Between Justice and Reality:

Access to Sexual and Reproductive Health Services in Romania

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Research conducted within the project
"Health for all of us. Increasing access to reproductive health and midwifery services"

The aim of this report is to foreground the real, often invisible barriers women face when they need to access sexual and reproductive health services. However, beyond the analysis, what makes this report truly valuable are the voices of those who have lived these realities.

First of all, we would like to thank from the bottom of our hearts the women who have had the confidence to share their stories with us. We know it has sometimes been very difficult, as many of them spoke about painful experiences, marked by racism, poverty, violence, shame or a lack of support. They did not just give us their time or share some words – they provided us with an actual insight into their lives. Thanks to them, this report is more than research: it is a mirror of real experiences. We can only hope that this document succeeds in doing them justice and reflecting the dignity with which they were shared.

We are also grateful to the several service providers who have been willing to speak openly about the challenges within the system. Through their perspective, we have been able to better understand the context in which these barriers arise or are perpetuated.

We would also like to express our gratitude to the women who conducted the interviews with professionalism, care and respect. We know that that this has been both a professional and a personal process for them. This difficult work entailed documenting painful experiences and situations that they already know all too well.

This research belongs, first and foremost, to the women who had the strength to speak out about their experiences. We hope that their voices will be heard, taken seriously and contribute to much needed change.

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FOREWORD

Andreea Chiriac

Although I am a Roma woman and a native speaker of Romani, I have been fortunate enough not to be discriminated against whenever I go for my annual gynecological check-ups because I can easily pass as non-Roma. However, while in the waiting room, I have witnessed other women being run down by the hateful and judgmental looks from the hospital staff, from the very security guards to the nursing aides, the nurses and the doctors; the women were of the same ethnicity as me, but their skin was darker, they wore long skirts or simply did not speak Romanian well.

Through this research, we aim to show the social, economic and cultural barriers that women in this country face when accessing sexual and reproductive health services, especially if they are socially vulnerable from multiple perspectives, as is the case for Roma women, women from rural backgrounds, women belonging to the LGBTQIA+ community, minors etc.

Although we have a public health system that includes various national programs, such as the *National Cancer Program* or the *National Cervical Cancer Screening Program* etc., designed to support the aforementioned categories and others, the truth is that they only exist in theory, because the number of people who access them is very small. And not only are these programs not being accessed, but very few people are even aware of their existence[1]. Advanced medical infrastructure is only found in certain hospitals, especially in private ones, which are located in large cities and thus not accessible to everyone. At the same time, highly trained doctors usually choose to work in urban areas or even in other countries, where they are paid more.

Access to sexual and reproductive health services is a difficult subject to broach because if you're not a white woman, at least middle-class, educated and self-empowered, the system will eat you alive. Women who come from already disadvantaged backgrounds are often reprimanded, berated and made to feel at fault when they go for a routine gynecological check-up or a pregnancy monitoring check-up.

“Some doctors behaved nicer, others [treated us] with indifference (...). They left us to suffer.” A., 46, Roma, Bacau

On the other hand, I have noticed that the discriminatory attitude disappears or is at least temporarily concealed when the nurses and/or doctors receive little gifts. The greater the “gift,” the greater their care, support and respect. But this attitude, which should be an integral part of their work, switches back to “normal” if they stop receiving gifts even for a day.

“...a nursing aide, in retrospect, treated me unfairly after going through this experience. It was my first birth and I was inexperienced, I didn’t know how it was all supposed to go. It seemed normal to me at the time, but now, 4 years later, I realize that I was wronged. What I am referring to is that when she lifted me from the ICU bed she was not gentle with me – she simply picked me up like a sack – and at that is when I began hemorrhaging. She left me there, telling me to wait as she brought in another person to the ward, and when she came back, she looked at me and said, ‘I take better care of you than your mother does!’. After she changed me, after she helped me into my wheelchair, she said, ‘I think I deserve an espresso and a hot chocolate.’ And then I took out the money, and I gave it to her. Then she asked me, ‘Are you in any pain, are you feeling anything?’, to which I replied, ‘Actually, yes.’ ‘Then you should give my colleague something in exchange for a painkiller,’ she then said. *(...) These things should have been a given because the medical staff was already being paid for this service.” B.O., 25, Roma, Bacau*

[1] https://e-romnja.ro/project/intersect-voices-in-europa/

Going to the hospital and to the doctor's to check if we are experiencing any health conditions or simply for a routine check-up is a responsibility we have towards ourselves. Most of the people in my circle know this in theory, but in practice things are different. We tell our relatives, friends or even people we barely get to see that they need to go to the hospital to "get their health checked," but oftentimes, when it comes to our own health, we follow the principle of "ignore it, it's fine."

Although I went to school and my skin color is lighter, I don't dress in traditional clothes and many people do not see me as a *typical* Roma, I carry with me the baggage of deeply-rooted principles, some good, some not so good, such as: 'Roma girls must be virgins at marriage,' 'I'll take you to the doctor to see if you are still a virgin, you will not embarrass me,' 'What do you need school for? You're getting married and having kids anyway!'. All these still echo in my head, even though I've been fighting to overcome them for many, many years. And my experience is not unique. These preconceptions were instilled in me not only by my family, but especially by the people around me, Roma and non-Roma friends, colleagues and teachers, because they "know better" that "this is our culture."

In high school, in a class of 34 students, only 3 of us were Roma girls. My classmates started telling just me that I was "not like the others." My other two Roma classmates, who were very smart, respectful and diligent in school, did not receive the same treatment from my teachers and classmates. Being dark-skinned, they were immediately labeled as "g*****s".

We face prejudice, discouragement and marginalization in the education system, where we should find an environment that is inclusive and open to diversity and where we should be able to learn about each other, to accept and embrace our differences. When it comes to accessing social or health services, we as Roma women face even more barriers, even more discrimination, even more marginalization.

*"Well, there was no way they were going to treat you the same, give you everything you needed. It was the same when someone gave birth. When I had my son, I didn't have him with me in the hospital ward; when you went to breastfeed, there were Romanian and g***y wards. When the Romanians would go for a check-up or you we had to give birth in the evening, as it was back then, they would take us somewhere else. And when the Romanians would come in, they kept them for longer. So, only they knew what they were doing in there, but they'd take better care of them. You know? With us, they wanted to get it over with." V. D., 41, Roma, Bucharest*

Male gynecologists, with their "cold hands," who don't know how to treat us as women, are also very expedient, as well as critical and accusatory when it comes to our own bodies, which we know best and when there is something wrong with them.

"...he told me I was fine. 'You're fine, it's just a little bleeding,' but it wasn't just a little bleeding, so it turned into a disaster. Then I told him, 'Doctor, please, if you've made a mistake or if you've forgotten something, I'm here. Nobody will know, I won't say anything. I came to you to save me. I don't want anything bad to happen to me; I have three children at home. I'm here and you can perform a curettage or a suction aspiration on me again and maybe you forgot something and it caused something inside my body and that's why I am like this.' 'Ah, no, no, no, that's not the problem! No, you were well taken care of, we removed all the tissue.'" M. N., 35, Roma, Giurgiu/Bucharest

"The lady doctor who performed a curettage on me said, 'Oh, child, how could you not be bleeding? You could have gone septic, you could have died, God forbid. If you'd stayed home for another 2 or 3 days, we wouldn't be standing here talking face to face'. And I asked, 'How come? The doctor told me I was okay.' 'You're not okay. The doctor… what he did do to you... he just scratched the baby. He scratched him a little, took very little out of him, but three-quarters of him are still inside you. He perform a curettage on you.'" M. N., 35 years old, Roma, Giurgiu/Bucharest

There are many girls, Roma women and others, who grow up with these toxic "values." We all grow up with the idea that our role is to give birth and take care of children; managing domestic chores, as well as caring for children is the sole responsibility of women. As for childcare, women are responsible for everything: they take care of them, feed them, take them to the doctor's, educate them, give them advice, show them affection etc. And if one does not have close or extended family to help them, child-rearing becomes an extremely difficult task, which instead of being

acknowledged, is normalized and devalued, reinforcing the stereotypical role that a woman should have.

However, pregnancy and the birth process are portrayed so beautifully and naturally that even women who do not want children end up considering having one just for the sense of fulfillment that motherhood promises.

Growing up, but also now, as a woman in my 30s who does not have children yet, but wants to, I have been told repeatedly that having children is the greatest fulfillment you can experience as a woman. What I think is problematic is that this rhetoric is not only spread by mothers: it comes from society as a whole – family, friends, the church and anyone who feels like putting in their two cents about a woman's body and her societal role. The conversations I have had with women who recognized that motherhood is not a perfect, unchallenging experience, made me reconsider having children or postponing the process as much as possible.

As a Roma woman, when I access the public health system, which is so bureaucratic and elitist, I feel that I am putting my life in danger every time I am in need of medical attention. Through this research, I have been able to participate indirectly in the life and health experiences of the interviewed women. I have had the opportunity to listen to the experiences of women who have accessed such services in state-run public hospitals and some of their testimonies are disturbing. Anger, disappointment, disgust, fear, pity, shock are some of the emotions that washed over me while listening to how, instead of receiving support and empathy, these women have often been neglected, disrespected or even abused.

Many women do not recognize or realize that they have gone through postpartum depression, they do not recognize the discriminatory treatment they have received from medical professionals, nor the violent and abusive practices to which they have been subjected. The majority unknowingly adopt various defense mechanisms in an attempt to protect themselves against complex emotions[2].

"No, I had no problems. Before the Revolution, depression was virtually unknown. How could we be depressed? When we gave birth, we took the baby, nursed it, bathed it, dressed it. There were no diapers back then. We cleaned after them. It's different nowadays, with ointments and all that." G.I., 46, Roma, Ialomita

On the subject of pregnancy, the experiences varied, ranging from the very best, where the doctors were involved in the whole process, monitored the pregnancy, called the expectant mother in for check-ups and assisted with the birth, to the very worst, where women were left to suffer to the point where they almost gave birth on their own, without the support of doctors or nurses.

"I have had quite diverse experiences. In general, when I have gone to the doctor's, they treated me very well and gave me useful information, but I have also been in some situations that were quite unpleasant, when I didn't feel like they paid enough attention to me. In my city finding specialists is difficult, which is why I prefer to go to Bucharest or another bigger city when I need more in-depth check-ups." C., 23, Romanian, Ialomita

I wonder why, as a Roma woman, I have to walk into the gynecologist's office, usually a man's, greet them politely and then hang my head, hoping to receive better treatment, free of prejudices and stereotypes such as the ones about Roma women having many children and a body that is good for childbearing, being more fertile and having a higher pain tolerance.

"They were talking offensively anyway. I could hear them even talking to other patients who were just as distressed as I was. They treated us the same way you'd treat a dog, that's how they treated us. They just left us there, lying in bed." A., 46, Roma, Bacau

There are women who have more than 10 children, but nobody asks "why?". Why is no one interested to know the background of these women, the reason for having so many children? Why does no one question whether there is abuse behind so many pregnancies? And finally, why did the medical professionals who assisted with all these births not react in any way or report the matter to the competent authorities?

[2] https://psycnet.apa.org/record/2015-21876-005

There are many more women in this situation who can barely make ends meet. And perhaps allowances are their only source of income, helping them send their children to school and put food on the table. Likewise, there are women who do agricultural work, some do sex work too, some go to their neighbors for daily work or go to other countries to beg; they do all this informal work to be able to provide a warm meal for their children. If we sent them to get jobs, nobody would hire them because they have no formal education. At the same time, the state does not do much to help them change their social and economic situation, so we do not know if there is an end in sight to this vicious cycle.

The fact that many women get to the hospital only when they are due to give birth is mainly because they do not have the money to pay the fare to the hospital, pay for the consultation and diagnostic procedures, buy food for the journey and pay the fare back home. And usually, these women live in marginalized communities with disastrous infrastructure that does not make this process any easier. And what about the fact that hospitals are tens of kilometers away?! Ambulances would be a solution – if they did not refuse to enter certain communities.

“No, I... I have a little girl at home. Before the ambulance came, I gave birth to her on my bed” O.E., 29, Roma, Bacau

“I would often go to the emergency room. That's how I found out about the baby, because I wasn't registered with a family physician and I my pregnancy wasn’t being monitored around the clock.” G.K., 23, Roma, Mures

As I have already said, these women do not have formal jobs so we cannot tell them to use health insurance benefits. Those who are lucky benefit from the Guaranteed Minimum Income allowance and have access to certain services covered by the National Health Insurance House. In theory, pregnant women are entitled to free health insurance[3], but in practice, the diagnostic tests they can access are not thorough enough. There are either not enough tests they can have done during pregnancy or many of them are not even aware that they have this minimal benefit.

Women usually perceive a difference in treatment when they access reproductive health services based on whether they are treated by a male or female gynecologist. A female gynecologist may have a higher level of empathy, and the women may feel more comfortable to voice all their concerns.

*“The doctors should also treat us with respect, ask us questions, listen to us and stop disrespecting us. We don't disrespect them, so they shouldn’t either. For example, let’s say I take my child to the doctor’s because they are unwell and I also decide to go for a check-up myself, since I might have a problem down there, like any other woman. ‘But that's how you g*****s are, you leave, saying that you are sick, but if the man lays on top of you, you are not sick anymore.’ So, we want to stop being insulted, to be politely spoken to, that's why you’re a doctor. I've been told before that we end up taking advantage of doctors.” C.I., 40 years old, Roma, Bacau*

*“I think so, because... It didn't just happen to me once, but several times. And I've been to the hospital and... the doctors at the hospital said, ‘The g*****s, they make babies, or they lose babies and then they get in our hair.’ They talk a lot of nonsense, but I don’t want to repeat their words.” D.A., 41, Roma, Bacau*

Family physicians are present in some, but not all communities. Even where they are present, their way of working with Roma patients is disastrous. They refuse to take care of Roma patients and their children, refuse to give referrals to specialists or write prescriptions and home visits “overstep their authority.”

“I get on well with him, but that's about it. When I go to see him, he doesn't look at the kids the way he looks at everybody else. He doesn't even examine them or use the stethoscope on them.” C.M., 43, Roma, Bacau

These are some of the reasons why women end up having emergency deliveries most of the time

[3] https://cnas.ro/

and are seen as an anomaly in society and blamed for not caring enough about their own wellbeing or the wellbeing of their children.

As far as Roma women's access to contraception or abortion services is concerned, I would go as far as to say that it does not exist. The few family planning clinics that used to exist across the country have all but disappeared over time. Fortunately, some hospitals have accessed money from the National Recovery and Resilience Plan to modernize or reopen this type of center[4].

Prevention is the most effective and affordable form of long-term healthcare. However, for many women, access to modern contraceptive methods is limited due to overlapping factors related to financial and bureaucratic barriers, such as obtaining a referral to a specialist from their family physician. Moreover, the lack of empathy among medical professionals and experiences with discrimination discourage women from requesting and accessing these services[5]. Family physicians could organize informative sessions meant to educate and raise awareness on various medical and health-related topics, not just for women, but for all the members of the community they serve. Through these sessions, women could learn that there are other ways to prevent pregnancy and that men are equally responsible for the women they impregnate and the resulting children. But unfortunately, this is rarely or never the case. Since they cannot access this information, many women resort to surgical abortion or vacuum aspiration as a method of contraception. This type of abortion affects the women's physical and mental health, but unfortunately, it is the only method that they are aware of or the only one they were recommended. Medication abortion[6] was also introduced in our country a few years ago and, although it is guaranteed to be very safe and effective, we have once again reached an impasse because women do not know about it and doctors do not recommend or provide information about it either. Indeed, it is recommended that abortion medication be taken no later than 63 days after the first day of the last menstrual cycle, but many women discover that they are pregnant far too late.

A significant percentage of doctors refuse to perform abortions on request, citing religious beliefs or ethical reasons. At the same time, the doctors who refuse to perform abortions in public hospitals, where costs are affordable, send the women to private clinics where they themselves work. The women who can afford it end up paying exorbitant fees for this service.

No one advocates for or supports abortion as a form of contraception, but it is a practice that is still happening today. Limiting the possibility of performing abortions leads to a high number of women dying or giving birth to unwanted babies. Medical abortion can be a solution for underage mothers[7], who are clearly victims of sexual abuse. But pregnancy must be detected early on and one needs to be able to afford to pay at least 500 lei for this type of abortion. We hold the lead in the European Union, but that is not something to boast about, as we rank first in some less than desirable categories, such as the high number of underage mothers nationwide.

Early marriages[8] within certain Roma communities, which are a form of modern slavery and lead to “children having children”9, are always culturally motivated, while all institutions turn a blind eye to these practices. Young Roma girls are not the only ones who become pregnant as teenagers, but only they are stigmatized and often blamed for it. What is more, the competent authorities, which are supposed to ensure the protection and safety of victims, often do not report cases of forced marriages or underage mothers because that would mean too much work for them, so they prefer to wash their hands of the problem and blame the culture of the Roma community.

Later on, no one shows any interest in the fate of the children who are left in abusive relationships or families and are forced to give birth to unwanted children from a young age. Therefore, a system that is supposed to protect them helps perpetuate such practices instead.

[4] https://www.ms.ro/ro/de-interes/apeluri-pnrr-c12-sanatate/investi%C8%9Bia-specific%C4%83-i15-cabi- net-of-family-planning%C4%83/
[5] https://www.hrw.org/report/2025/04/07/its-happening-even-without-you-noticing/increasing-barriers-accessing-sexual-and
[6] https://www.avort.md/avortul-medicamentos/
[7] https://www.avort.md/avortul-medicamentos/
[8] https://e-romnja.ro/project/reducerea-abandonului-scolar-in-randul-fetelor-rome/
[9] https://www.insmc.ro/wp-content/uploads/2021/02/Ghid-de-preventie_complet-6151-.pdf

Gender-based violence has reached alarming levels in our country[10]. With increasing frequency, we see and hear in the media about how women are beaten to death, stabbed or traumatized for life by their own partners. Although in the interviews conducted for this research, not all women admitted to having gone through such situations, I believe that the associated stigma runs so deep that the mere act of admitting to having an abusive partner can lead to criticism from those around them.

“Because that was the norm, at least in my family and in the community... it was normal for women to be beaten up. And when my turn came, the same thing happened; nothing happened until I couldn't take it anymore, so to speak.” V. D., 41, Roma, Bucharest, Romania

All these social barriers that I have mentioned so far intertwine with the cultural barriers that Roma women face when they go to the hospital. The lack of training in empathic communication in medical school significantly affects the doctor-patient relationship. Since being a doctor involves constantly interacting with people, it is important for the professionals to be trained in conveying difficult news and explaining medical procedures, diagnosis or treatments in a clear and accessible way, as most patients do not have medical expertise.

“All patients should be treated properly by doctors; they should stop differentiating between the rich and the poor. They should treat them all the same.” A., 46, Roma, Bacau

I believe that an intersectional approach to women's care would allow us to better understand how our different identities relating to sex, gender, ethnicity, class, sexual orientation, age etc. intersect and would positively influence our healthcare experiences and needs, as well as the access to these services. I am not trying to imply that all healthcare professionals should learn the Romani language or know the entire history of the Roma minority, but an empathetic, informed and socio-culturally sensitive attitude would be of great benefit in the doctor-patient relationship. An intersectional approach helps not only to reduce discrimination, but also to increase the effectiveness of medical care and patients' trust in the healthcare system.

“And last but not least, and I can say this with full confidence, it’s also about the social benefits and allowances they receive. There are so many pregnant women who are not necessarily underage – but if you’re over 18 and you already have two or three children, it doesn't matter that you're already of age – and who have children for the same reason: as a source of income.” Dr. D.B., 58, Mures

This overview of the problems and systemic barriers faced by Roma women when accessing health services comes from personal experiences, the testimonies given for this research and observations I have made throughout my professional activity. Most of the testimonies compiled in this research have had an emotional impact on me and some will remain etched on my memory and into my consciousness for a long time. However, there are healthcare professionals who argue that women do not face significant barriers in accessing sexual and reproductive health services, believing that this process is adequately carried out in the communities.

“... termination of pregnancy, no. This has only happened in medical emergencies if health problems occurred. Otherwise, all the women in the community want children, they raise them with love, so it's all perfect. Everything goes smoothly through collaboration and communication.” AMC N.C., 62, Bacau

“Here at commune level, frankly, if we communicate with one another and keep each other informed, we get along perfectly. I wouldn’t change a thing.” AMC N.C., 62, Bacau

[10] https://centrulfilia.ro/new/wp-content/uploads/2022/12/Barometrul-Violenta-de-Gen.-Romania-2022.pdf

At the same time, there are also voices in the medical sphere that urge women to keep their baby, stating that abortion is a sin, although there are many women who do not wish to carry their pregnancy to term for personal or medical reasons. This choice is extremely personal and should not be justified, in my opinion.

"Education in schools. We need to educate them from a young age, so that little girls know that, above all else, it is a great sin to have an abortion." AMG E.T., 50, Bacau

Although an attempt was made to involve a larger number of doctors in the research, only a few agreed to participate in the interviews. Lack of time and availability were the reasons cited for their refusal. From this we can infer how low their interest is in improving their patient care services.

When asked if they had the opportunity to express their opinion on how satisfactory the health services they accessed had been, many replied that they did not consider it relevant because the situation would stay the same anyway and no one would take their opinion into account. Moreover, some said that they were even afraid to give feedback.

"No, I didn't get the chance to because I was afraid." A., 46, Roma, Bacau

Of course, all women face various serious problems, but the problems of Roma women are often disregarded or not talked about enough. Even Roma women downplay their own problems because they are so used to being discriminated against and stigmatized. However, Roma women create support networks where they help each other with information on childbirth, breastfeeding, contraception etc.[11]

"The women around me taught me how to do it too." I.M., 40, Roma, Ialomița

The birth experience varies from woman to woman. It does not depend on how much pain you can endure, how much stigma you can overlook or how much you can let go so that "things go smoothly." It is a combination of factors that can either lead to a fulfilling experience or a traumatizing one. This is why we as doctors, nurses, life partners, family and members of society are responsible for how we want this experience to go for the women in our lives who want to have children. What I have observed during the interviews is that the women are extremely reluctant to talk about motherhood and all that it entails. None of the women aired their grievances after they were treated unfairly by the medical staff for fear of their children facing repercussions or not getting the care they needed. But even if they remain silent, systemic racism and obstetric violence are realities faced by women from vulnerable, racialized, poor etc. backgrounds.

As a potential future mother, I am terrified of what the "miracle of childbirth" has in store for me. Although it is often described as a unique and exciting moment, the thought of the pain, complications and immense responsibility that follows overwhelm me. While listening to the testimonies from the research, I began thinking more in depth about how the process will unfold, its risks and how I will cope with the unknown, but above all about the people who will be there by my side throughout this period.

It is our collective responsibility to take care of the girls and women in our lives, to show up for them and to let them know that they have our full support. I believe that we need to provide them with an environment where they feel cared for and encouraged, where they can express their needs, fears and insecurities. Destigmatizing access to health services must be a joint effort and going to the doctor must no longer be seen as shameful or as a sign of vulnerability, but as a normal process for maintaining an optimal level of health. Finally, we need to combat and overcome the prejudices surrounding certain medical conditions so that women no longer feel ashamed to seek these services when they need them. This requires cooperation and solidarity, which means standing by them, offering emotional support and encouraging them to access the services they need without fear of stigmatization.

[11] https://dajphen.ro/home/

Introduction

Research objective

This research aims to identify the barriers that women from vulnerable groups and communities in Romania face in accessing sexual and reproductive health services. It aims to compensate for the lack of such local analyses and to provide authorities, policy makers, civil society and the general public with a documented understanding of the factors that contribute to limiting access to such services, together with a set of recommendations for remedying this situation in the short, medium and long term.

