

## Romania: facing the challenge of translating research into practice – policy and partnerships to promote mental health among adolescents

Adriana Baban<sup>1</sup>, Catrinel Craciun<sup>1</sup>, Robert Balazsi<sup>1</sup>, Dan Ghenea<sup>2</sup>, Victor Olsavszky<sup>3</sup>.

<sup>1</sup> Babes-Bolyai University, Cluj-Napoca; Romanian Health Psychology Association, Bucharest.

<sup>2</sup> National Centre for Mental Health, National School for Public Health and Healthcare Management, Bucharest.

<sup>3</sup> WHO Country Office, Romania, Bucharest.

### Executive summary

The Romanian case study presents data on the mental health and well-being of Romanian youth from the 2006 HBSC survey, describes the socioeconomic context of public policies and intervention programmes, provides information on the “Health education in Romanian schools” programme and reveals lessons learned following its implementation.

Having to negotiate a period of political and economic transition and to adapt to its new status as an EU country has left a mark on the social context of Romania. Economic instability has contributed to the development of health inequalities, marginalization of vulnerable groups and a decline in the mental health and well-being of the general population. This creates the need to intervene at an early age to prevent psychological problems and promote mental health.

The 2006 HBSC survey showed that Romanian teenagers reported average mental health, with the majority being satisfied with their lives and considering themselves healthy. Social capital and socioeconomic differences emerged, however, reflecting the existence of mental health inequalities. Adolescents from a poorer socioeconomic background had the worst positive health as indicated by lower levels of mental health, self-perceived health and life satisfaction. Possessing high social capital, on the other hand, produced a protective factor, meaning that young people who had more social capital also enjoyed better mental health.

Following WHO recommendations, the Ministry of Public Health decided to prioritize prevention interventions in the field of mental health. This included the adoption of laws and the planning of implementation strategies that targeted children and adolescents. In the case study, it is described the present policy aimed at improving adolescent health and mental well-being. “Health education in Romanian schools” represents a successful example of intersectoral collaboration involving: the Ministry of Education, Research and Youth; the Ministry of Public Health; local authorities; NGOs; and universities and schools. It reflects their joint effort to organize a programme designed to help children and young people to grow up healthy, prevent mental health problems and promote social inclusion.

The partnership proved efficient in developing curricular, training and financing mechanisms, but effective process and outcome evaluation programmes need to be developed to measure the impact of this kind of educational intervention on the mental health of children and adolescents. Adequate financial and human resources need to be provided to help Romania face the challenge of translating research into practice.

Drawing on data from the HBSC study regarding mental health and its determinants can contribute to effective policy and programme development. This issue can be addressed through the development of interventions that help build bonding, bridging and linking social capital to promote social inclusion and augment mental well-being among adolescents.

### Introduction

During the last 16 years, Romania has been facing the challenge of changing from a communist regime to democracy and a market economy and is currently adapting to its new status as an EU country. Despite a rapidly growing economy, poverty remains a problem for many Romanians, with 14% of the population surviving on less than US\$ 2.5 per day. The GDP per capita in 2007 was US\$ 10 152, which represents an improvement from 2003 when it was US\$ 7140 (1). The World Bank estimated in 2002 that the Gini Index for Romania was 30.3, which placed it higher than other eastern European countries. Social disparities induce health inequalities reflected by the high incidence of tuberculosis, high number of children with low birth weight and the high rate of child and maternal anaemia found among low socioeconomic groups (2).

Of the population of 21.7 million (2002 census), 17.95% is comprised of children aged 0–14 years (2 million males and 1.96 million females). In 2004, 24.4% of Romanian children lived in poverty, while 8.2% were living in very poor households (3). Child poverty is most apparent in single-parent or extended households, in families where parents are unemployed, in rural areas and in Roma communities.

The Roma ethnic group is particularly subjected to the consequences of health inequality. Romania is estimated to have one of the largest Roma populations in Europe, with around 2 million (representing 9.21% of the total country population) (4). Among the factors that explain Roma people's poor health are high poverty (in 2002 it was estimated that almost 50% of the Roma population live in poverty), lack of proper living conditions, low level of education, poor nutrition and poor communication with health professionals. Moreover, due to a lack of identity cards, the majority of the Roma are denied the right to benefits from the health insurance fund and access to health services. Consequently, Roma life expectancy is 10 years shorter than for the general population and infant mortality is 40% higher than that of Romanian children (5). Levels of illiteracy and school drop-out rates are highest among this ethnic group.

