9

CASE STUDY

T. M .L. - Commune C - County A

"I met mothers in hospital who said they were going to abandon their children. Not just me, but everyone in the ward begged them to see their children. They didn't want these children, especially if they were boys. They had more pity for the girls."

"If City Hall gave me two rooms, I would take my children home. I don't know how to soften the heart of the mayor. I went to his office with Antena [TV station] and Curierul [daily newspaper], but he is afraid of no one."

"The lack of a home is the only reason I decided to leave my children with a foster parent."

My name is TML, and I come from commune C in county A. The commune is 37 km from the city of P. I am 25 years old, and finished eight grades in my village. I have given birth to 3 children, two boys and a girl. Two of the children, one aged 2 years and 5 months, and the other almost one year, are in the care of two foster parents.

I come from a large family with 5 children. I am the eldest, and the only girl of my mother's 5 children.

My parents divorced when I was 11 years old. The children all ended up in my mother's care. She had a hard life, and she wanted mine to be better. I was a good girl, and my mother and especially my grandmother told me I was pretty.

Both my parents remarried, and my father has another boy, who is now 14, with his present wife. I don't remember why my parents got divorced, and don't know whose fault it was. My father had been adopted by an aunt who could not have children.

When I finished eighth grade I started working daily in the village, in the homes of various people, digging fields, or cutting corn or wood. My parents were not and are not now rich people. I lived with my mother after the divorce in a two-room house. The first part of my childhood I spent with my parents, then I went to live with my paternal grandparents. It is they who taught me to work and earn money. They lived in a nearby village.

I met a boy from a rather well-to-do family in the village of my grandparents. He was 3 years older than me. I loved him and I think that he loved me too. When I turned 17 we decided to move in together in my grandparents' house, without being married. His family did not approve of our decision, because I was too poor. We lived together for a while and then he went back to his parents. When we broke up I was 4 months pregnant. He never acknowledged the baby, who is "registered in my name" only. All three of my children were born at home, as had been my brothers. I was the only one of my mother's 5 children born in a maternity ward.

I delivered my first child alone, and my husband helped me with the other two. After each birth I took the child to the maternity ward, because that is the rule.

After giving birth to my first child, I met my present husband in the hall of the hospital, and he immediately accepted my child. We became friends, and I moved in with him and my child, as he was living in a room in the hospital. They tolerated him there because he had no parents. Shortly after, we were legally married. I had two more children, but these two are in the care of Child Protection foster parents.

After living for some two years in the hospital, my husband lost his job because he had too many diabetic comas. We moved in with my mother's family, but the house was too crowded.

I left my last two children in the maternity ward, I did not run away, I did not abandon them. I spoke each time with a social worker. I didn't take the children home because I did not have the proper conditions to raise them. Both children were transferred from the maternity ward to a shelter, where they stayed for some three months, until foster parents were found to raise them. My husband and I both agreed that the children should be raised by foster parents. That was the advice I had received from the social worker, the family physician and from my husband.

I knew from my husband, who had lived in an institution in the town of R., that life was not good there. He told me that it was better for the children to be cared for by a foster parent. There are many children in institutions and the staff cannot take care of them all. I visit my two children at the re-integration center about every two months.

I now live with my husband and my first child in a room in the village cultural center. We have no electricity, running water or sewerage system. The room serves as bedroom, kitchen and wood storage. It is very shabby.

We got this room from City Hall, we do not pay any rent or other taxes for it, but it is not safe. We live in fear that we will be kicked out, although we live there because we were granted approval by the Mayor. The living conditions are bad and that is why I went to City Hall to ask permission to move into a smaller but better room in the same building, but was turned down. We live on 1,800,000 [Lei] in social welfare and on an allowance for the oldest child.

I earn about 100,000 lei a day and food when I work in the village. In the summer months we have about 4-5 million [Lei]. We don't do too badly money-wise, but much of it is spent on medication.

My husband is very ill. He is a diabetic. He has been insulin-dependent since he was 6 years old. At this moment he is in hospital, where he underwent surgery for peritonitis. He is not feeling well. The were complications because of the diabetes.

We petitioned City Hall for some land, but they didn't give us any.

There are some fields available in our village, where we could grow vegetables, but the Mayor did not give us his support for this.

The room in which we are living is not safe. There are other much better rooms available in the village cultural center. But the Mayor won't agree to let us using them.

We could move into a room with electricity. I don't know why the Mayor keeps turning us down. If we could have a contract, we would feel more secure about our dwelling, we would be able to take better care of it. The Mayor treats not only me like this, but acts the same way whenever anyone in the village asks him for something.

My memories of my childhood are very vague. I only remember that I liked to stay with my grandparents.

My mother gave me the freedom to do what I want and she has always respected my decisions.

I visit my brothers and my mother on a weekly basis. I even keep in touch with my father. They cannot help me. They have their own problems.

We don't have any friends in the village. We don't go to parties, to weddings. My husband doesn't like this sort of entertainment.

I don't want to have any more children. I took contraceptives for a while, but I stopped them after a year because I heard they can cause brain damage. That's when I became pregnant with my last child. Now I use the calendar method because it is the best.

I know about the availability of abortions, but I have never had one because I always got to the doctor too late. I had easy pregnancies and deliveries. I get along well with my husband, I take care of him, and we consult each other. I have more courage, he has less.

Whenever I came to the maternity ward with the child I had delivered at home, the medical staff treated me very nicely. They knew my husband.

Income

The ratio of mothers with relatively secure incomes does not exceed 15% in both groups. It is significant that occasional work is an important source of income for at least one third of the mothers (***Table 67***).

The minimum guaranteed wage, as a source of income, is mentioned by about one third of the mothers in the study sample. This is something that was also observed in other studies focused on extremely socially disadvantaged individuals.

The authorities have stressed that such income requires a person to have a fixed and legal residence in one place, and that such an income must be requested.

Table 67

	Total (n=350) %	Mothers who abandoned their children in maternity wards (n=201) %	Mothers who abandoned their children in pediatric/ recovery wards (n=149) %
Salary	14.8	15	15
Pensions	10	11	8
Profit	---	---	---
Renting land	1.7	2	1
Agricultural activities (crops)	5.4	2	3
Agricultural activities (livestock)	3.1	4	2
Occasional labor	35.9	35	37
Trade in recycled materials	7.4	7	7.7
Own trade	1.1	2	1
Unemployment benefits	2	2	3
Minimum guaranteed wage	33.9	34	32
Adult allowances	5.4	4	8
Child allowances	62.4	62	63
Begging	7.1	5	10
Child-raising allowances	7.1	6	5

Socio-Economic Status

In order to assess the socio-economic status of the families, information was collected on ownership of certain household appliances, presented in the table below.

Table 68

Appliances	***%***
Cooking stove	28.5
Refrigerator	13.7
Washing machine	8.3
TV set	24.2
Telephone	3.4
Vacuum cleaner	2.8
Car	2.0

The most common appliance is the cooking stove (28.8%) and the TV set (24.2%), the latter being the most common appliance among the general population (98%).

The socio-economic indicator was calculated by assigning equal values (1 point) for the possession of each of the following appliances: cooking stove, refrigerator, washing machine, TV set, telephone, vacuum cleaner, and car. The tally for each family was somewhere between 0 and 7. This tally was sorted according to four levels to establish the lowest socio-economic indicator for the possession of 0 to 1 appliance, a low indicator for 2 to 3 appliances, a medium indicator for 4 to 5 appliances, and a high indicator for 6 to 7 appliances. As a whole, the ratio of families whose socio-economic status was very low neared some 80%.

Table 69

	Total (n=350) %	**Mothers who abandoned their children in maternity wards (n=201) %**	**Mothers who abandoned their children in pediatric/recovery wards (n=149) %**
Very low	78.2	76.6	80.5
Low	16.5	18.4	14
Medium	2.6	2.5	3.5
High	2.7	2.5	2

Health

Some 80% of the mothers declared they were healthy, while the remainder indicated they have occasional illnesses. It is worth mentioning that some 10% of all mothers have a mental disability, and 3.45% suffer from a mental illness. This information was obtained by social workers (***Table 70***) and confirmed by persons conducting the qualitative studies.

Table 70

Mother's health condition	**Total (n=350) %**
Healthy	80.1
Physical disability	3.1
Mental disability	9.1
Sensorial disability	2.6
Tuberculosis	2.3
Type A Hepatitis	0.3
Type B Hepatitis	0.9
Type C Hepatitis	0.6
HIV/AIDS	0.3
Syphilis	1.7
Mental illness	3.4
Neurological illnesses	1.4

Antecedents of Mothers Regarding Delivery and Institutionalized Children

Some 10% of the mothers had their first pregnancy before the age of 15. Over 50% of them had their first pregnancy between the ages of 15–19.

Table 71

Age at the time of first pregnancy	Mothers who abandoned their children in maternity wards (n=201) %	Mothers who abandoned their children in pediatric/recovery wards (n=155) %
Under 15	11.4	10.9
15-19	66.9	61.9
20-24	16.4	19.3
25-29	4.9	7.3
30-35	0.4	0.6

Some 6% of the mothers had their first child before they were 15, while over 60% of them gave birth to their first child between the ages of 15–19.

Table 72

Age at the time of first child	Mothers who abandoned their children in maternity wards (n=201) %	Mothers who abandoned their children in pediatric/recovery wards (n=155) %
Under 15	6.5	5.6
15-19	65.2	62
20-24	21.5	23.9
25-29	5.9	7.8
30-35	0.9	0.7

As concerns the number of children born, there is a marked difference between the mothers who abandoned their children in maternity wards and those who did so in pediatric/recovery wards. Thus, most mothers (34.4%) who abandoned their child in a maternity ward have given birth to one child, while those abandoning children in the pediatric ward had more than four children (36.8%).

This information suggests that the reasons for abandoning children in maternity and pediatric wards may differ.

Table 73

Number of children born	Mothers who abandoned their children in maternity wards (n=201) %	Mothers who abandoned their children in pediatric/recovery wards (n=149) %
1 child	34.4	14.1
2 children	15.9	19.3
3 children	11.4	18.1
4 children	11.9	11.7
More than 4 children	26.4	36.8

Number of institutionalized children

About 41% of the mothers have at least one institutionalized child (including the child in this case study). Of these, 65.9% have one institutionalized child, 19.1% have two institutionalized children, 8.8% have three institutionalized children, and 6.2% have more than three children in institutions.

Table 74

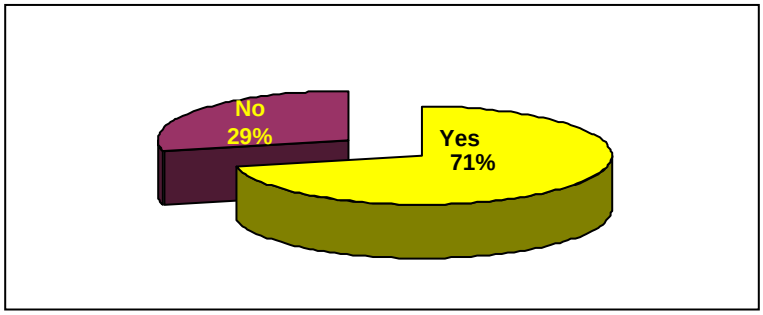
Number of children in institutions	% n=149
1 child	65.9%
2 children	19.1%
3 children	8.8%
More than 3 children	6.2%

Circumstances in which children abandoned in maternity wards and pediatric hospitals/ wards were born

The mothers who were identified were asked to answers certain questions pertaining to the history of the pregnancy and birth of the child temporarily or permanently abandoned.

When asked whether they had wanted the children they abandoned, only 29% of these stated that they had not wanted the child.

Figure 19: **Did you want this child?**



This figure, which may or may not be realistic, is very high for Romania, in conditions in which the causes have been insufficiently researched, it was observed (also in other studies) that very few mothers admit they did not want their child or had an unwanted pregnancy.

Of those that stated they did not want the pregnancy, only 7% claimed to have used some contraception (pills, condom, calendar method, etc.), while 93% of the mothers did not use any form of contraception to prevent an unwanted pregnancy.

The mothers claimed they realized they were pregnant based on the signs and symptoms presented in the following table (***Table 75***). More than 50% of them were familiar with the most important sign of a pregnancy, namely the absence of menstruation.