Specifically, the research centres the voices and experiences of SRH service users, especially women in situations of socio-economic vulnerability (Roma women, women without financial resources, women from rural or peripheral-urban environments). To date, this is the first initiative of its kind in Romania to document access to sexual and reproductive health services based on such a large qualitative corpus, providing a detailed insight into the structural barriers and the way they are experienced and perceived by the affected women.

Background

In the context of this research, the concept of ***sexual and reproductive health services*** is understood, according to the World Health Organization's vision, as a broad range of services intended to ensure the right to sexual and reproductive health as an integral part of the right to the highest attainable standard of mental and physical health. Ensuring access to a diverse service package covering, among others, family planning, maternal and newborn care, comprehensive prevention and treatment services for sexually transmitted infections, screening services (Pap smears, HPV genotyping, mammograms) or medical forensic services for victims of sexual assault provides multiple health, social and economic benefits, including a significant decrease in the number of unplanned pregnancies, unsafe abortions and maternal deaths, making it a solid foundation for personal dignity, empowerment and autonomy.

The limited access to SRH services and the associated risks are recognized across the European Union. According to the latest analysis in the Matic Report on Sexual and Reproductive Health and Rights in the EU in the context of women's health, access is hindered by a series of factors. The report highlights, among others, the legal, financial, cultural and information-related barriers to SRHR (for example, the lack of access to high quality affordable universal SRHR services, the lack of sex education, the lack of available modern contraception methods, gynecological and obstetric violence, the limited access to abortion services, doctors' refusal to perform certain procedures on moral grounds etc.) The report highlights that marginalized individuals and groups face additional barriers in accessing SRH services, pointing to the structural discrimination of people with intersectional experiences, which leads to dire consequences when it comes to ensuring their right to health. Some of these consequences include an increased risk of maternal mortality and morbidity, violence associated with prenatal, intrapartum and postnatal medical procedures, and a generally higher risk of experiencing gynecological and obstetric violence.

"[...] marginalised individuals and groups, including racial, ethnic and religious minorities, migrants, people from disadvantaged socio-economic backgrounds, people without health insurance, people living in rural areas, people with disabilities, LGBTIQ people and victims of violence, among others, often face additional barriers, intersecting discrimination and violence in accessing healthcare, as a result of laws and policies that allow coercive sexual and reproductive healthcare practices and failures to ensure reasonable accommodation in access to quality care and information; whereas there is a lack of substantive data on the issue of obstetric violence towards racialized women in Europe; whereas this discrimination leads to higher maternal mortality and morbidity rates (among black women, for example), a higher risk of abuse and violence (for women with disabilities), a lack of access to information and overall injustice and inequality in accessing SRH services."

(Source: Report on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health, A9-0169/2021, Committee on Women's Rights and Gender Equality, European Parliament, para. AB.)

At national level, several recent analyses have shown the multiple difficulties women face in accessing SRH services in Romania. The "Plan International Worldwide Annual Review" report of 2024 reveals a worrying situation characterized by legal, strategic, financial, cultural and social barriers, with an overwhelming impact on the way SRH services (sex education, abortion, prenatal and postpartum care, childbirth etc.)[12] are designed, delivered and accessed. Addressing these issues requires systemic measures at central and local government level, in policies in this area and at societal level. In particular, antenatal, intrapartum and postnatal care services are still infused with forms of *obstetric violence* characterized by insecurity, discomfort, disregard, a lack of privacy and consent, the refusal to prescribe analgesic medication, excessive medicalization, racism and other forms of abuse[13]. Moreover, in terms of access to care during pregnancy, the public health system in Romania is difficult to navigate, with information on the accessible medical services lacking transparency or not existing at all, leading to the underuse of these services to the benefit of private ones.[14]

Limited access to SRH services can often have dire consequences. These include a high percentage of pregnancies among minors and adolescents (for example, due to limited access to information or contraceptives)[15] and a high maternal mortality rate (as a result of inadequate antenatal care in terms of access, content and quality of services, especially at the level of family medicine).[16] In addition, a large proportion of public healthcare facilities do not offer abortion services, do not provide information and do not give referrals to other facilities where abortion is actually available, while the costs of abortion in public and private hospitals and clinics are often prohibitive).[17]

Romania has not had a specific unitary strategic framework regulating the delivery of SRH services since 2006. However, the recently approved National Health Strategy "Together for Health" 2023-2030 does include several measures and indicators specific to the field.[18] Among others, these refer to expanding and improving family planning and reproductive health services, ensuring postnatal care through integrated services at the level of primary healthcare, preventing unplanned pregnancies, especially among adolescents, ensuring access to quality perinatal care services, ensuring access to free contraceptives or directing networks of family physicians, pediatricians in specialized outpatient clinics, midwives and community nurses that would carry out integrated activities specific to monitoring child development, and, lastly, the use of a payment mechanism based on results.

[12] Plan International Worldwide Annual Review, 2024.
[13] Neaga, D.E., Grünberg, L., Radu, C., 2024
[14] Brînza, M.G., et al., 2022.
[15] Roman, G., Burcea, S., 2024.
[16] Stativă, E., et al., 2019.
[17] Independent Midwives Association, 2024.
[18] https://ms.ro/media/documents/Anexa_1_-_SNS.pdf, https://ms.ro/media/documents/Anexa_2_-_Plan_Actiuni.pdf

Methodology

The theoretical framework

The present research is based on the notion of *sexual and reproductive justice (SRJ)*, introduced and developed by the Black feminist movements in the United States in the 90s. The aim of the founding text drafted by a group of Black women was to foreground the challenges of unequal access to reproductive health services faced by poor women and women of color in the US, emphasizing that "*reproductive freedom is a life and death issue for many Black women and deserves as much recognition as any other freedom*." [19] In brief, SRJ can be defined as "the right to have children, not have children, and parent the children in a safe and nurturing environment, free from coercion or discrimination."[20]

The concept of SRJ broadens the sexual and reproductive rights perspective by introducing the *social equity* dimension as a response to structural inequalities affecting access to sexual and reproductive health. Therefore, while sexual and reproductive rights as fundamental human rights can be exercised in the context of the legal framework and public policies that guarantee and ensure the freedom to decide over one's own body, access to health information and services, protection against discrimination or violence[21], the SRJ emphasizes that these rights can only be exercised if the systemic social, economic and cultural barriers that limit access to resources and services are removed. For example, the nonexistent health infrastructure in rural areas or the long distance to the nearest facilities, the prohibitive costs of transportation and healthcare, and the racist, classist or ableist stigma and prejudice, among others, limit access to sexual and reproductive health services, particularly for people from the most vulnerable groups.

The social equity dimension of the concept of SRJ concerns the need to combat structural inequalities specifically by recognizing their *intersectionality*. Intersectionality, both as a lived experience and a critical tool, reveals how multiple forms of oppression "overlap and create specific barriers for certain groups,"22 as well as unique experiences of marginalization. For example, disabled low-income women in rural areas may frequently have to face the prohibitive cost or complete absence of healthcare services; they may also have to deal with inaccessible means of transport or services that are not adapted to accommodate them, insufficiently trained healthcare professionals and a lack of infrastructure, equipment and accessible information.23 Roma women often face unique experiences at the intersection of ethnic, economic and gender discrimination that severely limit their access to adequate healthcare. For instance, access to health services in Romania, including SRH, remains limited, particularly for Roma women from marginalized communities, from rural backgrounds, who have a low level of education or are part of from LGBTQ+ groups.[24] Roma women are often subjected to humiliating treatments and the intersection of racism and classism results in the need for "informal" payments to healthcare providers, long waiting times and superficial examinations. Roma women and non-Roma women must take different steps to access sexual and reproductive health services. These differences are influenced by the behavior and capability of the healthcare system to provide equitable access to services without discrimination, tailored to the needs of Roma women, as well as the way in which Roma women approach the healthcare system in itself, having been influenced by previous experiences where they were rejected, humiliated, made to feel distrust, where they did not receive nearly enough information or they faced financial constraints.[25]

[19] Black Women on Health Care Reform, The Washington Post, August 16, 1994.
[20] Ross and Solinger (2017: 9).
[21] For example, the right to comprehensive sexuality education, the freedom to decide freely and in an informed manner on one's sexual life without pressure or violence, the right to express one's sexual identity and sexual orientation, the right to decide on the number and spacing of births, access to safe abortion, contraception, perinatal care, protection from forced sterilization
[22] Crenshaw (1989: 140).
[23] Grigoras et al. (2021); Casebolt, M. T., (2020).
[24] Gheorghe and Mocanu (2021).
[25] In fact, the restrictive patterns of access to health services, especially reproductive health services, affecting Roma women in Romania are not an exception, but are part of a wider phenomenon in many countries in Europe where Roma women face similar barriers - systemic racism, persistent poverty, lack of health services in the areas where they live and reduced access to essential information on sexual and reproductive health, Janevic, T., et al. (2011), Colombini, M., et al. (2011).

In fact, the systematic erosion of sexual and reproductive autonomy is one of the *sui generis* expressions of intersectionality as the experience of Roma women with it differs from that of other women or Roma men.[26]

On the one hand, family or community values and beliefs that associate the role of women with motherhood, the taboo nature of discussions about sexuality and reproduction and religious beliefs may pressure Roma women into hiding their interest in seeking family planning and abortion services.[27] On the other hand, racist stereotypes that portray Romani women as "too fertile" fuel socio-medical policies and practices that become an *institutionalized form of fertility control for Roma women,*[28] ranging from facilitating free access or selectively recommending contraceptive methods all the way to forced sterilization practices.

Therefore, in the context of SRJ, the exercise of sexual and reproductive freedom requires a series of integrated measures that consider: (i) the universal coverage and equal access to health services for all people, regardless of income, health status, employment status, age or location;
(ii) the comprehensiveness of reproductive services that is covered and treated like any other health service and includes a full range of services (such as Pap smears, mammograms, contraception, perinatal care, childbirth, abortion, sterilization, infertility services, screenings and treatment of infections and HIV/AIDS); and (iii) the protection against discrimination of people of color, poor people, elderly people, disabled people or on the basis of sexual orientation.[29]

The research is also guided by an understanding of access to sexual and reproductive health (SRH) services as essential to ensuring the right to health as a human right, as recognized by the United Nations. Therefore, this right entitles women to sexual and reproductive healthcare services, products and facilities that are: (i) available in adequate numbers, including by ensuring that there are enough healthcare workers as well; (ii) physically and economically accessible, by expanding coverage in underserved areas and ensuring affordability; (iii) accessible without discrimination by challenging and transforming the social, cultural, political and legal factors that prevent women, adolescents or other people, especially from marginalized groups, from seeking such services; (iv) of satisfactory quality, contributing to good outcomes and the decision to use or not to use such services.[30]

In this context, the adoption of the SRJ framework in the present analysis is not an arbitrary choice; it is a grounded theoretical and methodological choice with significant practical and ethical implications for the formulation of sexual and reproductive health policies and interventions. SRJ offers an analytical tool capable of identifying and addressing structural inequalities in an intersectional and social justice-centered manner. Rethinking the system through this lens enables public services and policies to become aimed at meeting the needs of the most vulnerable women in society, thereby creating the conditions for the whole system to become more equitable, accessible and effective for all women, regardless of their social, economic or ethnic status. Therefore, the use of the SRJ framework does not only promote social justice, but it also becomes an essential evaluation criterion for the functionality and equity of the sexual and reproductive health system in Romania.

[26] Oprea A. (2017).
[27] European Monitoring Center on Racism and Xenophobia (2003, pp. 52-67).
[28] Vincze (2006: 62).
[29] Black Women on Health Care Reform, idem.
[30] United Nations, 2006: Alin. 17.

Scope of research and sources of data

The present research aims to identify both the difficulties in accessing SRH services and the possible solutions regarding a wide range of sexual and reproductive health services, such as antenatal, intrapartum and postnatal care and support, family planning and sex education (including aspects concerning pregnancy prevention or education on gender-based violence) and abortion services, among others.

In order to demonstrate the validity of the data, the comprehensiveness and the rigor of the research, the aforementioned issues were analyzed based on the triangulation of the collected data, by reviewing a body of relevant literature (national and international studies and research reports in the field, policies, grey literature or academic literature) and through semi-structured interviews with SRH service users and the service providers in their area.

The SRH service users who were interviewed were predominantly from groups or communities that are significantly more vulnerable to experiencing structural inequalities in accessing socio-medical services, including SRH services, such as women from rural backgrounds, Roma women and young single mothers with several children. The data thus obtained was triangulated with the information provided by the providers of such services (doctors, midwives, mediators) who work in geographical proximity and/or directly with the users interviewed.

Data collection and analysis process

Data collection took place between January 2025 and March 2025 in 5 counties by conducting 43 semi-structured interviews, of which 34 with female users of SRH services and the rest with service providers (doctors, nurses, social service providers) in the counties of Bacău, Mureș, Ilfov/Bucharest, Ialomița, Giurgiu and Iași. Many of the interviewed women belong to Roma communities, which are predominantly marginalized or compact, and reside in rural and urban areas. The age of the participants varies between 19 and 48 and their educational level is generally low (primary school, middle school or high school level, but without having sat the baccalaureate exam). Most of them are married or in consensual relationships, have between one and six children and face economic insecurity, being homemakers, unemployed or part-time employees[31].

The interview guides were pretested and modified by incorporating the results of the pretest. All of the interviews conducted were transcribed and the data was analyzed using a thematic analysis matrix that identified key themes for the research questions.

Ethical considerations and research limitations

The present research is being conducted within a framework bounded by several *ethical considerations* regarding: (i) the confidentiality and anonymity of personal data by maintaining and publishing the data collected in a way that protects the identity of the respondents; (ii) informed consent, which guarantees that the respondents have been informed and have understood the purpose of the research, the methods used, the conditions of use and access to the data, as well as the possible risks before deciding to participate and their right to withdraw at any time from this research; (iii) minimizing the risk of harm by paying attention to the emotional state and comfort of the participants during the interviews and avoiding prejudice and stigmatization; (iv) involving Roma women in the data collection to ensure positive relationships and access to information that may be sensitive in the context of the discussions about the research topic.

The research also faces a number of *limitations* inherent to the specifics of the methodology, such as: (i) its time-consuming and resource-intensive nature, since this approach of collecting and analyzing the qualitative data present requires a lot of time and effort, thus limiting the number of participants or the duration of research and reducing the scope of applicability; (ii) the limited capacity to explore the complexity of the research topic, given the limited number of interviews, as

[31] Socio-demographic data are presented in the table in Annex 1.

well as the relatively small geographical area and the short period of time over which they were conducted; (iii) the nature of the subject, taking into account that some of the topics addressed may cause anxiety or embarrassment, which could influence the completeness or authenticity of the answers.

The structure of the report

After presenting an overview on the access to sexual and reproductive health services in Romania and Europe, the theoretical framework centered on the notion of sexual and reproductive justice (SRJ) and the qualitative methodology that guided the research process, the next section is dedicated to the analysis of the results. In order to capture the complexity of the lived experiences of the interviewed women as faithfully as possible and to reveal the multiple barriers influencing access to SRH services, the analysis was structured thematically, following key stages and aspects of sexual and reproductive health as reflected in the participants' narratives. Their voices are at the center of the analysis: the illustrative quotes used extensively throughout the research not only support the interpretation of the data, but also bring to the fore the lived realities, subjectivity, emotions and strategies through which the women navigate life, remain resilient and advocate for themselves in response to an often unfriendly and discriminatory system. Therefore, the findings are organized around a few major themes – from general access to SRH services and the relationship with the family physician, to pregnancy monitoring, childbirth, postpartum support and medical consent – and include critical dimensions such as obstetric violence, access to contraception, sex education, abortion and teen pregnancy. The report ends with a conclusions and recommendations section that emphasizes the main implications of the research and devises concrete guidelines for more inclusive and equitable public policies.

Research results

The analysis of the interviews indicates unequal access to sexual and reproductive health services, influenced by socio-economic status, cultural norms and discrimination. In particular, women from vulnerable backgrounds (Roma women, women from a low-income background, women coming from the child protection system) face difficulties in accessing sexual and reproductive health services**, while institutionalized racism, classism, gender-based violence, lack of sex education and stigmatization of abortion continue to be critical issues.**

Access barriers to SRH services - overview

Sexual and reproductive health services are essential for everyone's physical and mental wellbeing and limiting access to them can have a severe negative impact on women's quality of life in the short or long term. In the short term, the lack of access to these services can lead to sexually transmitted infections going diagnosed, unplanned pregnancies, unsafe abortions and perinatal complications, maternal or infant death. In the long term, these barriers can cause infertility, mental health problems, an increased risk of cancer and chronic maternal health conditions. These effects are magnified by the lack of access to adequate screening and treatment, highlighting the need for policies to ensure universal access to sexual and reproductive health services. To be truly effective, SRH services must be available in adequate numbers, physically and economically accessible, offered without discrimination and of satisfactory quality. Unless these conditions are met, access to such services remains fragmented and unequal, disproportionately affecting women from vulnerable groups.

Limited access to health services, especially in the rural areas of Romania, is a significant barrier for women in need of specialized examinations, including SRH services. The interviews conducted show that in some regions the lack of adequate health infrastructure makes SRH services inaccessible in the immediate area, forcing women to travel long distances to receive medical care. This barrier is compounded by the lack of specialized medical staff (such as gynecologists in rural areas or in public hospitals in small towns), as well as by inefficient transport services that do not allow women to quickly reach hospitals or clinics in cities, leading to situations where women give birth at home without specialized care or even where the newborn ends up dying. For some of the interviewed women, the lack of specialized personnel in their area led to risky emergency deliveries or even the death of the newborn. Moreover, one of the professionals interviewed for the research mentioned a local authorities' initiative to create a mobile medical service (caravan) type of screening system in isolated or predominantly Roma communities, which would include gynecological services and provide primary or specialized medical services for the first time for some of the residents.

One of the most significant barriers identified in accessing SRH services is *poverty*, which significantly affects women's ability to access adequate services. Women who cannot access free or subsidized public services must turn to the private health system, where costs are often prohibitive, leaving women facing a double obstacle: the inability to access free public services (even when they have public health insurance) and the inability to pay for private services. In many of the interviews conducted, women from rural and peri-urban backgrounds drew attention to the prohibitive costs of either SRH services, including gynecological exams, routine examinations (such as Pap smears and mammograms), and abortion services, which are too expensive to be covered, or the costs of transportation to the localities where these services are available. These financial obstacles are exacerbated by the lack of universal health coverage in Romania, which could facilitate access to these services for all citizens, regardless of their socio-economic status. In this context, women are often forced to choose between accessing essential health services or meeting other basic needs. This situation reflects the structural problems of access to health services in Romania: in 2023, more than half of the people who needed to see a specialist could not do so either because they could not afford it or because the services were not covered by their health insurance, the differences between rural and urban areas being almost insignificant (National Institute of Statistics, 2024).

Sexual and reproductive health services in Romania are designed to serve mainly a certain type of beneficiary: heterosexual couples from the ethnic majority population, with a steady income and stable socio-professional status. Those who do not fit the mold – queer people, Roma people, people with a precarious economic status – face legal and financial barriers, but also other forms of exclusion, such as stigmatization or the disregard for their specific needs, which marginalizes them and forces them to seek solutions outside the system. For example, queer people are excluded from the national in vitro fertilization (IVF) program[32], which, although allows single women to apply, remains inaccessible to same-sex couples. This legal exclusion is amplified by the barriers encountered when interacting with the medical system, where heteronormative norms lead to intrusive questions or the absence of relevant information on sexual health. As the interviews show, infertility among Roma women remains ignored by the medical system, which often operates on the basis of stereotypes that automatically associate them with high birth rates. At the same time, Roma women in precarious economic situations face indirect exclusion from the subsidized IVF program because accessing it requires having public health insurance – a requirement which is inaccessible to those who work informally or have no stable income[33]. In this way, access to reproduction becomes a privilege conditioned by social and economic factors, while the contrast between the formal existence of rights and their actual enforcement remains stark.

[32] Minister of Labor and Social Solidarity (2002). Currently, the amount settled is RON 15,000, of which
5,000 for medicines and 10,000 for medical procedures in the form of vouchers, which only partially cover the costs of the IVF journey.

[33] In the case of couples, the condition of being insured in the Romanian social health insurance system on the date of enrolment in the Program applies to both partners.

Access barriers to SRH services

Women users of SRHS

“Yes, I can say that I needed a gynecological check-up, but I couldn't have one because there were no specialists in my area. Also, I could not afford to pay for the transportation or to go to a private clinic.” *(Interview 9)*

“When the pain started and I went to give birth, there was no doctor. Only the nurses were there and I needed a C-section. And the baby was asphyxiated at birth. The last time I gave birth it went well [...]. I had regular check-ups. Every time the doctor told me to do something, I did just that, but last time he wanted to perform the C-section here, at our hospital, near the train station. And again, there was no anesthesiologist. He looked for an anesthesiologist and couldn't find one. That's why he sent me to Bucharest. And I gave birth to A. at the Filantropia Hospital. My parents said ‘We don't want anything bad happening to her, don't keep her here for a second longer. We’ll bring her back when she's well, in Bucharest.’” *(Interview 7)*

“I didn't go [to have tests done or examinations during pregnancy] because I didn't have money, I didn't have access to any means of transport. I had no way of getting there. [...] I didn't [give birth to all my babies at the hospital], I... I [gave birth to] one of my girls at home. Before the ambulance came, I gave birth to her on the bed. [...] My mother helped me. [...] I couldn't go [to the hospital after the birth]. I probably needed a check-up myself... for my baby or for me maybe, but I couldn't afford it. I knew where to go, but I didn't have the money. How was I supposed to get there? I would have liked to go and have a check-up when I was pregnant, to understand what I was going through, but I didn't have the possibility to do so, not at all. [...] Here, in our village, I want [an OB/GYN’s office] [...] Yes, so that we wouldn’t have to go to Bacău, because having had one here, in our village, would have made things different, it would have been closer. I think I would’ve been going there twice a day.” *(Interview 13)*

“Only at the maternity ward [were we able to receive sexual and reproductive health services]. Because [our family physician] said we did not have insurance, he wouldn’t look at us, he would just tell us to go to Bacău. That's all. Anything else... he didn't do anything else for us. That was all.” *(Interview 14)*.