Romania has a legacy of more than 10 000 HIV-positive children, representing the largest child population living with HIV in Europe (6). Most of these children were infected between 1986 and 1991 in health institutions and orphanages through contaminated needles and unscreened blood transfusions. Having survived with the help of antiretroviral therapy – Romania being the first eastern European country to provide general access to this treatment – they are considered “miracle children”. Unfortunately, this has not been accompanied by an effort to fight the stigma against them. In Romania, HIV-positive children and adolescents are facing social exclusion that takes the form of denied access to education (less than 60% attend any form of schooling) and lack of professional integration (7).

Other groups who are prone to social exclusion and health inequalities in Romania are children with mental and physical disabilities. In addition, children who are currently inside or exiting the social protection system are facing difficulties in the process of social and professional integration.

---

## Mental health and well-being status among Romanian adolescents

---

In the following section, adolescent mental and physical health data collected from a national representative adolescent sample (n = 4654) are presented as part of the 2006 Romanian HBSC survey. Emerging social capital, gender and socioeconomic differences are discussed.

### Social cohesion

Social cohesion was measured by using a social capital index calculated from computing the following: social networks and social support; local identity; power and control thorough engagement; and perception of local areas.

The majority of Romanian adolescents enjoy strong social support networks. On average, communication within their peer group was perceived as being better than inside the family, with boys reporting slightly better peer communication than girls. In relation to social network structures (number of friends), more than two thirds of Romanian teenagers have three or more close friends. Gender differences concerning free time spent with friends appear only at age 15 and favour boys (p<0.05). These findings are confirmed by data from interviews with adolescents. Girls report more frequently that parents restrict their ways of spending leisure time with friends.

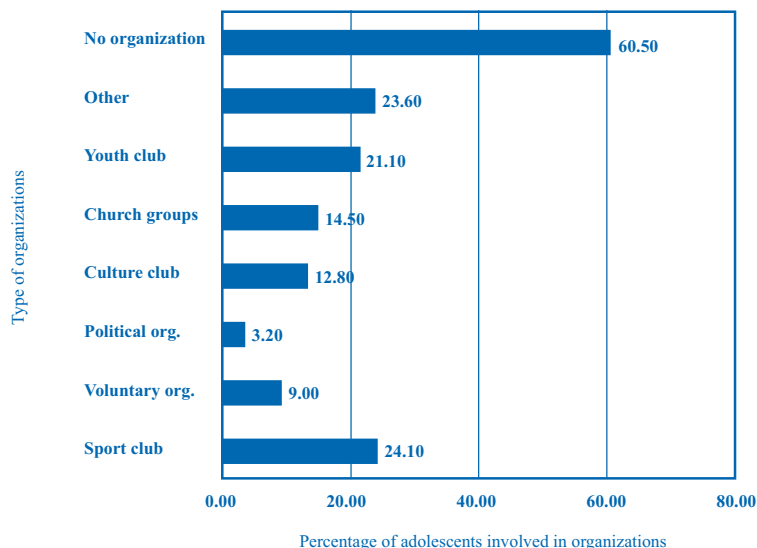
*Social support* within the school setting was measured by computing scores from three items: the extent to which classmates like to spend time together; the amount of extra help students receive from teachers; and the degree of interest that teachers show for their pupils as individuals. Fifteen-year-old girls perceived a higher amount of social support within the school setting than boys. This could be explained by the fact that girls were more often perceived as “good students” and consequently were rewarded with more social support from teachers.

Most Romanian adolescents did not participate in any organizations, which can negatively influence their capacity to develop social networks and the amount of social support they receive (Fig. 1). Among the barriers to joining organizations, clubs or extracurricular activities that were most frequently mentioned in interviews were interference with school work and lack of

attractive affiliation opportunities. Among those who got involved in organizations, girls chose voluntary activities, political organizations, church groups and youth clubs, while boys preferred sports clubs.

**Fig. 1**

Involvement of Romanian adolescents in organizations



*Local identity* was meant to reflect feelings of belonging and identification within the school setting. Two thirds of the sample felt integrated in the school setting, but gender differences emerged. More boys considered school a nice place to be, while more girls perceived school as a safe place. The percentage of adolescents who felt their classmates were nice or were involved in organizing school events dropped with age, reflecting a decline in feelings of belonging and received social support.

*Perception of local area* comprised feelings about safety, level of trust and leisure-time resources. Positive perception of one’s local area decreased with age, with only about half of the 15-year-olds reporting that they liked their neighbourhood, felt safe and trusted their neighbours. Significant gender differences ( $p < 0.01$ ) emerged, as boys tended to have a more flattering perception of their neighbourhood.