> *"These mothers are not familiar with the signs of pregnancy, and the pregnancy becomes a certainty for them only when the child begins to move."*
>
> Obstetrical – Gynecologists Physician

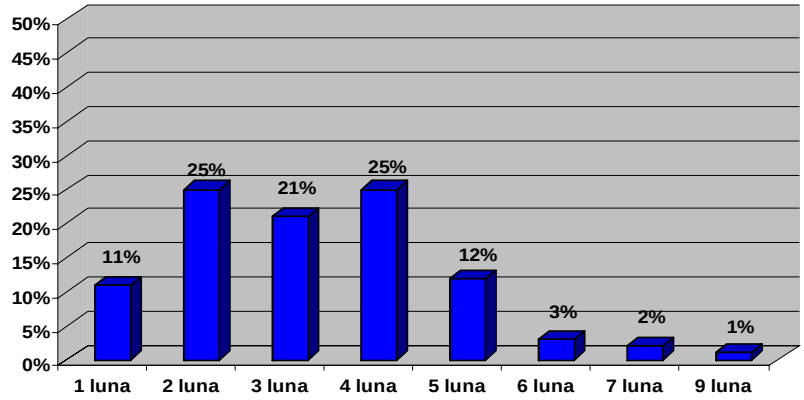
Table 75

	% (n=343)
I missed my period	54.5
My breasts hurt	3.3
I was nauseous/vomited	18.9
I was sleepy	2.5
I had an unusual appetite	0.5
My stomach expanded/I put on weight	13.4
I felt it moving/that I was going to give birth	6.9

Some 57% of the mothers realized they were pregnant up by and in the third month, while 43% became aware only as of the fourth month. One percent of the mothers stated they were unaware of being pregnant until the moment they gave birth. *"I found myself in labor and had no idea I was pregnant."*

> *"These mothers go to see a doctor only if they are in pain or feel unwell. They do not register as pregnant women. They have no idea about the symptoms of a pregnancy and consequently realize that something is happening to them only in the fourth or fifth month."*
>
> Obstetrical – Gynecologists Physician

Figure 20: **In what month did you realize you were pregnant? (n=350)**



At the time they learned they were pregnant, over 70% of the women were involved in a relationship, either marriage or a consensual union.

Table 76

What kind of relationship did you have with the child's father when you realized you were pregnant?	(n=350) %
Mere acquaintances	11.4
Friends	15.1
Fiancées	0.6
Common-law marriage	55.8
Marriage	16.2
Other	0.9

Over 80% of the fathers learned of the pregnancy at the same time as the mother (**Table 77**). Their reaction was most often one of rejection, refusal or denial of such a situation, with greater or lesser violence (**Table 78**).

Table 77

When did you tell him you were pregnant?	(n=350) %
As soon as I found out	83.6
When the pregnancy became visible	11.9
After the birth of the child	2.7
Towards the end of the pregnancy	1.8

Table 78

What was his immediate reaction?	(n=327) %
He was happy	59.6
He was indifferent	18.9
He denied it was his child	7.3
He recommended an abortion	7.3
He physically/verbally abused me	3.9
He threatened to leave me	2.1
He was angry	0.9

As a result, over 30% of the mothers were left by their partners (Table 79).

"*Women with unwanted pregnancies do not communicate with their partners, but rather themselves take on all the consequences of this situation. Their partners distance themselves from the problem and fail to provide any support for making the right choice in the child's best interest. This is one reason why the partners often deny they are the children's fathers. "*

Obstetrical – Gynecologists Physician

Child abandonment occurs when his parents do not participate equally in the "ritual of the child's intra-uterine development and delivery." In ordinary couples, responsibility for the mother's pregnancy is accepted by both partners, and the father "participates" in the child's intra-uterine development and the joy of his birth."

Director DJDPC

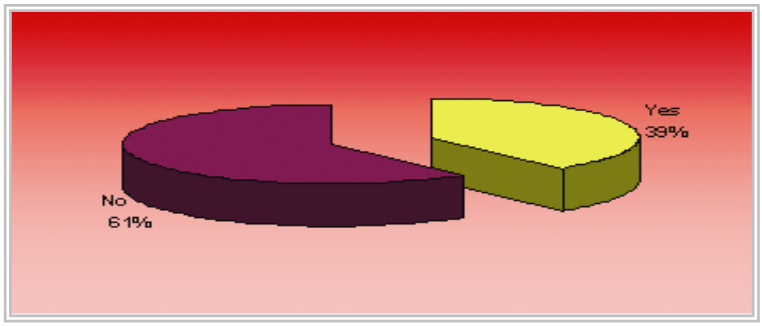
Table 79

How did the relationship develop during your pregnancy?	(n=337) %
We stayed together	69.7
We stayed together on the condition that I abandon the child	1.6
He left me/kicked me out	27
Other	1.7

Pre-natal medical examination.

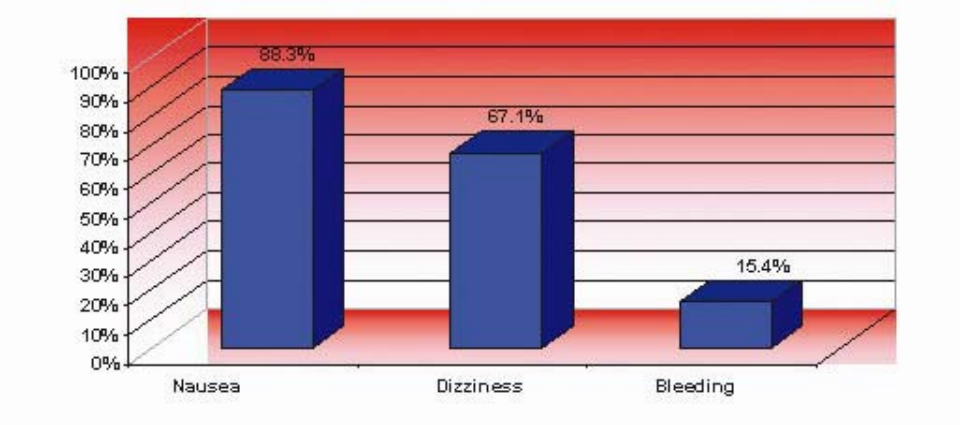
Over 60% of the mothers never had any pre-natal medical examination.

Figure 21: **Did you have any pre-natal medical examination? (n=349)**



Most mothers did not feel very well during their pregnancy.

Figure 22 **During the pregnancy period I experienced: (n=155)**



6.2. Specific features regarding only mothers who abandoned their children in maternity wards

Most of the mothers in this category were hospitalized on the very day they gave birth or even a few minutes before delivery (***Table 80***). Over one third were not accompanied by anyone at the time they were admitted to hospital (***Table 81***).

Table 80

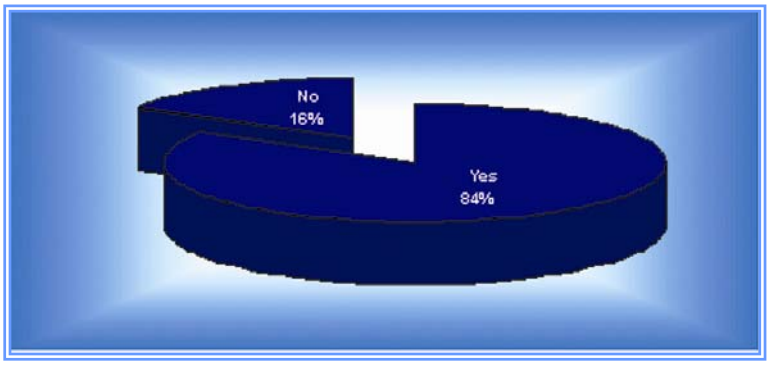
When were you admitted to hospital, in relation to the time of delivery?	% (n=201)
2-3 days before	26.3
On the same day	55.8
A few hours/minutes before I gave birth	17.9

Table 81

Who accompanied you?	% (n=201)
The child's father	29.7
My mother	15.8
Relatives	10.3
Friends	2.6
Acquaintances	4.5
Nobody	37.1

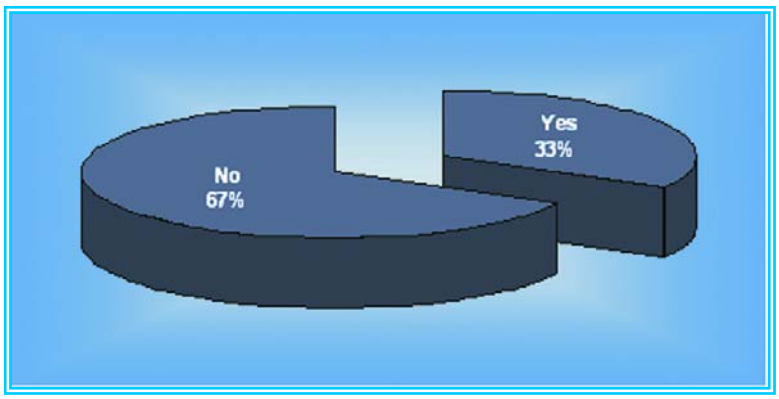
Some 16% of the mothers provided no identity documents when admitted to hospital.

Figure 23: **Did you provide your identity documents? (n=201)**



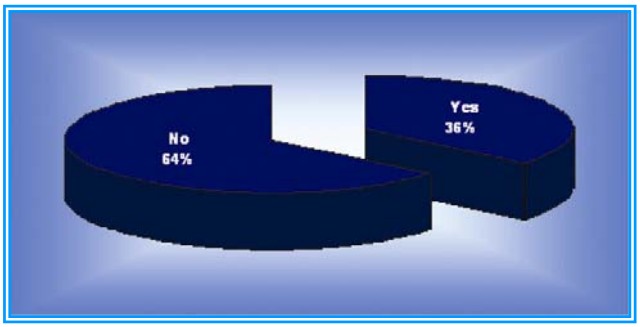
All the mothers arrived at the maternity ward with the thought of abandoning their child temporarily or permanently. However, 33% of the mothers stated that the child's birth led to a change in their decision to give up the child.

Figure 24: **Did the child's birth change your decision to temporarily or permanently give up**



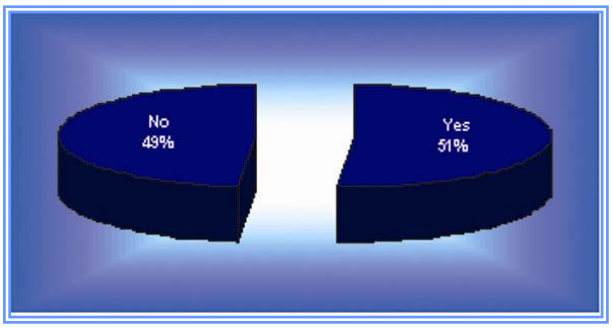
Some 36% of the mothers stated that they shared the same room with their baby after delivery.

Figure 25: **After birth, did you share the room with the baby? (n=201)**



Almost half of the mothers never breastfed their child.

Figure 26: **Did you ever breastfeed the child? (n=201)**



According to their declaration, more than a third of the mothers left the maternity ward within the first two days of the birth, over 20% left after 3-4 days, and the rest after five days.

Table 82

How long after the birth did you leave the hospital?	(n=197) %
1-2 days	34.9
3-4 days	21.3
on the 5th day	13.7
after 5 days	10.0
Do not recall	20.1

The reasons invoked by mothers for abandoning their children provide some indication of their despair when faced with a situation for which they consider there is no solution, and in connection with which they feel they received no support from those around them.

What were the main reasons which determined you to abandon your child?

- They would not take me in at home with the child.
- I had nowhere to go with the child.
- I did not want to abandon him, but rather just leave him for a short while.
- I did not have suitable living conditions.
- I don't know.
- My depression caused by the child's condition.
- I had no money to pay for the hospitalization.
- Large family. Financial difficulties.
- Lack of identity documents.
- I was discharged from hospital.
- I had other small children at home, and there was no one to care for them.
- I did not plan to abandon him permanently, just for a while, because I had no money, and my boyfriend did not care about the child.
- I did not know where I would get the money to raise my child, my husband does not help me at all, we always fight.
- I am single, my boyfriend left me, I am too young, I have no way of supporting the child.
- When my father learned about the child, even he refused to take me in with the child, as did my brother.
- I did not want him because I am single, my parents were against my having a baby, I have no job, I cannot handle having a baby.
- Lack of living conditions
- The health condition of the child in the family.

Most mothers claim they did not appeal for child protection services because they were not aware of their existence.

Why did you run away from the maternity ward and not appeal for child protection services

- I did not know who to appeal to.
- I did not know of the existence of protection institutions.
- I thought I would come back.
- I did not know what to do.
- I was frightened.
- I did not think about this.
- I did not want to abandon him for good, only for 2-3 months.
- I did not run away. I went home to talk to my husband about what we should do with the child.
- I left without the children because they were too young.

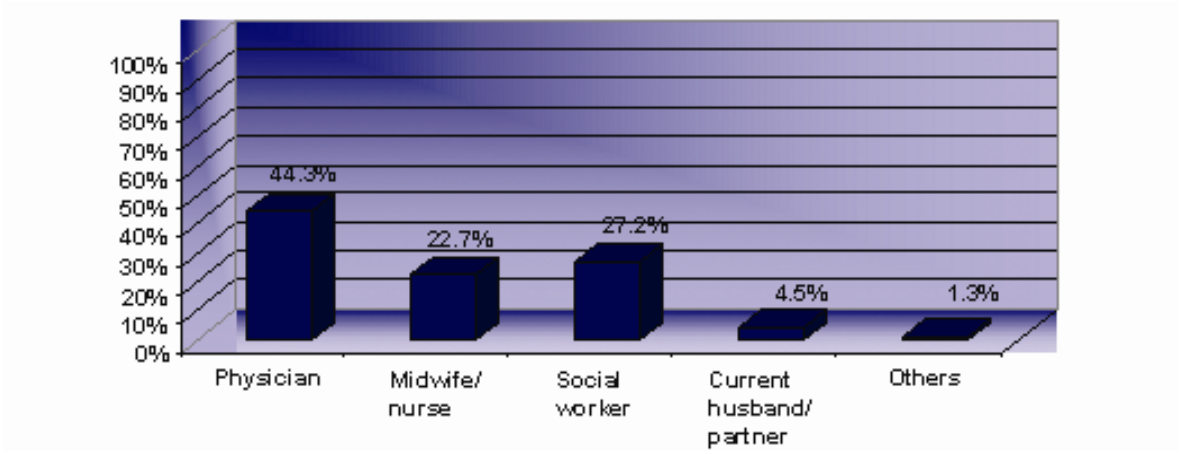
"These mothers have no information on the services they can call upon in the case of an unwanted pregnancy.
The abandonment of the children immediately after birth or in pediatric hospitals is also due to the fact that mothers are unfamiliar with procedures by which their children can benefit from services provided by the Child Protection Department. They firmly believe that the only and safest solution is to abandon the children in medical institutions."