“Well, some people are poorer and can't go [to the doctor’s]. I mean, poverty [is a reason].” *(Interview 7).*

“Well... Who’s going to provide you with these [SRH services] for free? [...] Even if we pay for our health insurance, we still get nothing.” *(Interview 32)*

“Apart from the usual screenings, I didn't access the other [SRH services] you listed, because you have to pay for them and we can't afford to do that. [...] You have to pay for the most important ones, such as Pap smears, HPV screenings, mammographies. Nothing is free for us here.” *(Interview 3)*

“[The abortion experience was] Very bad. [...] First of all, I felt no empathy from the doctors. That was the biggest drawback. And because the hospital was very dirty, [...] I was afraid of catching a viral or bacterial infection.” *(Interview 33)*

“For example, I would go to the hospital with my child because he had a cold or something. I'd go in and wait for five hours, but then I would leave. The doctors wouldn't look at us; I'd just stay there, with my child running a 40-degree fever. [...] There were many children and... I don't know. Yeah, they were understaffed, I don't know.” *(Interview 32)*

SRH service providers

“Clearly there are and always have been [differences in medical infrastructure or quality of services depending on whether the patients are from rural or urban backgrounds]. What are we talking about? The girls living in the countryside, the girls from more underprivileged areas, they cannot afford these services because they do not have money, salaries, jobs to... how shall I say it... get regular check-ups. [...] Moreover, if I have a patient from [commune name], from somewhere far away, somewhere about 10 km from [name of city] or more than 10 km, it's harder for her to get to me. In the city, there’s a hospital or a clinic or whatever else you need just around the corner. Of course, the infrastructure is very, very important.” *(Interview 35)*

“And where I gave birth, at the [...] Hospital, I don't think it's equipped to accommodate disabled people either. And neither is our facility, considering that people from all walks of life come here; we have had people with disabilities or different degrees of disability, mental and physical and so on. The medical staff in general is not prepared to deal with such situations, neither the nurses, nor the doctors. I see this as a terrible inadequacy because there are all sorts of situations. These people exist and we cannot pretend as if they didn’t.” (*Interview 38)*

“The situation regarding maternal care in our country and the hospitals where women give birth [limits women's access to giving birth in safe conditions]... There have been many instances of women getting an infection when they went to give birth. We have all heard of women going to give birth only to end up contracting an infection.” *(Interview 41)*

“Queer women have absolutely no access to reproductive health. No bill on IVF for same-sex couples has been submitted to Parliament. And most lesbian couples either lose the hope of having children in Romania, they leave the country or they do it in Bulgaria and Hungary. But this means additional costs; they don't even go to the doctor here in Romania to monitor their pregnancy because they can't go to their family physician for pregnancy monitoring with their partner for fear of discrimination, unlike a heterosexual couple, for instance. [...] And now also about sexual health, from this point of view many queer women fear discrimination when accessing gynecological services because the gynecological questionnaire involves the question ‘Are you sexually active?’. I mean, somehow those questions leave no other possibility. It's very heteronormative. And yes, indeed, I think as a gynecologist you can change the questions yourself. [...] But, as for the feedback they give after coming back from the gynecologist, queer women say that they were asked how they have sex – but in an invasive way, not in a medical way, like if they use protection during sex, if they have access to services. And even that, I mean there's this method [of STI protection] for queer women, which has recently become available in [store name]. And many queer women don't know about that and, in my opinion, it should be the responsibility of the gynecologist or even the family physician to inform them about that. So, there are resources that are being wasted because of discrimination, in my opinion.” *(Interview 43)*

Perinatal services

Perinatal services span the entire period from the onset of pregnancy to one year after birth and include medical care, psychosocial care and emotional support for the mother and the baby. These are essential for preventing complications, supporting the woman's physical and mental health, and ensuring a healthy start in life for the newborn. Perinatal services include regular prenatal check-ups, pregnancy monitoring, ultrasounds, laboratory tests, health education and nutritional counseling. During childbirth, women receive skilled assistance and in the postnatal period – which extends up to one year – they can access health monitoring services, breastfeeding assistance, childcare counseling and maternal mental health support. Such an extensive approach is an acknowledgement of the fact that women's needs do not disappear when they are discharged from the maternity ward, but that they evolve during a period of physiological, psychological and social transition. Without these services, the risk of neonatal complications and preventable deaths increases significantly, as shown by the latest UNICEF findings[34], which emphasize the importance of perinatal care in reducing global infant mortality.

Therefore, equitable access to perinatal health services is essential for preventing infant mortality and reducing urban-rural disparities. Data on infant mortality in Romania shows a significant decrease in the number of deaths among children under one year old between 2000 and 2023 by about 79%[35]. However, as of 2023 the rural-urban gap remains significant: the number of deaths recorded in rural areas is about 41% higher than in urban areas[36]. This disparity reflects persistent inequalities in access to essential health services, including postnatal care and sexual and reproductive health services. In rural areas, the lack of health infrastructure, trained personnel and preventive interventions contributes to the increased vulnerability of mothers and newborns, exacerbating the risks associated with childbirth and the immediate postpartum period. In this context, it is essential that public policies aim to expand health services in rural and disadvantaged communities by supporting the primary healthcare network, training staff and ensuring effective access to quality care for all women, regardless of their background.

Pregnancy monitoring

Women in rural areas and on the outskirts of urban areas face major difficulties in accessing pregnancy monitoring services. Many of the interviewed women have rarely or not at all had the opportunity to go for check-ups, have tests done or undergo other diagnostic procedures during their pregnancies, sometimes only getting to do so in the last trimester or when they had to give birth. The main barriers include the lack of specialized services close to their home, the fact that they have no financial resources or identity documents, the indifference of the family physician and the difficulty of traveling long distances to reach cities where such services exist. A lack of pregnancy monitoring can lead to the late detection of serious complications such as preeclampsia, gestational diabetes or other issues that threaten the life of the mother and/or the fetus, with one interviewee citing known cases where a lack of antenatal care or delays in accessing health services have even led to pregnancy loss.

[34] UNICEF (2024).
[35] INSP (2024).
[36] Ibid.

Although the lack of financial resources is a central problem, the lack of information is also a significant barrier. The fact that women are not informed about the availability of free perinatal services even without public health insurance, about the importance of pregnancy monitoring for the health of the mother and the fetus or about the services available contributes to them not going for check-ups regularly or not going at all, which renders adequate pregnancy monitoring impossible. Several interviews revealed that the women do not have information on the free services or other measures that pregnant women or mothers who have recently given birth can benefit from according to the legislation in force[37], such as examinations and tests during each pregnancy trimester, including for women who do not pay health insurance premiums,[38] or transportation to the hospital within or across county borders for pregnancy monitoring[39].This being so, women in marginalized communities or rural areas are often forced to forgo essential antenatal care because of the costs, leading to significant health risks for the mother and the fetus.

Although according to the legislation in force pregnant women are entitled to free pregnancy monitoring services even without health insurance, in reality exercising this right requires following several bureaucratic steps which in practice constitute significant obstacles for women in vulnerable situations. Access to these free services requires the pregnancy to be confirmed by a doctor – a family physician or a specialist – who will issue a medical certificate that is necessary for the pregnant woman to become registered in the system of the National Health Insurance House (NHIH) as an insured person during pregnancy. If the certificate is issued at a hospital or outside the family physicians' network, oftentimes the pregnant woman is the one who has to submit it to the insurance company in person – a difficult task for those who do not have easy access to transportation, information or administrative support. Thus, although pregnancy monitoring is theoretically paid for by the system, in reality access to these services remains conditional on health infrastructure, bureaucratic support and the individual's ability to navigate a complex system. All of these further perpetuate inequality and vulnerability for women living in poverty, isolation or without real institutional support. This situation highlights the responsibility of the health system to streamline the access procedures and remove the administrative barriers that end up excluding the women who are most in need of care instead of protecting them.

Pregnancy monitoring is essential for the early detection and prevention of potential complications, but information on the importance of this process often does not reach pregnant women. Regardless of socio-economic status or access to health services, many participants reported that they did not receive clear or consistent information about the role of pregnancy monitoring. In the absence of adequate communication, some women do not perceive pregnancy monitoring as fundamental to preventing complications, but rather as an intervention reserved for complicated situations. Several participants mentioned that *they did not need* to access health services because they felt fine or that *they got lucky* in the end. Other women explained that they *discovered* this information on their own while going through their first pregnancy and that they used this learning experience in subsequent pregnancies.

Consequently, without a coherent, consistent and accessible support system, antenatal care is not always part of the women's expectations or practices, as it is associated with an intervention in case of complications rather than a necessary routine. This type of attitude can be understood both as a manifestation of the belief that pregnancy is a natural state that does not require medical intervention, as well as a strategy for adapting to structural realities marked by inaccessibility, discontinuity of services and limited trust in the medical system. In this context, the lack of pregnancy monitoring does not reflect passivity or negligence, but rather the women's ability to navigate a fragmented system, managing uncertainty and risks with their own resources.

Some women end up having their pregnancy monitored only in the emergency room. Due to a lack of financial resources, access to family physicians or other specialists to provide information and support about and during pregnancy, some women have their first pregnancy check-ups (even to confirm the pregnancy or to find out the sex of the baby) only in the emergency room, but this cannot replace a regular pregnancy monitoring program, which includes tests, ultrasounds and

[37] Brinza et al. (2022) includes a detailed overview of the legal framework governing perinatal services in Romania.
[38] Ministry of Health (2021).
[39] Ministry of Health (2021).

other essential procedures. Using the emergency system as the only solution for women who do not have access to regular antenatal care can put pressure on the system, while also being an insufficient and potentially belated approach to managing pregnancy health by preventing and treating complications.

Moreover, the lack of consistent prenatal care can profoundly affect the emotional state of pregnant women, leading to insecurity, anxiety and a sense of isolation from their own pregnancy journey. Seemingly 'mundane' aspects, such as having an ultrasound on time, being able to understand what is happening at each stage of pregnancy or finding out the baby's sex, are not mere curiosities, but natural parts of a pregnancy that is experienced with confidence, dignity and peace of mind. These services should be accessible to all women, regardless of their social status or where they live. According to the World Health Organization, the right to sexual and reproductive health is not only about medical risk prevention, but also about enabling women to experience pregnancy as a positive experience – safe, assisted, informed and supported – a prerequisite for their physical, emotional and psychosocial wellbeing[40].

In this context, women sometimes have to deal with comments or attitudes from healthcare professionals suggesting that the absence of pregnancy monitoring is the result of personal negligence. Rather than exploring the real causes – not being informed, not residing in close proximity to the medical facilities, not having any institutional support or living in poverty, to name a few – comments about the lack of testing or monitoring are sometimes made in an explicitly accusatory way and their subtext sometimes contains a way of making the women feel at fault. This attitude, even when expressed indirectly, contributes to stigmatization and may increase women's reluctance to approach the health system, especially in contexts where they have neither the resources nor the support. In order to build a truly accessible and dignifying system for all women, healthcare needs to be accompanied by empathy, respect, and a deep understanding of social vulnerabilities.

The experiences of the interviewed women regarding the use of antenatal services confirm the common access problems identified in Romania, particularly among women from vulnerable groups. An important study on how many pregnant women receive antenatal care in Romania[41] indicates that 78% of pregnant women report having received inadequate antenatal care, with a higher rate among young women, women with a low socio-economic status, Roma women, unmarried women, women with a low education level, women from rural areas and women with several children. For example, according to the study, 71% of Roma women respondents had experienced inadequate antenatal care, a significantly higher percentage than that of Hungarian (35%) or Romanian (41%) women who had gone through the same experience.

[40] World Health Organization
[41] Stativă et. Al (2014).

Experiences with limited access to pregnancy monitoring services

Women users of SRHS

“No, I didn't [undergo any medical procedures, didn’t have any ultrasounds or any tests done during pregnancy] because I didn't have money. You need money to go to the hospital. By the grace of God the birth went well and they were born healthy” *(Interview 16*)

“I am not registered [with the family physician] here, in this village. [...] I have no relationship with this family physician. [...] Of course, if I’m not insured, he can't give me referrals for specialist care. [...] No, [the pregnancy was not monitored], only at the hospital when I gave birth.” *(Interview 20)*

“I went for a check-up because I didn’t know I was pregnant. They did an ultrasound on me and that revealed that I was pregnant. I went to a private practice, yes. [...] So my pregnancy was not [monitored]. It was only monitored when I went to [city name], that’s all I was told, that I was [pregnant]. No, here in our village I did not go to the doctor’s.” *(Interview 18)*

“I went to our dispensary once, when I was 5 months pregnant, and they said that everything was fine, the baby was fine, they performed that examination how they do it. [...] Well, I didn’t have the possibility [to have tests and ultrasounds done or undergo medical procedures]. I couldn’t get [to Bacău], I had no money, no social support to get some money from, no one was helping us.” *(Interview 12)*

“No, I don’t believe that [my pregnancy was monitored thoroughly enough], because it wasn’t done here in my locality, I had to go to Constanța and I couldn’t manage to have all the necessary tests done. [...] There have been plenty of such cases [where women suffered because they could not get to a doctor while they were pregnant]. There have been instances of babies even dying in their mother’s wombs or many other things. And the mothers ended up suffering because they couldn’t get to a doctor sooner.” *(Interview 3)*

“I know people who actually might have not received any [information during their pregnancy] and really didn’t know. And the result is abortions and unwanted pregnancies and many other things.” *(Interview 5)*

“One of them [the fetus] was dead, and I needed to have it done [the abortion]. He had been dead for 3 months. And when I began bleeding, I had no idea about it. They told me, 'Get on the table so we can perform the abortion because the child has begun decomposing.’ I had no idea. I started crying because I was scared, I didn’t want it to be true. My mother told me, ‘Child, you have to sign the papers, get on the table and let them perform it [the abortion].’” *(Interview 14)*

“I didn’t feel like I was sufficiently informed [on prenatal, intranatal and postnatal services] because I had nowhere to get this information from. As I’ve already said, at our hospital there is no gynecologist and receiving such information is more difficult. The family physician gave us some information.” *(Interview 3)*

“No, [I didn't keep a notebook, a file in which to put my things] or the papers [from the emergency room] because I had nowhere to put them, but I kept track of how [the pregnancy] was developing and if I thought something was wrong, I instantly ran to the hospital, so I didn't wait until something happened to the baby.” *(Interview 25)*

“I didn't do everything [the pregnancy check-ups] by the book, because they ask you to get a lot of tests done, which are very expensive. Yeah, some people can't do that because of the cost. [...] I would only go to the doctor

[gynecologist] for some tests and nothing more. There's not much you could ask from them anyway; they just do their job and that's it. They don't care that much unless you *finance* them, so to speak." *(Interview 32)*

"Well, [the gynecologist] would ask me to come in approximately once every 3 weeks, from what I remember. Yeah, generally, once every 3 weeks. It depended on how I was feeling. If he saw that I was not doing fine, he would ask me to come in even once a week during the last trimester. [...] I really did have a lot [of check-ups]." *(Interview 31)*

"Yes, I would sometimes go [to the doctor] here [in the locality, during my pregnancies], he would update the records, assess my condition, tell me how far along I was, how many centimeters I was dilated; he would tell me these things." *(Interview 12)*

"I have friends who also gave birth to babies with health issues because during the pregnancy they didn't get ultrasounds or undergo any other examinations that a woman should get in order to see if that baby is doing well or not." *(Interview 28)*

"I truly had no rights. When I was pregnant with the children, I didn't have any identity papers and I didn't really… I didn't know, I had no rights to go the doctor's or anywhere else. [...] I didn't have any identity papers. [...] Until I was about 30 years old. I would sometimes get a certificate from the town hall [to go give birth] which stated that I had no papers. When I had my third child, the ambulance didn't take me because they said, 'That's what you do, you g*****s, you have children and then abandon them in the hospital.' So, I took my sister-in-law's ID and went to give birth so I could at least register the birth of one of my babies. [...] Everywhere I went, they'd tell me it was abnormal. 'How come you don't have any papers at your age? Don't you have an ID? You don't fit in with the people or with this world, you're an alien.' And so I would often just stay home. I even lost a child before I gave birth to the boy and I remained home because nobody would take me in. [...] [I didn't have tests or examinations done during my pregnancies] because I didn't have any papers. I didn't have the money for it... They wouldn't speak kindly to me." *(Interview 19)*

"I would have liked them to talk to me like... well, not necessarily how I talk, but what I mean is that they use too many medical terms when they talk to you. [It's difficult to understand them,] Especially when you're from the countryside and don't have much of an education – I only went to middle school and we didn't do much there. They should have used different words, I don't know… And if they see that you don't understand something, they don't explain it further, they don't try to make you understand... [If] they see you didn't understand a few words, [the doctor tells you] 'Yeah, okay... the pregnancy is going fine, you are fine. You can go home, there is nothing to worry about.'" *(Interview 30)*

SRH service providers

“Well, [some women] don't receive [pregnancy monitoring services] because they don't seek them. They simply don't go to the doctor’s or they come to the emergency room for an ultrasound. They are not registered with a family physician. [...] Well, yes, even in urban areas, because there are certain neighborhoods that are more marginalized – a poorer, less educated, less informed demographic. And they come directly to the emergency room to have their pregnancy confirmed or to find out the sex of the baby.” *(Interview 38)*

“And I know of a case where this woman was even being judged for not receiving monitoring services during the pregnancy, but she didn't even know about this right, she didn't even have... she lived on the outskirts of [city name]. She didn't have the means necessary [...] I think that the doctors around her [had a judgmental attitude]. Well, I don’t mean that they were judging her, but there were questions like, ‘Why didn't you get tested?’, ‘Why didn't you get tested during your pregnancy?’, ‘How come you didn’t know about it?’” *(Interview 43)*

“Pregnant women, on the other hand, are entitled to free services by law. But to receive free services, the National Health Insurance House must be made aware of the pregnancy. In order for them to do that, we have to issue a certificate which the woman has to submit to the NHIH, where she gets registered as pregnant; oftentimes the family physicians help them, they send these certificates via e-mail, and so the women become insured because they are pregnant and get in the NHIH’s records; the NHIH has no way of knowing when a woman without health insurance gets pregnant.” *(Interview 37)*

“Women are not informed well enough; not even the women whose pregnancies are being monitored by doctors know everything they should about what childbirth means, what it entails and many other things that a mother-to-be needs to know [...] If this is their first time giving birth, they don't know what to expect, they don't know what childbirth entails, they don't know how to act in this situation.” *(Interview 38)*

“Unfortunately, there are [women who don't receive pregnancy monitoring services] and there’s quite a lot of them; they don't receive them because they don't seek medical services themselves. For example, during yesterday’s night shift I had a 15-year-old pregnant girl come in with a respiratory infection who was 20 weeks pregnant, so halfway through her pregnancy. She had never gone for a check-up before and probably wouldn't have done so either if she hadn't been feeling sick because of the respiratory infection. She was brought in by ambulance. [...] At a certain point, as I’ve said, after years and years of work and sleepless nights, of course you become somewhat irritated when you’re called for nonemergencies, which has been happening very frequently lately. And that's what pretty much all of my colleagues have been complaining about; it’s not exactly pleasant when someone who during those five, seven, eight months has never made an appointment with a specialist, never gone to a family physician to get a referral to a specialist, goes to the emergency room at night with some trivial thing, for example. I didn’t flat out deny them the services, but I wasn’t too invested in their situation either, as I regarded them as nonemergencies.” *(Interview 37)*

“I think the attitudes are the biggest barrier. The family environment sometimes. We have had situations where their partners wouldn’t allow them to come to us, except in emergency situations. But the most significant barriers they they face are their social environment and level of education. They only end up seeing a doctor in emergency situations, as I said. There are pregnant women who have never had a check-up. Many of them say that they didn’t have money for that. Which means... I don't know if money is necessarily the problem though, because basically they would only have to pay to get to the hospital, which is not that expensive.” *(Interview 37)*

Family physicians

The lack of access to the services of a family physician severely limits pregnancy monitoring. An essential aspect of care during and after pregnancy is continuous access to a family physician, the first professional a pregnant woman goes to for regular check-ups and for pregnancy complications prevention. The family physician is responsible for performing the first antenatal check-up in the first trimester of pregnancy, issuing referrals to a gynecologist or for other tests, providing information about the progress of the pregnancy, the available medical assessments and interventions, the rights and obligations of the pregnant woman or regarding keeping an antepartum record. However, several of the interviewed women – predominantly Roma women living in rural areas – did not have regular or consistent access to a family physician or did not regularly receive care from one. Without a family physician present, in the case of some of the women, only the gynecologist monitored the pregnancy.

Access to the services of a family physician during pregnancy depends both whether one has access to information about their right to this service and on whether there is a family practice nearby. Some of the women with no income, who were not registered with a family physician, were unaware that they were entitled to free medical care from a family physician when they found out they were pregnant. In other cases, either there were no family physicians in the area or accessing their services depended on the availability of transportation and not necessarily on the proximity of the service, with one respondent having to go to a family physician in a locality that was further away, but that she could get to by public transport. In this context, some women end up accessing the free medical services provided during pregnancy only occasionally, at a public hospital, perhaps in the last trimester of pregnancy or even only at delivery.

Registering with a family physician does not guarantee access to adequate and satisfactory medical services. The experiences of some of the interviewed women, especially those of Roma women and women with a low socio-economic status, suggest limited involvement and poor communication with the family physician, some mentioning that they were not available to provide appropriate treatment or do thorough check-ups, or that they paid insufficient attention to their health problems during pregnancy or later on to their children's. Some Roma women stated that they cannot access family medicine services whenever they would like or need to, sometimes having to insist to be given referral letters to specialists for their children or for treatments during pregnancy, while others underlined that they would not *dare* bother the physician, seeing it as *demanding* for them to answer to such a request, which shows the unequal and hierarchical nature of the doctor-patient relationship. Women who do not receive continuous care or who are unable to build a trusting relationship with their family physician tend not to seek medical help except in emergencies. In this context, women are forced to either turn to private medical services, which is difficult to do if they are in a precarious economic situation, or go directly to public hospital emergency rooms or to pay for medication that would have been covered by health insurance.

In fact, resorting to emergency services is commonplace among the general population in Romania, including for health conditions that could be treated in primary healthcare. A recent report of the OECD and the European Commission[42] highlights that this trend is supported both by the structural organization of the system, as well as real-life circumstances: funds predominantly allocated to hospital care[43], limited availability of family physicians, especially in rural areas[44], their skill level, and the difficulty in accessing specialized care directly. In particular, the fact that family physicians have no availability has significant implications for the mortality rate from treatable causes, as Romania currently ranks highest among EU countries[45]. This structural imbalance contributes to hospital overcrowding and hinders the development of accessible services providing preventive and continuous care in the communities.

[42] OCDE/European Commission & OECD (2023).

[43] 44% of the health budget, also reflected in the high number of hospital beds (7.2 per 1,000 people in 2021) compared to the EU average (4.8 per 1,000). (European Commission & OECD, 2023).

[44] Also indicated by another recent analysis of the underutilization of primary healthcare services in Romania (Lăcătuș et al., 2024).

[45] OECD/European Commission (2024). According to the same publication, Romania also has the third-highest rate of preventable mortality in the EU.

Family physicians and midwives can provide comprehensive care during pregnancy, childbirth and the postpartum period; their role becomes even more important in situations where access to specialized gynecological services is limited or nonexistent. For some women – those with no income, who live in rural areas or who are Roma – living far away from hospitals or gynecological practices, as well as the financial barriers, often make family physicians and midwives the only available maternal care providers. With their skills in monitoring normal pregnancies, counseling, antenatal education and postnatal care, they can cover many of the health needs of pregnant women[46], reducing the situations where immediate access to specialist services would be necessary since they are difficult for these women to access due to the cost or distance. Providing these services in disadvantaged communities helps prevent complications associated with the lack of prenatal care and provides ongoing health support for the mother and child, making care more physically and financially accessible and reducing the impact of geographical and economic barriers. In this regard, supporting the work of family doctors and midwives, including through the reimbursement of prenatal and postnatal services and the streamlining of bureaucratic procedures, is essential to allow them to focus on patient care.

