

Women's Reproductive Rights in Romania: A Shadow Report

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WOMEN'S REPRODUCTIVE RIGHTS IN ROMANIA:
A SHADOW REPORT

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Introduction

This report is intended to supplement, or “shadow,” the report of the government of Romania to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW). It has been compiled and written by the Center for Reproductive Law and Policy (CRLP) and the Society for Feminist Analysis (AnA), Bucharest, Romania. As has been expressed by CEDAW members, non-governmental organizations (NGOs) such as CRLP and AnA can play an essential role in providing credible and reliable independent information to CEDAW regarding the legal status and the real-life situation of women and the efforts made by ratifying governments to comply with the provisions of the Convention on the Elimination of All Forms of Discrimination against Women (Women’s Convention). Moreover, if CEDAW’s recommendations can be based firmly in the reality of women’s lives, NGOs can use them to pressure their governments to enact or implement legal and policy changes.

Discrimination against women permeates all societies and takes many forms. This report is focused particularly on reproductive rights and the laws, policies, and realities affecting these rights in Romania. As such, this report seeks to follow up on the December 1996 “Roundtable of Human Rights Treaty Bodies on the Human Rights Approaches to Women’s Health with a Focus on Reproductive and Sexual Health Rights” held in Glen Cove, New York by bringing to the attention of treaty monitoring bodies the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health. As articulated at the 1994 International Conference on Population and Development in Cairo, as well as the 1995 United Nations Fourth World Conference on Women in Beijing, reproductive rights consist of a number of separate human rights that “are already recognized in national laws, international laws, and international human rights documents and other consensus documents,” including the Women’s Convention. We believe that reproductive rights are fundamental to women’s health and equality and that States Parties’ commitment to ensuring them should receive serious attention.

This shadow report links various fundamental reproductive rights issues to the relevant provision(s) of the Women’s Convention. Each issue is divided into two distinct sections. The first, shaded section deals with the laws and policies in Romania relating to the issues and corresponding provisions of the Women’s Convention under discussion. The information in the first section is mainly obtained from the Romania Chapter of *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Central and Eastern Europe* (forthcoming, 2000), one of a series of reports in each region of the world being compiled by CRLP in collaboration with national-level NGOs. AnA collaborated with CRLP on the Romania Chapter of this report. The second section focuses on the implementation and enforcement of those laws and policies — in other words, the reality of women’s lives. AnA has provided nearly all of the information included in this section.

This report was coordinated and edited by Laura Katzive and Mindy Jane Roseman, both Staff Attorneys in CRLP’s International Program; Florentina Bocioc and Doina Dimitriu of AnA; Laura Grunberg, Director of AnA; and Daniela Draghici, a consultant to AnA. The following

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Principal Points of Concern

1. Reproductive Health Care and Family Planning (Articles 12, 14 (2)(b) and (c), and 10 (h) of the Women’s Convention)

There are a number of obstacles to women’s access to comprehensive, quality reproductive health care services. These include the following: the absence of a coherent strategy to promote family planning and to inform and educate the population; a limited supply of contraceptives, particularly in rural areas; insufficient access to new reproductive health technologies; and inadequate training of health personnel in the area of family planning and reproductive health.

Abortion remains the predominant form of fertility control in Romania. While the number of deaths due to unsafe abortion has declined dramatically since legalization of the procedure in 1989, unsafe abortion is still one of the primary causes of maternal death in Romania. Continued recourse to unsafe abortion procedures can be attributed, in part, to a lack of information about methods of family planning, especially for women in rural areas.

2. HIV/AIDS and Sexually Transmissible Infections (Article 12 of the Women’s Convention)

There has been a 50% increase in the number of adult cases of AIDS over the past two years and an increase among adolescents. The most frequent transmission path among adults is heterosexual sex — accounting for 48.8% of the total number of infections.

3. Marriage and Family Relations (Article 16 of the Women’s Convention)

Under Romanian law, the minimum age for first marriage is lower for women than it is for men. While the minimum age of consent for marriage is 18 for a man, it is only 16 for a woman.

In addition, women’s freely given consent to marriage is undermined by a provision of the Criminal Code, known as “reparatory marriages.” Women who are raped may remove their “shame” by “consenting” to marry the rapist. Under such circumstances, the crime of rape is construed as never having occurred. Because the stigma of rape is very strong in rural areas, consent to marry under such circumstances is tantamount to duress.

4. Sexual Violence within Marriage (Articles 5 and 16 of the Women’s Convention)

The Criminal Code does not explicitly prohibit rape within marriage. Legal jurisprudence suggests that the existence of a marriage implies the woman’s consent to sexual intercourse with

her husband. As no case dealing with rape within marriage has come before the court to settle the matter, the criminality of rape within marriage remains a disputed area of law.

5. Trafficking in Women (Article 6 of the Women’s Convention)

Trafficking in women is a serious problem in Romania, and it is thought to be underreported. Romania has been identified as both a “source” and a “transit country” for trafficked women and girls. However, the law in this area is vague and has not directly addressed the problem.

6. Education for Adolescents on Sexuality and Family Planning (Article 10 of the Women’s Convention)

Non-governmental organizations (NGOs) have taken the lead in providing sex education in schools. Their lectures, however, must be approved by the local school boards and their content varies from one organization to another. Thus, sex education in some areas is sporadic or nonexistent (especially in rural areas) and the information provided is variable. According to a 1996 study, the primary source of information on contraception for young women is a friend (27%) or a colleague (13%), followed by media (17%) and health providers (12%). Ten percent have heard about contraception first from their mothers, and 6% from their partners. Only 4% cited school courses.

7. Protection in Pregnancy and Maternity Leave (Article 11 of the Women’s Convention)

While Romanian law entitles women to maternity and parental leave and other benefits associated with pregnancy and childbirth, many private employers avoid paying for these benefits by hiring women without a contract. While this practice is illegal, the government has done little to discourage it. Temporary or short-term work contracts are other devices used to avoid paying maternity leave. A number of employers simply avoid hiring women altogether, regardless of their qualifications. The effects of this discrimination in hiring are revealed in a recent study that shows that women’s average wage is only 75% of the average wage earned by men.

A. Right to Health Care, Including Reproductive Health Care and Family Planning (Articles 12, 14 (2)(b) and (c), and 10 (h) of the Women’s Convention)

Introduction

Article 12 of the Women’s Convention requires States Parties to “take all appropriate measures to eliminate discrimination against women in the field of health care.” Specifically, Article 12 requires that women have access to services related to pregnancy, confinement, and the postnatal period and have adequate nutrition during pregnancy and lactation. Article 10(h) requires women to have “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.” Articles 14 (2)(b) and (c) direct States Parties to ensure that women in rural areas have access to adequate health care, including information, counselling, and services in family planning, and that they benefit directly from social security programs.

In its General Recommendation on Women and Health, CEDAW affirms that access to health care, including reproductive health care, is a basic right afforded to women under the Women’s Convention.¹ In that Recommendation, CEDAW identifies a state duty to “respect, protect and fulfil women’s rights to health care.”² To “respect” women’s right to health, States Parties must refrain from instituting legal or policy barriers to health care access that obstruct women’s pursuit of their health goals.³ The obligation to “protect” the right to health requires States Parties to prevent and punish violations of this right — particularly in the form of violence against women — by private persons and organizations.⁴ Finally, the duty to “fulfil” the right to health requires States Parties “to take appropriate legislative, judicial, administrative, budgetary, economic and other measures” to ensure women’s enjoyment of this right.⁵ In particular, CEDAW directs States Parties to ensure, *inter alia*, access to “information and services necessary to ensure sexual health,”⁶ and “appropriate services in connection with pregnancy, confinement, and the postnatal period.”⁷

1. Access to Health Care

Laws and Policies

The Constitution of Romania guarantees the right to protection of health.⁸ It is the responsibility of the state “to take measures to ensure public hygiene and health.”⁹ “The organization of the medical care and social security system in case of sickness, accidents, maternity and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of persons” are

established by law.¹⁰ Included in the state's constitutional obligation to ensure an adequate living standard for its citizens is the duty to provide medical care in public health establishments.¹¹

Access to health care is principally regulated by the Health Insurance Act.¹² The Health Insurance Act sets the framework and general principles of health insurance, including who can be insured,¹³ the rights of the insured persons,¹⁴ relations between health care providers and health insurance companies,¹⁵ funding of health care,¹⁶ and the structure of health insurance companies.¹⁷

As presented in the Governing Program of the current government,¹⁸ the national health policy is focused mainly on reforming the health system, with the goal of increasing accessibility of health care services.¹⁹ This reform has been planned since 1990, but it is only in the last two years that significant legal changes have occurred.

No specific legislation regulates the rights of patients and medical malpractice. Physicians are obliged to respect human life, and to exercise their profession correctly and with devotion.²⁰ Physicians are independent in the exercise of their profession and are completely responsible for their medical acts.²¹ They are regulated under disciplinary, criminal, and civil provisions of various codes.²² The Criminal Code protects the rights of patients only in extreme cases, where a physician intentionally and willfully injures, mutilates, or kills a patient. These would be the crimes of battery and murder.²³ There are no specific provisions in Romanian civil law concerning medical malpractice, but the general rules on negligence apply.²⁴

A patient's right to confidentiality is guaranteed by law.²⁵ Patients' health records are kept by the local health directorate, and the information can be released to third parties only in certain limited circumstances.²⁶ Employers and all other persons who have access to records must also respect the confidentiality of health records.²⁷ There are no special rules regarding consent of the patient to medical acts.

Reality

Each hospital and its subordinate polyclinics and dispensaries serve approximately 100,000 people.²⁸ There are 5,883 medical dispensaries and 540 polyclinics throughout the country.²⁹ A typical dispensary is staffed with two physicians, usually a general practitioner and a pediatrician, two medical assistants (nurses), a midwife, and one auxiliary staff member. The laws on health reform propose to merge General Practitioners and pediatricians into the new "specialty" of family physician. Currently there are around 15,000 family doctors, or 1,500 patients per doctor.³⁰

There is much to be commended in the Romanian health care system, although currently there is significant dissatisfaction among both providers and patients. The official system still

provides universal care financed through the national budget.³¹ However, the health insurance system is in the process of total reorganization. The implementation of the Health Insurance Act No. 145/1997 has been delayed, as have Law No. 100/1998 on social health insurance and the reform of the medical system.

Public health services are always free of charge for the whole population, with the exception of hospital services for which a 2% fee is charged as a contribution to a special health fund.³² Some medical services not paid for by health insurance are abortion in the absence of specified indicators, health services for occupational diseases and work accidents, some high-performance medical services, and certain types of dental assistance. Pre- and postnatal care is free of charge. Even where services are fully covered by health insurance, it is a common practice for patients to offer money or gifts in exchange for services. Patients pay for medications, but there are still state subsidies for some drugs for certain diseases depending upon one's employment status. Pregnant women and children under the age of 16 receive medication free of charge.³³ Pharmacies recently have been privatized and discussions are underway to develop a system of insurance payments for medication.³⁴

During the last three years, the Romanian health system has faced difficulties due to the national health reform strategy. The results of this reform are barely visible because of the lack of financial resources and the depreciation of the economic system. These factors are illustrated by the decline in health-related public expenditure from 2.9% of the GDP in 1990 to 2.6% in 1997. In 1998, the health-related expenditure was raised to 3.3%, but from a GDP lower than in 1990.³⁵ At the same time, the health insurance fund is below the anticipated level. As a result, the medical services provided and the medication funded are determined by the availability of resources and not by the needs of the population.³⁶

The difficulties in the health system are seen also in access to services and their quality. While 90% of the Romanian population have access to health services, there is a discrepancy between rural and urban areas. In 1997, a physician from an urban area assisted 360 inhabitants, while a physician from a rural area provided medical assistance to 1,475 inhabitants.³⁷ The number of inhabitants per physician is increasing in rural areas and decreasing in urban areas. In 1997, only 9% of spending in rural areas was spent on services (including health services), while in urban areas, 15.5% of spending was allocated to services.³⁸

The Romanian health care system's medical staff is highly qualified. However, equipment, medical centers, and hospital beds are in short supply in comparison due to lack of resources, which diminishes the quality of medical care. Efforts have been made over the last few years to improve the general health of the population. The situation, including the quality of medical services, remains critical. Private medical practices are a viable solution only for an extremely small proportion of the population, as the fees for service are prohibitive. While a growing number of private pharmacies exist, private medical practices do not yet offer a realistic alternative to public services.

2. Access to Comprehensive, Quality Reproductive Health Care Services

Laws and Policies

There is no comprehensive reproductive health policy that promotes women's health throughout their lives. The Ministry of Health works in cooperation with the Physicians Board of Romania in several important national programs that relate to reproductive health,³⁹ including the National Program on Family Planning and Protection of Mother and Child Health Status.⁴⁰

The Ministry of Health has prepared an Operational Plan to promote reproductive health. The objectives of the Operational Plan are to decrease the number of abortions performed in Romania, increase the use of contraceptives, and slow the advance of STIs. The Ministry of Health's Family Planning and Sex Education Unit; the National Center for Health Promotion; the Ministers of Defense, Labor, Education, and Youth and Sports; NGOs; and pharmacists and physicians are to work together to implement this program.⁴¹

Together with the Ministry of Education, the Ministry of Health also has presented programs meant to increase public awareness of reproductive health. The major objectives of this policy are to promote reproductive health; reduce the maternal death rate, especially the number of deaths related to abortion; reduce the number of abortions and abortion-related complications; disseminate modern contraceptive methods; increase the population's awareness of sexual activity and STIs prevention; reduce the number of unwanted pregnancies and thereby the number of abandoned children and the incidences of teenage pregnancies; and increase the number of healthy newborn children.⁴²

For care of pregnant women, the Ministry of Health's guidelines for prenatal care are highly specific. Normal, healthy pregnant women should receive 10 prenatal consultations. Women with risk factors or complications may have more visits and tests, as well as specialist care within polyclinics or, if necessary, hospitals. All women are to receive at least one home visit during pregnancy (by a nurse) to assess their social circumstances and receive prenatal education. The Ministry of Health also specifies the components of prenatal care.⁴³

Reality

Reproductive health services are considered to fall within the realm of primary health care. Dispensaries have consultations for family planning, obstetrics-gynecological services, and maternal health care. In January 1991, a Loan Agreement between the Government of Romania and the International Bank for Reconstruction and Development (IBRD) provided funds for the

improvement of reproductive health.⁴⁴ At the same time, some NGOs began to provide counseling and contraceptive services.