Director DJPDC

-

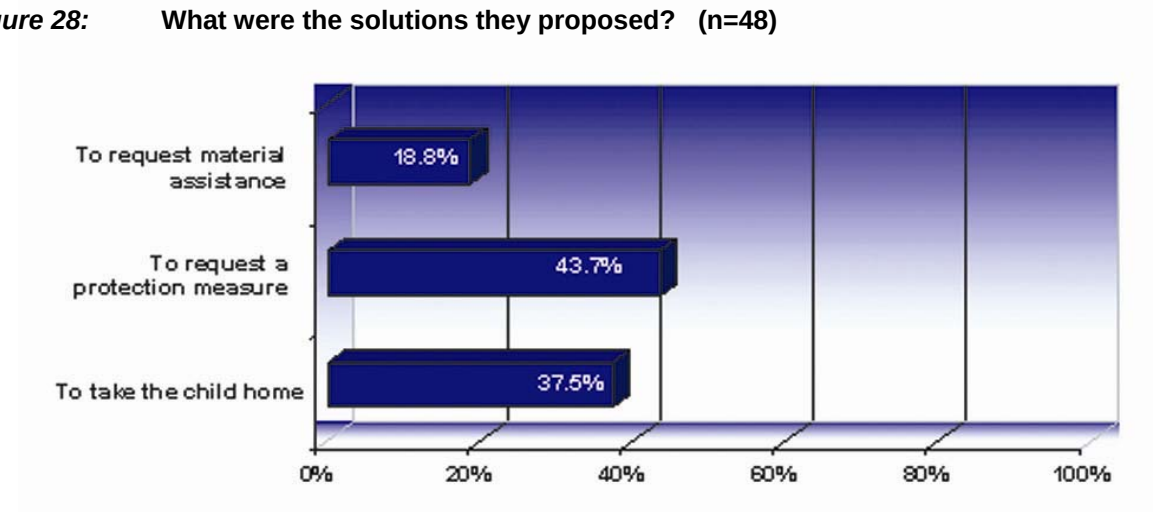
Nevertheless, 82% of the mothers claim they discussed their decision to abandon the child with someone, mostly members of the medical staff in maternity wards, and sometimes a social worker.

Figure 27: **Whom did you talk to? (n=88)**



The mothers claimed that only half of these people proposed a solution to *prevent* the abandonment of the child. The solutions proposed are presented in the figure below.

Figure 28: **What were the solutions they proposed? (n=48)**



An equal number of mothers claim there were people in the maternity wards who supported the idea of their abandoning their children (***Figure 29***).

Many physicians come to work as they did in the time of Communism, they do their work and leave. They do not get involved in the children's social problems."

"Disinterest of the medical staff; they do not know about the ways of solving such cases, and treat mothers at risk of abandoning their children with contempt."

Physicians, County Hospital

"I doubt that the medical staff contributes much to the mother's decision to abandon her child. This decision is "reasoned" by the mother before she is admitted to hospital. The cases in which mothers are labelled are isolated.

The language used by medical staff is sometimes too straightforward, and at other times too technical. I feel the medical staff should insist more on the fostering of a relationship between the mother and the newborn, a bond between mother and child, the involvement of the mother in the direct care of the newborn child."

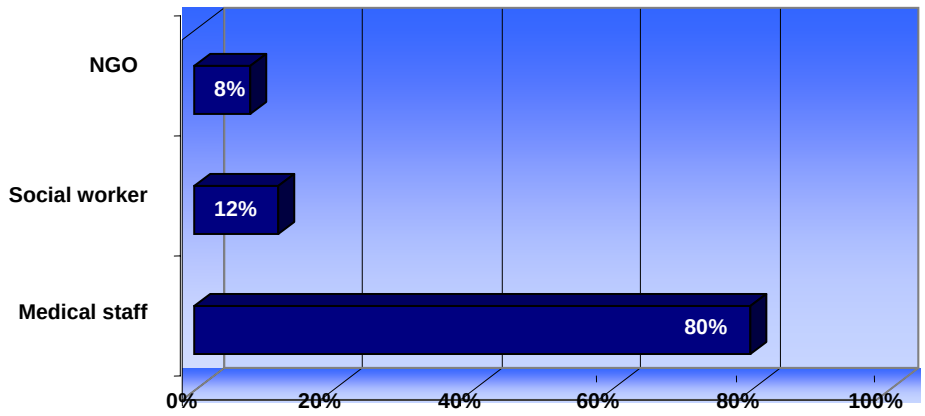
Interview with a physician – Obstetric & Gynecological Clinic and Maternity

As concerns the persons whom mothers indicated as having encouraged them in their decision for abandonment, 80% were medical staff, and 12% were social workers.

"Some mothers recount their life story, their difficulties, the fact that they have no husband, that they live in a common-law marriage that they have no job that they do not know what to do with their newborn baby. They seem to expect confirmation from those listening to them that their departure from the maternity ward without the child is rightful, justified. Such mothers are the easiest to work with, as they listen to advice and often renounce the temptation to run away."

Medical Assistant

Figure 29: **Who encouraged you in your decision to abandon the child? (n=48)**



Declaring the child

Failure to declare the children is one of the major causes for their prolonged stay in medical institutions. Some 89% of mothers claim they declared their child at birth. This information is questionable because the child was (most likely) declared once the authorities contacted the mother (***Figure 30***).

"Mothers with no identity documents are at risk of abandoning their child. "Patients with no identity documents make a statement about their identity at admission to the maternity ward, but such statements may include false information." Some of these women run away from hospital immediately after the birth.

In some maternity wards, mothers may be discharged with their baby even if their identity documents are expired, or after making a statement. In other maternity wards, the children of mothers without identity documents stay in hospital until the situation of the mother's documents is clarified and the child is declared.

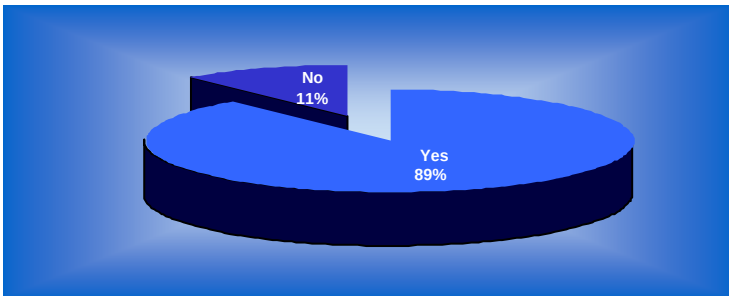
Even the bureaucracy involved in obtaining the mother's identity documents and implicitly in declaring the child, constitutes a risk factor for the abandonment of the child in the maternity ward."

Obstretical - Gynecologist Physician

"The procedures for the placement of children without identity documents with families or in institutions are lengthy and bureaucratic."

Physician, Pediatric Hospital

Figure 30: **Was the child declared? (n=188)**

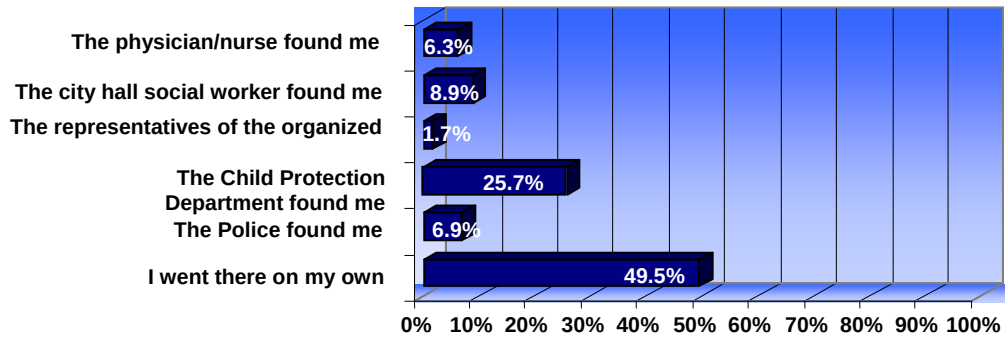


Mothers were asked to identify the way in which they were contacted by the authorities to decide what decision should be made about the child and the issuing of identity documents.

Although half the mothers claimed they came of their own volition, the social workers indicated that they came on their own after being summoned by various institutions (***Figure 31***).

Once the mother has run away from the maternity ward, obviously without declaring her child, the authorities of the medical and social protection institutions and community-level institutions attempt to locate her.

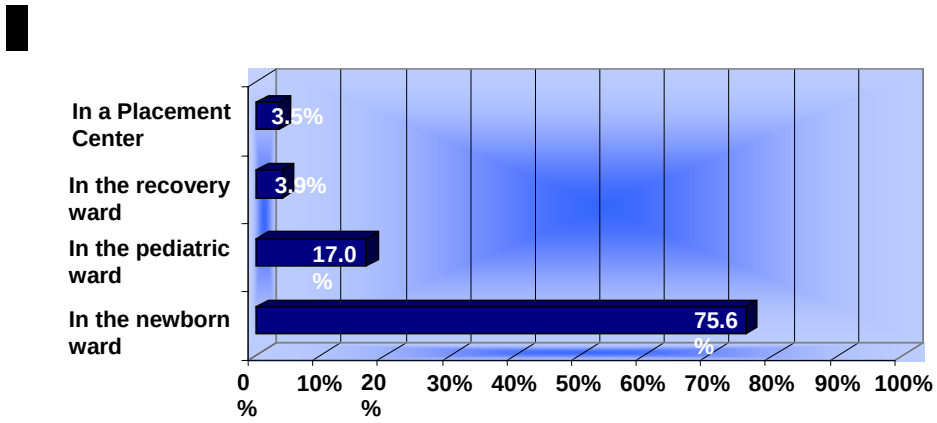
Figure 31: **How did the authorities contact you in order to decide the child's situation and issue his/her identity documents? n=201**



The above figure illustrates the non-involvement of these authorities and institutions in finding the mothers. Almost 50% of the mothers claimed they presented themselves voluntarily, but Child Protection Department social workers often contradicted this statement.

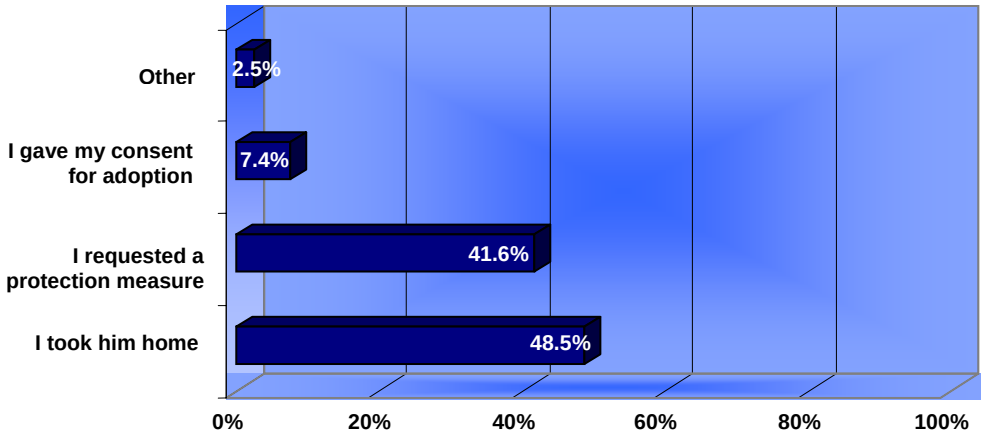
At the time the authorities contacted the mothers, some 75% of children were still in maternity wards (***Figure 32***). Over 20% had been transferred to pediatric and recovery wards, and in 3.5% of the cases a protection measure had been instituted for the children.

Figure 32: **Where was the child when the authorities contacted you? (n=201)**



After being located, almost 50% of the mothers took their children home or the child was taken home to them; 41.6% of the mothers requested a child protection measure and 7.4% gave their consent for adoption.

Figure 33: **What was your decision concerning the child's fate? (n=201)**



Mothers who took their children home felt greater support than those who temporarily or permanently gave up their child.

Kindly justify the decision concerning the child:

1. Decision to take him home to his family:

- I love him.

- I changed my mind and wanted to take him home.

- He is my child, I must raise him.

- I regret having considered the possibility of abandoning him, he also is my child.

- If I can feed 5 mouths, I can handle another two more. These are my children too.

- He is mine, I didn't have the heart to ruin the child's future.

- My mother would not let me abandon the child.

- When they brought him home to me and I took him in my arms for the first time, in spite of the problems I could not give him up.

2. Decision to give up the child, either temporarily or permanently:

- I could not get used to the Maternal Center.

- I want him to have better conditions in which to grow up.

- I couldn't raise him, I didn't have the financial means.

- He is a sick child.

- No money.

- I do not have the means to raise him, no money, my parents are separated.