Experiences with family physicians

Female users of SRHS

"With my previous family physician I also had problems. When I'd take my girls for check-ups, my youngest would always fall asleep in my arms, especially while on the bus. [The doctor would tell me] that he wouldn't examine her, not to wake her up, no more this and that... and he would be playing it by ear with the prescriptions." *(Interview 27)*

"I'm from [locality name], I've never lived in another town, never moved to another town, never gotten anything from school to be able to move to another town. My children don't have any medical records, only my youngest, my five-year-old girl. But my older children and I... my boy is 18 and my girl is 23. I've gone multiple times to look for the records, but they didn't find them. And they treated me badly. [...] We've chosen many times not to go to our family physician and went instead to [city name], to the ER, to [city name], to the ER. I went to the pharmacy and I picked up medicine for us, just so I wouldn't have to go to our family physician, because... they don't treat us nicely and they are very unkind. [...] During each of my pregnancies, I stayed home and only went to the family physician when I had to give birth." *(Interview 15)*

"[I would like to be registered with] a family physician, to go get a check-up and see if there's anything wrong. To be honest, I am 30 years old and I have never gone to see a family physician for a check-up." *(Interview 20)*

"I went to my family physician once, I asked for some vitamins that I needed because I was severely anemic, I would get dizzy, and he said 'No, I won't give you anything, go to the hospital.' He wouldn't even give me the prenatal vitamins. 'Go, buy Elevit 1, if you want, take them until the third trimester.' That's it, he gave me absolutely nothing. [...] [I] had to [go to a private practice], I went to see Doctor [gynecologist name], he gave me treatment, he also kept me in the maternity ward, in the hospital; he was the one who admitted me to hospital." *(Interview 14)*

"I mean, her [the family physician's] conduct is very... We are not on the same wavelength. For instance, if I want to ask something of her or get a referral or just anything in general, she gets very angry. I was actually thinking of going to a different family physician. It's not okay. [...] I can't [get referrals from her]. I mean, most of the times I've chosen to pay full price instead of seeing her, just because we can never get along." *(Interview 31)*

"I went [to my family physician after the birth] because I had had a C-section in [city name] and in the maternity ward they told me, 'You have some stitches that... you need to keep for longer and your family physician can take them out himself.' And then when I went to my family physician, he said, 'No, go to [city name].'" *(Interview 15)*

[46] Ministry of Health (2021), Ministry of Health et al. (2021).

SRH service providers

"Family physicians should play a much more important role, which they are not really able to fulfill because they are literally buried under a mountain of paperwork. We have this inside joke that patients often get in our way, that we don't have time to deal with them anymore given all the bureaucracy we have to deal with. And there's simply not enough time." *(Interview 37)*

Birth

The birth experiences of the interviewed women are diverse, showcasing both positive experiences, as well as a significant lack of empathy and the medical staff's abusive treatment. Several women recount experiencing **racism, humiliation, indifference and neglect** during labor and delivery, mentioning situations where they were left in **severe pain for a long time,** without the doctors or nurses intervening, or were ignored when they asked for information about their condition or the medical procedures. There is a stark difference between how Roma women and Romanian women are treated, it being a clear manifestation of discrimination and racism against Roma women, which is aggravated by their lower socio-economic status. In this context, giving birth in a private clinic was the solution for one of the women who had been abused during a previous birth in a public hospital, when she was verbally humiliated by the medical staff, forced to eat against her will and insulted when she tried to get out of bed to go to the bathroom. But this option is not available to Roma women facing economic hardship.

Childbirth is a medicalized and strictly regulated process, over which women have little control. According to the experiences of the interviewed women, the births are usually assisted by doctors, nurses, nursing aides and rarely midwives, while the presence of family during labor and delivery is restricted. Against the backdrop of these restrictive procedures, some women face a lack of emotional support during the critical moments of childbirth. In addition to this, although the benefits of early and continuous mother-infant contact for both breastfeeding and the infant's physical and emotional development and for the mother's postnatal recovery are well documented and already constitute internationally accepted guidelines[47], several experiences recounted in the interviews paint a different picture. Most of the women were separated from their babies immediately after birth, only being able to spend time with them during feeding, and only a few women mentioned that their baby was brought to them immediately after birth so that they could be together in the ward. How the newborn is fed is another aspect which, in some cases, is decided by the medical staff, with some women noting that they received no explanation as to why their baby was given formula even though they wished to breastfeed them.

[47] OMS & UNICEF (2009).

Birth experiences

Women users of SRHS

“Some doctors were nicer [when I gave birth], others were indifferent, others were alright... They left us in pain, [saying] that they were busy with other patients, that we had to wait.” *(Interview 16)*

“When I was in the hospital, they left me alone from the moment I got there up until the next morning; nobody paid any attention to me. I was left there all night, in pain. Nobody checked up on me. They came only to take my blood pressure and saw that it was high. They gave me a little pill and left me there until 10 in the morning, when I gave birth. No, [the doctor didn't assist with the birth]. He came to check up on me and he said he couldn’t perform a C-section because I hadn’t gotten any check-ups done at that hospital.” *(Interview 18)*

“From time to time [during the hospital stay for childbirth], there were doctors that would come to see how we were doing. But if I were to ask anything, like if there was anything wrong with me or if everything was going well... I would never get an answer. They’d say things like ‘Oh, what do you want to know?’ or ‘Is this really your concern right now?’ or ‘That’s my business.’ I fell quiet and stopped talking. They would only look at us if I had money to slip into their pockets. When I was there, in the hospital, I saw girls that were probably more well-off, who could slip money into their pockets: they were the ones who were actually looked after. But we were not. [...] I was alone, screaming, and they only checked up on me when I was about to give birth.” *(Interview 16)*

“No, [the pregnancy wasn't monitored by anyone,] only at the hospital, when I gave birth. That's it, yeah. [...] When I was in the hospital [for my last birth], they just left me there, unattended, on the hospital bed. Not a single medical staff member payed any attention to me, not even one nurse. They left me there until I gave birth on the bed. [...] A nursing aide began yelling at me... ‘What’s the matter with you, this is no disco, why are you screaming? Stop screaming!’ If I couldn't take the pain anymore, wasn’t I supposed to scream?” *(Interview 20)*

“I was admitted to hospital a few days before giving birth. They stopped giving me food and water and they kept scolding because I was screaming.” *(Interview 3)*

“They left me alone in pain for 73 hours, not once did they look at me. The baby started to come out and they said, ‘You are not ready to deliver, we are moving you to the predelivery ward’”. *(Interview 14)*

“Not really [I didn't really feel the medical staff knew or were interested in finding out what my needs were]. I mean, sure, they were doing their thing, because that’s what they were probably obligated to. They’d go, ‘Come on, you next, then you; hurry up, so we can check up on you too and then we wrap it up,’ you know? They weren't emotionally invested enough in the situation to take the time to ask us if it hurt, if it didn’t hurt, what we needed... ‘Don’t worry, everything's alright, we are here for you, you are in good hands.’ I was never told these words, the things a pregnant woman wants to hear when she's in that state.” (*Interview 30)*

“[I chose to give birth in a private clinic] Because in the state hospital I... faced racism and they were really nasty to me when I gave birth. During my first pregnancy I was a child myself, so to speak. I didn't know what was going on with me, and as for the nurses, I was simply going through labor with them, and they told me to stop screaming, to shut up; there’s no doctor to talk about because the doctor wasn't there [...] After I gave birth, the nurses forced me to eat. I told them I didn't want to eat and afterwards I threw up. After we women give birth... we bleed, but I didn’t know that, so I got up from the bed to go to the bathroom to throw up, but I fell to the floor and they called me a cow. They said I was a cow. I mean, it was a very ugly and difficult experience. [...] I mean, it's been... 9 years almost and I still haven't forgotten how they treated me.” *(Interview 31)*

“The fact that I was screaming in pain – because everybody knows what happens during childbirth, what pains you can experience – the fact that I was screaming so loudly bothered them, you know? And they would always come to scold me, asking me why I was screaming so much, telling me to stop screaming, because while I was getting f….d I was not screaming; that's how we [Roma people] are, ‘Look at this one, her organs aren't even fully developed and she’s here to have babies. Whoa, why are you yelling like that?’. I don't know, those were insulting, ugly words, you know?” *(Interview 28)*

“When I went to give birth, she started to tell me ‘That's how you g*****s are, you give birth every year, you're unwashed, you stink, you don't even know how to wash down there and yet you’re having babies.’ [...] I was crying, saying that I was in pain, that my stomach hurt, and that my back hurt. [The staff told me] ‘Calm down, it’s not like you’re giving birth right now.’ I don’t even want to repeat out loud the words used. ‘When you're with the man and he

climbs on top of you, it doesn't hurt then, but now it does?' So, they were hurling terrible insults at us... I was treated very badly." *(Interview 19)*

"And with my second child, my little boy, when I was in hospital there was a Romanian lady in the bed next to me, she was whiter and probably – I don't know, maybe more stylish, I don't know how to describe it – she was treated differently. I mean, they would come and rub her back, 'Are you feeling okay, are you still in pain? If it still hurts, let me know if you'd like something for the pain,' as she had back pain. But they didn't really ask me things like that. They didn't even help me when I wanted to go to the toilet and when I did I already felt that getting out of bed would cause me to bleed a lot, I mean, with the second baby. But I really had to go to the toilet to pee. I got out of bed and then..." *(Interview 30)*

"Yes, it affected me so much that I don't want to go through another pregnancy, to give life to another child, not because it would be hard for me to raise them, educate them and so on, but just because I went through this trauma. I can call it a trauma because now, when I think about it, it's like it happened just yesterday. And yes, I wouldn't choose to give birth at the hospital again because of the hospital staff, not because of the gynecologist and their staff. I would not choose to give birth there again, if I ever overcome this trauma. Although it's been four years and I don't want another pregnancy or to give birth to another child, I would have to choose a private clinic next time because honestly, I don't want a repeat of my first experience." *(Interview 17)*

"Honestly, after I was taken to the ward, I was so excited to see my baby because I had only gotten to see him when I gave birth, and then only the next day. Seeing the other woman's baby made me very excited to see my own, but the nurse who was in charge of taking care of the babies was busy discharging other babies and I had to pace around the hallway, always asking her when she was going to bring me my baby. [...] The next day [my baby was brought to me]. Because after I gave birth I was taken to the intensive care unit, I was kept there for the night and the next day, after lunchtime, after 12 o'clock, I was taken down to the ward." *(Interview 17)*

"Yeah, there were a couple of days [after I had a C-section during which I was separated from the baby], because I couldn't move, I wasn't allowed to exert myself. And then, on the third day, they brought him to my room." *(Interview 12)*

"After the C-section, I was separated from the baby for 12 hours and only after those 12 hours did I get to be next to him." *(Interview 6)*

"They said that the baby, my little girl, was very healthy [after birth], but [the medical staff] told me 'If you can get out [of bed, then attend to the baby], it's up to you. If you cannot, then don't.' But my little girl only got to stay in my bed after 3 days." *(Interview 14)*

"They didn't ask me [whether I wished to give the baby formula], they just gave it to him. And then she made me breastfeed him." *(Interview 32)*

"They didn't let me hold my youngest, the girl, [after I gave birth to her], except for when I went to feed her, that's all. But they wouldn't actually let me give her breast milk because they were giving her formula. But I asked, 'Doctor, why won't you let me breastfeed her?' But she didn't… I got no answer. 'At least tell me why I'm not allowed to do it,' and I still got no answer." *(Interview 15)*

SRH service providers

"The imposed birthing position, the aggressive, insulting language, the threats, the intimidation, are part of it [the manifestations of obstetric violence], in the hospital, at birth." *(Interview 40)*

"I know that *golden hour* is totally missing. [...] The postdelivery mother-baby bond doesn't exist. [...] If you have a C-section, you get to see the baby only the next day. I know this from some of my fellow residents who have given birth in the public system." *(Interview 43)*

Support after childbirth

Information on childcare after birth is not obtained in an organized manner through the medical system. Only a few of the interviewed women received substantial and consistent information about infant and maternal care after childbirth, either in the maternity ward, upon discharge, or during the immediate postpartum period. Many women noted that they learned how to care offor a baby either from family or acquaintances, or from their direct experience with previous births, and even fewer recounted positive experiences of receiving such information either in the maternity ward from the neonatologist or nurses, or later from their gynecologist, family physician, local social welfare services or through programs occasionally run by non-governmental organizations (for example, the 'Baby box' program run by the Samas Association)[48]. Some women feel overwhelmed, insecure and unprepared when they do not have access to essential information regarding newborn care and their own health immediately after birth, at a time when they need emotional and practical support to take on a new role.

Home medical visits after childbirth are not a widespread practice and the support women receive is limited. Only a few of the interviewed women explicitly mentioned receiving weekly or monthly home visits after childbirth from their family physician, nurse or health mediator, while others noted that they instead had to travel to the family practice or hospital for various emergencies. The lack of home visits is a common experience among women in rural areas, indicating a significant shortcoming in terms of access to postnatal care in these communities. As a result of the lacking support, some women reported that they had to *figure it out*, to *manage on their own* or with the help of their relatives, especially that of the women in their family, who represented their only support after childbirth.

Check-ups after birth are sporadic and are not necessarily aimed at ensuring that the mother and baby are well cared for immediately after birth. Few women mentioned receiving regular medical check-ups immediately after birth; in fact, the check-ups focused more on the newborn and rarely on the mother's health. Usually, women who experienced pregnancies and births with complications or women from urban areas with a higher socio-economic status reported having check-ups more frequently compared to women in rural areas. One of the interviewed Roma women living in a small rural community did not receive routine check-ups after any of her three births, only being examined shortly after her last birth due to a complication that occurred during delivery. In some cases, the only interactions with healthcare services after giving birth are solely to have the stitches from the C-section removed or the baby vaccinated, but even access to these procedures is limited by the availability of a family physician in the area or the ability of women from rural areas to cover the transportation costs to get to the nearest medical facility.

Most of the interviewed women have heard of midwives and recognize their essential role before, during, and after childbirth. Midwives are frequently mentioned as those who take care of the babies, teach mothers how to breastfeed, how to change their diapers and care for them properly, yet very few women actually received the support of a midwife in this context. Given that the number of licensed midwives currently remains low in Romania[49], it is unclear what was the actual profession of the people whom some of the interviewed women identified as the midwives who assisted their births or visited them immediately after giving birth. One of the licensed midwives interviewed for the research mentioned that, currently, licensed midwives are generally accessible only to women from of a higher social standing, who can afford to pay out of pocket for the services provided, as they are not reimbursed.

[48] https://www.programsamas.ro/cutia-bebelusului-4/

[49] According to data provided by the authors from the Independent Midwives Association, in 2023 there were 3,073 midwives with the right to practice (933 with higher education and 2,140 with post-secondary education).

Experiences with professional midwifery services are scarce and are found either among women who can afford to cover the associated costs or among those who gave birth within the medical systems of other countries. One of the interviewed women mentioned that she found out about the services of licensed midwives on social media and requested paid private services for breastfeeding support and managing abdominal diastasis. In another instance, a woman recounted highly positive experiences with midwifery services in Spain, receiving prenatal support, through pregnancy monitoring and childbirth preparation, as well as postpartum support, through infant care classes. As shown by the previous analysis, for many Roma women facing economic hardship, accessing the services of a licensed midwife, which are not reimbursed by the public health insurance system, is simply not an option.

Midwives play a key role in providing comprehensive and reliable care for pregnant women, mothers and newborns, promoting an approach based on respect for human autonomy and dignity, reproductive rights and cultural diversity, working together with women and their families[50]. Midwives provide continuous and personalized care through their competencies[51] that cover both horizontal issues (taking responsibility for decisions and actions, while respecting the principles of personal autonomy and transparency in their practice and maintaining respectful professional relationships with the women and other healthcare providers), as well as specific aspects regarding: (i) sexual and reproductive health (providing education and counseling on contraception and family planning, alongside supporting women and adolescents in making informed decisions); (ii) prenatal care (monitoring the progress of pregnancy and detecting complications, ensuring early interventions to prevent risks) (iii) childbirth (supporting the physiological process of childbirth, reducing the need for unnecessary interventions and managing potential complications); and (iv) the postnatal period (continuous care for women and newborns, supporting breastfeeding and maternal mental health, while also promoting recovery and integration into family life).

Support after childbirth experiences

Women users of SRHS

"No. The family physician never made [home visits after birth]. If there were any problems, we ourselves had to go to [city name where the family physician was located]. Or oftentimes we would just turn to home remedies." *(Interview 27)*

"The health mediator and the community health nurse, as well as my family, namely my mother and my mother-in-law, [visited me after the birth] [...] Unfortunately, [the family physician] did not. [...] [The health mediator and community health nurse made] home visits; they did check-ups on the baby and weighed him. They asked me what I was feeding the baby, as well as some questions about myself, how I was feeling, how I was cleaning the surgical wound, that sort of information. [...] They used to come twice a month." (Interview 17)
"The doctor there, the nurse, taught me how to breastfeed, how to change his diaper... She taught me. [...] Yes, a lady there, the nurse taking care of me, told me, 'On such and such date you should come for a check-up, to see how you feel,' and that's all she said to me. She told me that I needed to take care of him, to check on him at night, how to give him milk, how many milliliters, as I was giving him formula because I couldn't breastfeed. [...] I couldn't afford to pay the cost of transportation to go [for the postpartum check-ups] and come back. I had no money." *(Interview 12)*

"Unfortunately, during my first three days in hospital, there was no one to show me how to do things or guide me. But one evening, when a nurse from the neonatal unit saw me struggling to breastfeed the baby, she came over and showed me how to do it. She put the baby on a pillow, showed me how to hold my breast and how to hold the baby so that it latched onto it. [...] I was given an information sheet which stated that I had to take the baby for a hip ultrasound one month after birth and to have its eyes checked at two months old; it also included advice for me. Since I had a C-section, I had to take anticoagulants for two weeks straight and also follow an antibiotic treatment that the doctor gave prescribed me because I was experiencing problems with the incision site." *(Interview 17)*

[50] International Confederation of Midwives (2014, 2017, 2024a).
[51] International Confederation of Midwives (2024b).

“I went for check-ups and learned how to take care of him, how to feed him. And at home, a nurse sent by the family physician came over for weekly check-ups and monitored our baby. I mean, she brought a scale with her, weighed him, checked if he was being washed, if he was taken care of and that’s about it. [...] Yes, then the check-ups became every two weeks and they were still necessary. But as for me, no … nobody checked up on me. And these check-ups were done by the neonatologist at [city name] Hospital and as I said, in theory, these services are free.” *(Interview 3)*

“For example, whenever I wanted to talk to the baby's doctor, I couldn't reach her. I just simply couldn't. I have no idea what her actual schedule was because she was nowhere to be found. The fact that I couldn't ask for any details about what was happening [had a negative impact on me]... Eventually, my husband managed to reach to her.” *(Interview 32)*

“There is a difference between state-owned and private hospitals, that's true. We even had a psychologist come in twice a day after I gave birth and we would spend 2 hours talking about how we were feeling to boost our morale (...). And we even had midwife who taught us how to bathe the baby, how to nurse him and so on.” *(Interview 31)*

“The baby's doctor told me how to bathe him, how to wipe him, how to swaddle him, how to feed him, the position in which he should be held, how many times a day to change him, how many times a day and how much to feed him, how to clean his nose and eyes with saline solution, where to start, how to do everything. And that doctor, the gynecologist who helped me give birth, also gave me all kinds of instructions. He told me what medication to take and gave me advice on recovery, how long I should be standing up, how much and what I should be eating so that everything went well.” *(Interview 29)*

“I cried so, so much after giving birth to my first child. Yes, they brought him to me. Half an hour after they put me to bed, they brought him to me. They didn't teach me how to breastfeed the baby. My breasts hurt very badly because I had no nipples; I mean, they didn't help me figure out how to get milk out or how to use the breast pump. No! They basically left me alone, handed me the baby, I slept with him in bed. So nobody came to see if I had taken the baby and put him to bed with me, to keep an eye on me or to see if we were doing okay. [...] No, I didn't get any [information on newborn or maternal care after giving birth]. They told me absolutely nothing. They just dressed my baby, bid us farewell and wished us good health. That’s it. Even when I recently gave birth to my girl, no one came to offer me any guidance. You'd think that things have changed over the past 14-15 years.” *(Interview 30)*

“I was afraid to wash myself when I came home after giving birth to my daughter. Because how was I supposed to know what I was and wasn’t allowed to do down there, what to do if it hurt... You know? Everybody needs a little education on that.” *(Interview 28)*

“I wish... I mean, given that it was my first time giving birth, my first baby, I whish that [the medical staff] had treated me better, guided me, reassured me somehow, because it’s not like they didn’t see me crying.” *(Interview 30)*

“I received support from both my mother and the association from the town-hall. I received the box the day after giving birth, I don’t remember how. The Baby Box. It had all the essentials in it; I don't know, I got everything I needed.” *(Interview 14)*

“Yes, I did go to the family physician and to the gynecologist [during pregnancy]. I saw no point in reaching out to a midwife during pregnancy. [...] I have heard about midwives; I don't exactly know what role they play during pregnancy, but I do know that, if there’s no doctor during and after childbirth, the midwife can help you give birth and can also help you with taking care of the baby for the first two or three days.” *(Interview 3)*

“The [midwife] helps you in the hospital, during childbirth: when your due date comes, she helps you. But you have to pay, you have to give her something. And that is standard practice, as far as we know.” *(Interview 15)*

“I've heard what a midwife is supposed to do: make home visits, ensure the baby’s needs are met – that's about it.” *(Interview 20)*

“[The midwife] takes care of the babies, teaches the mother how to take care of them, helps her breastfeed, shows her all kinds of things: how to dress the child, how to take care of them, what to do if they have a fever, she helps you with all sorts of stuff.” *(Interview 14)*

“Yes, I learned that midwives may assist during childbirth and provide support with postnatal care.” *(Interview 9)*

“[The midwife] is the one who teaches you everything you need to know about pregnancy, the baby, caregiving and yourself.” *(Interview 6)*

“During my pregnancy, I had a midwife, I would go to her office every two or three weeks; she monitored the pregnancy, listened to my baby's heartbeat, measured him and so on. And I had a natural birth. And I was very, very pleased with everything, absolutely everything. [...] They also held classes [on newborn care], they would invite us to attend those classes to teach us how to breastfeed, how to give him a bath, how to massage him [...] The midwife, that's what they call it there in [EU country name] ... I would go to the midwife's office and she would teach me

everything. She also held childbirth classes during which she taught us how to breathe, how to push and we did special exercises. She also got the father involved." *(Interview 33)*

RHS service providers

"I believe that our country lacks [a postpartum support system]. A woman, if she wants to get informed, does so privately, on the internet, wherever she can... Now, there are these midwives... in the private system. [...] From this point of view, I could contrast our country to France, where after the birth of my first child I would go to a kind of dispensary on a weekly basis – or maybe two or three times a week in the beginning – to weigh the baby, to see if he was gaining enough weight. And they also had this informational side, where you, as a mother, could talk to a counselor, a breastfeeding counselor, whoever you wanted to. They had everything you could possibly want. And you had to pay nothing in the public system. This is a major shortcoming in our country and perhaps in other countries too, I wouldn't know, I'm just speaking from what I've lived and seen. I think this is a necessity. Because in a hospital you obviously cannot... The woman goes home after two or three days, it's impossible to offer her [this type of support]." *(Interview 38)*

"Given the fact that I basically can only offer services in collaboration with associations, practically in the private system, and that the services are not reimbursed, only women of a higher social standing, who earn a salary and pay for my services, have access [to midwifery services]. Yes, there is a financial barrier. [...] The consequences of limiting access to the services of a licensed midwife are increased maternal and infant mortality rates, increased risks of contracting sexually transmitted diseases, recurrent pregnancies in minors, just for starters. [...] [In the immediate postpartum period] they need support, accurate information, help, encouragement [which are all insufficient at present]. [This situation could be improved] by integrating midwifery into the public health system. Yes, if midwifery continuity of care were implemented, then they would have constant support and thus problems associated with pregnancy, childbirth and the postpartum period could be detected much earlier." *(Interview 40)*

"Unfortunately, you end up falling into a routine [as a doctor] after practicing medicine for so many years and you end up not putting so much emphasis on this advice [regarding puericulture]. Maybe it's our fault, too. We tend to leave it... as a topic to be addressed by the staff in the neonatology ward after the pregnant woman gives birth, but I have always offered advice when it was needed." *(Interview 37)*

Postnatal difficulties

Postpartum depression remains a common and difficult experience. The interviews show that many of the women have experienced symptoms of depression, but have not had access to screening services or have not been informed about the existence of specialized services. Some recognize the symptoms, but without access to specialized support, they are forced to manage their feelings of sadness, anxiety, helplessness or hopelessness on their own. Other women experience postpartum depression without realizing it and end up isolated and misunderstood. Limited access to specialized services coupled with a lack of family support only worsens their state, contributing to a vicious cycle of helplessness: women continue to feel that they are not good enough or not ready to be mothers, reinforcing feelings of powerlessness and worsening their depression. Sometimes depression can reach a critical point, which suggests that no early intervention has taken place and that an adequate support system does not exist, with short-term or long-term negative effects on both mothers and children.