In 1992, the Ministry of Health established the Family Planning and Sex Education Unit, responsible for the delivery of family planning services in Romania.⁴⁵ Currently there are 230 family planning and reproductive health clinics run by the State, and 11 referral centers operating in university centers.⁴⁶

Dispensaries, as already mentioned, deliver some reproductive health services, including counseling on selection of contraceptives and the provision of oral contraceptive prescriptions. Unfortunately, in most dispensaries, contraceptive pills, condoms, and IUDs are not available. Few dispensaries have educational materials on family planning methods. Obstetrician/gynecologists (OB/GYNs) in public hospitals, maternity facilities, and in private practice provide family planning services and counseling. They have been less active in offering family planning programs, however, than their colleagues in family planning clinics.

In principle, family planning clinical services and counseling should be available from general practitioners within the public health system.⁴⁷ As a component of the primary health care reform initiated by the Ministry of Health in 1997, family planning has been integrated in 1999 into the basic “package” of services provided to the population.⁴⁸ Reproductive health is one element of the general practitioners’ skill upgrading, and will be carried out in part through a United Nations Population Fund (UNFPA)-financed Family Planning Project with the Ministry of Health.⁴⁹ Some 400 general practitioners already have been trained and have competence in family planning services. Basic family planning training is being conducted for another 400 family physicians, midwives, and nurses staffing rural dispensaries. The training will be completed by June 2000.⁵⁰ The physicians and other staff who have been trained in family planning counseling are client-friendly. However, it has been observed that most male OB/GYNs who have not attended training sessions do not treat women very respectfully.⁵¹

Most urban family planning clinics have adequate supplies, but these supplies are being depleted quickly and the new system for supply distribution is not yet in place. Rural dispensaries are not yet allowed to dispense contraceptives, but an advocacy campaign is being conducted to reverse this policy.⁵² For the most part, clinic hours are convenient for women, especially where there are two staff members to ensure service provision from 8 a.m. to 8 p.m. Unfortunately, these centers are located only in urban areas. Better access to family planning services would be assured were the clinics financed directly by the Ministry of Health, rather than by the National Health Insurance Fund.

Regarding prenatal care services, data show that 70% of women receive fewer than the recommended 10 prenatal consultations. About 25% of women delivering at term report having three or fewer prenatal consultations. Roma women, teenagers, and women with low levels of education and low socio-economic status are most likely to have a poor pregnancy outcome. Proper care is also affected by transportation problems, the distance to services, clinic hours, attitudes towards professional care, and women’s social status. In a national survey of health

services for safe motherhood, 20% of women who had received prenatal care had never had a test for anemia, 12% of facilities were missing an ABO blood type, and 32% were missing an Rh type. Histories and physical exam findings were incomplete. Screening for infection (other than syphilis) or cervical cancer was rarely performed. A large number of women could not recall having been advised about lifestyle factors (e.g. smoking, drinking, use of medication), baby care, breast-feeding, preparation for delivery, or the possible signs of complications during pregnancy that would need immediate help.⁵³

The Ministry of Health guidelines for prenatal care do not guarantee quality of services. In fact, the system's organization makes it difficult to ensure quality. Prenatal services are covered in dispensaries by family doctors (general practitioners) and OB/GYNs in polyclinics and hospitals. In some cases, a woman may be admitted to hospital in labor and the attending obstetrician might not have seen her before or might not have access to her medical records.

Concurrent with the development of private medical practice, family planning has been developed within the private sector. The network of NGOs providing counseling, contraception, and training services has been growing. Family planning consultations are also provided by *Societatea de Educație Contraceptivă și Sexuală* (The Society for Contraceptive and Sexual Education - SECS) — an NGO with 20 consultations throughout the country. In contrast to the State system, the consultations at SECS are not free of charge,⁵⁴ but they are affordable at approximately 2 USD. SECS collaborates with the public sector and state facilities.⁵⁵ Other major international organizations, such as the International Planned Parenthood Federation (IPPF) and *Medecins Sans Frontières* (MSF) Belgium-France, have been the most active in this field. There are 11 family planning clinics organized by NGOs; all NGO family planning consultations are located in urban areas.⁵⁶ UNFPA's assistance over the last years has been crucial to the status of family planning services. UNFPA provides a total budget of about 700,000 USD as a national program support package.⁵⁷

A number of obstacles block women's access to comprehensive, quality reproductive health care services. First, the lack of a national strategy concerning women's health is reflected in the lack of a coherent policy to promote family planning and to inform and educate the population. Second, contraceptives are in limited supply and not always affordable, especially in rural areas. Third, some medical providers have insufficient access to new reproductive health technologies. Fourth, information on reproductive health is not a priority in the current health information and monitoring system. Fifth, there is a lack of clarity on the long-term role of the family planning centers. Currently, family planning is not even treated by managers and providers as part of the health system. Sixth, the personnel in primary health care units, especially in rural areas, lack training in family planning and reproductive health. Finally, there is a lack of clear guidelines for what specific reproductive health services each type of health care unit can provide and who will pay for them, as well as for the accreditation and competence criteria.⁵⁸

3. Access to Information on Health, Including Reproductive Health and Family Planning

Laws and Policies

The Ministry of Health is responsible for setting up a system for distribution of information on health care to the public.⁵⁹ The County Directorates of Public Health are responsible for providing information on health issues on the local level.⁶⁰ In cooperation with local authorities, educational institutions, and NGOs, these directorates organize educational activities on the health of the population, including reproductive health.⁶¹ The Ministry of Health also maintains a network of 40 Health Promotion Departments — one per county. These departments are also responsible, although not exclusively, for promoting family planning and reproductive health. At the regional level, there are Health Promotion Teams within the Ministry of Health's Institutes of Public Health. These teams review and provide information about family planning and reproductive health to the population.⁶²

A UNFPA project supports Reproductive Health (RH) Information, Education, and Communication (IEC) activities. An international consultant working with the National Center for Health Promotion (NCHP) and the Family Planning and Sex Education Unit (FPSEU) of the Ministry of Health developed a RH/IEC Operational Plan, which, after extensive consultation, was signed by various Ministries and NGOs and adopted as a national five-year RH/IEC strategy.⁶³

There are no specific legal constraints on reproductive health information. There are no direct regulations governing the advertisement of contraceptives. Possible threats to the free flow of information concerning contraception are the provisions of the Criminal Code on obscenity and the provisions of the Audio-Visual Law.⁶⁴ The law against obscenity in the Romanian Criminal Code imposes a prison term from six months to four years, or a fine, for selling, distributing, producing, or possessing with a view to distributing objects, pictures, written materials, or other materials having obscene character.⁶⁵ The law neither defines what “material having obscene character” is, nor specifies if medical material could be used in situations that could confer a character of obscenity. To date, there have been no convictions of any kind under this law. There are no regulations on advertising abortion services or information, or information on family planning methods.

Reality

A 1993 survey on reproductive health in Romania found that nearly 96% of women have heard about at least one method of family planning, either traditional or modern. The most

widely known method is the condom (89%), followed by the pill (79.1%) and IUD (71.2%).⁶⁶ Certain methods, such as injectables, vasectomy, and diaphragm, are unknown to most women.⁶⁷ The study found that 85% of women in a sexual relationship know of at least one source of family planning. The percentage of women from urban areas with knowledge of a source of family planning is greater than that of women in rural areas (90% versus 75%).⁶⁸ For some methods, there is a significant gap between the percentage of women who have knowledge of them and those who know how to obtain them. This gap is 29 percentage points for the pill, 25 percentage points for condoms, and 20 percentage points for the IUD.⁶⁹

The survey found that the primary source of information about any contraceptive method was a female friend or acquaintance (45%), followed by mass media (19%) and health care providers (10%). In the same survey, 57% of the respondents declared that they would like to have more information about contraception.⁷⁰ More than 56% of women from rural areas manifested their desire to have more information about this matter.⁷¹ Data showed more than 75% of women under the age of 25 reported a desire for information on this subject.⁷²

To improve the situation, a number of information campaigns have been launched. On October 6, 1997, the Ministry of Health, the Department of Health Promotion, and the National Center for Health Promotion launched a media campaign promoting contraception in order to reduce rates of abortion. The campaign targeted all major local and national TV and radio stations.⁷³ Another information campaign on reproductive health, called “Women Choose Health,” has also been launched in recent years. This campaign is widely supported by the Ministry of Health through Health Promotion departments, and by the NGO Coalition for Reproductive Health.⁷⁴ On March 8, 2000, the National Reproductive Health Campaign was launched. The objectives of this campaign are to heighten women’s awareness of reproductive health and family planning and the locations where services are available, increase women’s attendance at government and private family planning clinics, increase the use of modern contraceptives, and reduce reliance on abortion. The campaign is organized by the Ministry of Health and USAID, with technical assistance from Johns Hopkins University Population Communication Services. The target group is women aged 18 to 35, which is the group with the highest risk of unplanned pregnancy and abortion. The campaign uses video and radio spots, stickers, posters, and brochures. The brochures will be translated into Hungarian and Romani.⁷⁵

4. Contraception

Laws and Policies

No contraceptives are prohibited by law, nor are there specific laws regarding the sale and distribution of contraceptives. However, the laws and regulations concerning family planning indirectly address contraceptives.⁷⁶

Contraceptive products have the same legal status as any other drug used in Romania. All drugs need the approval of the Ministry of Health, through the Pharmaceutical Directorate and the Institute for State Control of Drug and Pharmaceutical Research, in order to be imported or sold. According to the Order of the Ministry of Health No. 1988/1996 relating to the quality control of pharmaceutical products and other products for human use, any pharmaceutical product may be distributed only after a quality verification, the issuance of a quality certificate, and registration of the product by the Commission for Drugs within the Institute for State Control of Drug and Pharmaceutical Research.⁷⁷

Reality

A 1999 Reproductive Health Survey reveals that contraceptive use is on the rise: The current rate is 64%, as compared to 57% in 1993.⁷⁸ The most important feature is the rise in the use of modern contraceptives. The most common methods are condoms (8.5%), oral pills (7.9%), IUDs (7.3%), spermicides (2.8%) and female sterilization (2.5%). Other modern methods accounted for only 0.5%.⁷⁹ When compared to the results of a 1993 study, these figures reveal that use of nearly all of these methods has more than doubled in six years. The previous study documented the prevalence of different methods as follows: IUDs (4%), condoms (4%) and oral pills (3%). Less than 1% of women used spermicides, and only 0.3% used injectable contraceptives, diaphragms, or other modern methods; only 1.4% of married women had been sterilized.⁸⁰

Several contraceptive methods, particularly oral contraceptive pills, are available but imported from other countries. Diaphragms and spermicides are the most difficult to procure. The pills and intrauterine contraceptive devices require prescriptions, and insertions may be performed only by OB/GYNs. There are no accurate sources of information about emergency contraception (EC) and it is not readily available. Non-governmental clinics are the primary source for EC.⁸¹

Governmental and non-governmental clinics provide contraceptive products. Thanks to the agreement with IBRD, within the family planning program framework the Ministry of Health imports contraceptive methods and sells them through a public network at lower prices than in pharmacies or private clinics. The price difference is considerable: Oral contraceptives distributed through this social marketing network are from 10 to 30 times cheaper; for IUDs, the difference is a reduction of 60-80 times the free-market price. In addition, according to the first principle of this agreement, the medical assistance given during these consultations is free of charge.⁸² However, the future of the governmental birth control pill subsidy is uncertain,⁸³ since the program with IBRD ended and the government must search for new sources for cheaper contraceptives.

The private sector has become increasingly active in the sale of contraceptive products.⁸⁴ The private sale of pills accounts for over half the total pills distributed in the country, and it is

estimated that the proportion is increasing dramatically. Recent figures show that commercial sale of oral contraceptives in 1997 was more than double the level in 1996. *Societatea de Educație Contraceptivă și Sexuală* (the Society for Contraceptive and Sexual Education - SECS) provides imported contraceptives with the financial support of IPPF, and their products are cheaper than the ones provided by the state.

5. Abortion

Laws and Policies

Under the dictatorship of Ceaușescu, abortion was illegal and there were mandatory workplace pregnancy screenings. After the abolition of the coercive and brutal pro-birth policies of the old Communist regime, abortion access was virtually free in Romania. The old anti-abortion law was among the first laws to be abolished in December 1989.⁸⁵

Under the Criminal Code, induced abortion is legal if it is performed by a medical doctor upon a woman's request up to 14 weeks from her last menstrual period.⁸⁶ Abortion can be performed at any time by a medical doctor if it is necessary to save the life, health, or bodily integrity of the pregnant woman. The woman's consent is required unless for physical, mental, or legal reasons, she cannot express her will and the abortion is necessary for therapeutic reasons.⁸⁷

The only absolute condition the law places on abortion is that it must be performed by a doctor.⁸⁸ There is neither a spousal consent requirement nor any mandatory counseling or waiting periods. The Criminal Code assigns penalties for the illegal performance of abortions "either by a non-physician, outside an authorized faculty, or beyond 14 weeks (with no legal indication)." The penalty is imprisonment from six months to three years.⁸⁹ Also, if an abortion occurs without the consent of the pregnant woman, it is punishable with a prison term of two to seven years.⁹⁰ If during the illegal abortion procedure the woman was injured, there is a three- to 10-year prison term, and if it leads to the death of the pregnant woman, the punishment is five to 15 years' imprisonment.⁹¹ Physicians who illegally perform abortions may lose their medical license.⁹² The woman who undergoes an illegal abortion is exonerated from any punishment.