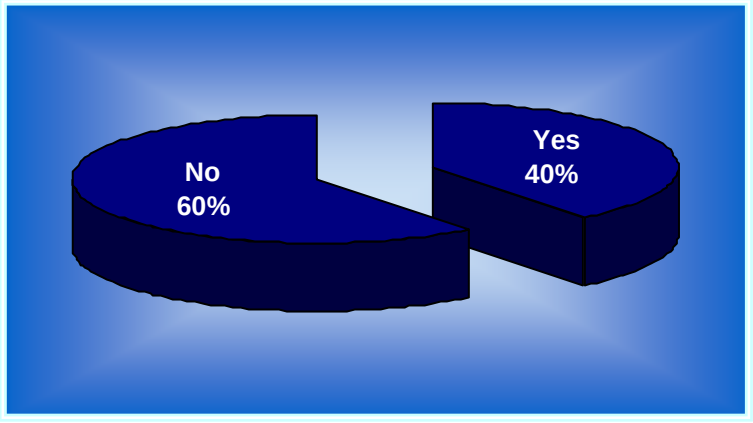
- I had nowhere to go with the child, my parents would not take me in with a child.

Interviews with mothers

The investigative teams were surprised to learn that a mere 46% of the mothers stated they knew what protection measure was taken for their child.

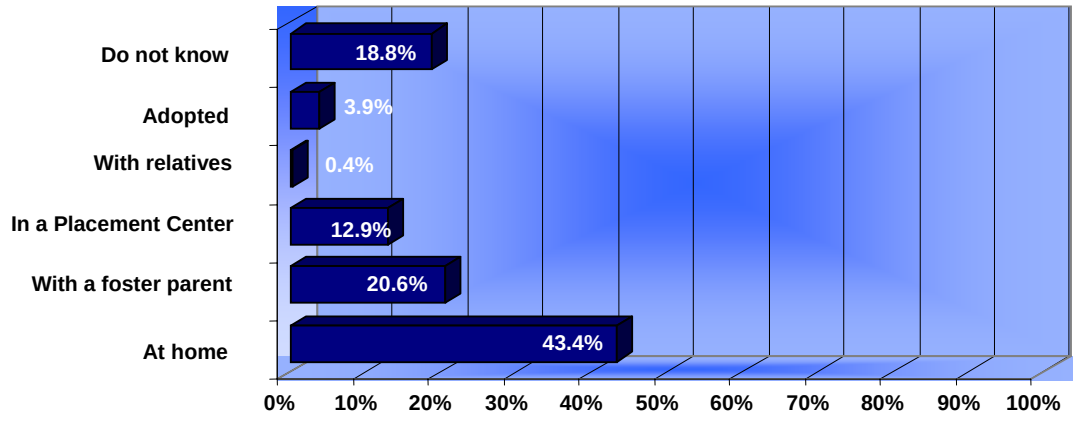
Furthermore, according to the statements of the mothers, only 40% of the fathers were aware of what kind of protection measure was taken for the child.

Figure 34: **Is the child's father aware of the protection measure undertaken for the child? (n=129)**



At the time of the interview less than half the children abandoned in maternity wards were with their biological families, for over one third of various protection measures had been taken. Here again the high number of mothers (18.8%) who do not know where their children are is startling.

Figure 35: **Where is the child? (n=129)**



It is to be underlined again the fact that the information presented in this figure is not representative for the entire group of children who were abandoned in maternity wards. This is because mothers interviewed constitute only 20% of the total number of mothers, selected not scientifically, but rather on the ability of investigators to locate these mothers. For this reason they are the most stable and easy to identify, quite uncharacteristic for the rest of the group of mothers.

Mothers giving up their children, in all the surveyed counties, were special cases. They would always find mothers who "wanted their children back", who claimed they had not given their consent for adoption. Further investigation of such cases revealed that these mothers had in fact given their consent for adoption, but the civil servants had not sufficiently explained to them what they were signing and what are the legal ramifications of their signature.

Mothers who requested a permanent or temporary adoption measure were asked what their thoughts were concerning the child's future. They were equally accepting of taking the child back home to the family and keeping him in the child protection system (this data is not presented).

The types of answers are presented in the box below.

What are your thoughts concerning the child's future?

- I want him to have a family.
- It is better for him to be raised in a secure family.
- I want to raise my child.
- We will visit him and if we can we will take him home in future.
- I want him to have a good family that will raise him well.
- If our financial situation improves, we will take him home.
- I will keep him.

- I want to take him home.
- I will try to take him home at some point.
- I want them to raise him until he turns 18.
- I don't know.
- I want the child to be placed in a center or receive some form of protection measure for his own good.
- I want to raise, care for and educate the child so that he does not grow up to be irresponsible.
- I would like to know him, to see him occasionally, I am sorry I gave up the child.
- I would like to raise them, to care for them, they are all mine.
- I would like him to have a father.
- I would like him to stay in the family and be raised here by us.
- I want him to be adopted.
- I want him to be healthy, to have a good future.

6.3. Particular aspects regarding only single mothers who have abandoned their children in maternity wards

A sub-category of mothers who abandoned their children in maternity wards is made up of single mothers who had not previously been in a couple relationship.

These mothers are at greatest risk of abandoning their children.

Some 93% of these mothers met their partners in places of entertainment, or by chance in public places, such as the street or on public transportation. They began having sexual relations shortly after their meeting. These relationships were usually very short-lived, resulting in their early break-up. Only 44% of these girls discussed pregnancy with their mothers, and the latter usually entirely rejected these pregnancies. A very small number of girls had discussed their pregnancy and the future child with their fathers.

"Many mothers receive no support from their parents or their older siblings to overcome the difficult situation they find themselves in. They are rejected, and are threatened that they will be kicked out of the house."

Family Physician

Only 14% of them requested support from the child protection services, especially in order to give up the child.

"Child abandonment right after birth is also due to the fact that mothers are unaware of procedures by which their children can benefit from the services provided by the Child Protection Department. They are convinced that the only and safest option is abandoning their children in medical institutions."

DPC Director

Some 30,5% of mothers claim they wanted to raise their child. 10,8% planned to request a temporary protection measure, while 58,7% wanted to give up the child right after birth and put him up for adoption.

Tabel 83

What did you think to do with the child after birth ?	%
To raise him	30.5%
To ask for a temporary protection measure	10.8%
To abandon/give him up for adoption	58.7%

The mothers justify their decision to abandon the child citing a lack of solutions and support from those around them.

- Nobody wanted him at home.
- It was cold in the shack in which we live and we could not raise him there; he was well taken care of in hospital; the doctor told me there was no need for me to stay with the child.
- I have no financial means to raise him.
- My mother told me she would not allow me back home with the child, I am in school, I have no income, I have no support.
- My parents would not accept him.
- I have no place to raise him.
- I had no place to go with the child from the maternity ward. That is why I went to the house of a friend to give birth and left the child there.
- I had no place to go to or any money to pay the rent.
- Even though I had not wanted him, it broke my heart to think I had no place to take him, I was frightened.

CASE STUDY

My name is SM and I was born in 1986. There are 4 people in my family: two parents, myself, and a brother three years younger, who is a High School student in the same locality. My mother works in a textile factory. She makes about 3 million Lei. My father is a qualified worker, but lately, since I have grown up, he has not had a steady job. He does not contribute to our care.

My parents are separated but not divorced. The separation took place when I was sixteen and a half; my father was away from home for long periods of time. Because we had no money when I was in the 9th grade, I spent one year in a Placement Center, a former boarding school. They provide free housing and meals. I have pleasant memories of the Placement Center, and I would go home every weekend.

I supported my mother's decision to separate from my father because he was violent, drank, did not work, did not earn any money. This made our living conditions very tense, especially for us, the children. Shortly before he left, my father had begun beating me and my younger brother as well. When I was little, I loved my father very much and I think this was why my mother postponed her separation from him. My father disappointed me very much, because he is a weak person, who was unable to give up drinking, in spite of realizing that alcohol brought him nothing but trouble. When I was about sixteen I began taking my mother's side, and even encouraged her to make the decision to separate from my father.

I was raised by both parents, but my mother was the primary caregiver. I lived with my mother and brother until about 2 months ago. I moved away and I am now living alone in an apartment that belongs to an acquaintance. I have no obligation to cover the maintenance expenses of this apartment, but committed to take care of the apartment so that thieves are not tempted to break in. I have no legal documents to justify my current residence.

I have very good relations with my mother, she has always supported me in difficult times. She gave me good advice, even though I never took it. She is understanding, good, and forgiving. I loved my father more, but now I want to forget him.

My maternal grandparents were no longer alive when I was born. I know my paternal grandmother, but she never loved me, never hugged me, never said nice things to me, she was a mean woman, and very distant to me.

I have no news of my father for about 2 months,. He does not know that I have given birth to a child.

I started my sex life when I was 16 with my boyfriend, someone my family knew, and who was 13 years older than me. I would often go visit him. I got along well with my boyfriend's family, made up of two children and the mother, I felt accepted and protected by them.

I am from the countryside, from a village close to the city of B. I am an 11th grade student at a very good High School; when I graduate I will have a secure and beautiful profession. I am single and I have a 7-month-old boy. I gave birth to him in the local maternity ward before I was 18. The child was born at 7 months, weighing 2,000 grams, and has a disability, a split in his upper lip, a malformation known as a "cleft lip".

I felt very well throughout the whole pregnancy, had no morning sickness, and only felt sleepy. I didn't eat very well during the pregnancy. I ate a lot of apples because I knew this was good for me. I did not speak to anyone about being pregnant. I hid the pregnancy by wearing baggy clothing so that it would not be visible. I realized I was pregnant from the very first month, because I had very regular periods, but I was hoping it was a false alarm, and postponed the decision until the child began moving. Afterwards, I started having feelings for the child and became attached to him. I tried to make contact with the child's father by phone but he never answered. I suspected he was not answering because he was expecting such news. I felt abandoned and alone, but knew there would be some salvation for me.

I went to school until the very last moment, because I did not want to drop out of High School. During the pregnancy I never went to see a doctor, I did not have any blood tests. My mother found out about the pregnancy two days before the child was born. She was the one who helped me get to the maternity ward. She was very understanding and reminded me that she had gone through the same thing with her first child, who unfortunately died at six months. It is an old story I knew from the family, but especially from my father's family when there were fights and misunderstandings.

Soon after the child was born, my teachers, classmates and many others found out about it. This was the second most difficult moment for me, because some of the teachers were very hostile and suggested I drop out of school because I was not a good example for the other girl students. I felt that some of the other teachers, especially the younger ones, were sympathetic to me.

My classmates supported me, both the girls and the boys. I remember the time when I was called up before the School Board to explain my behaviour. I "pleaded" to be allowed to continue my education, in spite of having given birth to a child by mistake and because I was naïve. The school accepted my situation, partly because of the support I had received from the Child Protection Department. I can say that I was fortunate. I remember my classmates asking me to take them to see the child. They helped me think more seriously about the child's future.

The child's father did not acknowledge him. He has only my name. I arrived at the maternity ward by ambulance with only my mother, who helped me most when I was upset and desperate. Upon admission to the maternity ward, although this was very hard for me, I did not hide the fact that the boy was conceived as a result of a short-term relationship, and that he would have only my name.

I had my identity documents with me when I came to the maternity ward, and a nurse filled in the admission chart. When she enquired about my husband, the child's father, she gave a condescending look, as if to say "what a stupid girl, with nothing better to do at her age than to have a baby."

I did not know what to do and was very confused after the child was born. What was I to do about him, about school, about my future. I stayed in the maternity ward with the child after the delivery for about 10 days; a single nurse suggested that it would be better for me not to see the child anymore, and to leave him there so that I could start my life over again. That same nurse explained that not seeing the child would help me not get attached to him, as this was not good for him. I breastfed the baby, in spite of some problems because I did not know how to do this. My mother and brother visited me during my stay in the maternity ward.

One month after I had the baby I met the child's father and told him everything. He seemed to be happy and told me he would acknowledge the baby. But this did not happen, he never called me again, and never kept his promise. I accepted this situation, thought about it for a while, and then set my priorities. At that time, school was the most important thing for me, so I decided to suspend my medical leave and return to High School to pass my exams and avoid having to repeat the grade. I talked to the nurse and the social worker from the Child Protection Department about all these things. I did not want to abandon my child, and left the maternity ward in "justified" circumstances to solve some problems related to school and the child's identity.

Before leaving the maternity ward I made a written request in the presence of the social worker to the Child Protection Department for my child to be put in a placement center. The child was transferred from the maternity ward to the placement center about one and a half months after I declared him and I obtained his birth certificate; this all happened while I was busy with my education.

I know what a placement center is, because I stayed in one for a year when my father left us and my mother could not afford to keep us in school. I heard that children with no financial support can also be cared for by foster parents. I did not want my child to end up in a family because I was afraid he would get attached to the respective family, and then there would be no way to get back to my initial decision. I know I can visit my child anytime at the Placement Center, according to my school schedule. The Placement Center can also arrange for an operation for my child to help him get rid of the flaw with which he was born.

Although the child was never acknowledged by his father, he is a child that was made with love. Unfortunately, this love was only mine and his father considered this relationship as just a bit of fun.