**Positive health**

Positive health was measured by using the following indicators: life satisfaction; self-perceived health; health complaints; mental health index; and level of self-esteem and self-efficacy. Life satisfaction was measured on a 1–10 scale, where “1” represents the worst possible life and “10” the best possible life. Romanian adolescents reported an above-average life satisfaction (Table 1).

**Table 1**

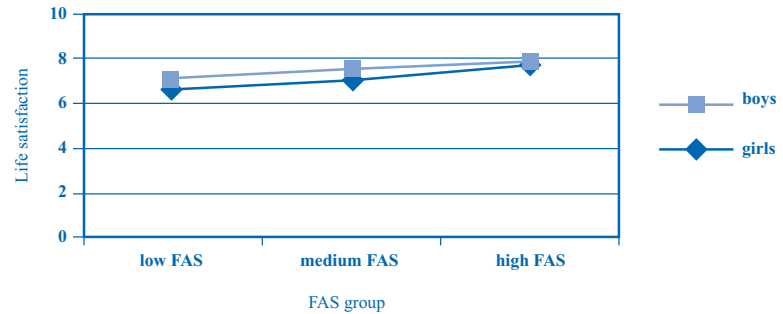
Young people with scores above the middle (>6) of the life satisfaction scale (%)

	11-year-olds (N = 1 625)		13-year-olds (N = 1 429)		15-year-olds (N = 1 600)	
	Boys	Girls	Boys	Girls	Boys	Girls
<b>Life satisfaction (&gt;6)</b>	80.3%	75.5%	86.2%	79%	83.2%	71.4%

There were significant gender differences ( $p < 0.01$ ), with girls reporting slightly lower satisfaction than boys (Fig. 2). Young people with a better financial situation (measured with the FAS) reported being more satisfied with their lives ( $p < 0.01$ ).

**Fig. 2**

Mean life satisfaction scores by FAS



*Self-perceived health* was measured on a four-range scale (“1” represents excellent health and “4” poor health). Most teenagers considered themselves healthy, with only a small number reporting fair and poor health, but “excellent” and “good” perceived health decreased with age. For each age group, girls reported poorer health than boys, as can be seen in Table 2.

**Table 2**

Self-reported health by age and gender (%)

Self-reported health	11-year-olds		13-year-olds		15-year-olds	
	Boys	Girls	Boys	Girls	Boys	Girls
Fair and poor	12.1%	18.8%	8.6%	17.7%	12.9%	25.5%

Adolescents who enjoyed higher economic status reported better health, with a slight advantage in the case of boys. Having social capital only made a significant difference ( $p < 0.01$ ) in the case of girls, those with more social capital considering themselves to be healthier (Table 3). Regression analysis results showed that having good communication within the family and peer group, possessing a local identity and perceiving one’s local area as being safe and nice to live in represented predictors of good self-perceived health ( $p < 0.01$ ). These social capital factors explained 7% of the variance in self-perceived health.

**Table 3**

Mean self-perceived health differences by social capital

	Self-perceived health	
	Boys (M, SD)	Girls (M, SD)
<b>Low social capital</b>	1.75 (0.67)	1.98 (0.64)*
<b>High social capital</b>	1.84 (0.67)	2.21 (0.71)*

\* mean differences in self-perceived health as a function of social capital at  $p < 0.01$

A standard symptom checklist was used to measure physical and psychological *health complaints* experienced in the last six months, on a scale from 1 to 5 (“1” means having symptoms almost every day and “5” rarely or never). Frequently experienced symptoms (almost every day, more than once a week and almost every week) are shown in Table 4. Health complaints increased with age and there were significant gender differences, with girls reporting more symptoms than boys. In general, psychological health complaints were more frequent than physical ones, with “feeling low” being the most commonly mentioned symptom. Among physical complaints, headache was the most recurrent.

There were no significant differences in the number of reported health complaints as a function of perceived affluence (measured with FAS), but there were significant differences in the case of social capital ( $p < 0.01$ ), with girls with more social capital reporting fewer health complaints (m 25.54; SD 6.93) than those with low social capital (m 27.75; SD 7.81).