Recently, the Ministry of Health developed an "Operative Plan to Promote the Reproductive Health for the period 1998 to 2003." The plan is essentially a public education campaign to promote family planning and contraceptive methods and encourage women to avoid abortion as a method of family planning.⁹³

In 1997, a member of the majority in Parliament proposed an anti-abortion law. The law was rejected mainly because of Romania's tragic experience before 1989. However, nobody mentioned the right of women to choose whether and when to have children.

Reality

Immediately after the legalization of abortion in 1989, Romania had the highest number of abortions in the region. The absolute number of abortions leaped from 192,500 in 1989 to 992,300 in 1990. It has been steadily decreasing since then, reaching 347,100 abortions in 1997⁹⁴ and 198,800 in 1999.⁹⁵ Even though abortion services are widely available throughout the country in both public and private facilities, there are still some illegal induced abortions.

As a result of the liberalization of abortion, the registered number of maternal deaths caused by abortion declined from 545 in 1989 (out of a total of 627 maternal deaths) to 51 in 1996, leading to a drop of 76% in the maternal mortality rate.⁹⁶ Even with the decline of this rate after abortion became legal, induced abortion is still one of the primary causes of maternal death in Romania, mainly because of the continuing recourse to unsafe abortions. This practice can be attributed to a habitual reliance on illegal procedures and a lack of information and economic resources, especially for women in rural areas.⁹⁷ In 1999, 44 women died due to unsafe abortions. This is a high number considering that abortion is legal and can be performed by professionals.⁹⁸

Abortion remains the predominant form of fertility control.⁹⁹ Most abortions — 89% — are performed in hospital facilities, and only 11% in private offices or clinics.¹⁰⁰ The official data regarding abortion does not include most abortions performed in private facilities. Safe abortion services are available and post-abortion complication rates (both immediate and long-term) are low. Still, the quality of abortion care is sometimes low because of a heavy caseload and limited time. Abortion counseling and post-abortion family planning counseling are not routinely offered in all abortion clinics.¹⁰¹

Public facilities that provide abortions and post-abortion counseling provide services either for free or at nominal cost. Family planning consultations in polyclinics and at maternity hospitals can provide more specialized counseling services. While reproductive health services are included in the range of medical services paid for by social health insurance, abortion is treated differently. Women who undergo an abortion in the public system must pay a surcharge of 60,000 ROL (around 3 USD). Categories of women exempt from paying the abortion fee include the following: pupils, students, the unemployed, women who have evidence (released by the City Council) of no personal possessions, mothers with four or more children, women with life-threatening pregnancy-associated diseases, women who have or whose partners have a family history of fetal malformations, women severely physically or mentally disabled, and women whose pregnancies result from rape or incest.¹⁰² Private medical facilities charge substantially more. Induced abortions provided in private clinics are paid for entirely by the patients and the charge varies depending on the clinic, reaching 500,000 ROL (25 USD).

Regarding the climate toward abortion, 72% of women believe that women always have the right to make decisions about their pregnancies, including abortion. At least two-thirds of

every segment of the population believed there should be no restrictions on abortion.¹⁰³ In a survey on young adult reproductive health, the data shows that 67% of young women and 53% of young men agree that a woman should always have the right to decide about her pregnancy, including the choice of abortion. Only 4% of young adults disapprove of abortion under any circumstances.¹⁰⁴

There is no official anti-abortion policy. However, in rural areas, the Orthodox Church is strong. Still, because of Romania's recent history, the "right to life" and anti-abortion movement is still in its beginnings. The Association of Orthodox Christian Students under the control of the Orthodox Church occasionally organizes violent anti-abortion and anti-gay actions.¹⁰⁵ In 1998, draft legislation outlawing abortion was co-sponsored by the Orthodox Church and the Catholic-Greek/Unitarian Church.

6. Sterilization

Laws and Policies

There are no specific laws in Romania regulating voluntary sterilization as a family planning method. No specific provision of the Criminal Code punishes the illegal performance of sterilization. In cases in which a medical intervention is performed without consent or by unauthorized individuals, the general laws on assault and battery are applicable.

According to medical guidelines, anyone seeking to be sterilized for contraceptive purposes must first undergo counseling. Notice must be given to both spouses concerning the permanence of sterilization.¹⁰⁶ The National Health Insurance Fund covers voluntary sterilization.¹⁰⁷ There is no policy that encourages individuals in Romania to choose sterilization as a contraceptive method.

Reality

There are no accurate statistics concerning the number of persons relying on sterilization as a contraceptive method, but it is presumed to be a small percentage of the population.¹⁰⁸ In 1999, 3% of women were sterilized.¹⁰⁹

7. HIV/AIDS and Sexually Transmissible Infections (STIs)

Laws and Policies

The Order of the Minister of Health No. 899 of November 1998 is intended to prevent the transmission of AIDS by requiring mandatory testing and reporting for certain categories of people. The groups that must undergo testing and reporting for HIV/AIDS are these: STI patients, pregnant women, long distance truck drivers, sailors, foreign students, and Romanian citizens working abroad for more than six months, or coming back after a travel longer than six months, as well as those working abroad in order to marry.¹¹⁰

A number of other laws deal with STIs and HIV/AIDS. Many govern the handling of blood and blood products.¹¹¹ Others concern intentionally transmitting HIV/AIDS, an act that carries a prison term of five to 15 years and court ordered medical treatment.¹¹² Evading treatment carries a penalty of three months to a year in prison or a fine.¹¹³ Knowingly engaging in homosexual activity that leads to the transmission of STIs is subject to a one- to five-year prison sentence.¹¹⁴ Other laws concern the protection of children with HIV/AIDS, particularly ensuring them access to education. Social benefits for persons living with HIV/AIDS are guaranteed by law as well. Persons with AIDS are entitled to a small “disability” pension. In case of children, the caretaker receives the funds.¹¹⁵

The National Program for AIDS, organized and funded by the Ministry of Health, is intended to ensure access to medical care, diagnosis, and prevention.¹¹⁶ AIDS is included in the group of 18 diseases for which, by order of the Ministry of Health, medications are to be provided free of charge.¹¹⁷

While HIV/AIDS has become an increasingly important concern in Romania, there has not yet been an integrated approach to addressing it. In 1995, under the guidance of UNAIDS, a National AIDS Commission was established, to promote AIDS education and prevention, and collect information on AIDS cases and their evolution at the county and national levels. UNICEF has supported training courses on sexual education and AIDS prevention for teachers, nurses, physicians, community leaders, and others.¹¹⁸

Reality

The reporting of HIV/AIDS, syphilis, and gonorrhea is mandatory by law, but statistics reflect only patients who seek medical care.¹¹⁹ AIDS has had a particularly devastating effect on children. As reported on March 31, 1999, one- to four-year-olds accounted for 37.3% and five- to nine-year-olds for 38.7% of registered AIDS cases.¹²⁰ There were 5,097 AIDS cases among

children registered on March 31, 1999, out of which 2,105 were girls.¹²¹ In 1998 there were registered 25 AIDS cases per 100,000 inhabitants, of which 23 were children.¹²² More than 50% of all European cases of children with HIV/AIDS are in Romania. Most were infected as a result of injections with contaminated blood and needles. A large number of children with AIDS have been institutionalized.¹²³

The number of adult cases of AIDS has increased by 50% over the past two years and there has been an increase in rates of infection among adolescents.¹²⁴ The most frequent transmission path among adults is heterosexual sex — it accounts for 48.8% out of the total infections.¹²⁵

STI rates are of much concern, especially primary and secondary syphilis. The reported syphilis rate increased by almost five times between 1986 and 1996, from 7.1 to 32.2 per 100,000 inhabitants.¹²⁶ However, many cases are not declared, making the official statistics inaccurate. The public health sector is in charge of STI services, organized within the dermatology and venerology units in polyclinics and hospitals. General practitioners are, in theory, not authorized to treat STIs, but in reality they do, without reporting the cases.

There is a willingness to introduce HIV/AIDS and STI prevention programs into the educational system. Nonetheless, inaccurate information and misconceptions about the infection and transmission of HIV/AIDS circulate widely.

The National Program for AIDS is grossly underfunded and thus has limited effect. The government's limited ability to address HIV/AIDS results from its precarious economic situation and its decreased budget allocations for health. While treatment and hospitalization for HIV/AIDS patients are free of charge, physicians often face shortages of lab materials and medications. Exacerbating the problem is the fact that those with HIV/AIDS have few financial resources at their disposal.

Anti-retroviral drugs are provided free of charge in a limited quantity by the public health system (2.2 million USD for 7,900 registered HIV/AIDS cases in 1997).¹²⁷ However, pharmaceuticals, including AZT and medications for opportunistic infections, often are not available at the local level. In health institutions, people with AIDS are isolated. Understaffing and poor training of the staff result in poor care. Social services agencies for families are understaffed, with social workers having caseloads of up to 130 families.¹²⁸

There is a high level of awareness of HIV/AIDS (97% of women and 98% of men), but the ability of young adults to identify other STIs is limited.¹²⁹ STI/AIDS prevention education is only beginning to be integrated into health services, whether private or public. The national network of health promotion and education (under the authority of the Ministry of Health) has given some priority to reproductive health and sexual education and the prevention of HIV/AIDS. However, underfunding, inadequate medical and social services, and failure to

address the issue through a comprehensive national strategy augment the highly negative personal and social impact of HIV/AIDS.

More has been done in the way of HIV/AIDS prevention by NGOs. ARAS is an NGO working almost exclusively in the fight against HIV/AIDS and STIs. Other organizations such as SECS and Youth for Youth are including these elements in all their programs.¹³⁰

8. Adolescent Reproductive Health

Laws and Policies

In January 1997, the Government established the Department for Child Protection. This new entity was the result of a revision the child protection legal framework intended to comply with the principles and provisions of the U.N. Convention on the Rights of the Child. These reforms also reorganized the local administration of child protection services and the National Committee for Adoptions.¹³¹

The Ministry of Health has developed an *ad hoc* Reproductive Health Policy to supplement the programs already in existence as a result of a formal plan. The objectives of this policy have been clear: a) reduce the rate of abortion generally, and especially among young women; b) increase the contraceptive prevalence rate; and c) slow the advance of STIs, including HIV/AIDS.¹³²

Reality

There are no separate family planning services for adolescents. The Ministry of Education allows students access to family planning services, including gynecological consultations, pre-marriage consultations, contraceptive services, and consultations for young families.¹³³

The family planning program was only recently instituted and a nationwide contraceptive distribution system is still under development. The biggest suppliers of contraceptives are both public and private pharmacies. The second most important source for young people is the public sector through contraceptive offices set up in hospitals, polyclinics, and dispensaries. Private physicians also supply contraceptives to adolescents. The principal family planning NGO is SECS (IPPF affiliate).¹³⁴

Sexual activity among teenagers in Romania is currently low and may remain low for a short time due to the continued conservative influence of parents and grandparents. This trend,

however, may not endure the country's pervasive social and economic upheaval. According to the Young Adult Reproductive Health Survey, 91% of all women aged 15 to 17 have had no sexual experience. The figure for men is 76%. Of women aged 18 to 19, 63% have had no sexual experience. Only 2% of young women had had intercourse by age 15, about 10% by age 16, almost 30% by age 18, and the majority of 20- to 24-year-olds reported having had a sexual experience.¹³⁵

In 1996, the percentage of women aged 15 to 19 reporting that they had ever had a pregnancy was 11%. Thirty-two percent of those women had an induced abortion. The abortion ratio dropped between 1990 and 1996 from 110 to 97 abortions per 100 live births among women aged 15 to 19.¹³⁶

Only 15.9% of women younger than 18 whose first intercourse was premarital and 31% of women between 18 and 19 years old reported the use of contraceptives. The most used method is withdrawal. The data shows that contraceptive use at first intercourse, although very low, was higher in urban areas than in rural areas (30% versus 21%). It also varied with levels of education. Almost 36% of women under 18 years of age with a higher level of education used contraception at first premarital intercourse, compared with 11.2% who had not completed secondary school.¹³⁷

Adolescents do not face discrimination in accessing reproductive health services. In the experiences of NGOs, adolescents are the majority of those who solicit their reproductive health services.

B. Family Relations (Article 16 of Women's Convention)

Introduction

Article 16 of the Women's Convention requires States Parties to "take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations." A woman's rights within marriage and the family greatly affect her ability to control her life and make voluntary, informed reproductive choices. Article 16(1)(e) of the Women's Convention draws the link between women's status within marriage and their enjoyment of their reproductive rights by specifically ensuring married men and women the "same rights to decide freely and responsibly on the number and spacing of their children..."

In General Recommendation 21 on Equality in Marriage and Family Relations, CEDAW takes note of a number of legal, political, and social forces that lead to women's subordination within marriage,¹³⁸ and thereby prevent them from exercising their rights to reproductive self-determination. In particular, CEDAW expresses concern about forced marriage,¹³⁹ early marriage and laws that set different minimum ages for marriage for women and men;¹⁴⁰ and

discrimination in the division of property following dissolution of a marriage or domestic partnership.¹⁴¹

1. Marriage and Domestic Partnership

Laws and Policies

Both the Constitution and the Family Code establish the principle of equality between spouses, relations of mutual respect,¹⁴² and common rights and obligations of spouses to each other,¹⁴³ over their common assets,¹⁴⁴ and toward their children.¹⁴⁵ Only marriages that are freely consented to are valid.¹⁴⁶ The minimum age of consent for marriage is 18 for a man, 16 for a woman.¹⁴⁷

In addition to the age differential based on sex, women's freely given consent to marriage is undermined by a provision of the Criminal Code, known as "reparatory marriages."¹⁴⁸ Women who are raped may remove their "shame" by "consenting" to marry the rapist. Under such circumstances, the crime of rape is construed as never having occurred.