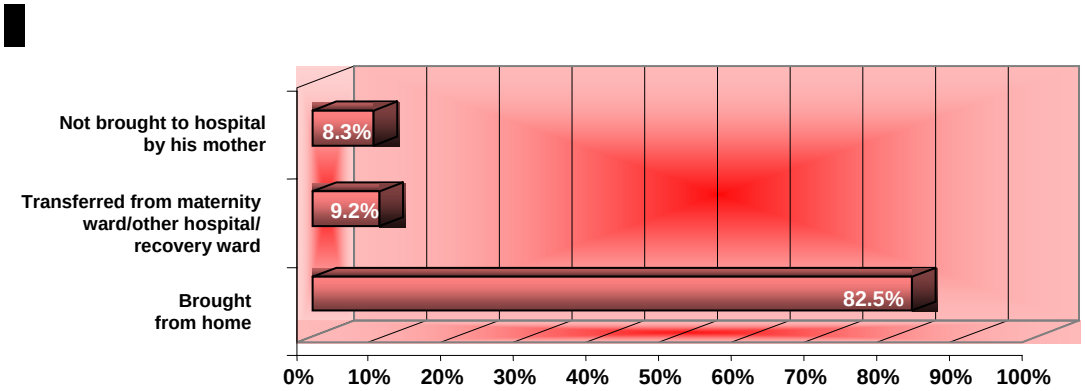
The news that I have an illegitimate child spread quickly in my village. When people asked about this, I denied it. I do not know how to fix this lie, but will think about it.

In future I want justice to be done to me, I will file a paternity suit, even though I know it will cost me a lot of money and energy, and will try to raise my child on my own.

6.4. Aspects related only to the mothers who abandoned their children in pediatric/ recovery wards.

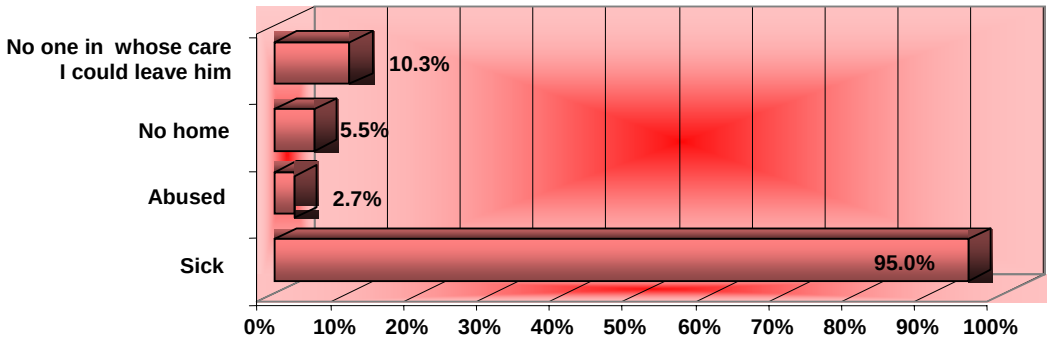
Mothers who abandoned their children in pediatric/recovery wards were questioned about the circumstances in which they abandoned their children. More than 80% of the children came from home to be admitted in medical institutions.

Figure 36: **Where did the child come from at the time of hospital admission? (n=149)**



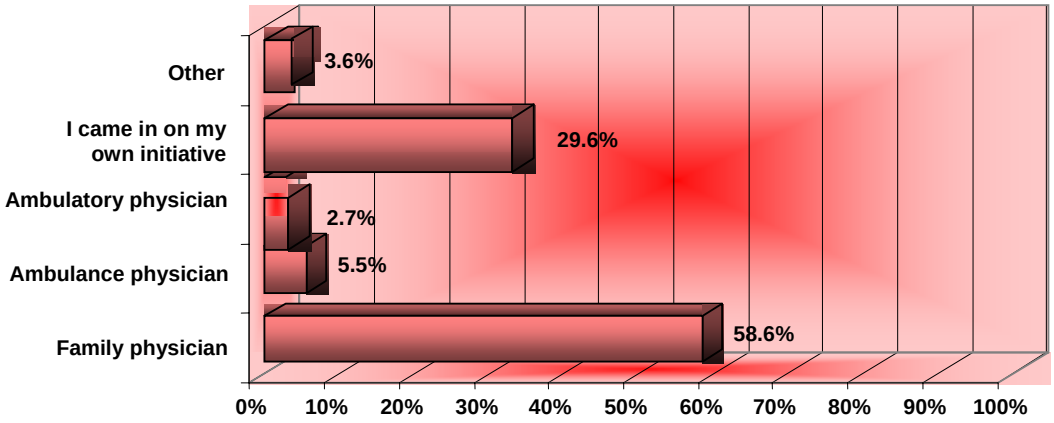
Some 95% of mothers claimed they brought the children in because they were sick. Almost 20% of them also indicated social reasons for the child's hospitalizing.

Figure 37: **What was the situation of the child at the time of hospitalization? (n=145)**



Some 70% of mothers had a written recommendation from a physician for the hospitalization of the child.

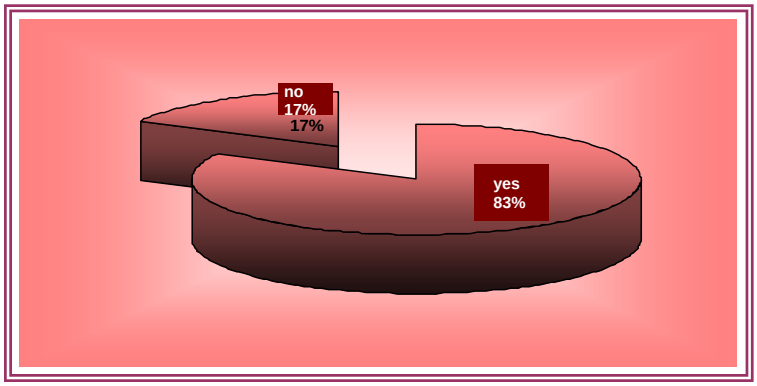
Figure 38: **Who recommended the child's hospitalization? (n=145)**



Some 17 % of the hospitalized children did not have a birth certificate (***Figure 39***).

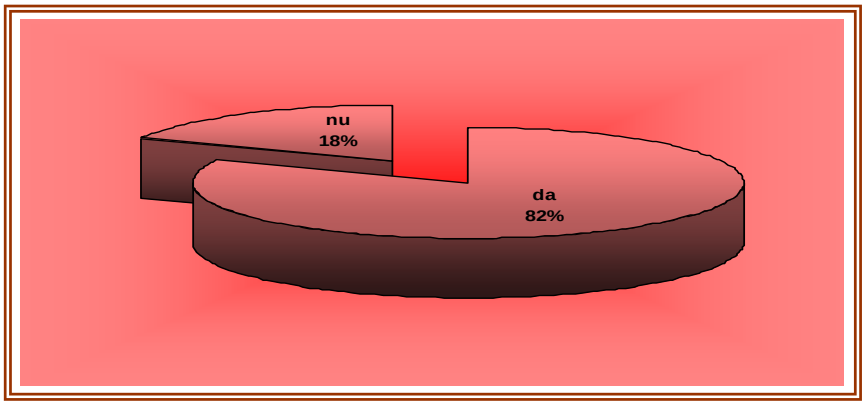
18% of the mothers did not provide an identity document at the time of hospitalization (***Figure 40***).

Figure 39: **Did the child have a birth certificate? (n=145)**



13% of the mothers no longer lived at the address recorded in their documents (the information is not presented).

Figure 40: **Did you provide an identity document at the time your child was hospitalized? (n=137)**



These mothers were also requested to justify their decision to abandon the child in the hospital.

The reasons given lead one to believe that these mothers are mainly from the category of women who have their own family, are raising several children, and are tempted to rely on the hospital for the child's social protection in difficult situations.

The types of answers to this question are presented in the box below.

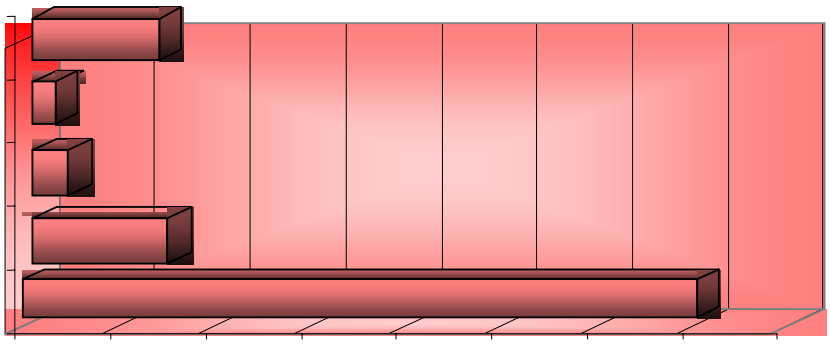
Please justify your decision for abandoning the child in the hospital/pediatric ward.

- I was 8 months pregnant.
- I had to go back to the other children.
- My family would not allow me to stay, I had other problems.
- I had another three children to care for.
- There was no one I could leave the other children with.
- I did not have suitable housing to keep him at home.
- I was depressed.
- It was winter and I did not have suitable conditions, I was pregnant again.

As in the case of the mothers from the maternity wards, the authorities of the medical, social welfare and community institution authorities attempt to locate the mothers in order to find protection solutions for the children. The mothers were asked about the whereabouts of the children at the time they were contacted by these authorities. The authorities had taken a protection measure for a small number of these children, but most of them were still in pediatric/recovery wards (***Figure 41***).

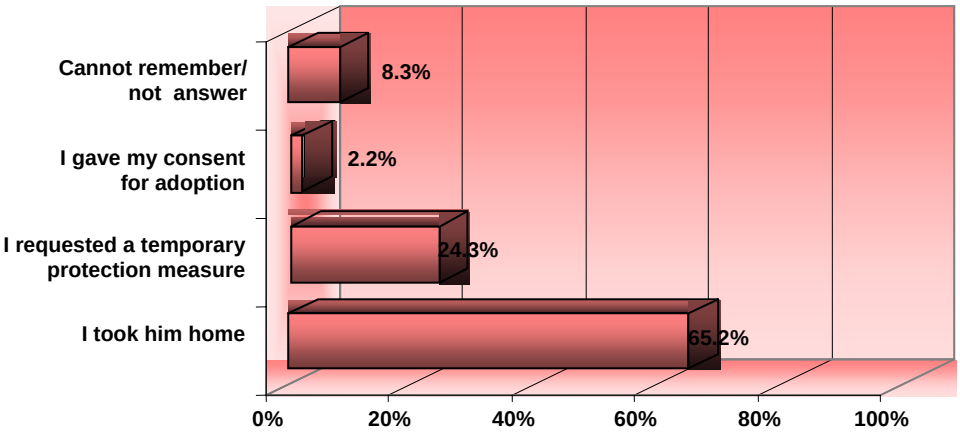
There was impossible to find out from the mothers how long the child had stayed in hospital, with no medical justification, because very few mothers remembered such information, and denied having left the child there with the intention of abandoning him.

Figure 41 ***:*** **Where was the child? (n=149)**



However, some 50% of the mothers requested that a protection measure be taken for the child, after the Child Protection Department contacted them (***Figure 42***). As the open questions revealed, there were cases in which the child was brought to the mother's home without prior notification of the Child Protection Department.

Figure 42 ***:*** **What was your decision regarding the child? (n=129)**



The mothers were again requested to justify their decision concerning the child. The statements of the mothers reflects the ambiguity of their decisions concerning the responsibility of raising a child and of placing him in an improvised protection situation, namely the pediatric ward.

Please justify your decision:

I took him home

- I want to raise him.
- I wanted to keep him.
- The hospital social worker brought him back to me.
- Because I wanted to.
- My mother wanted me to bring him home.

- I did not intend to abandon him and took him back quickly from the Dystrophic Ward.
- The hospital staff brought her to my mother and she brought her to me.
- I left him there temporarily, I did not intend to abandon him, but I had some problems and nobody helped me.

I requested a temporary protection measure

- It is better for the child.
- The lack of income.

I gave my consent for adoption

- It's in her best interest to go to a family.

The mothers whose children benefited from a protection measure were asked if they knew what type of measure was taken. Some 56% of mothers and 68% of fathers did not know what child protection measure had been taken.