**Table 4**

The frequency of experienced symptoms by age and gender (%)

Symptoms	11-year-olds		13-year-olds		15-year-olds	
	Girls	Boys	Girls	Boys	Girls	Boys
Headache	25.6	38.6	29.4	45.7	25.6	53.1
Stomach ache	19.4	28.4	20	28.4	13.9	29.8
Backache	17.5	22.4	23.1	32.5	22.6	31.3
Feeling low	44.6	47.8	47.4	59.9	51.2	73.8
Irritability	30.5	29.9	40.5	47.8	51.7	67.8
Feeling nervous	27.6	31.1	36.6	45.7	44,8	66.1
Sleep difficulties	19.2	24.4	21.8	26.7	26.1	36.4
Feeling dizzy	17	19.9	20.8	25	15.9	26.9

The *mental health index* was measured by a ten-item scale, with scores ranging from 1 to 50. It included questions about the emotional state (such as “*last week, did you feel sad?*”), cognitive state (“*last week, were you able to concentrate?*”) and behaviours (“*last week, did you have fun with your friends?*”). The majority of adolescents had an average mental health (m 34; SD 6.61). Overall, girls had significantly ( $p<0.05$ ) poorer mental health (m 32.98; SD 6.09) compared to boys (m 35.78; SD 7.08). High socioeconomic status and high social capital represented predictors ( $p<0.01$ ) of superior mental health, perceived family affluence accounting for 8% of mental health variation while social capital explained 20% of mental health variance. Among teenagers, those who possessed a large network of friends, enjoyed good peer communication, were involved in organizations and in making decisions that affected their lives perceived themselves as having better mental health ( $p<0.01$ ).

Self-esteem represents the evaluative dimension that reflects how much you value yourself. It has been shown to be an important determinant of health (8). Self-efficacy has been defined as the belief people have in being able to influence their environment by making use of their cognitive and motivational resources (9) and is also recognized as an important determinant of healthy behaviours (8). Most adolescents reported above-average self-esteem and self-efficacy. Significant gender differences ( $p<0.01$ ) emerged for self-efficacy, with girls (m 32.77; SD 4.52) considering themselves less self-efficacious than boys (m 33; SD 5.55). Regression analysis showed social capital to be a predictor for both self-esteem and self-efficacy ( $p<0.01$ ).

### Violence and bullying

Violent behaviour among teenagers has been measured by using three items from the HBSC questionnaire: number of times one has been involved in a physical fight; number of times one has bullied others; and number of times one has been bullied. On average, boys (m 4.4; SD 2.23) were significantly ( $p<0.01$ ) more aggressive than girls (m 3.37; SD 1.66), being involved frequently in *physical fights or bullying* of others.

Differences in relation to perceived family affluence emerged. Boys who had a better socioeconomic situation tended to be more aggressive towards others, while girls’ aggression decreased with perceived family affluence. On the other hand, both boys and girls who scored lower on FAS tended to be more bullied by others ( $p<0.01$ ). On average, young people who possessed higher social capital were also significantly ( $p<0.01$ ) less aggressive (Table 5).

### Risk behaviour

Several risk behaviours were measured within the HBSC questionnaire: smoking frequency (1–5 scale, with “1” meaning smoking daily and “5” no smoking); number of times being drunk (1–5 scale) and condom use (yes/no answer scale). Scores

**Table 5**

Mean differences in aggressive behaviour by social capital

	Aggressive behaviour	
	Boys (M, SD)	Girls (M, SD)
<b>High social capital</b>	4 (2.05) *	3.13 (1.49)*
<b>Low social capital</b>	4.70 (2.34)*	3.58 (1.77)*

\* mean differences in aggressive behaviour by social capital at  $p < 0.01$ 

from these items were used to compute a *risk behaviour index* and explore the relation between risk behaviour and social capital. A *risk behaviour debut index* has been computed for 15-year-olds by including the following items: the age of first sexual intercourse; the age one started smoking; age at which one started drinking; and the age of first drunkenness. The lower the score on this index, the higher the risk behaviour, as it stands for an early debut of risk behaviour adoption.

Generally, more boys reported smoking and drunkenness compared to girls. There were no significant differences in risk behaviour in relation to perceived family affluence. Nevertheless, adolescents with superior perceived wealth tended to smoke and drink more, probably as they could afford the material costs of these risk behaviours.

Young people with low social capital were more prone to engage in risk behaviour (Table 6). In relation to the debut of risk behaviour, 15-year-old girls with high social capital tended to start adopting risk behaviours earlier than boys ( $p < 0.01$ ). This can be interpreted as a negative consequence of high-bonding social capital, as being involved in a peer group that has norms which encourage risk behaviour is more dangerous for girls than boys. Other possible explanations could be that boys have more self-efficacy than girls in believing they can resist temptations, or that girls tend to conform more to the norms of the peer group even when these are damaging to their health.