Only marriages concluded in the presence of the public official in charge of the civil status office are valid.¹⁴⁹ By law, the mayor or one of his representatives officiates at the marriage.¹⁵⁰ The Constitution allows religious marriages to be celebrated only after the civil ceremony.¹⁵¹ Sexual relations outside of marriage (adultery) is a crime,¹⁵² as is bigamy.¹⁵³

Unmarried couples living together do not have the rights they would have in marriage. In this kind of partnership, there are no inheritance rights. In addition, if one partner wants to dissolve the union and divide the property acquired while living together, the rules of any ordinary division of property apply, and not those pertaining to spouses. As a result, a woman's housework and child rearing is not valued as "property investment." It is the woman who is disadvantaged in such a case, since the man, who usually performs economic activity outside the home, can prove his practical contribution to the unit. The lack of legal recognition of such relationships perpetuates women's subordinate economic status.

Reality

The number and rate of marriages have fallen since the beginning of the transition, playing an important part in the decrease in the fertility rate. The annual number of marriages per thousand population has fallen from 8.3 in 1990 to 6.8 in 1995 and 6.5 in 1997.¹⁵⁴ Difficulties in obtaining a place to live, increased unemployment, and the lack of a government policy to protect young families all contribute to declining motivation among young people to get married.¹⁵⁵

At the same time, the average age of both men and women at first marriage increased slightly, for women from 22 in 1990 to 23.2 in 1998, and for men from 25 in 1990 to 28.9 in 1998.¹⁵⁶ In rural areas the average age at first marriage is lower than in urban areas for both women and men.¹⁵⁷

Domestic partnership (concubinage), in spite of its growing frequency, is not a significant phenomenon. Marriage continues to exist in the Romanian society as a cultural model of choice, in which the tradition and social norms continue to favor marriage. However, it may be foreseen that domestic partnerships will be a new model of marriage, as this is the trend all over Europe.

2. Divorce and Child Custody

Laws and Policies

Divorce is permitted in Romania and is regulated by the Family Code¹⁵⁸ and the Code of Civil Procedure.¹⁵⁹ The court may determine that the marriage should be dissolved, if based on “solid grounds”, the relationship between the spouses is irreparably damaged.¹⁶⁰ The law does not define the term “solid grounds,” yet courts routinely recognize the following practices as sufficient: violent actions of one spouse against the other; adultery (stipulated by Criminal Code); physical discrepancies between spouses such as illness; non-fulfillment of the spousal obligations (including household and sexual duties).¹⁶¹ Evidence proving the guilt of a spouse often reflects the paternalistic stereotype concerning marriage. For example, women are commonly blamed for not doing the housework. “No fault” divorce does not exist under Romanian law; fault must be alleged and proved. However, the Family Code, modified by Law No. 59/1993, provides for the possibility of divorce on mutual consent without lengthy proceedings. The spouses must have been married for one year and neither can be less than 18 years old.¹⁶² Whenever there are minor children, divorce is permissible only for cause.¹⁶³

The Family Code provides mutual rights and obligations of spouses both during marriage and after its termination. Concurrent to declaring the divorce, the court must settle the issues of the names of spouses after divorce, custody of minor children and their alimony support, and property division. Under the Family Code, a spouse who did not work outside of the home shall benefit from a third of the net revenue of the other spouse, but together with any child support, the total support may not exceed half of the other spouse’s net revenue.¹⁶⁴

After divorce, either ex-spouse may sue for the payment of alimony if he or she is in need due to an inability to work, related to their time as a couple.¹⁶⁵ Non-married partners cannot request this alimony after their relationship has ended. The Family Code establishes the criteria

for awarding child custody. The court consults with the parents and with children over 10 years of age, taking into account the interests of the minor children.¹⁶⁶

Reality

The number of divorces per thousand people has not varied greatly in the last ten years — from 1.4 in 1990 to 1.5 in 1997. However, the number of divorces per hundred marriages has increased from 17.1 in 1990 to 23.6 in 1997.¹⁶⁷ The number of divorces is higher in urban areas (30 divorces per 100 marriages) than in rural areas (15 divorces per 100 marriages).¹⁶⁸ In the Western part of the country, the number of divorces is higher (the highest is Hunedoara with 38 divorces per 100 marriages). Every year, an average of 30,000 children have parents involved in divorces.¹⁶⁹

Although parents formally have equal rights following divorce, in most cases children are entrusted to the mother. In special cases, custody may be awarded to relatives, other consenting individuals, or child-protection institutions. The court sets each financial contribution to cover the expenses of rearing and educating the children.¹⁷⁰

The decrease in the number of marriages coupled with the increase in the number of divorces has resulted in an increase in the number of births outside marriage. Every fifth child born in the last three years has a non-married mother. Almost 75% of these women are under 25 years old.¹⁷¹ In 1992 there were almost 1,600 households headed by women, more than half of them unmarried.¹⁷²

3. Early Marriage

Laws and Policies

Girls may legally marry at 16 years of age. For boys, 18 is the legal minimum age for marriage.¹⁷³ If there are solid grounds, a woman aged 15 may marry with the approval of the executive committee of the town council of her residence, after a physician's examination.¹⁷⁴

Reality

As of 1996, 9% of girls between 15 and 19 years old were married.¹⁷⁵ Also in 1996, 7% of teenagers and 52% of 20- to 24-year-old women had ever been in a formal marriage.¹⁷⁶

4. Right to Access Family Planning without Spousal Consent

Laws and Policies

No spousal consent is required to obtain an abortion or to use contraceptive methods.

Reality

Studies indicate that only 5% of women do not use a contraceptive method because their partners oppose contraceptive use.¹⁷⁷ However, partner preference is one of the major reasons women prefer traditional contraceptive methods over modern methods.¹⁷⁸

C. Sexual Violence Against Women (Articles 5, 6, and 16 of the Women’s Convention)

Introduction

Sexual violence is one of the most destructive forms of discrimination against women. The Women’s Convention contains several provisions requiring state intervention to prevent this manifestation of sexual discrimination. Article 5 of the Women’s Convention requires States Parties to “modify the social and cultural patterns of conduct of men and women” in order to eliminate practices based on the idea of women’s inferiority. In addition, violence against women within marriage and the family is condemned by Article 16(c), which guarantees women and men the same “rights and responsibilities during marriage...” Article 6 is explicit in its requirement that States Parties “take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.”

CEDAW, in its General Recommendation 19 on Violence against Women, recognizes that gender-based violence discriminates against women and thereby denies women enjoyment of their rights and freedoms on a basis of equality with men.¹⁷⁹ CEDAW defines “gender-based violence” as “violence that is directed against a woman because she is a woman or that affects women disproportionately.”¹⁸⁰ It includes acts that inflict sexual harm or suffering.¹⁸¹ CEDAW emphasizes that the Women’s Convention is concerned not only with acts of gender-based violence perpetrated by governments, but also those acts committed by private parties.

Governments have a duty to act with due diligence to prevent such acts among all individuals living within their jurisdictions.¹⁸² In particular, CEDAW notes that “[f]amily violence is one of the most insidious forms of violence against women.”¹⁸³ CEDAW calls upon governments to “ensure that laws against family violence and abuse, rape, sexual assault, and other gender-based violence give adequate protection to all women, and respect their integrity and dignity.”¹⁸⁴

1. Rape and Sexual Crimes

Laws and Policies

The Romanian Criminal Code considers rape and other sexual assaults “violations related to sexual life.” Rape is defined as sexual intercourse by use of force or by taking advantage of a woman’s inability to defend herself or to express her will. Rape is punishable by a three to 10 year prison term.¹⁸⁵ Aggravated rape includes gang rape; rape when the victim was in the aggressor’s care, protection, education, supervision, or treatment; or when the victim suffered serious physical and health injuries. Aggravated rape is punishable by five to 15 years in prison.¹⁸⁶ The punishment is 10 to 20 years in prison if the victim was under 14 years old, or if the victim died or committed suicide as a result of the rape.¹⁸⁷ Attempted rape is a crime as well.¹⁸⁸

If a woman is under the age of 14, sexual intercourse is punishable regardless of whether there was consent.¹⁸⁹ Sexual intercourse between a girl under the age of 18 and her tutor, supervisor, physician, professor, or instructor who uses his rank to obtain sexual intercourse is also a crime.¹⁹⁰ The sentences are higher if the aggressor is someone to whom the girl has been entrusted (teacher, doctor, supervisor), if the victim is badly injured, or if she dies.¹⁹¹ Seduction is a separate crime concerning women under the age of 18. It entails obtaining sexual intercourse in exchange for promises of marriage.¹⁹²

Consensual sexual relations between same-sex adults and minors is considered a crime and is punishable by imprisonment of two to seven years.¹⁹³ If serious injury to bodily integrity or health of the minor results from the act, the sentence is five to 15 years. If the minor dies or commits suicide, the sentence is imprisonment of 15 to 25 years.¹⁹⁴ Obscene acts performed upon a minor or in his/her presence entail a prison sentence of three months to two years, or a fine.¹⁹⁵ Attempts to commit any of these crimes are also punishable.¹⁹⁶ The law does not outlaw pedophilia expressly. Instead, the crimes charged are rape, corporal harm, and sexual corruption.¹⁹⁷

A criminal action for rape is initiated only upon the complaint of the victim.¹⁹⁸ If the complaint is withdrawn or marriage between perpetrator and victim occurs, the investigation is

dropped. The so-called “reparatory marriage” between perpetrator and victim exonerates the perpetrator from criminal responsibility.¹⁹⁹ Such cases of marriage are frequently the result of family pressure.

Incest is defined by the Criminal Code as sexual intercourse between next of kin or between brother and sister and it is punished by imprisonment from two to seven years.²⁰⁰ Attempted incest is also a crime.²⁰¹

Article 197 of the Criminal Code does not distinguish between rape in or outside marriage. Statutorily, a married woman can be raped by her husband and could therefore pursue criminal charges against him. However, legal jurisprudence maintains that the existence of a marriage implies the woman’s consent to sexual intercourse with her husband. As no case dealing with rape within marriage has come before the court to settle the matter, the criminality of rape within marriage remains a disputed area of law. Other factors contribute to such a presumption. The reconciliation clause in Article 197 indirectly implies that a marriage exempts the criminal responsibility of the defendant. Furthermore, it is argued that rape within a marriage should be dealt with under crimes against the family, a different chapter of the Criminal Code.

Reality

The total number of women who reported being raped between 1997 and 1998 is 1,502. The reported number of minor women who had been raped decreased from 171 in 1997 to 159 in 1998. Regarding the relationship of the victims with the aggressors, the data shows that a stranger or somebody outside of the family is usually responsible for most rape cases against women.²⁰² This could be explained by the fact that most rape cases in the family are not reported to the authorities and the legislation does not incriminate marital rape. In 1998, from the total of 348 sexual crimes against minor women, 25 were committed within the family.²⁰³

Studies undertaken by the Prevention Service within the General Police Inspectorate have found that most victims of rape are aged 19 to 29. Most rape victims are single. Rape is more frequent in urban areas compared with rural areas. Victims tend to have lower than average educational level. At the beginning of 1997, counties with the highest rate of rape were Iasi, Constanta, Botosani, Prahova, Bihor, Bacau, Dolj, and Bucuresti.²⁰⁴ According to UNICEF, the country has an average of 108 sexual incidents per 1,000 women and 41 assaults per 1,000 women.²⁰⁵

Especially in rural parts of Romania, the stigma of rape is very strong and believed to ruin a single woman’s marriage prospects. Consent to marriage under such circumstances is tantamount to duress.

Romanian legislation does not provide for protective orders for victims of rape, sexual crimes, or domestic violence. There are not enough shelters for victims of sexual crimes, including rape.

The only shelter for sexually abused women and girls is in Cluj Napoca, and it is run by an NGO (Artemis Program). It provides shelter, legal assistance, and counseling.

There are no rehabilitation programs for men who commit rapes or other sexual crimes.

2. Trafficking in Women

Laws and Policies

The law in this area is vague and does not address trafficking directly. Those involved in trafficking may, however, be prosecuted for prostitution and procurement, falsifying documents, assisting individuals to cross borders illegally, blackmail, forced labor, or illegal deprivation of freedom.²⁰⁶

Prostitution is defined as the action of a person who earns his or her living by performing sexual intercourse with different people. It is punished with imprisonment of three months to three years.²⁰⁷ Pandering is defined as persuading or coercing someone to prostitute himself or herself, facilitating prostitution, taking advantage from that activity as practiced by someone else, recruiting, or trafficking for prostitution. Trafficking and recruiting for prostitution are sanctioned with imprisonment from two to seven years and loss of civil rights. When minors are recruited for prostitution, the criminal penalty is higher.²⁰⁸

Recently, a bill on establishing “Intimate houses” was submitted to the Chamber of Deputies. Its principal purpose is to decriminalize and regulate prostitution performed in certain places and under certain conditions. This bill is still being debated in a parliamentary special commission.²⁰⁹

Reality

Trafficking in women is a serious problem in Romania, and it is thought to be underreported. Romania has been identified as both a “source” and a “transit country” for trafficked women and girls.²¹⁰ Accurate statistics on the extent of the trafficking problem in Romania have not been collected. While records of individuals prosecuted for prostitution and procurement suggest that the number of trafficked persons has risen since 1997, this increase may be due to heightened law enforcement efforts in this area. NGOs estimate that several thousand women are trafficked to other countries each year. Representatives of the International

Organization for Migration report that their office processes two cases per month involving women trafficked to other countries who wish to return home.²¹¹

Official statistics reveal that in 1998, authorities stopped 28 groups trying to cross the country illegally. Women have reportedly been trafficked to Turkey, the Netherlands, and other West European countries, as well as to other Central and Eastern European countries, including Poland. In 1997, approximately 7,000 Romanian women were deported from Turkey.²¹²

3. Domestic Violence

Laws and Policies

There is no specific legislation concerning domestic violence and violence against women. Rather, laws relating to assault, public order, and divorce apply. Verbal abuse and cruelty that lead to mental and emotional injuries affecting a person's dignity can give rise to criminal sanctions as an insult or defamation.²¹³ Chasing away from the common home a spouse, the children, or other members of the family is a misdemeanor under the law.²¹⁴ Domestic violence actions are most commonly charged under battery, murder, or manslaughter.²¹⁵

For all domestic violence actions, the extent of the victim's injuries determines the severity of punishment. The Criminal Code mandates that the longer it takes a victim to heal, the heavier the penalty. If the victim is the perpetrator's spouse, the criminal penalty is more severe.²¹⁶ All victims therefore need to see the medical examiner, who must establish the approximate date of the injuries, how they were caused, and how long they will take to heal. The medical examination is ordered by the criminal investigator or the public prosecutor.²¹⁷

Legal procedures vary depending on the degree of the injuries. Certain categories of domestic violence, such as aggravated battery or murder,²¹⁸ obviously do not require the victim's prior complaint in order to start the criminal investigation. Others, however, such as simple battery, cannot be initiated by the police and prosecuted without the victim's involvement.²¹⁹

The Romanian Parliament is discussing a new law on domestic violence. The legislative intent is to make punishment for domestic violence more severe and to deny the perpetrator the right to live in the same house with the victim for at least two years.