Figure 43: **Do you know what protection measure was taken for the child? (n=64)**

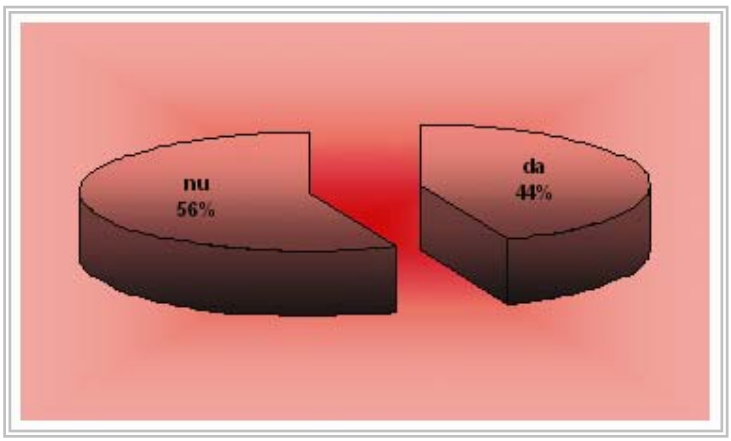
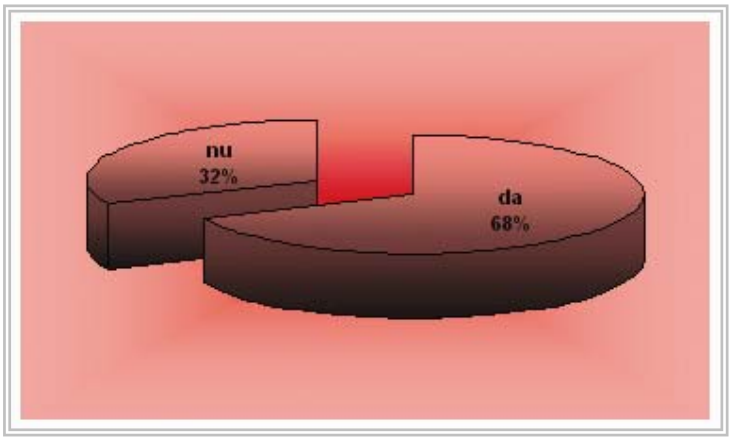


Figure 44: **Does the child's father know the type of protection measure that was taken for this child? (n=74)**



6.5. Family planning – the aspects below refer to all categories of mothers

The use of family planning methods constitute the most efficient way of preventing unwanted pregnancies. The aspects targeted during the interviews referred to the knowledge and usage of contraceptives. More than 50% of mothers know of at least one modern contraceptive method and 25% know of at least one additional/natural method. The most widely known methods are pills, the condom and the IUD. Their usage, however, is extremely limited. The most used methods were the withdrawal method and the condom (***Table 84***).

There is a difference between knowledge about and use of contraceptives. Qualitative studies show that this is justified with arguments that denote insufficient knowledge or lack of trust in such methods.

> *"There is a constant battle against rumors that birth control methods are harmful. There is great resistance to contraceptives because many women are more open to listening to advice given by their neighbour than by a physician."*
>
> Family Physician

Table 84

Methods	% Have heard about	% Have used
Withdrawal method	25.9	16.0
Calendar method	19.1	9.0
Injectable contraceptives	30.8	9.0
Vasectomy	2.0	----
Tubal occlusion	20.5	2.0
Diaphragm	3.7	----
Condom	41.6	14.9
IUD	40.2	5.0
Pills	54.1	12.0

The women were also asked how they knew about each method used.

The sources of information indicated for the pill, the IUD, the diaphragm, and tubal occlusion was **the physician and the nurse,** for the calendar method and the condom they indicated knowing from acquaintances, and about the withdrawal method they indicated their partner.

Contraceptives are less well known by Roma women than by Romanian ones, with the exception of injectable contraceptives.

> *"We have responsibilities regarding the prevention of abandonment. These are included in the national health care programme which provides family planning and birth control services to socio-economically disadvantaged categories of the population, whose educational level is low, and who have child abandonment antecedents. "*
>
> Medical Unit Director

> *"Another cause for child abandonment is the level of education of mothers. This is evident from the lack of know-how for using contraceptives and planned births. They come from a culture in which it is believed that men are supposed to know everything about sex, and have the experience to protect the woman."*
>
> Physician

Table 85

Have you heard of:	% Romanian (n=144)	% Roma (n=199)
Pills	59	50.7
IUD	46.5	35.1
Condoms	50	34.1
Diaphragm	5.5	2.5
Tubal occlusion	20.1	20
Vasectomy	2.1	2.1
Injectable contraceptives	27.7	32.6
Calendar method	26.3	14.1
Withdrawal method	29.1	23.1

In terms of usage, it was noticed that in the case of both ethnic group women in the sample, observing the limits presented at the beginning of this chapter, the traditional methods are by far the most widely used. As concerns modern methods, the Romanian women are making use most often of the condom and injectables, while the Roma use condoms and tubal occlusion.

Table 86

Have you used:	% Romanian (n=144)	% Roma (n=199)
Pills	25.5	9.5
IUD	10.2	14.1
Condoms	39.1	24.2
Diaphragm	----	----
Tubal occlusion	6.8	15.3
Vasectomy	30.7	9.5
Injectable contraceptives	38.4	53.3
Calendar method	61.9	60.8

"The Roma have great reluctance; they know little about basic; they refuse any contact; most of them reject contraceptives. Those who do accept these have had some education. They are very poor. Their attitude towards family and family life is different."

Professionists DJPDC

Induced abortion

The use of induced abortion is the most common method of birth control among educated mothers, whose socio-economic status is high, and who are aged 25-29 (***Tables 87 - 89***).

"Contraceptive measures are presented in school, and are a subject as commonly debated as teeth brushing. Unfortunately, this very information on contraceptives does not reach the most vulnerable segment of the population that has not had any form of schooling.

This segment of the population still resorts to septic abortions, although it is now possible to request an abortion, in conditions of maximum medical security. The ignorance of this category of people is profound, and cross-generational. These mothers do nothing for their own health, do not allocate even the smallest amount of money from the family budget to purchase any type of birth control or to pay for a legal abortion. They ask for advice from people who are as ignorant as they are."

Obstetrical Gynecologist Physician

Table 87

Schooling level	No abortion	1 abortion	2 abortions	3 abortions	4 abortions	More than 4 abortions
No education	31.6%	2.8%	3.1%	1.1%	1.1%	2.3%
Did not finish primary school	17.4%	4%	2.3%	0.9%	0.9%	1.7%
Finished primary school	10.8%	0.9%	0.6%	0.6%	0.6%	----
Grades 9-10	7.4%	1.4%	0.3%	----	0.3%	0.3%
Vocational school	3.4%	0.4%	0.3%	----	----	0.3%
High School	1.7%	----	0.3%	----	----	----
Post-secondary non-tertiary education	0.6%	----	----	----	----	----
Higher education	0.6%	----	----	----	----	----

Table 88

Socio-economic status	No abortion	1 abortion	2 abortions	3 abortions	4 abortions	More than 4 abortions
Very low	57.5%	7.1%	6.3%	2.0%	2.6%	2.8%
Low	11.1%	2.6%	0.6%	0.3%	0.3%	1.4%
Medium	2.6%	----	----	0.3%	----	0.3
High	2.3%	----	----	----	----	----

Table 89

Mother's age						
	No abortion	**1 abortion**	**2 abortions**	**3 abortions**	**4 abortions**	**More than 4 abortions**
Under 20	23.1%	3.4%	0.8%	-----	0.2%	----
20-24	15.9%	1.4%	1.1%	0.8%	----	0.5%
25-29	13.9%	2.8%	1.9%	1.1%	1.4%	1.9%
30-34	9.9%	0.5%	1.4%	0.5%	0.2%	0.2%
35-40	4.2%	1.4%	0.8%	----	0.5%	0.5%
Over 40	1.4%	----	0.2%	----	----	0.2%

CASE STUDY

"I don't know much about abandoned children. I only know what I have seen on TV. I believe abandoned children are those who are killed by their mothers or left in the garbage dump or out in the fields. They are children whom nobody wants, especially their mothers."

My name is TF, I am 28 years old and was born in a commune located in county A. I have been married since I was 16 to a boy whom I met in my village. We have a common-law marriage. The marriage was concluded based on an understanding between our families, as is the tradition among our people. We get along very well. We do not drink alcohol, as this is the root of all evil. We did not have a legal marriage because this costs money. I asked around and it would have cost me some two million (lei). You need money for the blood tests and other documents which are necessary to be legally married. For us, this is no longer important.

At the beginning of our marriage, we stayed at the home of my in-laws, then at my parents' house, because we had no place of our own. After about three years of marriage, we managed to build a very small one-room house, made of cement bricks. We have no sewerage system, raise no livestock, have no land except for a small vegetable garden.

I do not know how to read or write, I have never been to school. That is why I do not even understand the world I live in.

I gave birth to five children, all of whom were claimed by their father, but only four have survived. I delivered my first four children at home, where I was helped by a neighbor who knows something about mid-wifery. The fifth child, whom we are talking about, was born in the maternity ward. The first person I talked to about being pregnant was my sister-in-law, and later my husband. When I told him I was pregnant, he was not happy, and he advised me to "get rid of it" if it was not too late. But, unfortunately, I was over four months pregnant.

I was registered with a family physician, I had all the blood tests he prescribed. The family physician told me that, if I were on his list, I could use the ambulance service when my labour started. He did not tell me I would be unable to take my child out of hospital without a birth certificate, or else I might have done something about our identity documents in time. I am now 8 months pregnant. Of the children I have given birth to only one died. A little girl died, when she was three and a half years old, because she caught a cold, had convulsions, and they could not save her. She died in a hospital in Bucharest, where we went to have her cared for by the best doctors. I don't remember the name of the hospital.

The fifth child, my youngest, is 10 months old. I gave birth to him in the maternity ward located in the municipality of P.; he weighed 2,700 grams at birth. I was assisted at birth by a physician, whose name I can still remember.

After telling me the baby's weight and gender, they took him to the newborn ward. I saw him again about 24 hours later, when I was allowed to breastfeed him. When I was hospitalized I did not provide any identity documents because I did not have them on me. My husband and I had lost our identity documents during one of our many trips to Bucharest.

Five days after delivery, when I would normally have left the maternity ward with my child, I was told that it was compulsory, prior to the baby's discharge, to provide his birth certificate. My husband tried to obtain this but failed. That is when I decided to leave the maternity ward without the baby, in order to resolve the situation. I did not run away as other mothers do, instead I notified one of the nurses. I promised I would come back as soon as possible to get my child. I left the maternity ward with my husband. When I arrived home I immediately started the process of obtaining new identity documents, but this was complicated and it took a lot of time. In the mean time, my father passed away, and I had to take care of his funeral.

Shortly afterwards, about one and a half months after having left the maternity ward, the social worker from the Child Protection Department showed up at my door. He told me that if I did not discharge the baby from the newborn ward he would be sent to a Placement Center. After I solved the birth certificate problem, I took my child home. The child was in the newborn ward for about 3 months. As a matter of fact, this was better for him because it was winter and I did not have suitable conditions at home to raise him. I had no intention of leaving him for good. I took him from the maternity ward after the harsh winter passed. When I took my baby from the maternity ward, I was accompanied by my husband. We left by public transportation, by bus.

The child is now at home, he has a birth certificate, and my husband and I, and some sisters-in-law take turns caring for him. We live on the money we earn from day work in the households of various people. We help them to cut their hedges and wood for winter, cleaned yards, and various other agricultural seasonal work. We do not earn much but can manage. We also have the children's allowances. Recently, we filed a petition with City Hall to obtain social welfare. For me, the most important problem is the house. It is too small for so many children. We do not have much hope of building another room, as prices are very high. Come to think of it, I am living quite a hard life, harder than that of my parents, even though they had eleven children.

My mother used to have a job, as did my father. We are much poorer than my parents. When I was a child I had a better life. Now it is worse.

Family is very important to me. My husband and I support each other, and I also receive some help from a sister-in-law with whom we share the same yard.

I was raised by both parents, but especially by my mother. My grandparents also took care of me when my parents were at work. In our family, no children were placed in the care of institutions.

My mother taught me to listen to and respect my husband, love my children and be kind to them. I care very much for my children. The oldest one is enrolled in school because I can see how important school is today. I can not help him with his homework, so he has already had to repeat one grade.

I was taken to the maternity ward by my husband, by ambulance. Before leaving home, I took my slippers, my nightgown and everything else I would need.

My husband finished primary school, but he finds it difficult to read. He used to work at the Park Administration in our city, then the company was restructured, so he was left without a job, and subsequently received a support allowance. At present he only has occasional jobs.

I am now expecting another baby. I became pregnant very quickly because I did not breastfeed my child. The only thing I know is that, while you breastfeed, you do not get pregnant. My husband never uses any protection, he says it is my duty to know how to avoid getting pregnant.

I would love to stop having children, but do not know how. I spoke to the doctor in the maternity ward, but he told me to come talk to him about this problem when I was discharged from the maternity ward. I put this off every time, and then it was too late. I also know that I can have an abortion on request, on the condition that the baby has not yet moved.

6.6. Overview of the activities conducted by the County Departments for Child Rights Protection in 2003 and 2004

Because it is believed that child abandonment is also a sign of the inefficient operation of child protection services, the sources of inquiries and requests (noted *requests*) in our working charts were recorded, as well as the percentage of such sources at the level of each DJPDC included in the study.

The maternity ward comes in first place in both 2003 and 2004, which means that the establishment of the protection measure was preceded by periods of child neglect at an age when every day of neglect counts. A positive change was noticeable, in the sense that the percentage of requests filed by the parents in 2004 doubled over that in 2003, while the requests filed by medical institutions or other public institutions decreased rather significantly.

Table 90

Requests filed by:	2003 %	2004 %
Parents	11	23
4th degree relatives	5	9
Police	3	3
Maternity ward	34	28
Pediatric/recovery ward	25	22
Public institutions	13	7
Authorized private bodies	2	4
Private persons	7	4

With regard to the type of protection measures taken, there is evident a slight improvement in 2004, in the sense that the number of definitive measures was double.