Postpartum depression screening is not a common practice in Romania. At present, the responsibility for identifying the risk of postnatal depression lies with the medical professionals involved in the postnatal examinations (family physicians and midwives), who can refer the patient to specialized psychological or psychiatric services[52]. However, since many women in rural areas, Roma communities or in precarious situations do not have constant access to these medical professionals, the chances of receiving adequate support in the postnatal period decrease considerably. Not engaging with the care system at this fragile stage means that the symptoms of

[52] Ministry of Health (2021).

postpartum depression often go unrecognized and unaddressed, with significant consequences for the mother's mental health and the mother-child relationship.

In this context, another critical issue that emerges from the interviews is the absence of a postpartum emotional health assessment system and of access to specialized support, as the medical system focuses primarily on the health of the baby after birth, disregarding the emotional wellbeing of mothers. Unable to turn to specialized services, many women rely on family or try to manage their depressive episodes on their own, noting that greater support from their partner (which some of the interviewed women occasionally mentioned) and from extended family could significantly reduce the risk of postnatal depression.

Most of the interviewed women either firmly ruled out the possibility of a new pregnancy or they did not explicitly mention it, but their experiences suggest that a future pregnancy is not a priority. This attitude mainly stems from a lack of support, previous negative experiences and financial difficulties. On the other hand, women who had a strong support network are less emotionally affected by motherhood and might consider another pregnancy, indicating that the decision to have fewer children is the result of the absence of a support system rather than a manifestation of a supposed form of empowerment. Overall, the interviews suggest that the decision to have children is a choice deeply influenced by economic, social and emotional factors.

Experiences with postpartum depression

WOMEN users of SRHS

“I kind of went into postnatal depression. When I saw the baby, I automatically thought that I couldn’t bring the child with me on the street and I began thinking of abandoning him.” *(Interview 25)*

“Yeah, I felt that [depression]. I felt it with the twins. No, [I didn't seek specialized services]. No, I don't know [anything about depression screenings]. I don't know anything about these things, but they would be so useful! Mothers really should be monitored in a way after birth, I think. That depression comes and you don't even know it, you don't realize it. I was fortunate: I had already weaned the twins at the time. I had reached a point where I was thinking... I once remember thinking maybe ten times in one day about picking them up and jumping from the ninth floor. But I told myself that I couldn’t do that. So, what now? I don't know. [Some help] would be really good. I don't know, maybe chip the mothers and track them. And do this early screening, before it's too late. Or have mothers feel supported when they come home and have to live with the baby alone. And ok, the father also exists, but he probably has to go to work, which leaves you alone with the kid. And when it comes to anxious or depressed people, anything can happen.” *(Interview 21)*

“I spent about three weeks, almost four, struggling with this depression after giving birth. [...] I didn't get over it that easily. [...] During that time, my sister and my brother-in-law came home, because I didn't have a phone to call anyone at the time, I didn't have anyone to help me. And my sister and my brother-in-law came and they soon took me to [city name]. [...] The doctor gave me a prescription and told me ‘We’re giving her a stronger treatment so that she can heal and stop lactating,’ as I was breastfeeding then. And I got better, yes.” *(Interview 15)*

“I fell into a bit of a depression. Yeah, after giving birth, but they told me that it was normal. The world, my family, they all told me that it's normal to cry about everything. Yes, [I knew there were specialized services], but I didn't reach out to them.” *(Interview 32)*

“I haven't [struggled with depression myself], but I know people who have. Actually, one of my sisters-in-law... after giving birth, some evenings she would burst into tears for no reason. And she would just cry. [...] My brother took a leave of absence from work for an entire month after she gave birth. He stayed home with her and the baby every day. Basically, he mostly took care of the baby.” *(Interview 29)*

“Yes, when I had my first child I struggled with that [depression]. [...] My mother-in-law was always by my side, as in she moved into my room. My mother would spend all day with me, the baby and my mother-in-law. I mean, she never left me alone during those six weeks with the baby. They would comfort me, they taught me how to breastfeed the baby, how to wash him. [...] I thought about [turning to specialized services for depression], but living in the

countryside, I had my mother-in-law, God rest her soul, who comforted me a lot. She offered me so much reassurance. She had given birth to 7 children." *(Interview 30)*

"I've decided that for the moment [3 children] are enough. Eventually if I make a better future for myself and I get rid of my problems, then maybe, but until then, no." *(Interview 27)*

SRH service providers:

"No, [there are no screening programmes], although many go through difficult situations and they don't realize it and they immediately become isolated, they're misunderstood both by their family and... So, they really would be needed." *(Interview 41)*

"The information we provide is about the postnatal hormonal cascade, the signs of postnatal depression, and we do that with both parents and we stress the symptoms of postnatal depression to the father, so that he can identify them as early as possible. I mean, we put a lot of emphasis on that, but I can't tell you that it's a thing that everyone does. It depends on what each doctor was taught." *(Interview 43)*

Consent

Lack of consent in perinatal health care remains a common feature of women's experience with specialized services in Romania. A recent study on obstetric violence in Romania highlighted multiple situations in which women were not asked about or did not consent to medical maneuvers, procedures, the administration of medication during or immediately after childbirth[53]. The experiences of some of the interviewed women in the present research paint a similar picture, where women do not receive explanations regarding what certain medical maneuvers entail or are only partially informed about the medical procedures that they or their children will undergo, where students and residents attend births without the consent of the women giving birth or where women are touched inappropriately by medical staff without being asked. All these practices indicate a paternalistic approach in which medical decisions are imposed on the patients, who do not get to play an active role in the decisions that concern them, thus contributing to the erosion of women's autonomy in medical decision-making.

Informed consent is a fundamental right of the patient, regulated by the medical and human rights legislation, but it is either denied, treated as a formality or improperly put into practice. As inferred from several of the interviews, the process of giving consent entailed the women having to quickly sign some paperwork, without receiving any explanations, or them only being informed about a procedure after it had been carried out. In such cases, women do not have the chance to make a real decision and consent becomes just a "signature on paper." Information that is superficial or offered too late contributes to women perceiving consent as unimportant or as a mere formality to be carried out quickly, without receiving a detailed explanation of the process. In general, informed consent should include information on the nature, risks and benefits of the medical procedure or intervention, reasonable alternatives, along with their associated risks and benefits, and an assessment of the patient's understanding of the information provided. As a matter of fact, the World Health Organization standards recommend that informed consent practices in health services be developed and ensured for a positive birth experience[54].

[53] Grünberg et al. (2023).
[54] WHO (2018).

Consent still remains an unusual term and practice for many women accessing perinatal services. Several of the interviewed women seemed not to be familiar with the notion of consent in medical practices or seemed surprised when asked about their right to choose how their interactions with health care providers go. In particular, the interviewed women from vulnerable groups – women with no income, women from rural or peri-urban backgrounds, Roma women or women from the child protection system – are not used to receiving information or actively participating in medical decisions and, therefore, found this question unusual. In a society in which respect for the authority of doctors and medical staff is very strong or when there is no trust in the patient-doctor relationship, patients, especially women, may perceive questions about consent as a challenge to their authority. In such a context, women may feel that the doctor knows better than anyone what is best for their health, so the question about consent may seem unusual or even embarrassing. This may particularly be the case when women are not aware of their rights as patients and are not used to taking an active role in medical decision-making against the background of paternalistic practices in which patients – especially those from the groups mentioned – are not necessarily considered capable of understanding and giving consent.

Women users of SRHR

I was told that I will be undergoing [a medical procedure], but I was not asked for consent, they just informed me it was happening. And that's not all, there were times when the nurses would just grab my breast and squeeze it hard to prove to me that I had milk. They'd say, "What do you mean you can't breastfeed? Look, you've got milk." But the whole thing... it just felt so violating, you know? And you can't even react. They just walk up, grab you wherever, and you're expected to just take it, you know? That's what it was like, trying to breastfeed. *(Interview 21)*

After I had my daughter, they called me in to nurse her, but I didn't know how. The baby wasn't really latching right, either. One of the nurses would just grab my breast and literally shove it into the baby's mouth. What was I supposed to do...? I couldn't even sit down because of my stitches. I was completely torn up down there; they let me suffer so much. I couldn't breastfeed my daughter; I just didn't know how. [...] With my second child [...], it was pretty much the exact same routine. They just grabbed my breast and stuck it in his mouth. *(Interview 28)*

Yes, they asked for my consent [in the maternity ward]. They had me sign paperwork for the medication and everything. If the baby ever needed an X-ray, the mother had to give her written consent. *(Interview 14)*

They asked for my consent for all the medical procedures they did to the baby, but when it came to me, nobody ever told me what was being administered to me when I had IVs or anything like that. [...] But what can you do? There's nothing you *can* do. You just have to deal with it. (*Interview 3*)

They didn't ask [for my consent], they had me sign the paperwork, and they didn't ask me anything. *(Interview 30)*

SRH service providers

The way they handle [consent] is pretty questionable. Basically, the second a mother is admitted, she's rushed into signing a stack of papers, without really being told what she's agreeing to. And for a lot of the actual procedures, they don't even ask for explicit consent. They just tell her what they did after the fact, which obviously isn't consent. *(Interview 40)*

Since we're a university hospital, students often come in to watch a delivery, or a C-section, but no one ever asks the patient if she consents to having them in the room. It's basically taken for granted that women coming to a public hospital to give birth must comply with us, just because of who we are – public workers. I don't think that's okay at all. I would speak up about it, because I know human rights apply here, though I'm not exactly sure how they're covered in medical law. There are patients' rights, too, but who's even heard of them? Who's actually taking the time to explain them to the patients? *(Interview 38)*

The relationship with the medical staff

The relationship with the medical staff remains characterized by ethnic and racial discrimination. One of the most frequent and visible behaviors described is ethnic discrimination against Roma women. Several interviewed women mentioned racist practices and attitudes from medical staff expressed through the ethnic segregation of Roma women in maternity wards, insults and contemptuous treatment, refusal of medical care, inadequate or lower attention than that given to other patients or derogatory comments and generalizations about the Roma ethnicity. Discrimination undermines Roma women's trust in the healthcare system and makes them reluctant to seek the medical help they need or to follow the recommendations provided, which can endanger their health and lives. At the same time, when faced with the need for medical care and the racism of the medical system, Roma women are sometimes forced not to react out of fear that they will be judged or that they, or their children, will be denied medical services.

Limited access to health care is amplified by the intersection of ethnicity and class. Interviews suggest that bribes or informal payments are a measure that many Roma women are frequently forced to resort to, regardless of their socio-economic status, in order to receive the medical care and services they need. Some Roma women believe that bribery is a universal practice in the health care system for all women seeking quality services, regardless of ethnicity, citing situations where poor women have been humiliated or neglected because they could not pay a bribe. Other women point out that medical staff are more likely to expect informal payments from Roma people, fueled by existing racist prejudices. For Roma women who are poor or economically disadvantaged and unable to pay extra for public services to which they are already entitled, discrimination is exacerbated by the doctors' contempt for both Roma people and poor people.

The experience of women in need of perinatal care is often marked by severe forms of obstetric violence. The testimonies of the interviewed women illustrate multiple situations in which medical staff have used aggressive, offensive language, threats, intimidation, lack of care, humiliating comments or an aggressive attitude during a vulnerable period such as before or during childbirth. The interviews also reveal situations where maternity staff are indifferent to the women's needs and wishes, where they do not give them enough information or explain procedures to them, or where the women feel judged because they come from rural areas. The interactions between Roma women or poor women and the medical staff are often marked by extreme violence and deeply dehumanizing treatment of medical professionals. Ethnic and socio-economic discrimination is reflected in acts of severe verbal violence or brutal indifference and condescension that violate human dignity and induce deep trauma. The women recount, among other things, direct care denials, public humiliation and malicious comments, as well as other forms of verbal and emotional violence with a considerable impact on their physical and emotional health. This discourages them from accessing health services again and thus contributes to the perpetuation of marginalization and structural violence.

There is no effective framework that allows female patients to voice their grievances and thus contribute to improving the quality of medical services. The interviews show that there are no feedback mechanisms within medical services or that existing tools, such as feedback questionnaires that patients can fill out upon discharge, are ineffective. This is either because they are not accessible to people who cannot read and write, or do not allow for the recording of the patients' reactions in real time, or because they do not generate institutional feedback. Several women pointed out that they were not asked directly about their experiences with medical staff, which would have given them the opportunity to complain about abusive behavior or inappropriate treatment. Even so, verbal grievances are often not taken seriously, and women feel powerless to change the situation, losing their trust in the system ever being held accountable. Discrimination and unfair treatment that are not properly investigated or sanctioned lead to a normalization of abusive behavior and the perpetuation of a system where patients' rights are not respected.

Currently, there are no courses on diversity and non-discrimination in the compulsory curricula for students at Romanian universities with health study programs, nor is there a requirement for a specific number of credits that health professionals must complete as part of their continuing professional development. Discrimination can be combated through the implementation of policies and strategies that promote equal treatment and respect for cultural diversity in health care systems. The education and continuous training of health professionals, as well as the development of policies to ensure equitable access to health services for women from vulnerable groups, are important steps in creating a more inclusive, responsive and patient-centered healthcare system. Although several study respondents (both service users and providers) emphasized the importance and need for such training, exposure to this information currently usually occurs only in the context of voluntary participation in courses provided by civil society organizations or through working in health systems in other countries with more inclusive medical practices.

Experiences with the medical staff

Female users of SRHR

He [the family physicians] treats me awfully. Whenever he sees us, he discriminates against us for being Roma people and not Romanians. So, when I went to see him about this stomach pain I've had for months, he told me, "I don't even have to see you." "But I'm insured, I just lost my card." "I don't even need to see you. Get out of my sight!" I begged him, "Doctor, at least give me a prescription to buy medicine." [He just told me] "You're not allowed in here right now. Make an appointment for another day!" But when I went back, the same thing happened. *(Interview 14)*

[The staff should] have more patience. For example, when I went to the hospital with my two-week-old baby, instead of rushing around in such a hurry, they could have just taken a minute to explain to me why they were giving my baby an IV, and how it might affect him. *(Interview 25)*

I didn't like [the doctor's behavior during delivery] even one bit. I was totally drained with my first [baby] - well, with all of them, honestly. During that first delivery, through all the pain and pushing, I was breathing heavily, panting, and, without even realizing it - because you're in so much pain that you don't realize what you're doing... saliva came out of my mouth. The doctor stopped and snapped, "What are you doing? You're spitting on me!" Right away I said, "I'm so sorry, forgive me, I didn't realize, I didn't mean to, it's just the pain". The midwife next to me, an older lady, stepped in and said, "Doctor, it's her first birth". That calmed him down a bit. But, after I gave birth, he stitched me up without any anesthesia or anything, it was awful. I asked how long the stitching would take and he just said, "As long as I want, I'll keep you here until morning if necessary!" After that I just kept my mouth shut so he'd get it over with and leave me alone. Needless to say, I wouldn't recommend that doctor to anyone. *(Interview 24)*

When she lifted me off the ICU bed, she wasn't gentle at all, she practically manhandled me, and that's when I started hemorrhaging. She just left me there, told me to wait while she took another patient to the ward. When she finally came back, she looked at me and said, "Oh, my! Not even your own mother takes care of you the way I do!" After she changed me and helped me into the wheelchair, she said, "I think I deserve an espresso and a hot chocolate for this." I took out some pennies and gave them to her. She then asked me, "Are you in pain? Do you feel anything?" I told her, "Yes, yes I do." "Then give something to my colleague as well, and she'll get you a painkiller." All of this should have been covered; it was already paid for. *(Interview 17)*

To give you an example, the nurses there were making me fill out forms and I told them, "I'm sorry I'm writing so slowly, you see, I didn't really go to school..." They then snapped, "Shame on you!" I mean, it was like this every time, everywhere we went… I went for a check-up at a private clinic, the one where I've previously given birth. I went there because I had some contractions, but my regular doctor wasn't there. The female doctor covering for him was just as racist as him. She checked me, but she was so visibly angry, she kept glaring at me… She was disgusted to even touch me. *(Interview 31)*

They kept insulting me. There were patients who looked just as miserable as I did, and the staff wouldn't talk any differently to them. They talked to us like we were dogs, that's how they treated us. They just left us lying there sick in bed. *(Interview 16)*

Some of the medical staff were empathetic, but there were times when I felt disrespected. [...] Yes, sometimes I felt judged just for coming from a rural area. *(Interview 9)*

I spent time with some of the girls who were there in the hospital with me, and yes, they had been insulted. These were poor girls who came from the countryside, who didn't have much, and yet the medical staff was mean to them. They really... they wouldn't even look at them. They just left these poor girls struggle through natural labor. *(Interview 32)*

Well, discrimination has always existed and always will. It's been this way my whole life, ever since I first had to deal [with the medical system]. But I've always kept my head down; it didn't bother me enough to make a scene; I didn't want to make them discriminate against me. [...] I've heard a lot about discrimination. [...] [The women] had no choice but to put up with it because they needed the [medical] care. *(Interview 5)*

One time, my child burned his hand. Since I don't have much schooling, and rarely go to the doctor, I figured I'd just go straight to him and ask what was going on. He told me, "Take a picture of the child's hand and bring it to me." Later, he told the nurse to put a "graft" on it. So I asked him, "Doctor, please tell me, what is a 'graft'?" "You go to the market, buy a grapefruit, peel it and put the peel on his hand." Then, a nurse, actually, a female doctor, told me, "No, mother C., don't worry, it means they'll take a piece of skin from his leg and put it on his hand." And that's when I got really upset, because I was blatantly mocked. If I'm a mom and I'm with my child in the hospital, shouldn't he give me a straight answer? He should be explaining things - "Look, this means this, watch out for that, etc." After this incident, I called the NGO, talked to the girls there, and told them how we were being treated. [The staff] overheard and started in on me, "You shouldn't have called that number, you should have talked to someone else, you are a g***y who can't even pronounce their own name, you don't even know your child's birthday, and you're calling places you shouldn't." I fired back, " I have rights and so does my child!" Only then did they clean his hand, his palm. It was swollen and for three days, they hadn't done a thing - no painkillers, nothing. They only started paying attention to us because I caused a scene. *(Interview 19)*

When a woman goes in for a checkup, she's already feeling vulnerable, anxious, and intimidated of the doctor. I've been told so many times that "I haven't had a checkup in forever." "Why?" "Because my last visit was such a nightmare." *(Interview 35)*

Awful. Truly awful. I wasn't the only one dealing with it [the medical staff's racist behavior]; other women {from [village name]} got the same treatment. All the doctors, everyone looked down on them and talked trash about them. [...] Of course it affects all of us girls, it affects everyone. When someone is seen differently, is therefore treated differently. [...] I've skipped [going to the doctor when I needed to] so many times, just because I knew we wouldn't be welcome there. *(Interview 15)*

I feel so humiliated because, whenever we try to speak [to the maternity ward staff], they just ignore us. They act like they can't hear us and just say, "Ugh, leave me alone, speak only if it's an emergency or if I ask you a question." *(Interview 14)*

They wouldn't say it to my face, but I could definitely feel that I was, how should I say, being treated differently than the

patient next to me, who had a different ethnicity. [...] I've given up [on seeking medical services], I just tell myself, “I'll pop a pill and stay at home, [it’s better] than dealing with whatever they have to say; I can do without.” *(Interview 11)*

I’ve been treated terribly by the medical staff [just for being Roma] on multiple occasions. Whenever I go to the hospital, I hear the doctors saying things like, "These g*****s, they pop out babies, or lose them, and then we have to deal with the mess." That’s the kind of nonsense they say, but I’m too ashamed to even repeat how they talk. *(Interview 15)*

Yes, at the hospital they’d just call us g*****s right out loud. ”The g*****s are here, making a racket again.” *(Interview 20)*

[As a Roma woman], you just aren’t treated like everyone else. That goes for childbirth, too. Look, when I went in to give birth to [baby's name], I had to go to a different ward to breastfeed. They literally had Romanian wards and g****y wards. In the evening, we would go get [vaginal] douches. When the Romanian women went in, they were allowed to stay in there as long as they wanted. When we went in, they rushed us right out. *(Interview 28)*

Look, Roma women or... women with less education or women from... I don’t know, from rural areas who don’t know their rights - they weren't treated the same. I saw it firsthand. They didn’t have the education, and so they didn’t know how to advocate for themselves or ask for what they needed. *(Interview 21)*

Unfortunately, in Romania, [society's perception of Roma women accessing SRH services] hasn’t changed... We are still stuck in the past. If you go for a check-up and you are Roma, you are treated differently. Especially if they see you in [traditional] clothes, like our skirts or something like that... *(Interview 28)*

I know of a situation where it wasn't the doctor who was out of line, but the nurse. I was admitted, and there was this Romanian lady there who was incredibly distressed. Her husband would always show up drunk when coming to pick her up from the hospital. She only had two nightgowns, her own and a hospital one, and while she was there, she would wash them in turns, wearing the clean one until the other one dried. And I remember one night she asked her husband to bring her soap and a razor because she was about to go into labor. Of course, he didn't show up all day and only stumbled in late that evening. By then, the nurse had already taken her to the delivery room. But when she came back to our ward, the nurse complained, ”Ugh, I had to help that filthy woman, and she didn't have any money, she's poor, she's stinky...” You don't even want to know the things she said! I was completely speechless for a while. I just couldn’t wrap my head around the sudden switch in her behavior, because when she first came to take her to the delivery room, she was so sweet, saying stuff like "Come on, mommy, I've got you." But afterward, she was so vicious. She flat-out admitted she was mad because the woman was dead broke and couldn’t give her any money. That really broke my heart but I personally never had any issues. *(Interview 29)*

Unfortunately, two years ago, at [hospital name] I had a bad run-in with an anesthesiologist. She was being rude to me and I felt humiliated, [like I was] a nobody. [...] I tried to keep calm because my life was in their hands; they held all the power, so I just prayed it would be over soon. [...] I just wanted to get out of there as fast as I could and scrub that hospital from my memory. *(Interview 33)*

I think that in every Romanian hospital, Roma people are treated differently, especially if they don't offer bribe. It's a disaster [...] Yes [I do think that Roma people have to pay more than Romanians], just because people assume they are uneducated, backward, thieves, etc. *(Interview 30)*

Like I said, every single time we went to the doctor, we had to bring bribe money, we learned this growing up. If you don't have the cash, you simply don't go to the doctor. And since I didn't have much money, I didn’t go, you know? That's how it worked. *(Interview 28)*

Other patients were treated well, because they offered bribe. But I didn't have any money, and so they only gave me a pill and called it a day. [...] No, I didn't have the opportunity [to voice my grievances about the medical staff], because I was afraid. [...] They treated us so terribly the entire time. Nobody bothered to ask us anything or do anything to help us. (Interview 16)

No, so far [I have not had the opportunity to give my opinion on the services provided by the medical staff]. Nobody ever asks. I’ve only ever talked to my family about it. *(Interview 5)*

I didn't have the guts to ask them, "What's wrong with me? How is it going? How is my uterus? When do I need to come back?" When they were hurling insults at you, all you could do was keep your head down and stay completely silent. *(Interview 19)*

I didn't even bother complaining [that the nurse was mean to me], because the doctor was just as bad... I mean, they don't even talk to you, they don't ask you any questions, they just throw you on an exam table. Whether you’re in for a standard check-up or admitted to the hospital, no one ever stops to ask, "Are you feeling good? Are you in pain? Did the staff treat you right? Were the nurses okay?" They just don't ask those kinds of questions here. *(Interview 30)*