Reality

Domestic violence is a common fact in Romania. According to a UNICEF report issued in September 1999, the country has an average of 108 sexual assaults per 1,000 women and 41 non-sexual assaults per 1,000 women. Police are reluctant to intervene in cases of domestic violence.²²⁰ Most cases of violence against women in the family are considered under the law as physical injury or serious physical injury.²²¹ The reported number of women victims of domestic violence increased five times from 1996 to 1998. In 1998, 13% of women victims of domestic violence died. Also in 1998, according to a study made in collaboration with the Pilot Center for Women Victims of Domestic Violence from Bucharest, 74% of women victims of domestic violence were attacked by their husbands, 4% by their partners, 7% by their ex-husbands and 15% by other relatives.²²²

Victims of domestic violence are often reluctant to file a complaint because they do not trust the police, most of whom are men, and because the police believe that they do not have the right to interfere with “family business.”²²³ Thus, in practice, few victims of family violence turn to the courts. Even when the accusations are proven, the criminal penalties do not deter the behavior. Furthermore, while the case is pending before the court, the victim often continues to live with the alleged perpetrator. The court cannot issue an “order of protection.” There is no legal means by which to remove or exclude a violent perpetrator, even temporarily, from the family home. Because of the onerous nature of the proceedings and the ineffective remedies, the survivors choose to withdraw their complaints or to reconcile with the aggressor.²²⁴

There are no specialized police units to deal with domestic abuse crimes and there are no special training sessions or guides for the police officer. Training sessions and awareness information for professionals are available but not mandatory. The police, prosecutors, and judges as well as teachers, health workers, social workers, doctors, and many other professional groups do not receive mandatory regular training sessions on domestic violence.

In 1997, a shelter for victims of domestic violence opened in Bucharest as part of a government pilot project. While the shelter can accommodate only four people, demand for its services appears to be high. In 1998, it received 490 calls for help on a hotline and registered 230 walk-in victims.²²⁵ Some NGOs, such as the Romanian Independent Society of Human Rights (SIRDO), have established programs focusing on family violence. One such program includes an initiative called “Stop Family Violence.” The goal of this initiative is “the realization of a harmonious family climate by stressing women’s and children’s rights according to international covenants.”²²⁶

According to a 1995 study, domestic violence is pervasive in Romania and it crosses all social and economic lines. Compounding women’s subordinate role in private and public life in Romania are the challenges posed by the economic and political transition, by poverty, and by alcoholism. The housing shortage in Romania further contributes to domestic violence by forcing women to stay in abusive relationships because they have no other place to go.²²⁷

D. Education and Adolescents (Article 10 of the Women’s Convention)

Introduction

A crucial determinant of women’s ability to control their reproductive lives is access to education. Education permits women to assert themselves in the civil, political, social, economic, and cultural spheres of society. Without education, women may be powerless to overcome their subordinate role within the family and society and may thus be denied their reproductive rights. A basic component of education for adolescents and women is counseling and information regarding sexual and reproductive health and methods of family planning.

Acknowledging widespread discrimination against women in access to education, Article 10 of the Women’s Convention requires States Parties to “take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education.” Among the required measures enumerated in Article 10 are the elimination of stereotyped concepts of the roles of women and men in all forms of education and the reduction of female student drop-out rates. Article 10(h) explicitly requires States Parties to ensure access to “information and advice on family planning.”

1. Access to Education

Laws and Policies

The Constitution of Romania provides that “[t]he right to education is provided for by the compulsory general education, by education in high schools and vocational schools, by higher education, as well as other forms of instruction and post-graduate refresher courses.”²²⁸ It guarantees free public education to all.²²⁹ Women as well as men benefit from equal access to all forms of education under the Romanian Constitution. The law pertaining to national education guarantees equality in access to education, regardless of social status, gender, race, nationality, or political or religious belief.²³⁰

Reality

Enrollment rates increased constantly in preschool education (from 90.8% in 1990 to 99.8% in 1998) and higher education (from 10.6% in 1990 to 25.4% in 1998), but decreased in secondary education (from 90.7% in 1990 to 67.8% in 1998). In 1998, the gross enrollment of women in primary school was 98.8%, in secondary school 81.4%, and in higher education 27.9%.²³¹ In 1997, the enrollment rate at all levels of education was slightly higher for women (63.5 %) than for men (62.3 %), although the level of adult literacy is higher for men (98.7%) than for women (95.4%).²³² While female enrollment in high schools and universities has gone up, so has the share of young women not receiving or abandoning compulsory education.²³³

In rural areas, the rate of enrollment has risen, from 78.4% in 1990 to 97.7% in 1998. However, education in rural areas is now facing difficulties due to the general financial crisis, the precarious condition of school premises and poor logistics, and a shortage of qualified teaching staff due to low wages.²³⁴

Certain gender disparities do exist within the educational system regarding access to and attainment of specific qualifications, skills, and opportunities. There tends to be gender stratification as a result of socialization and training in accordance with gender-stereotyped curricula and extracurricular activities. Women predominate as students in the social sciences, humanities, and the fields of health, law and education, which coincides with the sex segregation found in the labor market. Women are still under-represented in leadership positions. But there are no special programs to combat female illiteracy, re-train older women who wish to enter the labor market, or assist adult women with limited education and women with disabilities. No attention has been given to developing gender-neutral curricula or to ensuring women better access to and participation in technical and scientific areas.²³⁵

Traditionally, especially in predominantly rural areas, women marry and start their childbearing at young ages. At the same time, early marriage and/or childbearing may end a young woman's formal education, limiting her future job prospects.

2. Information and Education on Sexuality and Family Planning

Laws and Policies

There are no laws either restricting or permitting sex education in schools. Under the dictatorship of Ceaușescu, elements of reproductive biology were taught in high school in the biology and anatomy classes, and short lectures about venereal diseases were sometimes taught by visiting health professionals. Often, these lectures were held separately for boys and girls.²³⁶

To focus strategically on adolescent reproductive health in Romania, the Ministry of Health approved in 1997 a UNFPA project entitled “Reproductive Health and Sexual Education for Adolescents.”²³⁷ The project is administered by the national NGO Youth for Youth and is aimed at building capacity and educating adolescents, largely through volunteer peer sex education in schools, and STI/HIV prevention videos and print materials.

Reality

According to a recent survey, the few efforts that have been made to introduce sex and contraceptive education in the secondary school curriculum have been hindered by the resistance of both teachers and parents and the lack of adequate training of teachers. The primary source of information on contraception for young women is a friend (27%) or a colleague (13%), followed by media (17%) and health providers (12%). Ten percent have heard about contraception first from their mothers and 6% from their partners. Only 4% cited school courses.²³⁸

After 1990, with the continuous support of several international agencies, local NGOs started to send volunteers to lecture in high schools about methods of birth control and sexually transmitted diseases. These lectures must be approved by the local school boards and their content varies from one organization to another. Thus, sex education in some areas is sporadic or nonexistent (especially in rural areas) and the information provided is variable. Both young women and men overwhelmingly supported sex education in school, regardless of their age, residence, education, social-economic status. More than 93% feel that reproductive biology, birth control methods, and STI topics should be part of the school curriculum.²³⁹

While there has been a rise in the number of young people living in urban areas who are better educated and more informed about lifestyle choices, there are still many young women who have little education and low incomes. These young women tend to have little control over their lives, poor understanding of their bodies and little knowledge of or access to family planning. In their marriage and childbearing patterns, these young women are behaving more like their rural mothers than their urban peers.

Sexual education for young women who have left school is practically nonexistent. There are no special governmental programs to target them, and their only source of information remains the family planning clinics and family doctors.

E. Employment Rights (Article 11 of CEDAW)

Introduction

A woman's ability to exercise her reproductive rights is dependent upon her social and economic status. For this reason, any examination of women's ability to control their reproductive lives must include an assessment of women's rights in the workplace. Women in many countries face discrimination in employment. Article 11 of the Women's Convention requires States Parties to "take all appropriate measures to eliminate discrimination against women in the field of employment."

In some cases, women are denied the ability to make reproductive choices by employment policies that do not permit maternity or childcare leave. Article 11(2)(a) requires States Parties to prohibit dismissal on the grounds of pregnancy or of maternity leave and Article 11(2)(b) mandates the institution of maternity leave with pay and without loss of employment, seniority, or benefits. Article 11(2)(c) obligates States Parties to "encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities...."

CEDAW, in its General Recommendation 19 on Violence against Women, notes that "[e]quality in employment can be seriously impaired when women are subjected to... sexual harassment in the workplace."²⁴⁰ CEDAW recognizes that "[s]uch conduct can be humiliating and may constitute a health and safety problem."²⁴¹

1. Protection during Pregnancy and Maternity Leave

Laws and Policies

The Labor Code specifies special treatment for women during their pregnancy and while breast-feeding their children.²⁴² The rationale is that employed women should be assured the conditions necessary to protect their health while pregnant and that of their infant children. Pregnant and breast-feeding women are prohibited from working where there are dangers and risks to health or during the night.²⁴³ If a pregnant or lactating woman changes her workplace to avoid such risks, her pay may not be reduced.²⁴⁴

During pregnancy and immediately after delivery, women are entitled to a paid leave of 112 days (52 days before the birth and 60 days afterward).²⁴⁵ The rate of pay for this leave depends upon the woman's length of service, her monthly wage, and the number of her children. The amount of the indemnity varies between 50%, 65%, 85%, and 94% of the monthly base

wage, depending upon the length of the employment. For employees with three or more children, the pay during maternity leave is 94% of the monthly wage regardless of the length of employment, thus providing incentives for giving birth to more children.²⁴⁶

According to Article 156 of the Labor Code, women who are breast-feeding are entitled to reduce their workload and to take breaks up to two hours per day in order to breast-feed. This is permitted until the child is nine months old, with the possibility to extend it up to 12 months.²⁴⁷

A woman's employment contract may not be terminated during the period of maternity, breast-feeding, and medical leave for tending to a sick child.²⁴⁸ Persons self-employed in agriculture and their family members over 15 years of age who perform unpaid household work (or other unpaid work) are entitled to birth and maternity benefits as well.²⁴⁹ Women are granted the right to paid medical leave for taking care of a sick child, if the child is up to three years old.²⁵⁰ Women taking care of children up to six years old may work half-time without losing any seniority.²⁵¹ Teachers may take a break of up to three years in order to raise children, with a guarantee of keeping their jobs.²⁵²

Maternity leave may be combined with family leave for taking care of children under the age of two years old.²⁵³ This leave may be taken by either parent.²⁵⁴ Provided the parent has worked at least six months, the amount of paid leave is 85% of the monthly base wage, paid out of the social insurance budget.²⁵⁵ Women who interrupt their work to raise children are entitled to receive an unemployment benefit dating back to when they officially enrolled at the Labor Offices.²⁵⁶

A very recent victory for women's rights was the adoption by Parliament of the Law on Paternal Leave.²⁵⁷ The law aims to ensure the effective participation of fathers as caretakers for their newborns.²⁵⁸ The father of a newborn is entitled to five business days of leave.²⁵⁹ If he participates in the state social insurance system, the paternal leave is paid.²⁶⁰ If the father does compulsory military service, he is entitled to seven calendar days of leave.²⁶¹ If the mother dies during childbirth or maternity leave, the father is entitled to the remainder of the maternal leave, benefits included.²⁶²

Reality

In practice, private employers avoid paying for maternity and other leave simply by hiring women without a contract. This is obviously illegal and prejudicial, and deprives women of their social security, health care, and record of employment for pensions, unemployment, and other benefits. This "illegal" labor market does, however, observe some rules, such as the minimum wage law, in order to avoid governmental intervention. Temporary or short-term work contracts are other devices used to avoid paying maternity leave.²⁶³

Another tactic used by employers to avoid paying maternity benefits and leave and to avoid absenteeism due to child-related problems is to hire men, although there are female applicants with equal training for the same job.²⁶⁴ The effects of this discrimination in hiring are revealed in a recent study that shows that women's average wage is only 75% of the average wage earned by men.²⁶⁵ Women who raise their children alone are in an especially difficult position. Women perform the majority of unpaid work like household, child and elder care. Even when they work for wages, they are more likely to be employed in low-paid occupations.

Protective legislation focused exclusively on maternity protection at work and payment of some financial benefits (e.g. allowance for children) results in an increase in inequality of opportunities and of women's discrimination on the labor market. The precarious position of women in the labor market serves to reduce the constitutionally acknowledged principle of equality and non-discrimination.

2. Sexual Harassment

Laws and Policies

There is no specific legislation pertaining to sexual harassment. However, there is a draft law on Equal Opportunities between Women and Men, initiated by the Directorate for Equal Opportunities within the Ministry of Labor and Social Protection. This draft would forbid sexual harassment on the job and establish regulations in this field. The draft law is currently being debated within the Senate and Commission for Human Rights.