Table 91

Type of protection measure	2003 %	2004 %
Emergency placement	38	39
Foster parent	9	9
Placement center	15	13
Placement with persons/families/up to 4th degree relatives	27	23
Entrustment in view of adoption	7	8
Domestic adoption	4	8

Number of requests recorded in 2003: 2,508

Number of requests between 1 January 2003 and 31 March 2003: 747

Number of requests recorded in 2004: 1,873

Number of requests between 1 January 2003 and 31 March 2003: 867

Number of reported children for whom a protection measure has been established and who subsequently were not visited for at least 6 consecutive months: in 2003: 128; in 2004: 129

CHAPTER 7

CONCLUSIONS

1. Characteristics of the phenomenon

Current situation

This study shows that under-five child abandonment continues to be a harsh reality for Romania, which has been insufficiently influenced by the reforms implemented since 1989 in the area of child protection.

The coordinates of child abandonment in 2003 and 2004 were the same as those 10, 20 or 30 years ago. Many reforms put in place since 1990, followed by the creation of numerous child protection institutional structures and services, evolved alongside the phenomenon of child abandonment, as long as maternity wards and pediatric hospitals continued to serve as "choice hosts" for such children.

As concerns the scope of this phenomenon during the 2003 and 2004 reference years of the study, it was noted that some 4,000 newborns were abandoned (in each of these years) in maternity wards. To this must be added the over 5,000 children abandoned (annually) in pediatric hospitals/wards.

The scope of the phenomenon was determined according to the rate of abandment (number of children abandoned per 100 births/admissions).

The rate of abandonment in maternity wards stood at 1,8% in both 2003 and 2004.

In pediatric hospitals and wards the rate of abandonment constitutes the number of children abandoned per 100 admissions, 1.5% in 2003 and 1.4% (2.1%) in 2004. Based on the method used to calculate the rate of abandonment in pediatric hospitals and wards this rate is in fact an under-estimate because the number of children abandoned relates to the number of admissions and not to the number of persons admitted.

Evolution of the phenomenon

Concerning the evolution in time of this phenomenon, direct and precise comparisons cannot be made because cases of abandonment were not previously recorded.

Comparing the rates with data contained in publications, mentioned in the Introduction, a slight rise in the phenomenon is noticeable.

Comparing the situation in 2003 and 2004 with that at the end of 1989, one can see no less than a doubling of abandonment cases in maternity wards. Such a statement is based on the following data: some 10,954 children under the age of three were in Romanian "nurseries" in 1989 (Source: Ministry of Health). As the number of under-three children leaving such institutions was insignificant, it can be estimated that some 3,651 children children abandoned in maternity and pediatric wards were admitted to "nurseries" annually. According to the data of certain studies, 83% of these came directly from maternity wards (namely 2,623 children). If related this figure to the number of births in 1989, 36,954, a 0.7% abandonment rate will be obtained.

However, the figure of 10,954 children does not adequately reflect the number of children abandoned in maternity wards in 1989, because many abandoned children remained and grew up in maternity wards, or were moved to pediatric or dystrophic wards. In 1989, dystrophic wards could accommodate 3,500 children. As such, the rate of abandonment in maternity wards could have been higher than 0.7% at that time. On the basis of these estimates the rate could have been as high as 1%. These supplementary explanations complicate the estimates, but reconfirm the growth of the phenomenon.

These conclusions will tempt comments and comparisons. Therefore, the fact that almost half of the children abandoned in maternity wards in 2003 and 2004 were there for short periods of time (5-10 days), because they were taken from there directly home to their parents without the Child Protection Services being notified, can mean that this category of children was unjustifiably eliminated from this category of abandoned children.

The analysis of the routes of all abandoned children shows that a mere 6.5% of those abandoned in maternity wards and taken straight to their parents ended, in fact, at home (therefore, these do not reenter the circuit which assumes there is a break with the mother/parents).

2. Characteristics of children abandoned in maternity wards, hospitals and emergency reception centers

a. Health and Rank

The most significant indicator differentiating abandoned children, in terms of health, is birthweight. The ratio of abandoned children born with low birthweight was four times higher than that among the general population (34% as compared to 8.5%). Delayed intrauterine growth is caused by the mother's rejection of the child, her precarious living conditions, the existence of risky behaviour, and not least, lack of knowledge about how to use pre-natal services.

These findings involve numerous implications and consequences. As concerns the child, the recovery of this delayed growth will be hampered by the absence of the mother and the prolonged stay in a medical institution.

The existence of disabilities in 9% of the abandoned children constitutes an even greater risk for these to end up on a long route before stable and permanent protection solutions are found.

As in the case of children in maternity wards, over 50% of these are rank 1 and 2.

b. Identity, sex and leaving condition

A significant number of abandoned children have no identity. The data generated by this study indicates that the ratio of such children is 64% at the time of release from maternity wards, 30% from pediatric hospitals and less than 10% from emergency child protection services.

Many maternity wards have a practice of "deliverying" abandoned children to their mothers (who ran away from these wards) without notifying the Child Protection Services and prior to their having had identity documents issued to them. This practice, that goes against the regulations in force, runs counter to the most elementary measures to protect children from serious negligence and abuse of any kind, without anyone being able to be held responsible (without a birth certificate you do not exist!).

There is a slight 2% over-representation of boys over girls.

There is an almost equal proportion of children from the two environments, urban and rural.

c. Conditions of stay in maternity wards and pediatric hospitals

As concerns several aspects relating to the organization and operation of maternity wards that might encourage the respecting of child's rights, it was noted that most maternity and newborn wards are set up according to the traditional system (without mother/child rooming-in areas) which in fact supports the separation of the mother from her child. Furthermore, more than half of the institutions are not complying with the consecutive regulations stipulated in the Joint Ordinance of the Ministry of Health and the National Authority for Child Protection and Adoption in 2003 on hiring a social worker, notifying/enrolling a newborn on the list of a family physician, and immediate, written notification of specialized public services. Contrary to regulations stipulated by legal provisions, a mere 20% of the pediatric units have hired social workers, only in 10% of the cases a notification of the Department for Child Protection was recorded on the children's charts, while 13% also contained the decision/provision of the DPC.

Concerning the organization and operation of pediatric hospitals and wards, it was noted that such units are more likely to allow the admission of mothers with under-five years old children than that the latter be visited (37.1% of the pediatric hospitals/wards never allow parents to visit their children).

In connection with the length of stay of abandoned children in maternity wards, as compared to the initial years of the tradition of abandonment, they now stay here much less time. The experience of this study has shown that the length of stay in maternity wards is not necessarily relevant to the respecting of the rights of the child and its developmental needs. What is equally important is where the child goes.

In 2003 and 2004 some 30% and 35% of the children, respectively, spent less than 10 days in maternity wards, while a third and fourth in those same years stayed for more than one month in such wards. Those children who spend less than 10 days in maternity wards are usually those who are taken directly to the mother's home (some 40%), and only in a few cases are the local protection services notified. Most of the children will become part of the protection system following an intermediate stay in pediatric medical institutions.

About one third of the abandoned children are transferred to pediatric medical institutions, while the remainder become immediate part of the protection system. Some 65% of the children abandoned in pediatric wards are under the age of two. The tendency to abandon children after that age drops as the age increases.

From an analysis of the circumstances of children being hospitalized it was noted that pediatric wards are also used as social protection institutions. The hospitalization of most children was justified medically or socially, although this can also take place without a medical diagnosis, and some 10% of abandoned children fall into this category.

To ensure the "protection" of abandoned children, recovery wards were reinstated to host such children, especially those without identity documents. Children can live "peacefully" in such places for months or years without their certain psychological breakdown alarming the social protection services.

In some places, these wards, with tens or hundreds of beds, have replaced or are those very same "nurseries" that were abolished recently.

Examining the observation charts, investigators noted the lack of information on children in these files, something that can be attributed to the lack of illnesses that would have justified observations by physicians caring for sick children. Even so, it is difficult to make a connection between the information in many observation charts and the children whose charts these are.

There is an inadmissably large number of observation charts containing no indication of where the children went after being released from hospital, as there was very little information to be able to identify the family or the child's place of residence. This situation is further aggravated by the fact that some 30% of the children without birth certificates, and as such "non-persons," can be subject to any treatment without anyone being notified.

Furthermore, there are no standard country-wide observation charts for pediatric wards. Sometimes the use of charts not specifically designed for children facilitates the omission of vital information needed to follow up on the child, because such information is not requested in the fields of the forms.

d. Conditions for placement in emergency reception services

Contrary to the notion itself, the measure for emergency placement was created for those children abandoned in health institutions for long periods of time, once the steps to establish their identity have been finalized. There were less than 10% of children lacking identity documents in such institutions, and this is all the more significant as many children are brought here from the street.

Regulations governing the emergency placement measure are not respected. Some two thirds of children are kept in this situation for periods exceeding the admissible limit (30 days). Most children remain in emergency placement for at least two months but there are also cases exceeding one year.

With the exception of emergency reception services that operate through a foster parent, these have more recently been organized within the framework of placement centers. It is likely that such "neighborliness" fosters such children being "forgotten" in this situation.

The fact that these laws are not respected gravely affects the chance and right of the child to benefit from a permanent and stable protection measure.

3. Route of the abandoned child

All children identified in maternity wards, pediatric and recovery hospitals and wards, and in emergency reception services were followed up in the documentation of the county protection services. It was an intention to learn about the route these children had been on and the type of protection measure they had been offered.

This route is important because it offers information about the quality and adequacy of protection services to meet the child's developmental needs. The route reconstitutes the places the child has passed through during the time he has been without his mother and the temporary or permanent protection solutions he has benefitted from until this day. It is to be mentioned that files and information were found for a mere 694 of 1,935 children.

48 types of routes for the children were identified in the study sample.

Two thirds of the children abandoned in maternity wards pass through pediatric/recovery wards at least once before some form of protection measure is taken.

Only one third of all children abandoned in 2003 and the first three months of 2004 had benefitted from a permanent protection solution (with their biological family or adopted), which shows that children are kept for long periods of time in various temporary forms of protection.

Very few children, about 6.5%, enjoy the "ideal" route, namely that from maternity ward to family. Eight of the routes have 3 stops without arriving at a permanent form of protection, another 8 routes have 4 stops before ending in a final protection solution, and one has 5 stops without a permanent protection form.

An analysis of routes brought to light the fact that the pediatric hospital/ward is the most convenient social service substitute accessible to both parents who want to abandon their child

"temporarily" or "permanently" and, paradoxically, to social child protection services which use the pediatric hospital to host the child in difficulty while searching for and identifying a protection measure.

The study of the type of mortality table (Kaplan – Meier) of the length of route shows that:

- children starting their route in a maternity ward, as compared to those starting elsewhere, have better chances of ending up in a permanent protection measure;
- children whose parents have given their consent for adoption end up more often in a permanent form of protection, but only after at least one year of other temporary protection measures;
- the shorter the stop in the health institution, the shorter the interval for reaching a permanent protection measure (natural or adoptive family).

4. Characteristics of the mothers

Compared to the number of children who were identified as being abandoned, the number of mothers who were tracked in order to be interviewed represents less than 20% and, for this reason, the level of their representation is questionable.

An analysis of the characteristics of this sample indicates that such mothers are subject to high social risk, marked by lack of education, extreme poverty, and reduced social support.

As such, 42.2% are illiterate and 27% have not completed Junior High School; some 80% of mothers have a very low socio-economic level; 85% live off uncertain income; 28% are under 20 years of age at birth of the child.

Concerning ethnical origin, the data must be carefully analyzed, taking into account the specifications made above. Thus, in the sample of the survey there is an over-representation of Roma women, both in terms of abandonment in maternity wards and (especially) in pediatric hospitals (51% and 66%, respectively).

In some economically developed counties, mothers of abandoned children are almost exclusively Roma. In poorer counties abandoned children belong to other ethnic groups too. Such cases are much more evident among those abandoned in pediatric hopsitals. Such findings indicate that it is not ethnicity itself but rather the socio-economic characteristics of the mothers that predisposes them to abandonment. There are greater and lesser pronounced differences between mothers who abandon their children in these two types of medical institutions.

Concerning the marital status it was found that the ratio of single mothers is double in the case of those abandoning their children in maternity hospitals compared to those doing so in pediatric hospitals.

Mothers abandoning their children in maternity wards are somewhat more educated and less poor than those who resort to abandonment in pediatric hospitals.

However, the rejection of the child is much more severe among mothers who abandon their children in maternity wards than those who do so in pediatric hospitals, and the decision to give the children up for adoption is similary more determined.

Most single mothers who abandon their children in maternity wards belong to that sub-category of women who resort to abandonment mostly because they are not married and come from a

culture in which such a situation is, in itself, gravely sanctioned (without there being a need for other obstacles that would not allow the child to be brought up in the family).

Another category of mothers who abandon their children in maternity wards are those who were in a relationship for a while, who were abandoned by their partner either upon finding out they were pregnant or somewhere along the pregnancy, or whose continued relationship was conditioned upon the abandonment of the child.

Both of these categories of mothers, either dependent upon their family or their partner, are unable to assume the responsibilities without community service support.

Mothers who abandoned their children in pediatric hospitals are poorer and less educated than those who abandoned them in maternity wards. They perceive the hospital as a place for the upbringing of their child and not necessarily for the child's abandonment. Often both parents are convinced that the child will be better off in hospital, and that their presence there is less important. Frequently they come to see their child only at the insistence of child protection services.

They do not accept a foster parent as they are afraid a strong bond might come about and also because they might lose various financial resources by accepting measures of protection.