Results from this first wave of HBSC data collection will be disseminated through a variety of channels to inform key policy decision-makers from the Ministry of Public Health, the Ministry of Education, Research and Youth, local school

**Table 6**

Risk behaviour index as a function of social capital

	Risk behaviour index			
	13-year-olds		15-year-olds	
	Boys (M, SD)	Girls (M, SD)	Boys (M, SD)	Girls (M, SD)
Low social capital	5.67 (1.15)	5.30* (0.81)	4.67* (2.50)	3.41* (1.86)
High social capital	5.61 (0.12)	5.11* (0.78)	4.26* (2.18)	2.70* (1.39)

\* differences in risk behaviour as a function of social capital, sig. at  $p < 0.01$ 

inspectors, NGOs, mass-media representatives and teachers and parents. Strategies for translating research into practice and encouraging intersectoral collaboration will be explored and implemented.

## Policy context: national mental health strategies

Following WHO recommendations, the commitment to improve health has become one of the government's priorities, leading to the adoption of the following laws and policies:

- the National Anti-Poverty and Social Inclusion Plan (2002)

- the National Action Plan for the Reform of the Health Sector (2004)
- the Mental Health Strategy of the Ministry of Public Health (2002).

The last on this list comprises a legislative module that includes law for the promotion of mental health and the protection of people with mental illness, developed in accordance with the “Principles for the protection of people with mental illness and the improvement of mental health care” adopted through Resolution 46/119 by the United Nations National Assembly in 1991. Other policy measures consist of:

- national programmes for the prevention of psychiatric and psychosocial disorders
- education policies that favour the insertion of mental health in the health education school curricula
- education programmes targeted at vulnerable groups such as the Roma population
- national campaigns for violence prevention.

Several institutions are involved in making sure that the right to health is exercised in conformity with Article 34 of the Romanian Constitution: the Romanian Government, the Ministry of Public Health, the Ministry of Education, Research and Youth, the Ministry of Finance, the Ministry of Justice and the Ministry of Environment. Local authorities and several NGOs were also drawn into this process to help engage the community in decisions related to its health.

Mental health represents one of the six priorities of the national public health strategy developed by the Ministry of Public Health and approved by means of the Minister of Public Health Order No. 923/06/16/2004, published in the OJ No. 662 of 07/22/2004. According to the action plan for the implementation of the mental health strategy, the Ministry of Public Health is prioritizing prevention modules, programmes and actions targeting adolescent and child mental health, including the following.

### **Primary prevention**

This consists of actions designed to promote positive mental health and to reduce the incidence of mental health problems or, if risk is already present, to help adolescents and their parents to develop their coping abilities. The module includes:

- stress management, crisis and conflict management programmes
- parent education programmes regarding adolescents’ substance use
- child abuse prevention programmes
- mass-media campaigns that promote healthy lifestyles
- assistance programmes for crisis situations (disasters).

### **Secondary prevention**

These interventions target the detection and treatment of problems in their early stages to reduce their prevalence. Measures in this area focus on:

- programmes for institutionalized children
- programmes for children and adolescents who have alcoholic parents
- programmes for the inclusion of children/teenagers with HIV/AIDS.

### **Interventions**

These target positive mental health promotion by creating the necessary conditions to ensure an optimum psychosocial environment:

- creating prenatal counselling centres;
- creating counselling centres for families with children in difficulty (such as those with disabilities, risk behaviours, low socioeconomic status and risk of abandonment);
- introducing programmes for the mental health of schoolchildren by matching work demands with the cognitive and emotional potential of pupils;
- training primary health care physicians to offer information and counselling on mental health; and
- promoting mental health in schools in collaboration with the Ministry of Education, Research and Youth.

Despite the great number of mental health promotion initiatives, these have not yet become real government priorities. Following the *Mental Health Action Plan for Europe (10)*, the “Twinning light” programme was developed between the ministries of health of Romania and the Netherlands with the purpose of supporting the mental health strategy of the Romanian Ministry of Public Health.

The Romanian League for Mental Health, an NGO founded in 1990 with the aim of shaping government policy and promoting alternative mental health practices, has assumed an active role in the promotion of mental health in schools and has developed several programmes:

- “Now you know why you have to care”, the first national campaign on mental health developed in collaboration with the Estuar Foundation and other local NGOs;
- “Stop violence in schools”, developed by UNICEF and the National Institute for Science and Education; and
- “Early intervention and education”, developed by UNICEF and the Step-by-Step Foundation.