Reality

Sexual harassment is a well-known phenomenon in Romania, although there are no statistics to indicate how many women have been victims. Some job advertisements explicitly specify requirements as to the gender of the employee. A September 1999 report by UNICEF found that violence against women in the workplace is not uncommon. An ombudsman position was created within the Department for Child, Woman and Family Protection in 1998, but the total budget for women's programs for the year was less than 75,000 USD (1.4 billion ROL).²⁶⁶

NOTES

¹ Committee on the Elimination of Discrimination against Women (CEDAW), *General Recommendation No. 24 on Women and Health*, 20th Sess., para. 1 (Feb. 20, 1999) (visited May 9, 2000)

<<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>>.

² *Id.* para. 13.

³ *Id.* para. 14.

⁴ *Id.* para. 15.

⁵ *Id.* para. 17.

⁶ *Id.* para. 18.

⁷ *Id.* para. 26.

⁸ CONSTITUȚIA ROMÂNIEI [CONSTITUTION OF ROMANIA CONSTITUTION OF ROMANIA], art. 33(1) [CONST.]. The Constitution was adopted on November 21, 1991, was approved by referendum and entered into force on December 8, 1991, and was published in the MONITORUL OFICIAL [OFFICIAL GAZETTE OF ROMANIA] [M.Of.] Part I, No.233/Nov. 21, 1991. The English translation can be found at <http://www.uni-wuerzburg.de/law/ro00000_.html> (visited Nov. 30, 1999).

⁹ *Id.* art. 33(2).

¹⁰ *Id.* art. 33(3).

¹¹ *Id.* art. 43.

¹² Legea asigurărilor sociale de sănătate [Health Insurance Act] No. 145/1997, M.Of. No.178/Jul. 31, 1997, amended by Ordonanța de urgență [Emergency Statutory Order] No. 30/1998, M.Of. No. 421/Nov. 6, 1998. Other major acts include Legea privind exercitarea profesiei de medic, înființarea, organizarea și funcționarea Colegiului Medicilor din România [Law Concerning the Exercise of the Profession of Physician, the Creation, Organization and Functioning of the Romanian Board of Physicians] No. 74/1995, M.Of. No. 149/Jul. 14, 1995; Legea privind asistența de sănătate publică [Law on Public Health Assistance] No. 100/1998, art.8, M.Of. No. 204/Jun. 1, 1998; Ordonanța privind organizarea și funcționarea cabinetelor medicale [Statutory Order Concerning the Organization and Functioning of Medical Facilities] No. 124/1998, M.Of. No. 328/Aug. 29, 1998.

¹³ Law No. 145/1997 on Health Insurance, arts. 4-10.

¹⁴ *Id.* arts. 11-39.

¹⁵ *Id.* arts. 40-50.

¹⁶ *Id.* arts. 51-61.

¹⁷ *Id.* arts. 62-81.

¹⁸ GOVERNMENT OF ROMANIA, GOVERNMENT PROGRAM, POLICIES REGARDING HUMAN CAPITAL – HEALTH CARE (visited Nov. 30, 1999) <<http://domino.kappa.ro/guvern/programul.nsf/arhivaEng/0007?Open Document>>.

¹⁹ *Id.* para. 2.

²⁰ Legea privind exercitarea profesiei de medic, înființarea, organizarea și funcționarea Colegiului Medicilor din România [Law Concerning the Exercise of the Profession of Physician, the Creation, Organization and Functioning of the Romanian Board of Physicians] No. 74/1995, art. 3(2), M.Of. No. 149/Jul. 14, 1995.

²¹ *Id.* art. 4(2); *see also* Ordonanța privind organizarea și funcționarea cabinetelor medicale [Statutory Order Concerning the Organization and Functioning of Medical Facilities] No. 124/1998, art. 6(2), M.Of. No. 328/Aug. 29, 1998: “Physicians and other medical staff who work in a doctor’s office are personally responsible for their professional decisions, in conformity with the law, with regard to possible injuries against patients.”

²² Law No. 74/1995 on the Profession of Physician, art. 39.

²³ Codul penal [Criminal Code] [C.PEN.], arts. 174-176, 178, 180-184, BULETINUL OFICIAL [OFFICIAL BULLETIN] [B.Of.] No. 79-79bis/Jun. 21, 1968. The Criminal Code has been successively amended since 1968. The most important recent changes were adopted by Law No. 140/1996, M.Of. 289/Nov. 14, 1996.

²⁴ Codul civil [Civil Code] [C.CIV.], arts. 998-1003 (3rd ed. ALL 1994); the recent Hospitals Act also provides that hospitals are responsible for injuries caused to patients, including medical malpractice. Lege privind organizarea, funcționarea și finanțarea spitalelor [Law on the Organization, Functioning and Financing of Hospitals] No. 146/1999, M.Of. No. 370/Aug. 3, 1999.

²⁵ Legea privind asistența de sănătate publică [Law on Public Health Assistance] No. 100/1998, arts. 30, 31, M.Of. No. 204/Jun. 1, 1998.

²⁶ *Id.* art. 30(1) (a)-(d).

²⁷ *Id.* art. 30(2).

²⁸ THE NATIONAL COMMITTEE FOR CHILD PROTECTION & UNICEF ROMANIA COUNTRY OFFICE, THE SITUATION OF THE CHILD AND FAMILY IN ROMANIA 41 (1997) [hereinafter THE SITUATION OF THE CHILD AND FAMILY IN ROMANIA].

²⁹ INSTITUTE FOR MOTHER AND CHILD CARE, MINISTRY OF HEALTH & DIVISION FOR REPRODUCTIVE HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION, ROMANIA REPRODUCTIVE HEALTH SURVEY 1993, FINAL REPORT 1 (1995) [hereinafter REPRODUCTIVE HEALTH SURVEY]. By 1997, there remained only 511 polyclinics and 5,205 dispensaries. CENTRUL DE CALCUL, STATISTICĂ SANITARĂ ȘI DOCUMENTARE MEDICALĂ [THE CENTER FOR CALCULUS, MEDICAL STATISTICS AND DOCUMENTATION], MINISTERUL SĂNĂTĂȚII [MINISTRY OF HEALTH], ANUARUL DE STATISTICĂ SANITARĂ [ANNUAL REPORT OF MEDICAL STATISTICS] (1997). For a comprehensive study, see OBSERVATORUL NAȚIONAL ROMÂN [ROMANIAN NATIONAL OBSERVATORY], STRATEGIA NAȚIONALĂ DE DEZVOLTARE A RESURSELOR UMANE [NATIONAL STRATEGY OF HUMAN RESOURCES DEVELOPMENT] (1999) (visited Dec. 14, 1999)

<<http://servernt1.exec.gov.ro/die/docasoc/docro/sndru/strateg.htm>>.

³⁰ Communication with Dr. Marius Mărginean, Head of Family Medicine Department, Institute of Public Health Timișoara, Member of the National Council of the National Society of General & Family Practice of Medicine, Romania (Jan. 17, 2000) (on file with The Center for Reproductive Law & Policy).

³¹ See WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE, HEALTH CARE SYSTEMS IN TRANSITION, ROMANIA (PRELIMINARY VERSION) (1996) (visited Jan. 14, 2000)

<<http://www.who.dk/observatory>>.

³² UNITED NATIONS DEVELOPMENT PROGRAMME, NATIONAL HUMAN DEVELOPMENT REPORT: ROMANIA (1997) (visited Jan. 14, 2000) <<http://www.undp.ro/nhdr97>> [hereinafter NATIONAL HUMAN DEVELOPMENT REPORT 1997].

³³ Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy).

³⁴ Legea asigurărilor sociale de sănătate [Health Insurance Act] No. 145/1997, art. 14(1)(a)-(c), M.Of. No.178/Jul. 31, 1997; THE SITUATION OF THE CHILD AND FAMILY IN ROMANIA, *supra* note 28, at 41.

³⁵ UNITED NATIONS DEVELOPMENT PROGRAMME, NATIONAL HUMAN DEVELOPMENT REPORT: ROMANIA 49 (1999) [hereinafter NATIONAL HUMAN DEVELOPMENT REPORT 1999].

³⁶ *Id.* at 49.

³⁷ *Id.*

³⁸ *Id.* at 98.

³⁹ Legea privind asistența de sănătate publică [Law on Public Health Assistance] No. 100/1998, art.33, M.Of. No. 204/Jun. 1, 1998.

⁴⁰ *Id.* app. 1, Nos. 4, 12, 26.

⁴¹ NATIONAL CENTER FOR HEALTH PROMOTION, MINISTRY OF HEALTH, REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, at 1, 10 (1998) [hereinafter REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003].

⁴² Documentation on file with Societatea de Analize Feministe (AnA) [Society for Feminist Analyses].

⁴³ THE SITUATION OF THE CHILD AND FAMILY IN ROMANIA, *supra* note 28, at 42.

⁴⁴ Law No. 79/1991, app. 2, M.Of. No. 267/Dec. 31, 1991; see also Alin Stănescu & Luminița Marcu, *Politica sănătății reproducerii: evaluarea disponibilității serviciilor de planificare familială în România, Raport Final [The*

Policy on Reproductive Health: The Assessment of Family Planning Services Availability in Romania, Final Report] 3 (CEDPA, 1997).

⁴⁵ Under the World Bank Health Rehabilitation loan project, Law No. 79/1991 art. 1. WORLD HEALTH ORGANIZATION & UNITED NATIONS POPULATION FUND, FAMILY PLANNING AND REPRODUCTIVE HEALTH IN CCEE AND CIS 81 (1997).

⁴⁶ Stănescu & Marcu, *supra* note 44, at 3.

⁴⁷ An effort to upgrade the skills and competence of General Practitioners has begun and will eventually cover 499 rehabilitated dispensaries under the auspices of the current Health Sector Rehabilitation Project sponsored by the World Bank and coordinated by the Ministry of Health. *See* <http://www.worldbank.org.ro/eng/prj_e/health.htm>(visited Dec. 6, 1999). The upgrading process has been slow, often deliberately so in anticipation of the major changes expected in the new Health Insurance Law. The Board of Physicians will play a major role in the redefinition of GPs terms of reference, professional standards, expectations, and accreditation; and the Institute of Post-Graduate Education will provide training competence and skills. REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41, at 7.

⁴⁸ Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy).

⁴⁹ REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41, at 7; Support to the Romanian National Family Planning Programme (visited Jan. 14, 2000) <<http://www.unfpa.ro/2.html>>.

⁵⁰ Interview with Daniela Drăghici, Country Representative, The POLICY Project (Romania) (date) (on file with AnA – Societatea de Analize Feministe [Society for Feminist Analyses]).

⁵¹ *Id.*

⁵² *Id.*

⁵³ THE SITUATION OF THE CHILD AND FAMILY IN ROMANIA, *supra* note 28, at 43.

⁵⁴ MANAGEMENT SCIENCES FOR HEALTH, ENTREPRENEURIAL FAMILY PLANNING CLINICS IN ROMANIA (visited Apr. 5, 2000) <http://www.msh.org/projects/fpmd26_72ro.html>.

⁵⁵ *See Planul de activitate al societății de educație contraceptivă și sexuală din România pentru anul 1997 [Plan of Action of the Society for Contraceptive and Sexual Education for 1997], Portofoliu de programe [Programs Portfolio] and Scurtă descriere a proiectelor [Short Project Description]* at <<http://www.zpok.hu/sbnet/org/secs>> (visited Dec. 7, 1999).

⁵⁶ REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41, at 7.

⁵⁷ Support to the Romanian National Family Planning Programme (visited Jan. 14, 2000) <<http://www.unfpa.ro/2.html>>.

⁵⁸ Interview with Daniela Drăghici, Country Representative, The POLICY Project (Romania) (April 2000) (on file with AnA – Societatea de Analize Feministe [Society for Feminist Analyses]).

⁵⁹ Legea privind asistența de sănătate publică [Law on Public Health Assistance] No. 100/1998, art.12(h), M.Of. No. 204/Jun. 1, 1998.

⁶⁰ *Id.* art. 15(1)(b).

⁶¹ *Id.* art. 16.

⁶² REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41, at 10.

⁶³ OVERVIEW OF UNFPA ASSISTANCE TO: ROMANIA, RUSSIA, MOLDOVA, BELARUS, UKRAINE (1998); Development of Information Modules on Reproductive Health, Reproductive Health and Sexuality Education for Adolescents, and Support for Policies and Programme Development (visited Jan. 14, 2000), <<http://www.unfpa.ro/2.html>>.

⁶⁴ Legea audiovizualului [Audio-Visual Law] No. 48/1992, art. 2(4), M.Of. No. 104/May 25, 1992 (forbidding the broadcast of obscene materials).

⁶⁵ C.PEN., art. 325.

⁶⁶ *Id.* at 62.

⁶⁷ *Id.* at 66.

⁶⁸ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 65.

⁶⁹ *Id.* at 62-63.

⁷⁰ *Id.* at 111.

⁷¹ *Id.* at 112.

⁷² *Id.* at 111.

⁷³ FAMILY PLANNING AND REPRODUCTIVE HEALTH IN CCEE AND CIS, *supra* note 45, at 81.

⁷⁴ Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy).

⁷⁵ Interview with Daniela Drăghici, Country Representative, The POLICY Project (Romania) (April 2000) (on file with AnA – Societatea de Analize Feministe [Society for Feminist Analyses]).

⁷⁶ As a consequence of concluding the loan agreement with the International Bank for Reconstruction and Development in 1991 (approved by Law No. 79/1991, M.Of. No. 267/Dec. 31, 1991), the Government adopted a decision on temporary exemption from the payment of custom duties for a series of imported products, including contraceptive products. Hotărâre privind modificarea Hotărârii Guvernului nr. 393/1996 privind exceptarea temporară de la plata taxelor vamale a unor produse din import [Government Decision Amending the Decision of Government No. 393/1996 on the Exemption of Some Imported Products from Custom Taxes] No. 1392/1996, M.Of. No. 340/Dec. 11, 1996.