The rejection of the child is much more pronounced in mothers who resort to abandonment in maternity wards and have made a definite decision to give up the child for adoption, compared to those mothers that abandon their children in pediatric hospitals, convinced that the latter are better alternatives for the raising of these children, and that they themselves are dispensable.

More than half of the mothers have heard of at least one modern method of contraception to prevent unwanted pregnancies. The pill, the intra-uterine device (IUD), and injectable methods are the most widely known (in that order). But they are seldom used.

It is gratifying to know that the national family planning promotion programmes, aimed at socially disfavoured groups, have yielded some results. Here the reference is done mostly to the use of condoms (39% by Romanians and 24% by Roma, the figures reflecting the situation within the sample group, with all the limits of representativity presented before in this study), and of injectable methods (30% Romanian women and 9% Roma within the surveyed group).

CHAPTER 8

RECOMMENDATIONS

1. Characterization and monitorization of the phenomenon – indicators

The definition adopted in this study for *abandoned child* was not conditioned upon the duration of abandonment. If the systematic and uniform reporting of cases of abandonment is felt to be necessary and useful then such examples make the acceptance of a uniform term for abandonment essential.

At present there is little possibility to follow up the various evolutions in the central and local-level child protection systems. The statistical indicators used by the National Association for Child Protection and Adoption are insufficiently relevant to follow up progress registered in the respecting of child rights. The least information is recorded about the most serious problems, such as abandonment, in all its aspects, in maternity wards and pediatric hospitals. The fact that such indicators have not been established reflects the level of understanding and importance afforded to this phenomenon.

- **In this context, the systematic and uniform reporting of cases of abandonment is considered necessary, as is the uniform acceptance of the terms of abandonment/abandoned child. The immediate and rigorous application of the new law on the child could lead to the statistical reporting of cases in maternity wards.**

The law stipulates it is mandatory that the medical institution notify (by telephone and in writing) the Child Protection Services within 24 hours of determining that a child has been abandoned, at the risk of heavy sanctions for non-conformity. Once recorded, such events can become part of regular statistical reporting.

The respecting and enforcing of legal regulations is sustained by scientific arguments of theories related to the development of the child, that can be debated and assimilated within the framework of continuing education for the personnel.

- **As such, there is a recommendation for the initiation and development of professional and institutional capacities.**

The files of the children are incomplete and hard to find. There are fewer social inquiries than established protection measures, which raises numerous questions on the manner in which the protection measures are periodically reevaluated.

- **In this context it is considered necessary the elaboration of an operational computerized system for the administration of the social child protection service cases, according to which any child can be found with all information up-to-date.**

The processing of such information will allow for the evaluation of the measures taken, and of challenges and progress relating to the adoption of various legislative measures in the area through the prism of the Convention on Child Rights.

2. Prevention

a. Prevention of low birthweight

Keeping the child born with low birthweight in a medical institution for a prolonged period without his/her mother cannot be in his best interest. It is unlikely that such children can grow normally in medical institutions without the presence of their mothers.

Low birthweight can be the result of premature birth, intra-uterine growth retardation, or both. The incidence of intra-uterine growth retardation in Romania is much greater than that of premature births. Children who have experienced intra-uterine growth retardation are more likely to suffer from permanent growth deficits, making their hospitalization in this respect even less beneficial.

- **As such, it is recommended the initiation and sustaining of a programme for preventing low birthweight, to decrease the risk of early separation of the child from its mother, and implicitly its abandonment.**

Such a programme must be sufficiently comprehensive for the many tangible factors that impact on intra-uterine growth and the duration of gestation: demographic, psychosocial, obstetrical, nutritional and behavioural factors.

b. Identity of the child

One of the reasons given for a healthy child to be kept in a medical institution was the lack of of identity documents.

The Child Protection Services avoided taking any emergency placement measures (in spite of regulations in effect to allow this), arguing that accounting laws did not permit the allocation of resources for a child that “does not exist”.

Therefore, children without identity documents were transferred within the medical system, from one ward to another, until such documents were issued to them.

The new law more clearly provides for the institution of protection measures, even if a child is lacking the constituent elements of its identity, on the basis of a record.

But the admission into the protection system of a child without identity documents requires supplimentary safety measures to prevent its being “lost”.

- **In this sense, it would be beneficial if there were some enforcement of the child’s personal numeric code being communicated to the maternity ward in which he is born, so that this code can be recorded in the child’s observation chart. The observation chart should be filed only after the child’s identity has been established.**

This recommendation is to be insisted on because Law 272/2004 stipulates nothing in this respect, and the measure proposed would be to confirm the established identity. This recommendation is meant for both the child abandoned in the maternity ward and that abandoned in the pediatric hospital/ward.

- **Concerning the child’s identity, strict regulations must be issued for the enforcement of the the filling out of all fields in the observation charts, and in this case, especially those relating to the name, address and identity documents of the parents.**

A uniform computer programme would be useful in this sense, to prevent that one or another field be skipped and not filled out (even with a mention that “this information is not available”).

c. Improvement of maternity ward and pediatric hospital services

The manner in which maternity wards and pediatric hospitals are presently organized offers little opportunity for the development of early attachment between mother and child, an attachment that is necessary for the basic mental health and normal socio-emotional development of the child.

The standard practice, to be found in more than half of the maternity wards, involves the separation of the newborn from his mother immediately after birth, and puts them in contact only according to a strict breastfeeding schedule. This model, associated with significant physical distance between mother and child, and the practice of tightly bundling the child, are well-known elements that promote a break between the mother and child in the risk categories.

- **In this sense, it is recommended the sustained promotion of the rooming-in system, which does not immediately change the decision of the mother to abandon her child, a decision with which she often arrives in the maternity ward before giving birth. In addition to the system, it is also recommended the promotion of new practices and attitudes relating to the mother and child, which encourage permanent contact, breastfeeding, and will help the new twosome find ways to form a bond and support each other.**

Certain "rituals" from the birthing period and immediately afterwards could "activate" some natural, instinctive resource within the mother to help her care for her child. In the study obstetricians themselves recommend early physical and visual contact with the child: looking at and holding the child immediately after his birth, early breastfeeding etc.

In most pediatric hospitals and wards mothers can be admitted with their sick children, an important benefit for preventing the psychological trauma of repeated separation.

Concerning the visits of parents to their hospitalized children, many hospitals restrict or prohibit the admission of parents to such institutions, citing epidemiological rules.

- **As such, it is recommended the initiating and sustaining of contact with the mother and parents, and more flexibility in relation to outdated practices that are today scientifically refuted.**

In the case of abandoned children or those brought to these institutions for social reasons of social protection, it is essential that the staff understand that hospitalization is not beneficial to the child.

- **Therefore, it is recommended the development of new integrated services to help mothers look for other protection solutions, and unlearn the reflex that leads them to believe that the hospital is an emergency shelter for any type of difficulty the child might be experiencing. The acceptance and perpetuation of such situations not only means a breach of the law, but especially an acute lack of understanding of the developmental needs of the child.**

Repeated hospitalization is another way of perpetuating child abandonment. A solution must be found to ensure that the interests of medical staff do not go against those of the child, not the case at present, according to indicators of efficiency in medical institutions.

On the other hand, these practices have been consolidated because of insufficient community social services, virtually non-existent in cities other than county seats or rural areas.

3. Shortening the route

The routes traversed by abandoned children, with few exceptions, include at least one stop in a pediatric hospital/ward. What is of concern is the finding that such stops are decided upon and approved by the Child Protection Services, based on their limited organization and resources, or the incoherent legislation in this area. A Protection Service is not in a position to justify the demand for hospitalization or retention of healthy children in hospital on the grounds that there is no "space" in the system or that the children have no identity documents, as this is a breach of child rights.

Law 272/2004 contains a series of measures by which these limits will be (and are) overcome on the condition that their application does not run counter to the laws in effect or those that will appear in other areas.

- **The institutionalized collaboration between the medical and child protection systems in the area of legislation is recommended and useful to avoid blockages in the application of laws regarding children and their rights. Furthermore, a clear, efficient and transparent methodology for putting laws into effect is necessary both for proper collaboration between institutions and that of institutions and mothers benefitting from services.**

4. Strengthening of primary assistance of community services and increased access to such services for families

Although regulations and laws were issued in the past few years to ensure access to primary health care for marginalized segments of the population, results have been very poor. Provisions making it mandatory for maternity ward health care staff to register any newborn on the list of a family physician are not respected. Many physicians have blamed non-compliance on the many regulations and laws that have been issued over a short period of time, while family physicians justify themselves by invoking the incoherence of the various measures in existence and the stipulations contained in the framework of the contract.

Non-compliance is also possible because there are no provisions for prosecution/sanctions for that. But beyond these shortcomings, disadvantaged families need not only a family physician but also home *education* from community level medical and social professionals, to be able to benefit from already existing community services.

- **Therefore it is recommended the sustaining of community services that can converge their results to support the maintaining of the child in his/her family environment.**

Educational visits to families that meet the needs of such families would be extremely beneficial in preventing all types of social exclusion, including the prevention of child neglect and abandonment.

- **Furthermore, it is recommended the diversification of various services to meet the needs of children, and provide support for mothers and families. Existing crèches (non-existent in rural areas) could develop services for disabled children, to prevent the separation of such children from their families and the justification for separation on the basis of a lack of such services in the community. In rural areas, existing kindergartens (possibly also schools), currently under-utilized due to a drop in natality, could expand their activity by offering services needed to keep children in their families.**

- **And not least, an important means for preventing abandonment lies in the promotion of family planning programmes. Such programmes must reach populations at greatest risk, including those with special health needs: alcoholism, psychological and mental problems, and disabilities.**

About half of the women have heard of (modern) contraceptive measures, but very few make use of them. The population in the study can be characterized primarily by a great lack of education and extreme poverty. The reference points of their way of life are unstable and very unsure. Written messages cannot reach their mark as these women are illiterate.

Their male-dominated culture prevents them from making their own decisions for fear of "reprisals" from the men. To a greater extent, their lives are a succession of disappointments and hopes for the "privilege" of being able to depend on a man, and the fate of the child that appears is decided directly or indirectly by this.

In such a culture, the intercession of planning programmes for preventing pregnancies that might end up in abandonment are/might be very inefficient if they do not take such particularities into account.

To sensitize them after the birth on such means rarely succeeds, because they leave shortly after the birth.

It is believed that specialized public services could have a special role, insufficiently used, in promoting family planning, as these come in periodic contact with most of these mothers. Professionals that are part of these services can inform and offer counselling through means specific to each case.

5. Other recommendations for attentioning those who develop policies and strategies in the area of respecting child rights

- **Ensuring the right to education**

Improve scolastic inclusion and the completion of mandatory education to prevent illiteracy, marginalization and social exclusion.

- **Improve professionals' training**

Include information on child development and the importance of early childhood in socio-human education programmes.

Analysis and "capitalization" of Romania's negative experience to promote another model for approaching and understanding the child, from the perspective of his rights.

- **Raise the competence of the professionals involved in the various decision-making stages, to shorten the route of abandoned children, to arrive at stable and permanent protection solutions.**

Law 272/2004 on the protection and promotion of child rights sets forth the obligation of local administration authorities to guarantee and promote the rights of the child.

In the spirit of this law, it is recommended training for the following:

- **Staff of local level institutions and services, through whom the importance of early childhood and of necessary conditions for child development can be promoted;**

- **Specialists of Child Protection Commissions, through whom the values of childhood and the value of the child can be transmitted;**
- **For the solidarity of members of the Commission, in the promotion of common values build on the recognition of the rights of the child; making them responsible for the proposals of protection measures; the application of the spirit of the law in particular and specific favour of each child in part, so that the law can be of help to the child in the optimal meeting of his development needs, instead of in-regulations that short-circuit his evolution.**

The following should comply with the law functionally and not just formally:

- **the individual child protection plan, according to which each child is assured of individualized and personalized care, and**
- **the services plan, to ensure that the child is not separated from his family.**

Decision-makers must be capable of drawing up local policies and making sure that there is improvement in the situation of the child, including that of abandoned children. Such policies and strategies must be elaborated in collaboration with all involved from medical institutions, the Department for Child Protection, local councils and City Halls, based on the existing situation, proposing efficient measures and carrying out periodic evaluations.

6. Fighting discrimination

Unfortunately, during the research excercise, various forms of racist and discriminator rethoric directed against Roma minority (either from the part of the social actors or from the part of the staff in the social care or medical services) have been encountered and documented. We deliberately wanted to document these expressions by the actors in the field of social services in order to shed light on the magnitude and manifestation of the phenomena not only among the public but also among the service providers and possibly decision-makers. It is hoped that such exposure will stimulate the adoption of firm measures for the elimination of such racist attitudes and discourses from within the social services sector, as well as to contribute to the promotion of democratic and inclusive attitudes in the Romanian society at large.

In this context it is necessary that:

⇒ programmes for the development of professional capacity include aspects related to fighting discrimination;

⇒ activities within the next anti-discrimination campaigns be aimed at more specialized targets, such as professionals in the medical and social services system;

⇒ programmes for monitoring the rights of the child be started, and they should publicly address any trespassing of these rights;

⇒ interventions related to the social inclusion of minoriries be made more frequent and efficient.

The study has been made possible
thanks to UNICEF Romania technical and financial assistance
with funds kindly provided by the Government of The Netherlands -
Matra Program

Printed in 300 copies