SRH service providers

Disadvantaged groups deal with double, if not triple the stigma. From what I've seen, there are fewer resources out there for Roma women and women with disabilities. I think that they're heavily discriminated against, and that they don't get full-quality care services. I mean, I can easily see doctors refusing to treat them. I actually know of cases where [Roma women were] turned away. I mean, maybe not explicitly refused, but told there was no room for them [...] at the gynecologist. *(Interview 43)*

There is a massive double standard [in how Roma, poor, or disabled women are treated compared to other women]. There's so much discrimination and hatred. I can feel it. Sometimes you even catch yourself normalizing it. It simply exists, and I don't know how it could be prevented or dealt with, because, at this point, the bias is completely baked into the culture. *(Interview 38)*

Unfortunately, both in the general healthcare system and in this [reproductive healthcare] system, the discrimination is obvious in how Roma women are treated. They are left to suffer in agony, day and night, until they no longer have the strength, before anyone bothers to check on them. For example, unfortunately, in [name of town], Roma women were forced into a separate ward. *(Interview 41)*

Unfortunately, during the gynecology internships, I realized that only about half the doctors were empathetic, knew how to talk to patients, asked for consent, and so on. The other half treated patients like meat on a table, not human beings. I remember assisting this natural birth where a Roma teenager was the one delivering, and she was having a very hard time; she was exhausted and struggling to push. The nurse and the doctor were yelling, "Push! You're killing the baby!" The sheer cruelty of it made me sick to my stomach. I was just a first-year student then, and I remember thinking, "If I were in her shoes, I wouldn't push either, I'd just give up and that would be it." Especially since the teenager probably didn't even want the baby to begin with. And that wasn't an isolated incident. If a Roma patient comes in, the doctors immediately start whispering about her ethnicity. It's such a hostile environment for these women. *(Interview 42)*

Hardly any [patients] ever speak up, most of them just put up with it, even though staying quiet helps no one in the long run - not them, and not the patients who come after them. Maybe if more people raised hell about the issues, things would actually get fixed. [...] [The complaints we do get are usually about] hospital conditions, the food services and sometimes about the staff. In our unit, hardly anyone fills out the complaint forms, and even when they do, in my opinion, they skip over the most important issues. People do complain orally, though. [...] Yes, there are anonymous feedback surveys, but, in most cases, you are forgotten once you're discharged. And what about the patients who can't read or write? Oral complaints go nowhere. *(Interview 38)*

It'd be great [if patients could actually leave feedback]. But I haven't heard of any public hospital where patients can fill out feedback surveys, not even online ones. For all I know, that's only a thing abroad. However, I've noticed that private clinics usually have paper surveys sitting around, so patients can fill them out before heading home. But in the public system? Nothing. It's a public hospital, so nobody really cares if the patient liked the care they received. *(Interview 42)*

Gender-based violence

Prevention and intervention in situations of gender-based violence are essential components of the spectrum of sexual and reproductive health services. They can be facilitated, for example, by (i) prevention and screening services to identify situations of violence (provided by the family physician or other socio-medical staff such as school doctors, community health nurses, health mediators, midwives, school psychologists); (ii) referral to specialized and possibly integrated services such as shelter, psychological counselling and/or legal support; (iii) emergency care through provision of emergency contraception, post-exposure prophylaxis or STI treatment for victims of sexual assault, forensic services, psychological counseling; (iv) support for reproductive health decisions by facilitating access to contraception, safe abortion services or antenatal care; or (v) long-term community-based intervention through education and awareness-raising on prevention and intervention in cases of gender-based violence, as well as funding for support groups and survivor networks. The results of the present research highlight multiple barriers to accessing these types of services, whether in terms of the small number of dedicated services at the local level, the lack of information about the existence of these services or the inefficient way in which authorities intervene.

Gender-based violence, especially domestic violence, remains a common experience for women, regardless of their background or socio-economic status. Interviews show that physical, verbal and psychological abuse are everyday scenarios and contribute to a landscape of normalized violence in which abuse is not perceived as exceptional but as part of everyday life, which sometimes makes it difficult for women to realize the seriousness of their situation, to perceive their experiences as violations of their rights and their bodies, or to take action. The normalization of violence further affects the way young people relate to violence, in the absence of a point of reference that allows them to distinguish what is acceptable and what is not in interpersonal relationships. This can lead to the perpetuation of a vicious cycle in which young people become victims or perpetrators themselves in their future relationships.

Experiences of gender-based violence are marked by powerlessness, lack of support or anxiety and can have a severe impact on women who find themselves in such situations. Some interviews reveal either a lack of community intervention, suggesting a normalization of violence at a societal level, or, where it does exist, it lacks the mechanisms for meaningful interventions in the lives of women who deal with such things. In many situations, violence is seen as a private matter, and the community does not often intervene in cases of abuse, especially when the abuse comes from partners. This attitude of non-intervention is sometimes motivated by the desire to avoid internal conflicts and to maintain community cohesion, even at the cost of ignoring serious situations - an attitude explicitly criticized by some of the Roma women interviewed. In this context, some women mentioned that they would not intervene in such a situation and *would* not *interfere* in the family of a woman they knew was going through such hardship, while others indicated a readiness *to immediately come* to the aid of another woman in their vicinity who was experiencing physical domestic violence.

Access to information on the courses of action and forms of support available to women in situations of gender-based violence remains limited. Several women suggested that they do not have information on what would help them in situations of violence; for some, the *first step* is *to run away* or *stay* away from the perpetrator in cases of domestic violence or to seek advice from their extended family. Existing information is obtained on an ad hoc basis: through repeated everyday experiences of violence, online, from friends or family, through national TV campaigns or, rarely, from the family doctor. It is also sometimes provided by social workers, health mediators, NGOs or local authorities who either have specialized services or run dedicated initiatives in rural communities. The lack of accessible information about available services sometimes leaves

women having to go to extraordinary lengths to find help in life-threatening situations. The 112 emergency service remains the most widely known solution that women can turn to, while only a few of the women interviewed mentioned the restriction order as a measure that can be applied to support women in such situations.

There is a need for highly visible support services that can be accessed quickly in situations of gender-based violence. The interviews revealed a mismatch between the real needs of women experiencing gender-based violence and the support provided by the authorities through information or specialized services, as well as the importance of institutional intervention, suggesting that the authorities have both the responsibility and the capacity to organize informative sessions on gender-based violence and how to intervene. This indicates that currently, in some places, such initiatives are still lacking or, if they exist, they do not reach vulnerable people, highlighting the need to universalize access to services so that every woman knows where to turn to in case of domestic violence.

Intervention and support from the authorities in situations of gender-based violence are regarded at times with skepticism, and at others as the primary solution. The interviews also revealed alarming experiences of institutional neglect of survivors of domestic and sexual violence accompanied by a deep distrust in the justice system and the police' ability to offer real protection, with some women fearing that perpetrators may go unpunished due to corruption or manipulation of the investigation. The police are not seen as a service that can offer real support or protection in such cases. One of the women interviewed recounted an episode where she had to deny that she had been subjected to violence by her domestic partner, fearing that the violence would most likely escalate after the police left and took no action, while in another situation where the woman urgently needed intervention, the police simply did not come. At the same time, several women indicated that the Police is the first institution they would turn to in such situations and that they primarily trust the existing legal framework as a form of protection.

Young people in rural communities are vulnerable to online harassment such as bullying and other forms of digital abuse. One of the women interviewed pointed out that teenagers or children are not always aware of the seriousness of these forms of online abuse and do not know how to protect themselves or seek help and may become victims of harmful practices such as revenge porn or manipulation for sexual exploitation. In Romania, there are laws in place to protect victims of online abuse (Law 506/2004 on the protection of personal data and Law 161/2003 on the fight against cybercrime), but digital literacy needed to identify potential online abuse is insufficient, especially in rural areas.

Experiences with gender-based violence and information on specialized services

Female users of SRHR

I kind of learned [how to handle violence and ask for help] just by being out on the street. As a girl, you're putting yourself at risk just by walking around or going out late at night. You really have to stay on your toes, try to stick to places with security cameras, where there are lots of people, and never go out alone. So, yeah, I figured out [how to act]. *(Interview 25)*

I believe the [Local] Council could step up here. [...] I was actually thinking today - with all the meetings they have, they should hold one maybe once a year, or even every few months, specifically about domestic violence. They could do it at a community center or somewhere accessible, so that the information reaches all the girls who need it. *(Interview 24)*

Honestly, no, I don't really know [what services are out there for victims of violence]. The only thing I know is to call the emergency phone number 112, but you never know what to expect when calling 112, because you don't know whether the person [the aggressor] has friends in the police force, and if he does, of course he'll get off easy and just turn it around on you, claiming you were the one who wanted to have hardcore sex, you know? *(Interview 26)*

But they grow up in these abusive, dysfunctional families. Even if the dad doesn't physically hit them, he's verbally abusive, or there's a lot of drinking going on. That's the environment they live in. I think abuse has become normalized for them. *(Interview 21)*

[...] swearing in front of underage girls, little girls, constant fighting. He threatens to kick me out of the house, to cut my head off with a chainsaw, to stab me with a knife. And that day when... he actually kicked me out and told me that if I didn't leave, he'd stab me. [...] That's how I found out about the center. I thought, "Let's Google it and see what comes up." And I found this shelter that didn't list an address, it had a secret location, and I tried calling them. *(Interview 27)*

The first thing I did was call [the police]. I explained the situation (that my windows were smashed, I was alone with no man around, just me and the kids) and they told me a unit was on the way. But they never showed up. They just never came. [...] [If I see a man beating his wife] I try to help. I'll call the police or try talking to her. Some people say [that] if it's husband and wife and they tell you to "stay out of it", maybe you should just stay out of it. But if she were screaming and begging for help, maybe they'd step in... or at least they should. *(Interview 15)*

I come from a predominantly Roma community and, at least in the one I grew up in, many people chose to look the other way so they didn't start drama. However, that's so wrong. I, for one, can't just stand by and watch. I haven't witnessed stuff like that myself, and I hope I never do, but this is what I've heard from others. *(Interview 17)*

Yes, I highly trust the law. That's what I would turn to [if things got violent]. As individuals, we have no power. The law must step in. That goes for domestic violence and just for violence in general. [...] Yes, I did get help. I used to be in [this] situation where my husband would beat me constantly, I couldn't live like that. I went to the state authorities, and they fined him and issued a restraining order. *(Interview 1)*

[If I saw a woman getting beaten by her partner] I'd tell her to go to the police and press charges. She shouldn't just sit there and take it; she should leave! [...] I'd jump in and help her. [...] Too many people just stand around and watch without getting involved. *(Interview 2)*

Often, if it's a family issue, on the partner's side, people don't react much. But if it's a stranger, people get involved, they definitely step in. *(Interview 3)*

It depends on the type of violence. If it's just people arguing, and yelling at each other, that's one thing... But if it escalates into a serious physical fight... I haven't been through that, but I think you'd know what you need to do: call the police and get out of there. I mean, you can't stay in that environment. If your partner is very aggressive, can't control his temper, and the abuse is getting worse and happening more often, you clearly need to get a restraining order, separate, divorce... [...] I've looked up this stuff for my friends [looked for information on what to do in violent situations], because so many women deal with this. So, I shared what I found with them. I told them about women's shelters too, because some of them have nowhere else to go and no family to lean on. *(Interview 29)*

In my home and in my community growing up, women getting beaten was considered normal. So when it happened to me, it felt like the same old story. Nothing changed until I finally hit my breaking point, so to speak. [...] I always step in now. I'm here, there, and everywhere. I intervene no matter what, be it verbal or physical aggression. In our neighborhood everyone beats their wives, so you need to go over to their house to sort things out. I mean, even now, if somebody, I don't know, if somebody needs something or I know they have a problem, I try to help them, I try to do something. *(Interview 28)*

No, we never talked [to our family physician about the violence], because he never brought it up, and nobody else told us anything about it. I probably would've opened up if he'd asked, but since he didn't ask or seem to care... We just didn't say anything. *(Interview 16)*

SRH service providers

Very few women know what resources are out there [for domestic violence]. The vast majority don't even realize how serious the problem is, because their mothers and grandmothers went through the exact same thing. I mean, they see it happen in their families, so it seems normal to them. And those from higher social circles? They don't ask for help either. I know them very well; they keep quiet to protect their image. Because they are public figures. *(Interview 39)*

No, [women generally have no information on how to proceed in case of violence]. And I mean, I'm a doctor, I'm the one who should know how all this works, and even I don't. So I find it hard to believe that women who are in these situations know the procedures. [...] First of all, the whole process needs to be simplified. Right now, a victim of sexual violence, for example, has to jump through a million hoops and bounce back and forth between places just because

the hospital, the police and all the other authorities involved don't cooperate properly. We need better communication between departments and better training for the people handling these cases. *(Interview 42)*

Contraception and sex education

In Romania, sex education is marked by several significant obstacles and gaps. Although partially provided for by national legislation as an integral part of the optional school curriculum[55], sex education in Romanian schools faces significant challenges, including limited implementation and legislation that makes adolescents' participation conditional on parental consent. A recent report[56] highlights the limited nature of sex education provided in schools, which focuses more on medical or scientific aspects of the reproductive system and does not cover essential sexual and reproductive health issues such as contraception or consent. The consequences of this poor system can be seen in the inadequate information available to young people, who often turn to unreliable sources such as social media or the internet to learn about sexual and reproductive health. Misinformation and myths about sex are also common; lack of comprehensive sex education being an important barrier, among others, in the process of pregnancy planning, thus contributing to high teenage pregnancy rates.

Access to contraceptive information from formal sources remains limited. Interviews reveal that in many cases women are under-informed about available contraceptive options, and the information they do receive comes largely from informal sources, such as friends or other women or from the internet. Occasionally, women mention information received from non-governmental organizations or from the community nurse or health mediator. Although the family doctor should play a crucial role in informing patients on this issue, the interviews show that this does not usually happen, with one woman even mentioning the aggressive refusal of the family doctor to explain to her how to use contraceptives. Without access to information, some women mistakenly believe contraception is an irreversible way to stop getting pregnant. Others are left to navigate solutions on their own, learn through trial and error, just to eventually face the consequences of misinformation received about contraceptive use, such as pregnancy.

The cost and availability of contraceptive methods are significant barriers for women seeking to control their fertility. The experiences of the women interviewed suggest that financial constraints can play a decisive role in contraceptive choice and use, limiting the options available to women from precarious backgrounds. The high cost of some methods (such as contraceptive pills or condoms) or their sheer unavailability in pharmacies can force women to make decisions that drastically impact their sexual and reproductive health. In the absence of a public system to subsidize basic contraceptive methods and ensure their consistent distribution, the responsibility is shifted exclusively onto women, directly affecting the most vulnerable groups - rural, low-income, and Roma women - who lack the resources to exercise their reproductive rights.

[55] At present, Law 272/2004 on the protection and promotion of children's rights provides for the systematic implementation in schools, starting with the 8th grade, with the written consent of the parents or legal representatives of the children, of health education programs to prevent the contracting of sexually transmitted diseases and pregnancy of minors (Art. 46, Para. (3) i).

[56] Plan International (2024).

Limited access to information and resources on sexual and reproductive health may reinforce social pressure and cultural norms on contraceptive use and family planning. The perception of some of the Romani women interviewed is that low contraceptive use stems from immense social pressure to become mothers, as childbirth is perceived as a woman's essential role within the family and community. While one interviewee noted (albeit unsuccessful) family resistance to her decision to use contraception for fertility control, other interviews paint a broader picture: the influence of social norms and values is reinforced by other factors. Family planning often involves medical consultations and access to financial resources or public services, all of which can be difficult for women to secure in communities where access to the health system is already limited. In this context - of limited access to health services due to the economic hardship and discrimination already highlighted above - 'family planning' can become an irrelevant notion and an inaccessible practice for many Roma women.

Contraceptive use may occur in a context in which the conditions for an informed decision are not in place. IUD or ligation of the fallopian tubes were mentioned by several Roma women as contraceptive methods recommended by doctors immediately after childbirth or by other health professionals such as community health nurses. Based on some testimonies, it is unclear whether the choice of this contraceptive method was preceded by a rigorous discussion in which information about contraceptive alternatives, benefits, and risks was provided to ensure an informed decision. In fact, one of the women interviewed even points to a common practice where young Roma women who resort to tubal ligation are rather not told what the procedure actually entails. Another recounts a situation where her mother was sterilized in the hospital while unconscious and unable to consent. In this context, and particularly in the immediate postpartum period, the influence of the doctor's authority to recommend sterilization or tubal ligation alone can weigh heavily in this decision, if women are not encouraged to explore multiple options. Both IUDs and tubal ligation require costly medical interventions for insertion, monitoring during use, and removal or reversal, placing an additional burden on women already facing economic hardship.

Tubal ligation may serve as a valid contraceptive solution in the absence of other affordable long-term options or when hormonal contraception is contraindicated (as highlighted in some interviews). However, suggesting these methods exclusively to Roma women raises concerns about violations of reproductive rights and ethnic erasure. Similarly, exclusively recommending IUDs, without adequate counseling, alternative options, or post-application follow-up, may be perceived as a form of reproductive coercion. This is especially problematic for Roma women, who already face multiple barriers in accessing health services. In many cases, health professionals may view Roma women's bodies and fertility as more 'manageable' through such methods of contraception, without regard to their specific needs, wishes or circumstances. Forced, coerced or influenced sterilization of Roma women has been part of European history since the 20th century in several countries such as Czechoslovakia, Hungary, Sweden, Norway, and even more recently in the Czech Republic and Slovakia after the 1990s[57]. In addition, in Slovakia, Roma women have on several occasions been exposed to the practice of non-consensual sterilization. For instance, doctors would condition postpartum hospital discharge on sterilization, or they would refuse to remove the IUD after the maximum period of use[58].

[57] European Roma Rights Center (2016); Center for Reproductive Rights (2003). The latter report identified 140 cases of sterilizations without consent, 110 of which occurred in the post-communist period. In 2011 and 2012, several of the women concerned won cases against Slovakia for involuntary sterilization at the ECHR.
[58] Center for Reproductive Rights (2003: 63-4).

Without adequate sex education, young women find it difficult to understand and choose safe and suitable contraceptive methods. The lack of systematic sex education in schools creates an information vacuum that is often filled with rumors and misinformation. Even when there are teachers who try to make up for this lack through informal education, not all students benefit from this support, and those who would need it are not always open or able to ask for help. This leaves young people vulnerable to the risks of early pregnancy, sexually transmitted infections and other health problems. At the same time, the home environment is often unsuitable for discussions about sexual and reproductive health: children avoid turning to their parents when they are curious, and parents are not always prepared to discuss these topics with their children because they are not informed about the importance of sex education. This exacerbates young girls' sense of isolation and confusion, perpetuating a cycle of ignorance that threatens adolescent development. Given these factors, it is all the more important to prioritize comprehensive sex education, provided without parental consent by medical, social or teaching staff who are trained, monitored and continuously evaluated to ensure the best interests of the child and adolescent.

Experiences and perceptions on contraceptive use and sex education

Women users of SRHR

I first got pregnant at the age of 22, but, unfortunately, it was a spontaneous abortion. That’s not what I wanted. I didn't even know I was pregnant before having the miscarriage. *(Interview 3)*

I was 19 when [I first heard about contraception]. I was at school. No, not at school, but a classmate told me about it, in Mures. And she told me, "Be careful, do this, do that." And I said, "Come on..." [...] She told me about condoms. And I said, "Get out of here, I don't know about stuff like this yet. I'll take care of it when the time comes." My first pregnancy came unexpected. [...] I remember one more thing from when I had my little one. They asked me if I wanted my tubes tied. *(Interview 27)*

I was told [about contraceptive methods] at the hospital. The doctor [told me] to take birth control, so that I would stop getting pregnant, and prevent having too many abortions. [...] When I had my third child, I don't know how old I was. But I wasn’t on the pill for long because it made me sick, and I stopped. We had to resort to the pull-out method. *(Interview 16)*

No, I didn't have the money to buy them [contraceptive pills]; I didn't know how to take them. I thought, “What if, God forbid, something happens to me? What if I hemorrhage?” I thought, “I’ll just follow God’s plan and have as many children as He wishes, rather than go against it and have something bad happen to me.” *(Interview 13)*

I gave birth to my first child without knowing I was pregnant, and after I gave birth, I took [contraceptive] pills to avoid a second pregnancy After that, I couldn’t get the the pills anymore, and I got pregnant again. [...] I simply wanted [to take contraceptives] because I knew what hardships come with having a baby. I was afraid of having a second child. *(Interview 12)*

I've had an IUD since I was 25. [...] A lot of people told me to get an IUD so that I don't [get pregnant]. I have no income, I don’t have anything. I don’t have a place where I could stay and raise children.... I don’t have the proper conditions. And that's why I decided to get an IUD. *(Interview 20)*

I only found out [about birth control pills] when I was 19, after I had my first daughter. Since there’s no pharmacy in this village, you can get them for free from the doctor, given you show an ID copy. However, the doctor doesn’t explain how to administer them, he just says "Get out!"... before we get the chance to say anything. I would take the pill for 4-5 days, then have a 3-4-day break. After 6 months I got pregnant with this little girl who's 16 now. I woke up one day and I was like "Oh, my! What's moving in my tummy?! I'm on the pill." Here [in the village] I didn’t get a proper check-up, so I went to the maternity hospital in [town’s name] to get one. They told me, "Yes, you are pregnant." I decided to keep taking them [the pills]. I asked there, in the maternity ward, how to take them, and they taught me. *(Interview 14)*

Their availability and price [influenced my decision to use contraceptive methods], but so did the information from the doctor. [...] However, for example, at the pharmacy here, they didn't have the product that the doctor had recommended. *(Interview 9)*

Yes, they [my family] didn't want me to get an IUD; [my partner] wanted another child, but, in spite of all this, [I decided] not to listen to them. *(Interview 5)*

Yes, I got an IUD, because that's what the doctor recommended. He mentioned that if you get a C-section you have to wait for 2 years before giving birth again. [...] Well, I didn't really use [contraceptive methods], but I got an IUD, because the doctor told me to. Since I have quite a few children, I had to use it, because I don't want to get an abortion, I'd rather use a contraceptive method. *(Interview 7)*

You know, other doctors are happy when they get patients who want to get their tubes tied, especially if it's a Roma woman... I mean I've heard girls who... the first thing [the doctor] would say to them, would be "Let's have a cesarean birth and tie your tubes, because you have too many children," and the women would simply say, "Okay." I mean, I know lots of girls who had their tubes tied just because the doctor told them to; they had no idea what having your tubes tied meant, and yet they did it. *(Interview 31)*

Well, my mom was clearly a victim [of medical abuse]; [...] during her last curettage she almost died, we [my siblings and I] were old enough [to understand what happened]... And the doctor basically made the decision and tied her tubes, you know? She had then gone into a coma or something, I don't remember exactly how it went, but she didn't know basically [that she will get her tubes tied], she didn't give her consent, you know? *(Interview 28)*

No, nobody told me [about contraceptive methods], but I knew some things from the internet, and from other women. *(Interview 3)*

With us, it's... we're Pentecostal and people of our faith don't condone abortions or birth control pills. They say, "If it's God's will, you should have children." But us girls, having more of an open mind... not wanting to be so worried about children, wanting to have time for ourselves, we said we could stop giving birth. We also keep some birth control pills because we gave birth at a very young age. *(Interview 14)*

No, they weren't free. I paid like 50 lei for two boxes, or something like that, I don't remember exactly. I just got them at the drugstore. [...] I knew you had to take one [contraceptive pill] every day to avoid getting pregnant, that's all. But I didn't know how your body reacts after taking them or if they're fit for you or not. I thought that they'd be some pills that protect you, that won't do you any harm. *(Interview 30)*