⁷⁷ Laws regulating pharmaceuticals (production, import, distribution, compensation, etc.) include the following Ministry of Health Orders: Ordin privind unele măsuri pentru supravegherea calității medicamentului și a unor produse de uz uman [Order on Some Measures for the Supervision of the Quality of Drugs and Other Products for Human Use] No. 1010/1992, M.Of. No. 327/Dec. 18, 1992; amended by Order No. 59/1993, M.Of. No. 24/Feb. 10, 1993; Ordin pentru aprobarea Normelor privind eliberarea autorizațiilor de funcționare a unităților farmaceutice, precum și a regulamentelor de organizare și funcționare a acestor unități [Order on the Approval of Norms Concerning Licenses to Authorize the Functioning of Pharmacies, as well as on their Rules of Organization and Functioning] No. 2234/1994, M.Of. No.44/Mar. 8, 1995, amended by Order No. 1573/1996.

⁷⁸ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 69; REPRODUCTIVE HEALTH SURVEY 1999, PRELIMINARY REPORT; Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy) [hereinafter REPRODUCTIVE HEALTH SURVEY 1999].

⁷⁹ REPRODUCTIVE HEALTH SURVEY 1999, *supra* note 78.

⁸⁰ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 69.

⁸¹ Interview with Daniela Drăghici, Country Representative, The POLICY Project (Romania) (April 2000) (on file with AnA – Societatea de Analize Feministe [Society for Feminist Analyses]).

⁸² Stănescu & Marcu, *supra* note 44, at 17.

⁸³ The subvention is underwritten by the World Bank Rehabilitation Program, which allows the pills to be purchased below their market value. NGOs are actively at work to maintain the integral financing of reproduction health services from the Health Insurance Fund and/or from the state budget in order to make contraception affordable for all.

⁸⁴ REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41, at 1, 10.

⁸⁵ Decret pentru reglementarea întreruperii cursului sarcinii [Decree to Regulate Abortion] No. 770/1966, B.Of. No. 60/Oct. 1, 1966. Abrogated by Decret-lege [Decree-Law] No. 1/1989, M.Of. 4/Dec. 4, 1989.

⁸⁶ C.PEN., art. 185. This means 12 weeks from the date of conception or, alternatively, 14 weeks from the last menstrual period.

⁸⁷ *Id.* art. 185(3).

⁸⁸ Under punishment by art. 185(1)(b) of the Criminal Code.

⁸⁹ C.PEN., art. 185(1).

⁹⁰ *Id.* art. 185(2).

⁹¹ *Id.* art. 185(3).

⁹² *Id.* arts. 185(4), 64(1)(c).

⁹³ In 1997, the Parliamentary Commission for Human Rights submitted for public debate a bill against the legalization of abortion (initiated by the governmental coalition at the time). Women's NGOs voiced their opposition and the project was dropped. AnA - SOCIETATEA DE ANALIZE FEMINISTE [SOCIETY FOR FEMINIST ANALYSES], STATUTUL FEMEII ÎN ROMÂNIA. 1998: FAPTE ȘI CIFRE [THE STATUS OF WOMEN IN ROMANIA. 1998: FACTS AND STATISTICS] (visited Feb. 29, 2000) <[http://www.anasaf.ro/index\(rom\).html](http://www.anasaf.ro/index(rom).html)>.

⁹⁴ INTERNATIONAL CHILD DEVELOPMENT CENTRE, UNICEF, WOMEN IN TRANSITION 117 tbl.2.8 (1999) (visited Apr. 10, 2000) <<http://www.unicef-icdc.org/pdf/rmr6.shtml>> [hereinafter WOMEN IN TRANSITION].

⁹⁵ REPRODUCTIVE HEALTH SURVEY 1999. PRELIMINARY REPORT, *supra* note 78, at 12.

⁹⁶ WOMEN IN TRANSITION, *supra* note 94, at 64.

⁹⁷ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 59.

⁹⁸ Information provided by Dr. Alin Stănescu, Executive Director, Institutul pentru Ocrotirea Mamei și Copilului [Institute for Mother and Child Care], Bucharest.

⁹⁹ See REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 45-60. For a comparative perspective, see *Stanley K. Henshaw, Susheela Singh and Taylor Haas, The Incidence of Abortion Worldwide*, INTERNATIONAL FAMILY PLANNING PERSPECTIVES, 1999, 25(Supplement):S30–S38, <<http://www.agi-usa.org/pubs/journals/25s3099.html>> (visited Dec. 8, 1999).

¹⁰⁰ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 55.

¹⁰¹ Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy).

¹⁰² Hotărârea Ministerului Sănătății [Health Ministry Order] No. 206/1997 on Abortion Exemptions.

¹⁰³ *Id.* at 100.

¹⁰⁴ FLORINA ȘERBĂNESCU & LEO MORRIS, NATIONAL INSTITUTE FOR MOTHER AND CHILD CARE ET AL., YOUNG ADULT REPRODUCTIVE HEALTH SURVEY ROMANIA 1996, at 130 (1998) [hereinafter YOUNG ADULT REPRODUCTIVE HEALTH SURVEY].

¹⁰⁵ The Orthodox Patriarch has regularly condemned homosexuality as the “acceptance of the degrading, abnormal, and unnatural as a natural and legal style of living.” EVENIMENTUL ZILEI, Dec. 16, 1993.

¹⁰⁶ SORIN LUCIAN PAIA & BOGDAN MARINESCU, COMPENDIU PRACTIC DE PLANIFICARE FAMILIALĂ: PENTRU UZUL MEDICULUI GENERALIST [PRACTICAL GUIDE OF FAMILY PLANNING FOR GENERAL PRACTITIONERS] 177-199 (1998).

¹⁰⁷ *Id.*

¹⁰⁸ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 65.

¹⁰⁹ REPRODUCTIVE HEALTH SURVEY 1999. PRELIMINARY REPORT, *supra* note 78; Communication with Dr. Mihaela Poenariu, Programme Director, East European Institute of Reproductive Health (Apr. 27, 2000) (on file with The Center for Reproductive Law & Policy).

¹¹⁰ Hotărâre privind școlarizarea cetățenilor din alte țări în România, în anul de învățământ 1991/1992 [Decision Regarding the Education in Romania of Foreign Citizens for 1991/1992] No. 627/1991, M.Of. No. 195/Sept. 27, 1991. Article 7 requires applicants to submit to a medical and epidemiological test, AIDS included. The AIDS test's cost will be covered by the applicants.

¹¹¹ Legea privind asistența de sănătate publică [Law on Public Health Assistance] No. 100/1998, art.15(h), (i), M.Of. No. 204/Jun. 1, 1998.. The provision charges the directorates for public health at the county level and in Bucharest to organize, guide, and control the detection, treatment, and prevention of STIs according to norms set out by Ministry of Health to ensure the detection of HIV, HBV, HCV, and other viral infections transmitted by blood, and to control the implementation of the legal norms in force concerning the medical assistance and correct treatment; Lege privind donarea de sânge, utilizarea terapeutică a sângelui uman și organizarea transfuzională în România [Law Concerning Blood Donation, the Therapeutical Use of Human Blood and the Organization of Transfusion in Romania], M.Of. No. 9/Jan. 18, 1995. The law designates the Ministry of Health as the main authority in the field of blood donation and transfusion.

¹¹² C.PEN., art. 309(2), (3). The first paragraph of this provision imposes a prison sentence of one to five years for transmission of STIs.

¹¹³ *Id.* art. 309¹.

¹¹⁴ *Id.* art. 309(1).

¹¹⁵ Hotărâre privind acordarea de burse și alte facilități financiare și materiale pentru copii, elevii, studenții și cursanții din învățământul de stat [Decision Concerning Scholarships and Other Financial and Material Benefits for Children and Students Attending State Schools] No. 859/1995, app. 1 pt. III (A)(1)(a), M.Of. 250/Nov. 1, 1995. ; Hotărâre privind aprobarea Planului național de acțiune în favoarea copilului [Decision for the Approval of the National Plan for Children] No. 972/1995, app. pts. I (A)(10), IV(11), M.Of. 290/Dec. 14, 1995.

¹¹⁶ UNAIDS, ELEMENTS OF NATIONAL RESPONSES TO HIV/AIDS 7-8 (1999).

¹¹⁷ Health Ministry Orders No. 493/1995, 1423/1993 (on file with AnA – Societatea de Analize Feministe [Society for Feminist Analyses]).

¹¹⁸ JULIA SOUTH, UNAIDS, SNAPSHOT OF EXTERNAL SUPPORT FOR NATIONAL RESPONSES TO THE EPIDEMIC OF HIV/AIDS IN CENTRAL & EASTERN EUROPE (INCLUDING CENTRAL ASIA) AS REPORTED BY CO-SPONSORS, BILATERAL AGENCIES AND NGOS 54 - 60(1999); ELEMENTS OF NATIONAL RESPONSES TO HIV/AIDS *supra* note 116.

¹¹⁹ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 165. The new health insurance system mandates that doctors be paid based on the number and age of patients, the achievement of prophylactic activities, and the number and value of points. For example, for each patient between 19 and 44 years, the doctor receives four points. Sexually transmissible infections also are valued at four points. Thus, doctors have an incentive to keep track of and report all diseases. Hotărâre privind introducerea experimentală a unui nou sistem de acordare a asistenței medicale și de alocare a resurselor în acest domeniu [Decision on the Introduction of an Experimental System of Health Assistance] No. 370/1994, M.Of. No. 185/July 20, 1994; Communication with Dr. Marius Mărginean, Head of Family Medicine Department, Institute of Public Health Timișoara, Member of the National Council of the National Society of General & Family Practice of Medicine, Romania (Jan. 17, 2000) (on file with The Center for Reproductive Law & Policy).

¹²⁰ See MINISTRY OF HEALTH STATISTICS, tbl. 3.1 (March 1999) (on file with The Center for Reproductive Law & Policy).

¹²¹ *Id.*

¹²² NATIONAL HUMAN DEVELOPMENT REPORT 1999, *supra* note 35, at 93.

¹²³ COMMON COUNTRY ASSESSMENT, *supra* note 144, at 38 – 41.

¹²⁴ NATIONAL HUMAN DEVELOPMENT REPORT 1999, *supra* note 35, at 93.

¹²⁵ MINISTRY OF HEALTH STATISTICS, *supra* note 142, tbl. *Distribuția cazurilor SIDA la adulți după calea de transmitere [Distribution of AIDS Cases for Adults Taking into Account the Mode of Transmission]*.

¹²⁶ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 165.

¹²⁷ COMMON COUNTRY ASSESSMENT, *supra* note 144, at 39.

¹²⁸ *Id.* at 38-41.

¹²⁹ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 166 – 169.

¹³⁰ COMMON COUNTRY ASSESSMENT, *supra* note 144, at 38 – 41.

¹³¹ Romania ratified the Convention on the Rights of the Child through Law No. 18/1990, M.Of. No. 109/Sept. 28, 1990. Other major acts regarding children include Ordonanța de urgență privind înființarea Agenției Naționale pentru Protecția Drepturilor Copilului și reorganizarea activităților de protecție a copilului No. 192/1999, M.Of. No. 599/Dec. 8, 1999; Legea concediului paternal [Law on Paternal Leave] No. 210/1999, and M.Of. No. 654/Dec. 31, 1999; Lege privind alocația de stat pentru copii [Law Concerning the State Allowance for Children] No. 61/1993.

¹³² See REPRODUCTIVE HEALTH PROMOTION: OPERATIONAL PLAN 1998 – 2003, *supra* note 41.

¹³³ Nota privind reforma asistenței medicale pentru elevi și studenți [Note on the Reform of Medical Assistance for Students] No. 10364/April 21, 1999 (visited Feb. 26, 2000) <<http://www.edu.ro/no10364.htm>>.

¹³⁴ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 86-88.

¹³⁵ *Id.* at 43.

¹³⁶ *Id.* at 59-61.

¹³⁷ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 151-152.

¹³⁸ CEDAW, *General Recommendation No. 21 on Equality in Marriage and Family Relations*, 13th Sess. (Feb. 4, 1994) (visited May 9, 2000).

<<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>>.

¹³⁹ *Id.* para. 16.

¹⁴⁰ *Id.* paras. 36, 38.

¹⁴¹ *Id.* para. 28.

¹⁴² CONST., *supra* note 8, art. 44(1): “Family is founded on the freely consented marriage of the spouses, their full equality, as well as the right and duty of the parents to ensure the upbringing, education and instruction of their children.”; Legea No. 4/1953 [Family Code] [C.FAM.], B. Of. No. 1/Jan. 4, 1954; amended by Legea No. 59/1993,

M.Of. No. 177/Jul. 26, 1993. Article 1 provides that men and women have equal rights with regard to their children. Article 25 established that men and women have equal rights and obligations in their marriage. Furthermore, they decide by common agreement everything concerning their marriage (art. 26).

¹⁴³ C.FAM. arts. 25, 26.

¹⁴⁴ *Id.* art. 30.

¹⁴⁵ *Id.* art. 97(1).

¹⁴⁶ CONST., *supra* note 8, art. 44(1); C.FAM. art. 1(3).

¹⁴⁷ C.FAM. art. 4(1).

¹⁴⁸ C.PEN., art. 197(5).

¹⁴⁹ C.FAM. art. 16(1), as amended by Law No. 23/1999, art. 2, M.Of. No. 35/Jan. 28, 1999.

¹⁵⁰ Legea administrației publice locale [Law on Local Public Administration] No. 69/1991, arts. 44(1)(t), 46(2), (3),

M.Of. No. 79/Apr. 18, 1996.

¹⁵¹ *Id.* art. 44(2).

¹⁵² C.PEN. art.304.

¹⁵³ *Id.* art. 303.

¹⁵⁴ WOMEN IN TRANSITION, *supra* note 94, at 127 tbl.5.1.

¹⁵⁵ NATIONAL HUMAN DEVELOPMENT REPORT 1997, *supra* note 32, ch. 3.