### **Health promotion policy: the national programme of “Health education in Romanian schools”**

Following prioritization of health promotion in schools, the “Health education in Romanian schools” programme was developed in 2003 by the Ministry of Education, Research and Youth and the Ministry of Public Health. Its main objective is to introduce health education in all Romanian schools as an optional subject or as an extracurricular activity aiming to develop responsible attitudes towards one’s own health and the health of others. The main objectives of the programme are the following:

1. well-being and health promotion among Romanian pupils through:
  - ensuring an optimal somatic, emotional, social and spiritual functioning;
  - developing a healthy lifestyle;
2. individual growth and development through:
  - building a positive self-image;
  - developing responsible decision-making skills;
  - developing stress-management skills;
  - developing a personal career plan;
3. illness prevention through:
  - preventing accidents and reducing risk behaviour;
  - preventing negative attitudes towards self, others and life;
  - preventing interpersonal conflicts, social inadequacy and crisis situations.

The health education curriculum for grades I-XII was approved by Education Minister Ordinance 4496/2004. It is structured in six modules, designed for the three distinct educational cycles (primary, secondary and high school). The health education curriculum includes the following major themes:



- human anatomy and physiology
- stages of physical, mental and emotional development
- personal hygiene
- physical activity and relaxation
- healthy nutrition
- environmental health
- mental health
- reproductive health
- risk behaviour and substance misuse
- accidents, violence and abuse prevention.

In relation to *mental health*, the curricula include:

- communication and interpersonal knowledge
- stress management
- developing tolerance for difference
- building social cohesion.

Educational materials for health education in Romanian schools (textbook, video, CD, booklets) were created between 2003–2005 by the Ministry of Education, Research and Youth, Ministry of Public Health and NGOs. Financing of the “Health education in Romanian schools” programme was provided in the period 2002–2005 by the Ministry of Education, Research and Youth, Ministry of Public Health, NGOs, international donations (including from organizations such as UNICEF, the United Nations Development Programme (UNDP) and the United States Agency for International Development (USAID) and sponsorships.

“Health education in Romanian schools” sets an example of effective intersectoral collaboration (see Fig. 3). A national partners’ committee was formed and includes: the Ministry of Education, Research and Youth; Ministry of Public Health; Ministry of Youth and Sports; Ministry of National Defence; the National Authority for the Protection of Consumers; NGOs; international donors; and private companies. The committee had the task of designing and coordinating the “Health education in Romanian schools” programme and the extracurricular health education activities. Several partners were responsible for programme implementation in schools: the district school inspectorates, district directorates for youth and sports, district directorates for health and local NGOs.

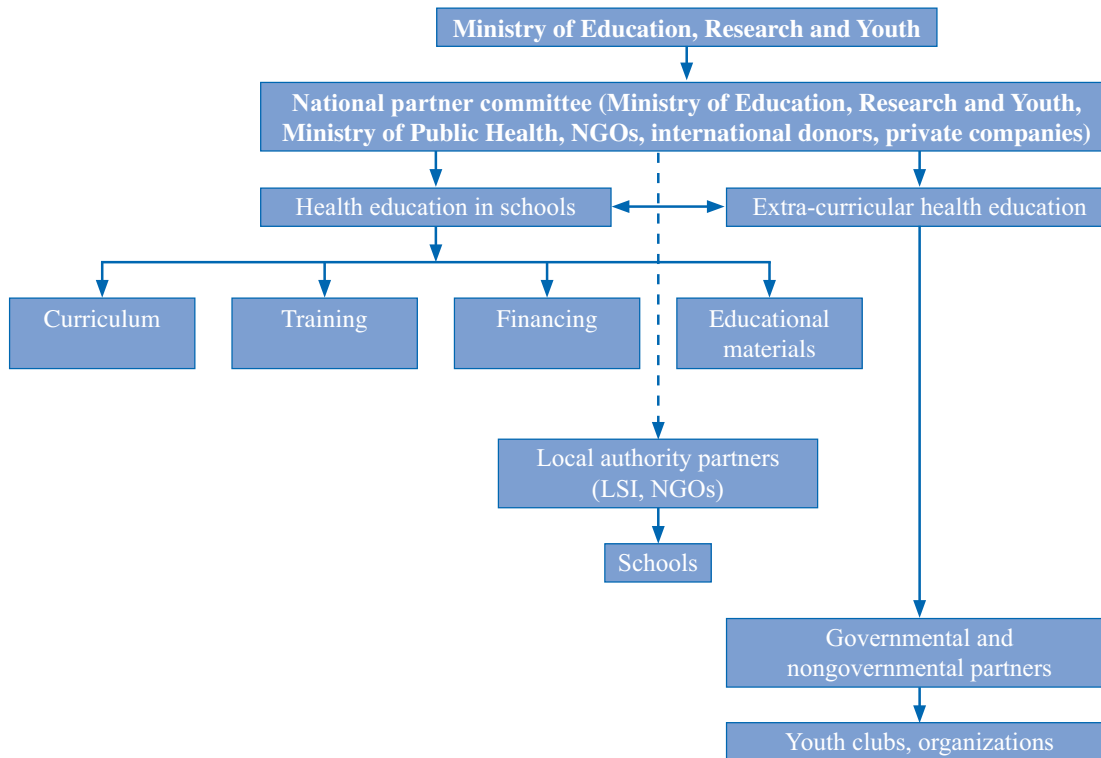
Last but not least, the schools were partners in the project and were directly involved in health education activities. Extracurricular health education activities were developed and provided by several governmental and nongovernmental partners. Youth organizations and authorities in charge of adolescent summer camps took part in the implementation process.