SRH service providers

First of all, sex education is still not taught in schools. So, there are still a lot of girls who have no idea that if you have sexual intercourse, you can get pregnant. [...] Many of them can't afford to buy a contraceptive pill packet or a morning-after pill. (...). Some of them even said to me, "Mrs. [name of interviewee], please, help me. I don't have the money to buy it." Also, lately, more and more women wish to get their tubes tied. They no longer want children. "Mrs. [name of interviewee], please, help me, I don't want to have children, I can't have children anymore", so, yeah, some of them are aware. But because there's a lack of resources... Anyways, sterilization is a very sensitive topic, and there's a fine line between simply talking about a medical procedure versus strategic ethnic cleansing. *(Interview 41)*

I don't know, if I were to rate it [access to information on contraceptive methods] on a scale from 1 to 10, I think I'd say it's no more than a 5. Because a lot of people still resort to abortion. Not as much as they did 15 years ago or 10 years ago, but there are still many people who do it. [Contraceptive means] are still not used. So, I don't even know whether at the very least 30% of the patients who come in for an abortion seek contraception. Although they are counseled [on different contraceptive methods], you find, to your own disappointment, that after 5 or 6 months they come back with the same problem. So, yeah, there is not enough information. *(Interview 37)*

There were women in our community who, after giving birth 2-3 times, decided they didn't want any more children. With the help of the public health department and through our informative sessions on reproduction and sexual health services, we put them in contact with gynecologists who could insert their IUDs. Thanks to the appointments they were able to book, the girls then went ahead and consulted the doctor on the best course of action regarding family planning and contraception. *(Interview 36)*

The family physician offers no information [on contraception], and he should be the one who takes care of this. Families, mothers or, well, parents in general don't teach their children about it, they simply don't. If the person is interested in this information, then yes, they can get it from an information center or a doctor or somebody, anybody, a nurse who can inform them. Otherwise, the information doesn't get to them. [...] In my opinion, we need to work with family physicians, so that we can get the information out there. You know the toothpaste commercials or whatever they have out there in the hallway? We could do that. Because it's a very important part of everybody's life. And girls need to know what their options are. And they should be able to choose. For example, my mom - she never talked to me about it. If it weren't for my girlfriends, I wouldn't have known about contraceptives. Or condoms. Unfortunately, people from rural areas don't really talk about it. But the doctors, the doctors should talk about it. There used to be those dispensaries you could go to. Those should be safe spaces where the information can reach people more easily. *(Interview 38)*

Most patients want children. The ones who already have six, seven, or even eight children don't want to have any more babies, but they simply don't know that they have the possibility to do something about it. However, when they do get the information, their family prohibits them from taking action. Therefore, those who do know, whether they like it or not, are forced to keep the pregnancy. We are talking here more about the Roma population, where, unfortunately, the [Roma] woman's sole purpose on this Earth is to have as many children as her womb can bear. Many of them would like [to stop having children], but they are afraid. There have been doctors who refused to do tubal ligation, despite the patient's request, because of their young age. They've claimed to have done so on religious grounds, or... I don't know what the reasons were. *(Interview 38)*

Abortion

Access to public abortion services is significantly limited either by the refusal of doctors to perform abortions or by the related costs. The public health system in Romania provides abortion services only under certain conditions, and many hospitals refuse to perform the procedure for religious or moral reasons[59]. As one of the interviews revealed, due to restrictive or unofficial policies imposed by hospital management[60], some doctors resort to coding abortions under other diagnoses - such as "missed miscarriage" - in order to ensure women's access to care and avoid administrative sanctions. Consequently, since most public hospitals have eliminated or restricted access to abortion, many women are forced to turn to private clinics. While the procedure there is faster and more accessible, the costs are considerably higher, meaning that only women with sufficient financial resources can afford to access these services without obstacles. At the same time, the interviews confirmed that pregnancy terminations are carried out for a fee even within the public system; however, even in this situation, the amounts remain prohibitive for low-income women or require disproportionate financial efforts. In addition, the majority of the women interviewed were neither informed by their doctors nor aware of the option of medical abortion as a less risky and intrusive method than surgical abortion. Therefore, they would not know how to request should they need a termination. Among the interviewees, the only experience with this method of abortion came from a woman who was in another European country at the time.

Access to abortion is strongly influenced by economic factors, and women from vulnerable backgrounds are the most affected. The costs associated with an abortion vary depending on the type of medical facility (public or private), geographical location, the methods used and the need for additional consultations. For many women, the cost of the abortion procedure is not the only economic barrier. Access to abortion services involves additional expenses: transportation to clinics or hospitals in other cities, possible mandatory medical consultations before and after the procedure, and sometimes the cost of post-procedure medication. Women with low incomes or financial instability face a severe dilemma - either carrying a pregnancy to term without the means to raise a child or struggling to pay for an abortion – forcing them into a highly distressing position. Women who cannot afford the procedure simply *have no other choice* and are often forced to carry a pregnancy to term, even if this profoundly affects their quality of life.

Conversely another perception of abortion - shared, for example, by one of the medical professionals interviewed in the research, but also recognizable in the broader public and professional discourse on abortion - presents it as a procedure that women, including those with many children or in precarious situations, manage to access even in difficult financial circumstances. In this view - resonant with a broader social imaginary of reproductive responsibility - access to abortion is not seen as obstructed by economic barriers but rather as an indication of a supposed lack of responsibility in using contraceptive methods. In some cases (particularly regarding Roma, uneducated or economically vulnerable women), repeated abortion is even interpreted as an improper form of contraception. This deepens the perception that women consciously choose to avoid preventive methods and contributes to the construction of a stigmatized image. Women who repeatedly terminate pregnancies are seen primarly through the prism of individual choices, without consideration for the structural causes that constantly limit access to family planning services: a lack of sustained counseling, the cost of contraceptive

[59] A recent survey showed that 552 out of 959 public and private health facilities (57.5%) do not offer abortion on demand. In addition, 90% do not refer patients to other facilities, contrary to the obligation laid down in the Code of Medical Ethics, and of those who claim to do so, more than half indicate facilities where the service is not actually available. AMI (2024). A recent Human Rights Watch report from 2025 presents a complex picture of the barriers to access to abortion services in Romania, including the reasons cited by doctors and hospitals.

[60] A recent investigation showed that the refusal of hospitals in Romania to provide abortion-on-demand services is rarely officially regulated: out of 116 hospitals analyzed, 34 do not offer such services, and only two have issued a written administrative decision to this effect (Oncioiu, D., et al. - 2023).

methods, a shortage of medical personnel in the vicinity, the absence of a trusting relationship with doctors, but also previous experiences of stigmatization or humiliation. This disconnects between the professional perspective and the lived realities of patients' risks turning the recourse to abortion into an indicator of personal rather than systemic failure to provide accessible options and ongoing support.

Abortion procedures in public facilities can sometimes lead to serious complications. Several of the women interviewed recounted experiences of abortions performed in public facilities, which subsequently led to serious complications, forcing them to seek emergency medical care in the capital or another municipal hospital. Generally, women in rural areas or from poor families are usually more vulnerable to these types of risks, as they have limited access to quality health services and the high costs of private clinics or adequate treatment put them in a precarious situation. At the same time, some women including those from large urban settings have described extremely painful experiences with surgical abortion performed under local anesthesia as traumatizing and abusive. Such experiences suggest structural inequalities in access to safe abortion services, which affect women from both vulnerable and urban settings when the public system is marked by a lack of resources, negligent or distant attitudes from the medical personnel, and interventions performed under conditions that ignore the physical and emotional needs of patients.

Roma women's access to abortion services is also affected by ethnic discrimination. Some of the women interviewed highlighted the difficulties faced by Roma women in need of abortion services, including being refused by medical personnel either because of their manner of expression, traditional dress or low income. In these situations, women are forced to resort to insistence or informal payments in order to receive essential services and to be treated appropriately. These situations reflect manifestations of institutional racism, in which Roma women's access to basic health services is implicitly conditioned on conforming to majority norms of language, appearance or social status.

Experiences with access to abortion services

Women users of SRHR

Because at our hospital, when I was in the maternity ward, they told me that they don't do [abortions] anymore. And... me, being the bold person that I am, I looked for a private clinic. *(Interview 14)*

I didn't know [about the option to have a medical abortion], because I hadn't been told about it, even though I had both pregnancies when I was very young. *(Interview 33)*

He performed the abortion, but he left tissue inside me. Therefore, I developed sepsis because he didn't clean me out properly. [...] I had to beg my sisters in Bucharest to take me to a doctor there. The doctor drained the pus I had, performed a D&C, and put me on IVs because my weight had dropped to 35 kg due to all of this. [It all happened because] they were expecting a bribe, and I had no way of paying them. I didn't have a job, I wasn't working, I barely had enough to support myself and the children. [...] The hardship, the misery, the poverty [are what made me get abortions]. That's what made me do it. I didn't want my children to be born and raised in suffering. *(Interview 16)*

I lost [the baby] here, at home. And when I went by ambulance to [city name], I blacked out from the pain; that's how things were back then, and... There, in [city name], they performed a D&C on me without anesthesia. *(Interview 15)*

First and foremost, poverty. Poverty leads to abortion. But things have changed a bit. Patients have slightly more agency now, however destitute they may be. They have more access to information – they know that contraceptives exist, that condoms exist, and so on. But poverty... When patients show up at the clinic, they're told at the reception desk that we don't perform abortions, so they never make it into our clinic. Poverty, deprivation, lack of a job, lack of housing. That's what makes people resort to abortions. (Interview 35)

I gave birth twice and I was glad to have two children, but afterwards I had a termination, because we couldn't afford to

raise any more children, even though we wanted to. *(Interview 1)*

Well, some [women] truly didn't [have the money for an abortion]. So, they gave birth to them. They didn't stop to think about what they would be able to provide for that child. They made the decision based on their financial means. *(Interview 5)*

I went to have an abortion for my fourth pregnancy. But I couldn't, because I was too far along. *(Interview 20)*

I think so [that some Roma women have a hard time finding a place to get an abortion], because of the way we Roma carry ourselves, and because of our traditional clothing, the way we dress. I think that's the case for some women, yes. [...] As a workaround, they just insist until they succeed. They beg the doctors, pay the so-called bribes, just to be acknowledged and treated properly. *(Interview 33)*

Yes, at times, yes [my identity as a low-income Roma woman impacted my ability to access abortion care]. But if you have money, they treat you better. If you don't, you're not really treated with respect. [...] Yes, I know people who couldn't afford [an abortion] and ended up having the children. [...] They didn't have the money, yes, exactly. *(Interview 32)*

So, I had made a mess in the examination room, and they put an adult diaper on me while waiting to perform the D&C. The female doctor did the procedure. She said to me, "Girl, how could you not be bleeding? You could have developed sepsis and died, God forbid! If you'd stayed at home for 2-3 more days, we wouldn't be sitting here, talking face to face." And I said, "Well, how is that possible? The male doctor said I was fine." "You're not fine." What the doctor did to you... he basically just scraped the fetus. He scraped it a little bit, removed a very small part of it, but three-quarters of it is still inside you. He didn't actually perform a curettage on you." [...] Now, regarding my last D&C, I can say I was treated abusively because it hurt terribly, I was in an agonizing amount of pain. I even told him "Stop, doctor, if you don't stop, I'm going to pass out right now!" That was truly abusive. *(Interview 30)*

Yes, I knew that unfortunately, for those of us coming out of the [child protection] system, that's [abortion] what we usually end up having. A year or two after leaving the system, we get pregnant, even though we attended prevention programs. I mentored [other young women who had been in the system], I reminded them of the advice [on sex education] received from the [residential center] staff. Some got abortions, others didn't; each of them got to choose. *(Interview 25)*

SRH service providers

In state hospitals they no longer perform abortions, only medical abortions, and those up to a certain gestational age. We have also had cases where babies have died because women took the pills after the indicated age. That would be the biggest problem. Again, and lack of information. Because I don't know. I've had people asking me "Where can I go to get an abortion? And how do I do it?" [...] Yes, [in private practice] you pay, you get paid, you get contracted, whatever you can. But not in state hospitals. *(Interview 38)*

I'm not certain that in [name of county] they still do private abortions, because there have been some problems with some infections and I'm not convinced that they are still allowed to do it, but they do it in the hospital on request, both in our county and in the municipality for a fee. Now, for some [women], maybe that amount of money is vital. [...] Quite a lot, as far as I know, I don't know exactly myself. Well, prices may differ, but now.... It's not a very big amount, but for families, I mean, well, for women who come from poor families, it's a big amount for them. *(Interview 39)*

Most gynecologists have refused lately, and it allows them to do so, to stop performing abortions. Yes. Because of religious beliefs, because of.... Yeah. It has happened. It happened not once, but many times. *(Interview 35)*

[Factors that limit access to abortion are] The mentality and values that the doctor who decides whether or not to give you an abortion has, their religion or maybe in many hospitals, even though the doctor himself would like to do the abortion, he offers this service, the hospital management doesn't agree with this practice and they have to obey - I have heard at various public hospitals in Bucharest that they are forced to undergo a different diagnosis or a different type of treatment when they perform an abortion on someone or, for example, they have to say that the pregnancy stopped in progress instead of stopping it medically or surgically. [The consequences of limiting access to abortion are] First of all, women fail to have autonomy over their own bodies. They are forced to have children, to raise them when they may have neither financial nor emotional resources, especially when you are a young, teenage mother, as well as much more serious consequences. These women can induce abortion at home, they can end up in the emergency room with various complications and you simply remain a country with oppressed women. *(Interview 42)*

[access to abortion] isn't limited. So, the moment [women] don't want [to keep the pregnancy], they manage somehow. No

matter how much it costs, they go for abortion. [...] I don't know where they get the funding for that. The bigger problem is that there are people who have two or three children and who also have fifteen or sixteen abortions in their history, seven or eight of which I have done. And I asked them "I called you, I told you to come, to do something, to prescribe you something". [They replied] "Yes, you told me, but..." Yes. Until the next pregnancy came and... So, they don't necessarily have barriers to terminating the pregnancy. No, they don't. The problem is they get that far. [...] I've always explained and told them. And at the time when the classic surgical abortion was done, what are the consequences, what are the repercussions, what are the risks if they resort to this method of terminating a pregnancy, which they could avoid if they used contraception. And since medical abortion, I have been counseling them, but very few of them come back for contraception. I think, I don't know, 20-30%, more, not more than that. *(Interview 37)*

Pregnancies among underage and adolescent girls

The number of pregnancies among girls and teenagers continues to remain high in Romania. In the European Union, 45% of girls under 15 who become mothers are from Romania[61]. According to INS (National Institute of Statistics) data, in the last 10 years, the rate of pregnancies among underage girls and adolescents under 19 has only slightly decreased - from 10% of all births in 2013 (19,154 births) to 9% in 2023 (14,363 births)[62] with the number of pregnancies among girls under 15 falling from 709 to 627. Child and adolescent pregnancies are associated with several factors that contribute to their occurrence. Poverty is the most frequently cited determinant in literature, acting as a catalyst for other contributing factors, such as limited access to education[63] or lack of access to contraceptives, in addition to family structure and background, abuse, level of community involvement, or ethnic minority status[64].

Early pregnancies often occur against a backdrop of a lack of education, affecting the quality of life for girls and adolescents. Interviews show that a lack of information, inadequate sex education or the absence of family role models are conducive to early pregnancy. In this context, some girls are unable to continue their education, and social stigma makes them drop out of school. Many of them lack the courage to return to school after becoming mothers because of shame or the perception that they no longer belong in the education system. At the same time, there is currently no public policy response to the high incidence of pregnancy among girls and teenage girls; instead the education system tends to encourage exclusion or dropout due to a lack of integrated and effective programs to support underage and teenage mothers in continuing their education[65]. A recent study shows that only a third of the pregnant minors/young mothers (39% of the young mothers and 24% of the pregnant mothers) continue their schooling, with a lack of financial resources and family support being the most frequently cited barriers[66]. Moreover, interviews show that in some cases parents are also helpless and do not know how to support their daughter's education, sometimes allowing their daughters to marry or to leave their homes with older men so that they escape social or economic pressures.

The ethnicization of pregnancies among underage girls and adolescents can have significant negative effects on how problems are identified, and solutions are designed. There is currently no official data in Romania on the ethnicity of underage or teenage mothers, but some of the interviews conducted mention, for example, the prevalence of early pregnancies among Roma teenage girls and girls from certain communities. The contexts in which these

[61] Save the Children (2024).

[62] National Statistical Institute (2014, 2024).

[63] Two-thirds of pregnant minors or mothers dropped out of school before becoming pregnant (Save the Children 2024: 27).

[64] Neculau, A. et al. (2022).

[65] Currently, underage mothers are considered at risk of school exclusion and are entitled to a monthly grant of 700 lei once reintegrated in an educational unit, during the period of teaching activities, provided they attend classes (Law no. 198 of July 4, 2023 on pre-university education, Art. 108. Alin. 19 and the Order on the Framework Methodology for granting scholarships No. 5518/2024). However, according to the centralized list of scholarships, until October 31, 2023, only 741 scholarships were awarded, a very small number compared to the number of births in the same year among minors and teenage girls attending school. In addition, the financial measures are not complemented by provisions to destigmatize and discriminate against pupils who become pregnant.

[66] Save the Children (2024: 26).

pregnancies occur are characterized by multiple factors, including poverty and material deprivation, limited access to education or to health services (including sexual and reproductive health). The reality of these pregnancies needs to be addressed by taking into account all the economic, social and educational structural factors affecting not only Roma communities but also other vulnerable groups. This is also crucial for preventing and combating the stigmatization of Roma girls and women and the perpetuation of existing stereotypes, especially in a context where teenage pregnancy is often seen as a Roma-specific “cultural problem”.

Ethnicization often intersects with moralizing and economic interpretations of motherhood, which construct the image of girls and young women from precarious backgrounds as "strategic beneficiaries" of the welfare system. From this perspective, pregnancy among underage girls is often understood not as a result of their socio-economic structural position, but as a calculated gesture to capitalize on their own fertility. Some interviews with socio-medical service providers reveal a type of discourse that portrays low-income adolescents or young women, in particular, as consciously resorting to motherhood in order to access social benefits, thus securing a form of 'steady income' in the absence of other resources. The child is reduced, in this view, to an economic value, and fertility is interpreted as a survival strategy, not as a result of a lack of access to contraception, family constraints or social pressure. This understanding of early motherhood ignores the structural dimension of the phenomenon - the lack of jobs, the inequalities in the education system, the inaccessibility of family planning services - and places the responsibility exclusively on girls and adolescents. This narrative reflects a collective imaginary in which motherhood in a context of poverty becomes suspect and illegitimate, being treated more as an economic tactic than an emotional choice or the effect of systemic constraints. This view is found not only in socio-medical services but also in dominant public discourses on reproductive responsibility, contributing to the reinforcement of racist and classist stereotypes and the stigmatization of women in the most fragile social positions.

In addition to this perspective, some service providers' accounts offer a different understanding of early motherhood, in which pregnancy is perceived as a form of personal affirmation or a symbolic transition to adulthood. According to this interpretation, for some girls, motherhood may represent a form of social positioning or a way out of difficult family contexts, as well as a way to find a more stable place and role within the family or community - especially where other means of being supported or listened to are lacking. From this angle, motherhood is no longer seen simply as an effect of vulnerability or a lack of resources, but also as a way for girls to seek recognition, security, and meaning in an environment where alternatives are few or inaccessible.

An intersectional understanding of pregnancy and early motherhood allows us to move beyond these simplifying narratives, providing an analytical framework in which motherhood is understood as a situated response at the intersection of class, gender, ethnicity, and age constraints, as well as unequal access to resources and opportunities. Such a perspective does not look for a single cause or a linear explanation but examines how inequalities overlap and multiply to highlight the real decision-making capabilities of adolescent girls. It takes into account the lack of access to sex education, discrimination in the healthcare system, the pressures of gender norms, ethnic marginalization and the lack of institutional support - not as separate elements, but as factors acting simultaneously and profoundly shaping reproductive choices. Intersectionality thus not only clarifies the complex reality of early motherhood, but also provides a direction for interventions that are equitable, non-discriminatory and tailored to the life context of girls and adolescent girls. This implies public policies that guarantee universal and equitable access to comprehensive sex education and sexual and reproductive health services, regardless of ethnicity or socio-economic status. It is also essential to train socio-medical personnel in a non-discriminatory and empathetic approach to avoid blaming and encourage a deeper understanding of the realities faced by girls and adolescent girls. Finally, an intersectional perspective implies the elimination of racist clichés - from viewing it as a "cultural problem" or claiming "they have children for the allowance" - in favor of recognizing early motherhood as a social and systemic phenomenon, which often reflects an institutional failure to create real, dignified and accessible alternatives.

Lax legislation or the passivity of judicial bodies can contribute to the phenomenon of underage pregnancies. One of the women interviewed underlined the shortcomings of the justice system in responding to possible offences that lead to underage pregnancy, highlighting that although cases are reported to the police, the authorities do not have an effective and transparent response, and the seriousness of these situations is often minimized. From this perspective, the absence of more stringent legislation and the authorities' lack of response contribute to the normalization of power inequalities and non-consensual relationships between minors and adults. For example, a recent report by the Judicial Inspectorate[67] points to multiple court rulings that were favorable to the perpetrators in cases where a non-consensual sexual act resulted in a pregnancy carried to term, where the victim was financially dependent on the defendant, or where the minor was of Roma ethnicity. In the latter situation, the report mentions, for example, the lack of evidence regarding the possible coercion of the victim in relation to the sexual intercourse or the existence of a valid cohabitation agreement with the defendant. Several of these cases ended with the charges being dismissed, the prosecution dropped, or the legal classification changed to a crime other than rape. The report invokes "Roma tradition" to explain why Roma people choose to break criminal law but it does not present an analysis of the premises and consequences of these court decisions in this context. The invocation of Roma culture thus becomes an argument for the lack of intervention or differential application of the law, acting as an expression of the institutionalized racism within the justice system

[67] Judicial Inspection (2022).