¹⁵⁶ WOMEN IN TRANSITION, *supra* note 94, at 127, 128 tbls.5.2, 5.3; UNDP & NATIONAL COMMISSION FOR STATISTICS, FEMEI ȘI BĂRBAȚI ÎN ROMÂNIA 1999 [WOMEN AND MEN IN ROMANIA 1999] 6 (forthcoming 2000).

¹⁵⁷ WOMEN AND MEN IN ROMANIA 1999, *supra* note 180, at 6.

¹⁵⁸ C.FAM. arts. 37 – 44. as amended by Law No. 59/1993, art. VIII, M.Of. No. 177/Jul. 26, 1993.

¹⁵⁹ Codul de procedură civilă [Code of Civil Procedure] [C.PROC.CIV.], arts. 607 – 619, as amended by Law No. 59/1993 art. I (34)-(41).

¹⁶⁰ C.FAM. art. 38(1) as amended by Law No. 59/1993, art. VIII(1).

¹⁶¹ It is because of this that draft law on marital rape was rejected.

¹⁶² C.FAM. art. 38(2) as amended by Law No. 59/1993, art. VIII(2).

¹⁶³ C.FAM. art. 38(2); C.PROC.CIV. art. 613¹, both amended by Law No. 59/1993, arts. I(36), VIII(2).

¹⁶⁴ C.FAM. art. 41(3).

¹⁶⁵ *Id.* art. 41(2).

¹⁶⁶ *Id.* art. 42(1).

¹⁶⁷ WOMEN IN TRANSITION, *supra* note 94, at 128, 129 tbls.5.4, 5.5.

¹⁶⁸ NATIONAL HUMAN DEVELOPMENT REPORT 1999, *supra* note 35, at 133.

¹⁶⁹ WOMEN IN TRANSITION, *supra* note 94, at 129 tbl.5.6.

¹⁷⁰ *Id.* arts. 42(2), (3).

¹⁷¹ WOMEN AND MEN IN ROMANIA 1999, *supra* note 180, at 5.

¹⁷² *Id.* at 7.

¹⁷³ C.FAM. art. 4.

¹⁷⁴ *Id.* art. 4(2).

¹⁷⁵ UNITED NATIONS STATISTICS DIVISION, AGE AT MARRIAGE AND PERCENTAGE MARRIED AMONG 15 TO 19-YEAR-OLDS, BY SEX, 1985/96 (visited Apr. 18, 2000) <www.un.org/Depts/unsd/gender/1-4dev.htm>.

¹⁷⁶ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 43.

¹⁷⁷ REPRODUCTIVE HEALTH SURVEY, *supra* note 29, at 80.

¹⁷⁸ *Id.* at 82.

¹⁷⁹ CEDAW, *General Recommendation No. 19 on Violence against Women*, 11th Sess., para. 1 (Jan. 30, 1992) (visited May 9, 2000)

<<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>>.

¹⁸⁰ *Id.* para. 6.

¹⁸¹ *Id.*

¹⁸² *Id.* para. 9.

¹⁸³ *Id.* para. 23.

¹⁸⁴ *Id.* para. 24(b).

¹⁸⁵ C.PEN., art. 197(1).

¹⁸⁶ *Id.* art. 197(2).

¹⁸⁷ *Id.* art. 197(3).

¹⁸⁸ *Id.* art. 204.

¹⁸⁹ *Id.* art. 198(1). The sentence is one to five years in prison.

¹⁹⁰ *Id.* art. 198(2).

¹⁹¹ *Id.* art. 198(3), (4). In the first two cases, the sentence is three to twelve years in prison. If the victim dies, it is seven to 15 years in prison.

¹⁹² *Id.* art. 199. The sentence is one to five years in prison, but reconciliation between the two parties removes criminal responsibility.

¹⁹³ *Id.* art. 200(2).

¹⁹⁴ *Id.* art. 200(4).

¹⁹⁵ *Id.* art. 202.

¹⁹⁶ *Id.* art. 204.

¹⁹⁷ BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, U.S. DEPARTMENT OF STATE, 1999 COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES: ROMANIA §5 (released Feb. 25, 2000, visited Apr. 18, 2000)

<http://www.state.gov/www/global/human_rights/1999_hrp_report/romania.html>

[hereinafter STATE DEP'T REPORT].

¹⁹⁸ C.PEN., art. 197(4). Prosecution of rape is difficult because it requires both a medical certificate and a witness.

STATE DEP'T REPORT, *supra* note 197, §5.

¹⁹⁹ C.PEN., art. 197(5). In cases of gang rape, reparatory marriage with any of the perpetrators waives the criminal liability of all participants.

²⁰⁰ *Id.* art. 203.

²⁰¹ *Id.* art. 204.

²⁰² UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), DE LA TRAUMĂ LA INTEGRITATE, FEMEILE DIN ROMÂNIA ÎȘI REGĂSESC IDENTITATEA: CONFERINȚA FEMEILOR 28 – 30 APRILIE 1999 [FROM TRAUMA TO INTEGRITY, ROMANIAN WOMEN REDISCOVER THEIR IDENTITY: WOMEN'S CONFERENCE 28-30 APRIL, 1999] [hereinafter 1999 WOMEN'S CONFERENCE].

²⁰³ *Id.*

²⁰⁴ UNITED NATIONS DEVELOPMENT PROGRAMME, STATUS OF WOMEN IN ROMANIA 1997 – 1998, at 109 (1999).

²⁰⁵ STATE DEP'T REPORT, *supra* note 197, §5.

²⁰⁶ *Id.* §6.f.

²⁰⁷ C.PEN. art. 328.

²⁰⁸ *Id.* art. 329.

²⁰⁹ See Ileana Mălăncioiu, *Colapsul și localurile intime* [Collapse and Intimate Places], ROMÂNIA LITERARĂ No. 12/1999 (visited May 16, 2000) <<http://romlit.sfos.ro/www/texte99/r1912mal.htm>>.

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Id.*

²¹³ C.PEN. arts. 205, 206.

²¹⁴ Lege pentru sancționarea faptelor de încălcare a unor norme de conviețuire socială, a ordinii și liniștii publice [Law for the Punishment of Acts that Infringe on Norms of Social Behaviour, on Public Order and Tranquillity] No. 61/1991, art. 2(ș), M.Of. No. 196/Sept. 9, 1991.

²¹⁵ C.PEN. arts. 174-176, 178, 180-184.

²¹⁶ *Id.* art. 175(c).

²¹⁷ Codul de procedură penală [Code of Criminal Procedure] [C.PROC.PEN.], art. 114, M.Of. No. 78/Apr. 30, 1997. The medical examination and expertise is further regulated by arts. 115-127.

²¹⁸ C.PEN. arts. 174-176, 178, 182, 183.

²¹⁹ *Id.* arts. 180, 181, 184. Articles 279-286 of the Code of Criminal Procedure regulate the procedure of criminal complaint. The complaint, addressed to the court, the police, or the public prosecutor, depending on the specific

charge, must present the facts, the aggressor, the evidence, and whether the victim asks for damages. The complaint must be submitted within two months of the date the victim knew who the attacker was.

²²⁰ STATE DEP'T REPORT, *supra* note 197, §5.

²²¹ 1999 WOMEN'S CONFERENCE, *supra* note 202.

²²² MINISTERUL MUNCII ȘI PROTECȚIEI SOCIALE [MINISTRY OF LABOR AND SOCIAL PROTECTION], VIOLENȚA ÎN FAMILIE: STUDIU AVÂND LA BAZĂ ACTIVITATEA CENTRULUI PILOT DE ASISTENȚĂ ȘI PROTECȚIE A VICTIMELOR VIOLENȚEI ÎN FAMILIE [DOMESTIC VIOLENCE: STUDY BASED ON THE ACTIVITY OF THE PILOT CENTER FOR ASSISTANCE AND PROTECTION OF VICTIMS OF DOMESTIC VIOLENCE] (Jan. 1997 – May 1998) (1999).

²²³ 1999 WOMEN'S CONFERENCE, *supra* note 202.

²²⁴ MINNESOTA ADVOCATES FOR HUMAN RIGHTS, LIFTING THE LAST CURTAIN: A REPORT ON DOMESTIC VIOLENCE IN ROMANIA (1995) (visited May 16, 2000)

<<http://www.mnadvocates.org/mahr/women/public/romania.htm>>.

²²⁵ STATE DEP'T REPORT, *supra* note 197, §5.

²²⁶ MINNESOTA ADVOCATES FOR HUMAN RIGHTS, *supra* note 249.

²²⁷ *Id.*

²²⁸ CONST. art. 32(1).

²²⁹ *Id.* art. 32(4).

²³⁰ Legea învățământului [Education Law] No. 84/1995, art. 5(1), M.Of. No. 167/Jul. 31, 1995.

²³¹ NATIONAL HUMAN DEVELOPMENT REPORT 1999, *supra* note 35, at 52.

²³² THE STATUS OF WOMEN IN ROMANIA. 1998: FACTS AND STATISTICS, *supra* note 109.

²³³ NATIONAL HUMAN DEVELOPMENT REPORT 1999, *supra* note 35, at 67.

²³⁴ *Id.* at 53.

²³⁵ COMMON COUNTRY ASSESSMENT, *supra* note 144, at 59.

²³⁶ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 15.

²³⁷ UNFPA, REPORT OF THE EXECUTIVE DIRECTOR FOR 1998: REGIONAL OVERVIEW ¶¶ 32, 33 (visited Feb. 27, 2000) <http://www.unfpa.org/execboard/1999sessions_/1999061423_/a4dp997p3/7702x.htm>. This project, ROM/97/P01, having a total budget of 265,000 USD for the period 1997-99, will have close links with ROM/97/P02, and will make use of common and coordinated technical assistance.

²³⁸ YOUNG ADULT REPRODUCTIVE HEALTH SURVEY, *supra* note 104, at 37. However, as the study shows, there has been a slight increase in the contribution of health providers (from 9% to 12%) and mothers (from 7% to 10%).

²³⁹ *Id.* at 16.

²⁴⁰ CEDAW, *General Recommendation No. 19 on Violence against Women*, 11th Sess., para. 17 (Jan. 30, 1992) (visited May 9, 2000)

<<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>>.

²⁴¹ *Id.* para. 18.

²⁴² Legea No. 10/1972 [Labor Code] [C.MUNCII], arts. 151-158, B.Of. 140/Dec. 1, 1972.

²⁴³ *Id.* art. 152(1).

²⁴⁴ *Id.* art. 152(2).

²⁴⁵ *Id.* art. 155(1); *see also* Lege privind concediul plătit pentru îngrijirea copiilor în vârstă de până la doi ani [Law Concerning the Paid Parental Leave for the Benefit of Children up to Two Years Old] No. 120/1997, art. 1, M.Of. 149/Jul. 11, 1997.

²⁴⁶ Lege pentru modificarea și completarea unor reglementări din legislația de asigurări sociale [Law to Amend Some Provisions of the Social Insurance Legislation] No. 49/1992, art. IV(5), M.Of. No. 107/Jun. 26, 1992.

²⁴⁷ C.MUNCII art. 156.

²⁴⁸ *Id.* art. 146.

²⁴⁹ Lege privind pensiile și alte drepturi de asigurări sociale [Law Concerning Pensions and Other Social Security Rights] No. 80/1992, art. 1, M.Of. No. 180/Jul. 29, 1992.

²⁵⁰ Legea privind pensiile de asigurări sociale de stat și asistență socială [Social Security Law] No. 3/1977, art. 72, B.Of. 82/Aug. 6, 1977, as amended by Law No. 49/1992, art. III(8), M.Of. No. 107/Jun. 26, 1992; C.MUNCII art. 157.

²⁵¹ C.MUNCII art. 158.

²⁵² Lege privind Statutul personalului didactic [Law Concerning Rules that Govern the Status of Teachers] No. 128/1997, art. 106(1), M.Of. No. 158/Jul. 16, 1997.

²⁵³ Lege privind concediul plătit pentru îngrijirea copiilor în vârstă de până la doi ani [Law Concerning the Paid Parental Leave for the Benefit of Children up to Two Years Old] No. 120/1997, art. 2, M.Of. 149/Jul. 11, 1997.

²⁵⁴ *Id.* art. 6.

²⁵⁵ *Id.* arts. 3, 7.

²⁵⁶ Lege pentru protecția socială a șomerilor și reintegrarea lor profesională [Law on the Social Protection of the Unemployed and Their Professional Reintegration] No. 1/1991, art. 7(4), M.Of. No.257/Sept. 9, 1994.

²⁵⁷ Legea concediului paternal [Law on Paternal Leave] No. 210/1999, M.Of. No. 654/Dec. 31, 1999.

²⁵⁸ *Id.* art. 1(1).

²⁵⁹ *Id.* art. 1(2).

²⁶⁰ *Id.* art. 2(1).

²⁶¹ *Id.* art. 3(1).

²⁶² *Id.* art. 5.

²⁶³ Lege privind unele măsuri de protecție a persoanelor încadrate în muncă [Law Concerning Some Measures of Protection for Employees] No. 83/1995, M.Of. No. 166/Jul. 31, 1995. Art. 4(1) provided that part-time and temporary employees are not covered by social security and unemployment benefits. Law No. 83/1995 was abrogated by the new law on social protection for employees No. 130/199, M.Of. No. 355/Jul. 27, 1999. In an attempt to correct some of the problems created by the old law, Law No. 130/1999 provides that part-time employees can be covered by social security (art. 5), but not by unemployment benefits (art. 6).

²⁶⁴ STATUS OF WOMEN IN ROMANIA 1997 – 1998, *supra* note 229.

²⁶⁵ ACADEMIA ROMÂNĂ [ROMANIAN ACADEMY], RAPORTUL NAȚIONAL AL DEZVOLTĂRII UMANE ÎN ROMÂNIA [NATIONAL REPORT OF HUMAN DEVELOPMENT IN ROMANIA] 34 (1997).

²⁶⁶ STATE DEP'T REPORT, *supra* note 197, §5.