The training of health educators started before the development of “Health education in Romanian schools”, creating the necessary human resources for the implementation of a national health education programme. Several NGOs were actively involved in training teachers to teach health education: the Open Society Foundation; Youth for Youth; Romanian Health Psychology Association; and Save the Children. Their training programmes were accredited and supported by the Ministry of Education, Research and Youth.

One of the first NGOs involved in training health educators was the Open Society Foundation, which trained more than 500 school teachers within the Project “Education 2000+”. The main focus of the health education programme was risk behaviour prevention and positive health promotion. Another important outcome of this programme was the development and national dissemination of a teacher guide for health counselling (11).

**Fig. 3**

The structure of health education in schools, adapted from the Ministry of Education, Research and Youth



Another NGO actively involved in school health education is “Youth for Youth”, which mainly focuses on adolescent reproductive health and developing family life skills. In addition to its training activities, a school textbook, *Education for family life*, was published in 2001 for use by teachers (12).

Another successful intersectoral cooperation example between the Ministry of Education, Research and Youth and local education institutions (the psychology department from Babes-Bolyai University, Cluj-Napoca) is the “MAGISTER” programme, which was developed as a training course for school teachers and kindergarten educators. Several county school inspectorates are involved as partners in the implementation of the project. The programme was accredited by the Ministry of Education, Research and Youth in June 2003; since then, 6000 teachers from all regions of Romania have been trained.

“MAGISTER” is being financed by the Ministry of Education, Research and Youth and funds are being administered through the county school inspectorates. Several topics relevant to the mental health of schoolchildren are included: socioemotional development; communication skills development; stress management; risk behaviour prevention; and positive health promotion. These are included in a published textbook (13).

An important further step of all the above-described health education programmes is the development and implementation of process and outcome evaluation, which would monitor the effectiveness of the intervention.

In accordance with the *Mental Health Action Plan for Europe* (10) and the recommendations of Chapter 6.1.1. from the Green Paper *Improving mental health of the population: towards a strategy on mental health for the European Union* (14), the “Health education in Romanian schools” programme focuses on building mental health in children and adolescents. In addition to fostering the training of human resources necessary to teach students on health-related topics, it also covers parity of funding based on intersectoral collaboration.

## Lessons learned

Effective health education needs to be based on scientific research and theories which confirm its value. Taking into consideration the lack of process and outcome evaluation data on the impact of school health education on Romanian teenagers, the development of evidence-based health education programmes in Romanian schools is recommended. In addition, research results on child and adolescent mental health, such as HBSC data, can be used to inform the further improvement of the health education curriculum and the design of useful process evaluation and outcome evaluation measures.

Based on results from the 2006 Romanian HBSC survey, public policy concerning adolescent mental health should focus on three broad objectives:

- preventing social exclusion of vulnerable groups (children and adolescents from low socioeconomic backgrounds, Roma ethnicity, teenagers with disabilities or with delinquent behaviour) by offering information, promoting acceptance of individual and group differences, encouraging interaction and providing equal opportunities;
- providing help to support major life transitions (all the physical and psychological changes that are characteristic of adolescence, entering high school and deciding on a future career) by making prevention and counselling services available; and
- sustaining community development efforts to create friendlier neighbourhoods.

As Romanian HBSC data show, teenagers who possess more social capital report having better mental health and fewer health complaints (both physical and psychological); actions should therefore be taken to build social capital to promote adolescent mental health and reduce health inequalities. This can be achieved by developing policies to help adolescents develop bonding, bridging and linking social capital.

An increase of bonding social capital can be encouraged by:

- stimulating the development of social networks (within the family, the peer group and school setting) and providing spaces where families or peer groups can spend time and socialize as a group (for instance, within community parks, cultural centres and sport centres); and
- building self-esteem and self-efficacy among teenage groups, as these represent predictors of social capital and of mental health; this can be achieved through education and counselling interventions.

The development of bridging social capital can be influenced by:

- encouraging teenagers to involve themselves in clubs and organizations; and
- offering the possibility of joining clubs and organizations within schools or the community.

The growth of *linking* social capital can be stimulated by offering opportunities for adolescents to involve themselves in decisions made within the school setting (such as consulting them regarding health education curricula and offering career orientation classes).

Previous reports on the mental health of Romanian youth have pointed to the lack of available data on this issue. The 2006 HBSC survey represents an improvement, as it can be used as a means of strengthening the evidence base on child and adolescent mental well-being and providing a base for mental health promotion development.

At the moment, Romania has a suitable set of policies and strategies regarding mental health in general and youth mental well-being in particular. To achieve the effective adoption of these guidelines and the development of high-quality infrastructures, however, adequate human and financial resources are necessary.

One of the strengths of the “Health education in Romanian schools” programme is that it helped build a network of trained professionals who can teach health education in schools. It also provides an example of effective intersectoral collaboration between the Ministry of Education, Research and Youth, Ministry of Public Health, local authorities, NGOs and schools and universities which helps guarantee quality training in the domains of health education and mental well-being promotion.

The WHO assessment of mental health in Romania revealed that most progress in mental health promotion has been achieved by involving NGOs. The lack of cooperation and involvement of public authorities formed barriers to effective mental health promotion which resulted in the development of only a small number of programmes and little continuity within activities. Collaboration with local and international NGOs could provide a solution to the problem of shortage of financial resources. In addition, a good partnership between ministries can help raise the necessary finances through joint budgeting to implement existing mental health strategies. A good example is represented by the “Twinning light” programme, an alliance between the health ministries of Romania and the Netherlands created with the purpose of facilitating the implementation of the Ministry of Public Health mental health strategy.

Even if mental health promotion and health education have only recently become governmental priorities in post-Communist Romania, joint intersectoral efforts have been made towards the implementation of a national school health education policy. But to certify its effectiveness, the challenges of improving financial mechanisms and conducting evidence-based interventions still have to be faced.

---

## References

1. *10 health questions about the new EU neighbours*. Copenhagen, WHO Regional Office for Europe, 2004.
2. *The European health report 2005. Public health action for healthier children and populations*. Copenhagen, WHO Regional Office for Europe, 2005 (<http://www.euro.who.int/document/e87325.pdf>, accessed 28 July 2008).
3. *Annual report*. Bucharest, UNICEF Romania, 2005.
4. *Romania case study on Roma*. Bucharest, UNDP, 2006.
5. *UN report on social, economic and cultural rights, submitted by special rapporteur Paul Hunt, Economic and Social Council*. New York, NY, United Nations, 2005.
6. *Report on the global aids epidemic*. Geneva, UNAIDS, 2004.
7. Bencomo D. “Life doesn’t wait.” Romania’s failure to protect and support children and youth living with HIV. *Human Rights Watch*, 2006, 18:6(D).
8. *Life skills education for children and adolescents in schools*. Geneva, World Health Organization, 1997.
9. Bandura A. *Social learning theory*, Englewood Cliffs, NJ, Prentice-Hall, 1977.
10. *Mental Health Action Plan for Europe*. Copenhagen, WHO Regional Office for Europe, 2005 (<http://www.euro.who.int/Document/MNH/edoc07.pdf>, accessed 22 May 2008).
11. Baban A, Petrovai D, Lemeni G. *Counselling and guidance: a teacher guide*. Bucharest, Humanitas, 2002.
12. Youth for Youth. *Education for family life*. Bucharest, UNICEF, 2001.
13. Baban A. *Educational counselling for health*. Cluj, Psinet, 2001.
14. *Improving the mental health of the population: towards a strategy on mental health for the European Union*. Brussels, EC Health and Consumer Protection Directorate-General, 2005 ([http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/green\\_paper/mental\\_gp\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf), accessed 22 May 2008).