Insights on pregnancy in underage and adolescent girls

Women users of SRHR

It is what it is, they made the decision to get married young. Also, I don't think they have this kind of information either. I think it's just how things work in their family: you have a baby, you're stuck with it... I don't know, I think it's also about a lack of information and things like that. *(Interview 31)*

For example, there are young girls whose parents don't know that they are sexually active. Once a friend asked me to go and pretend to be a girl's sister or aunt, to help her get an abortion. She was a minor in high school and couldn't get help without her parents there. I didn't do it, I didn't help her, but I don't know whether, in the end, someone from her family went with her or if she found someone else to go and pretend to be her family. *(Interview 29)*

I was 15 and a half when I had my daughter. I knew absolutely nothing. [...] I didn't learn many things when I needed to; I found out later, after I got to know other people, left my community and experienced other things. But I had never heard about or received sex education. After I gave birth, I needed someone to teach me - since I was a child myself having to care for another child - what I should have done, how I should have behaved.... Well, not how I should have behaved, but what I, as a child, should have done with the baby. I didn't know a thing. I do know that my daughter was raised by my father and my mother. *(Interview 28)*

People, especially older people - or maybe even the younger ones, the teenagers - think it's all a joke. They think [it's easy to have a child], but a child isn't just born; it takes work, and it's not easy to raise one. Older people say, "Let them have it; it's just a child," but no, no, it is not. I don't agree with that. I chose to have a child at 16 or 17; that's not normal… There was no one to teach us how to give birth. That's how a child ends up raising another child. *(Interview 19)*

Well, they don't have it [access to information]. Sometimes, it seems to me that we, the teachers who go there, are their only source of information. Otherwise, they don't learn anything. They also don't know how to filter information from the media. They take everything they hear for granted and don't look up other sources. Their parents are helpless, they wake up to find their daughters pregnant at 12, 13, 14 years old. Maybe they don't know what to do either. A school for parents would be good as well. So that they also learn how to handle things. They don't know what to do with their own children. They say, "Mrs., but I don't know what to do with her." I can't tell her what to do, I don't know how to make her do her own research or how to, how to forbid her from running away from home, because she keeps leaving home. There's nothing I can do." *(Interview 21)*

I would run a parenting program that focuses on community well-being. All the people there need to be seen, heard, and understood, because there's a lot of illiteracy and a lot of poverty. All these lead to, I don't know all the things it can lead to, but it leads to 14-year-olds having babies. Children having children. There are scholarships for young mothers. They became available this year. I have three young mothers in my class and I have to re-enroll them every year because they get marked as dropouts at the end of each one. So, yeah, young mothers have the opportunity to get back to school, but, in most cases, once they're out, they don't come back out of embarrassment. They either think they're too old or that they're living a grown-up life and don't belong in school. Or they are just downright embarrassed. *(Interview 21)*

We file a report with the police for all cases of pregnant minors that come to our attention. Whether the minor is 13 or 17 years old, it is not my job to determine whether the sexual act was consensual, or whether it constitutes a crime. This is why all cases are reported to the County Police Inspectorate. Only in 1% of cases do we receive updates on the status of the proceedings regarding the, I don't know, police side of things, so to speak. Of that 1%, in many cases, it is concluded that the two were in love, that they had a consensual relationship, that the man intends to acknowledge the child, so we have no reason to stand in the way of their love. And then they let everyone live happily ever after. I think that if the legislation were stricter and there began to be visible consequences in certain communities, I believe the incidence of teenage pregnancies would be lower. *(Interview 22)*

SRH service providers

Apart from a few public health campaigns, we don't have any sex education. That would have been the best form of prevention [against recurring pregnancies in girls/teenage girls], but we don't have it. It seems to me that any attempt by the public health authorities to reduce the number of pregnant teenagers is failing. *(Interview 42)*

I've encountered very few pregnant teenage girls ... teenage girls who are not of [Roma] ethnicity, that had unwanted or accidental pregnancies. Such cases are rare. But, unfortunately, Roma girls get pregnant as young as 12 or even in pre-adolescence. But this is their culture now. It's a double-edged sword. You can't interfere... I mean, I don't know how things could be resolved. Change can only come from within the community, perhaps. Because you can't do anything from the outside. The poor girls know... [...] A child giving birth to a child... It's terrible. It's painful. Especially since, by comparison, we were playing with dolls at that age. We didn't even know what a sex life meant. And they, poor things, come in to give birth. It's heartbreaking. *(Interview 38)*

Lately we have had fairly few cases; I mean, looking back, a few years ago we would get called to the wards not just for minors, but for adult women too, who'd say they wanted to abandon their baby, or who'd run away from the hospital. That happens very rarely now, extremely rarely. So, it has really decreased a lot. Well, not for the Roma population. That's where there are the most pregnant minors, the most underage mothers recovering from childbirth. Why? Because that's their culture. At 13 they get married, and at 12-13 they automatically get pregnant. They automatically get pregnant and then there's nothing you can do about it. *(Interview 39)*

We have also noticed in the community [with Roma residents] that many minors already have children - minors who may still be in school, who lack the necessary education and information - and so you end up with children raising their own children. [...] In some cases, if a girl had a sex and got pregnant, it's just "Look, I got married," and that's it. Some see it as a way out of a difficult home situation, but also, being pregnant brings about a new status, both within her family and in the community. The girl gets to be regarded as a grown woman. That's what I have observed. Now, of course, most pregnancies are unwanted and, unfortunately, there are communities where people choose to have children just for the social benefits. Unfortunately, a pregnancy has become a source of income for many of them. *(Interview 41)*

We've come to joke about it, but it's dark humor – the fact that both our ward and the pediatric ward serve patients of the same age group. During my shift last night, I had two pregnant women come in. A 15-year-old and a 16-year-old. Pregnant women here have their third or fourth baby at the age of 18. [...] I think it all comes down to the level of education, the level of poverty, and the lack of schooling. These are generally girls who I think drop out after the forth or sixth grade... So, that's what their schooling amounts to. Hardly anyone goes further than that, and then... There are certain traditions that they follow, like having their family marrying them off or arranging their marriages. But the majority doesn't go through that. So, I don't think that these girls, out of all the underage pregnant girls, represent more than 20%. No. So, for the most part, not really. The level of their quality of life, in terms of education and overall conditions, is far below the practical limit. I don't know, I think that's the only concern. And last, but not least - and I take responsibility for saying this - the social benefits and the allowances received. There are many pregnant women who benefit from those, not necessarily minors, but if they are 18 and they already have two or three children, it doesn't matter that they are already of age. [...] For many, it's their only source of income, because when you tell them that they need to take contraceptives or get an IUD the answer is "I'll come after the 15th, when the allowance comes in". Or they only make all their purchases at that time, so they depend on the child allowance, and then, what can we understand from this? That the child allowance is actually their source of income. And when you have ten children (I've had a woman pregnant with her tenth child come in four days ago)... With ten children, if we do the math, I don't know exactly how much they receive, but it's a steady source of income, which for them is a fortune. And that's how they live. (*Interview 37)*

Social and cultural barriers

Discussions on sexual and reproductive health remain taboo in certain settings. Several of the Roma women interviewed, predominantly those from rural or marginalized urban communities, indicated that discussions about sexual and reproductive health are largely taboo or surrounded by shame and reluctance, whether within the family or the community. However, women continue to seek information and find solutions regardless of social pressure and how they are perceived. This lack of discussion can also hinder access to accurate information about sexual and reproductive health. Even though there has been a shift in sex education, especially among young women, there remains a lack of sufficient access to accurate information about contraception and family

planning. For example, the younger generation is much better informed about contraception and the prevention of unplanned pregnancies, but this is not the case uniformly across all age groups or in all regions.

Social perception and norms regarding motherhood and fertility among women in certain groups are still widespread. Interviews show that women from certain social groups, such as Roma women, especially those from traditional communities, or young women who have grown up in the child welfare system, are perceived as having excessive fertility. Such representations, typically rooted in racist and classist stereotypes that associate poor or Roma people with a lack of education and irrational or uncontrolled behavior, perpetuate negative images of Roma women who have many children, often in a context of poverty, irresponsible behavior, or potentially early marriage. In addition, generalizations about a collective 'culture' characterized by or encouraging excessive fertility ignore the diversity of Roma women's experiences with reproductive health and silence the difficulties (for example, those regarding infertility) mentioned by several of the women interviewed.

The transformation of socially shared norms regarding specific aspects of sexual and reproductive health is transgenerational. Several of the Roma women interviewed emphasized the generational shift in the practices surrounding the age of marriage or motherhood, with today's adult women living their lives differently from their grandmothers or mothers. All Roma women interviewed - including those who had their first pregnancy as minors - indicated that at least 18 is the appropriate age to have a child, even though in a few cases this did not align with the view shared by their community or family. In addition, the shame felt by underage girls who give birth without a partner has now diminished alongside the wider acceptance of diverse family situations. This transgenerational shift is also occurring against the backdrop of other factors, such as financial difficulties. For example, some of the women emphasized that the stigma associated with certain procedures or choices, such as abortion or the decision not to have children, has faded largely due to a lack of the considerable resources needed to raise a child. Such decisions are now understood as an unwanted, but responsible choice in the face of financial and personal challenges.

Social and cultural barriers

Women users of SRHR

I'd say that I don't think [discussions about sexual and reproductive health] are so taboo anymore, because... now everybody knows about everything, you know? What can I say? I think they're obsolete. There's still no formal education to teach these things, but accessing information is possible, you know? That doesn't mean there's no need for education, because, even though we learn how to [have sex] quickly, after that, it's hard to change your lifestyle once you start your sex life, you know? *(Interview 28)*

Okay, I mean, in the times we're living in now, it's no big deal. There's no more shame or fear. At least I don't think there is… I learned about the morning-after pill about five years ago from a 14-year-old girl. I mean, kids who are between - let's not say 10 years old, that sounds too young - but 14 to 20, they already know a lot more than we do. They know how to protect themselves, they know what to do, they know what to take to prevent pregnancy, and what to take in case they do get pregnant, what to do, how to do it. Things are different now. [...] If you'd asked me this question 7, 8, or 10 years ago, maybe I would have told you that it's considered shameful to have children at the age of 15-16, or to be a single mother, or to have your husband leave you, especially when you were pregnant... Now things have changed, it's not so overwhelming anymore. Many girls, even if they're abandoned, find the strength to carry on. They keep the child and that's that. *(Interview 29)*

People talk [about women who want to have abortions, who use contraceptives, etc.], but we [don't] listen to them. [...] Yes, they are against it, they ask us, "Why do you do this? Why do you do that?…" *(Interview 12)*

Some belittle them [the women who want to have abortions, use contraceptives etc.], while others encourage them to carry on. It would be good if someone taught them what's best for them. *(Interview 16)*

I think there are still prejudices about women accessing sexual and reproductive health services, especially in smaller communities, like my town, for example. Sometimes people consider contraception to be a shameful discussion topic. However, attitudes are gradually changing, especially among the younger generation. I mean younger people, teenagers mainly, are much more open-minded than people in their early 30s. [...] I think that it is essential to normalize and to have discussions about sexual and reproductive health as normally and openly as possible, so that women no longer feel embarrassed or judged when they need help. *(Interview 10)*

My community has been influenced by the Romanians, we don't wear long skirts – not that I'm judging those who do, God forbid! But, within my Roma community, we don't go by the rule "I need to have kids at 15." No! That's forbidden among us. I mean, for me, having a baby at 19 was okay. 19, 20, 21 - I mean, you should have some time for yourself. Because if I have a baby at 13, I'm still a kid myself, I don't know anything. You don't know what to do when you're 20, let alone when you're 13... In my community, it's forbidden to have a baby at a young age. *(Interview 30)*

Oh, [Romanians would say] g*****s have many children. But those who use their reason and know what the situation is like, [say] let them have another baby or go get an abortion. *(Interview 15)*

We are trying hard to make them [the family/community] understand that it's not good [to have children] at a such a young age, but rather a little bit later, though, I mean, a child is always welcome. *(Interview 33)*

They'd think we're crazy women [if we were interested in knowing more about sexuality and contraception] [...] Yes, [they would say that] at their [young] age, all they think about is sex. *(Interview 1)*

Physically, I think that a good age to have children is around the age of 30, between 25 and 30, because I believe by then a woman's body is mature enough to carry a healthy pregnancy to term, but spiritually, I think that when you know you are ready, that is the best time to do it. *(Interview 10)*

In our community, people don't get involved and don't give their opinion [on contraception, abortion, pregnancy, childbirth]. I think. I don't know what to answer to this question. All these things are settled and discussed within the family. [...] These things are not really discussed in the community or even within the family, so, I suppose I can say that it's a taboo subject. [...] In the community, from about the age of 18, a woman is expected to have children. In my opinion, the ideal age is 25. *(Interview 3)*

From my perspective, while in the past it was a shameful to openly admit that you were going to get an abortion or that you didn't want to have another baby, I think that, nowadays, this isn't such a big problem anymore, because times are getting harder and harder, and children really need a lot of things. After all, raising a child is not exactly easy. *(Interview 17)*

In my family, it's no longer an issue [underage pregnancies], because our children have been raised differently and they didn't follow in our footsteps, so to speak; they didn't have children at a young age. *(Interview 28)*

In my opinion, a woman should think about this [pregnancy] once she finishes her studies, so up until she gets a college degree, a master's degree, up until she gets a job and gains independency - only then should she think about giving birth to a child, because, I repeat, a child needs many things to grow up well. I personally didn't follow this piece of advice, as it was God's will to have a baby, but I don't regret it at all. *(Interview 17)*

[Society looks] down [on girls in the child welfare system]. Because they're from the orphanage, everyone thinks: "When they get out of the system, they're going to get pregnant anyway; they have babies at a very young age." So, we are looked down upon by certain people [...] Because that's their mentality. *(Interview 25)*

Well, the age at which a woman can have children is not a fixed or standard age. The right age, according to myself and others, is when she starts a family, so that she can provide that child with stability, care, education and everything that the child needs. *(Interview 5)*

Well, back then we used to get married young, but things are different now. These days, girls get married and have children at a later age. *(Interview 1)*

You know what they say, the grandmother is the head of the family. My grandmother got married when she was 12 and so she encouraged us not to get married too young. Considering we're a big family and pretty much all of us got married at 20 or 21, we didn't really get married when we were very young. *(Interview 31)*

SRH service providers

I think that if we look at the measures taken to help these women [who want to access SRH services], their very absence shows that in society, the mindset is... 'If you are a woman, you must be pure. Why are you interested in sex? Why are you interested in contraception?" It's such a national shame. [...] I think [that Roma women, disabled women, and low-income women] are simply pushed to the margins of society. It seems to me that our society wants to appear meritocratic, but the reality is that there is no such thing as meritocracy when we don't all start from the same point. We like to point the finger at someone. So, who is the most vulnerable? A Roma woman, a disabled person and so on. And rather than looking at ourselves and how we perceive them, we prefer to blame them and treat them as if they were an impediment to the efficient functioning of the world. *(Interview 42)*

First of all, I would focus heavily, very heavily - if it were up to me - on prevention. By prevention, I mean regular checkups, but handled properly, because there are indeed people, doctors who have certain moods or attitudes. The woman feels vulnerable and fearful during the consultation. I've very often had women tell me, "I haven't had a checkup in so long." “Why?” "Because at my last consultation I had a bad experience." *(Interview 35)*

Conclusions and recommendations

The results of the present research outline a social reality in which access to sexual and reproductive health services remains a right that is almost impossible to exercise, limited by a complex web of structural barriers that disproportionally affect women from different backgrounds and social groups. In particular, women from rural areas, Roma women, and women of low socio-economic status face severe obstacles in accessing essential support and care: inadequate healthcare infrastructure, prohibitive costs, lack of information and ethnic and racial discrimination.

The lack of adequate medical services and infrastructure remains a major obstacle, especially in rural areas or small urban settlements characterized by a lack of access to family physicians, gynaecologists, midwives and other specialized personnel, as well as by the absence of adequate medical facilities in close proximity. The absence of health services in rural and Roma areas is the result of persistent policies of unequal resource distribution, leading to the predominant concentration of health services in urban areas. Driven by a lack of financial incentives, poor working conditions and deficient infrastructure, healthcare professionals prefer to work in more developed cities or regions. This imbalance contributes to an unequal distribution of health resources, leaving impoverished or peripheral communities without access to specialized healthcare. The phenomenon is exacerbated by a systemic devaluation of rural areas versus urban ones, both in political and institutional discourse and in the allocation of funds and development strategies. In this context, access to health services - including sexual and reproductive health services - becomes profoundly unequal, perpetuating cycles of exclusion and structural vulnerability.

Women living in these areas thus face major difficulties in obtaining quality healthcare because of the long distances to hospitals or clinics and the lack of specialized medical personnel nearby. This can lead to risky unassisted home births, miscarriages or newborn deaths. For example, in many rural communities, women do not have access to a family physician to monitor their pregnancies and provide antenatal or postnatal care, and so may only go to the doctor in an emergency, or often, wait until the last trimester of pregnancy, when complications may have already become severe. In the absence of a family physician, midwife or gynecologist, many women have to travel long distances to receive care, which can discourage them from seeking necessary help in a timely manner.

Moreover, the shortage of gynecologists, midwives, and other specialized healthcare professionals in disadvantaged areas makes it impossible to access essential services such as cervical cancer screening, pregnancy monitoring, routine gynecological check-ups or family planning consultations.

This directly affects women's sexual and reproductive health, exposing them to the risk of late detection of serious conditions or a lack of appropriate medical treatment. In addition, the scarcity of gender-based violence (GBV) services – such as integrated case management, shelters, psychological counseling, legal aid, or crisis intervention - contributes to perpetuating a climate of silence, fear and impunity. In the absence of an adequate support infrastructure, violence becomes an everyday and often unavoidable reality for many women who find themselves in such relationships with no real alternatives. For Roma women - those living in rural areas or those in economically precarious situations - racism, poverty and geographical isolation amplify existing obstacles and considerably reduce the chances of receiving real and equal protection and support against violence.

The lack of information about existing services and the dimensions of sexual and reproductive health is one of the major factors preventing women from accessing such services, jeopardizing their health and safety. In the absence of accurate and accessible information, many women do not know what rights they have or how to access essential services, and thus cannot safely exercise their sexual and reproductive rights. Due to limited access to information on sexuality education, contraception, available support in situations of sexual and gender-based violence, or specific socio-medical services, many women face unplanned or unwanted pregnancies, prolonged exposure to gender-based violence or medical treatments performed without consent. In the case of pregnancies, for example, many women from vulnerable backgrounds do not know what check-ups and tests they are entitled to free of charge, where and how to access them, or are not informed about the importance of antenatal services. This can lead to the late identification of serious complications that can jeopardize the health of the mother and child.

Poverty limits access to essential sexual and reproductive health services, affecting both women's ability to access quality healthcare and their capacity to make informed decisions about their health, thus reproducing a state of continued vulnerability. Given the lack of services in rural areas which often concentrate poor or at-risk-of-poverty populations, women are forced to either travel long distances to public services in other towns or bear the costs of services in private health facilities, neither of which are not real options for women with no or low incomes. Moreover, poverty has a cascading effect on access to SRH services: the absence of sex education, information about contraception, subsidized contraceptives, and affordable abortion services negatively affect women who are forced to carry pregnancies to term despite facing considerable financial deprivation to provide care for a child. For many of these women, the high cost of abortion in the private medical sector or even in public hospitals, where services are not subsidized, becomes an insurmountable barrier.

Institutionalized racism also characterizes the SRH services in Romania as a systemic form of discrimination that disproportionately affects Roma women. This research revealed several types of institutional practices, policies or attitudes that go beyond the occasional or individual character of ethnic and racial discrimination. For example, the interviews reveal a picture of a perinatal healthcare system marked by physical and verbal abuse, humiliating and dehumanizing treatment of Roma women, denial of care or superficial care, medical negligence, and the segregation of Roma women into separate wards. The reproduction of institutionalized racism is mirrored by the lack of systemic measures to train medical staff or to provide a safe framework in which these experiences can be reported by Roma women without fear of repercussions, and which can truly hold institutions accountable. In this context, several of the Roma women interviewed preferred to stop using health services or chose not to report the negative experiences they had faced, fearing potential escalation, negligent treatment or the outright denial of medical care for themselves or their children.

Racist practices and attitudes are aggravated and experienced differently by Roma women with low socio-economic status, low levels of education, those from traditional communities or those with darker skin. This highlights an intersection of ethnic, racial, and class-based discrimination that carries much higher costs for these women. At the intersection of these identities, the amplification

of discrimination comes with fewer opportunities to mitigate racist treatment and attitudes that higher education or lighter skin color might otherwise provide. For example, bribes or informal payments represent an additional cost that Roma women are forced to bear to counteract the effects of institutionalized racism. These payments act as an incentive or compensation for doctors to appropriately treat Roma women they would otherwise refuse or neglect. In this context, women who cannot afford to provide informal payments to medical staff continue to face exclusion or marginalization.

The limitation on the exercise of sexual and reproductive freedom is an effect of the intersection of a complex set of structural factors. Sexual and reproductive autonomy has different meanings for women from different groups. Although sexual and reproductive rights guarantee, in theory, the ability of every person to make informed and free decisions about her or his own body, in practice, for Roma women and women living in rural areas or in poverty, these rights are often stripped of practical meaning, and choices become constraints. Access to abortion or contraception becomes a privilege when costs are prohibitive, and the lack of information and the racist propensity to limit the fertility of Roma women gives rise to imposed practices such as the coerced or forced use of intrauterine devices (IUDs) (amidst a lack of alternatives, access to information and access to nearby health services that would facilitate monitoring). Moreover, the decision to carry a pregnancy to term is not always the result of a real choice, but of a necessity dictated by precariousness. Such dynamics highlight how reproductive freedom is not only a matter of individual will, but also of equitable access to rights and resources. **This is at the heart of the distinction between rights and justice: the former implies the existence of norms that protect sexual and reproductive freedom, while the latter implies the actual conditions that enable all women to enjoy these rights equally.** Without a recognition of these inequalities and without measures to remove economic, social and cultural constraints, sexual and reproductive rights remain inaccessible to the most vulnerable women, thus perpetuating a profound injustice.

The interviews also yielded a series of proposed **recommendations** that represent concrete steps towards creating a more accessible and equitable sexual and reproductive health system, especially for women in vulnerable communities. From actively supporting family physicians and sex education to integrating midwives and eliminating discrimination, each measure aims to improve women's access to and confidence in health services. Implementing these changes would help build a more equitable, inclusive and respectful system that supports women in all aspects of their sexual and reproductive health.

1. Active support from the family doctor

Central to the research participants' recommendations is the importance of the family physician as the first point of contact for women, especially those in vulnerable communities. The family physician should not only offer regular consultations, possibly at home, but should become that constant support for his or her patients, accompanying them throughout pregnancy, and providing clear information about the changes that occur during pregnancy, preparation for childbirth and postnatal care. The family physician should not only provide information about the necessary consultations and investigations during pregnancy, but also about their availability and accessibility. In addition, the family doctor is the first source of information on contraception and family planning, as well as on detecting situations of gender-based violence and referring patients to specialized services.

I think that [in order for women to trust SRHR] the family physician should offer support. That's where it all starts. Because, for example, if there is a pregnant woman who has no one to give her information, it is very important that she receives it from her family physician. So that she knows what to do and has someone there for her. [...] that guides her, tells her what to do, prepares her for childbirth, tells her about the changes during pregnancy (when you go from one state to another)... I think this is where it all starts. (Interview 24)

We should have more access to information, more support from our families and from our family physicians. For example, I didn't know about midwives, I didn't know that we even have midwives in Romania. I only found out half a year ago from someone I know, not from my family physician. The family physician should inform us about all of these services. In fact, he or she could be the one to offer them to us. (Interview 38)

I think that the best informed should be the family physicians, because usually they are the first to be contacted. They are the ones who should do the screening in the community, they should know their patients and be the first ones to give them information on where to go next, or help them identify abuse, because maybe some patients don't realize that what they experience is abuse, or how serious it is, or that it can escalate. (Interview 39)

I, for one, would bring in medical professionals, even family medical professionals, someone to come to each family's home, at least once a month. Especially for families lacking financial means, or the families that are less informed. (Interview 5)

For family doctors to be able to carry out their roles effectively, it is essential that patients have easy access to them, and that the organization of services - including equitable coverage of areas, manageable numbers of patients per doctor, and the tracking of and attention given to vulnerable cases - supports this objective. It is also important that family physicians are able to collaborate effectively with the social and community care system, as well as with sexual and reproductive health and related professionals. This is the only way to ensure multidisciplinary and professional care for all patients, especially those at the intersection of multiple vulnerabilities. Access, collaboration, and integration with other services, building a trusting relationship with patients, providing information and education in an empathic manner tailored to each patient's level of understanding, and constantly updating knowledge in line with evidence-based medicine and best practices can significantly contribute to improving sexual and reproductive health.

2. Comprehensive and accessible sex education

Another important aspect highlighted in the interviews is comprehensive sex education for young people, which needs to be ongoing, clear and accessible via the development of interactive educational programs. These programs should be accessible through media channels, the internet or schools, reaching as many young people as possible to provide clear and accurate information about consent, contraception, pregnancy and responsibility for one's own sexual and reproductive health.

It's important to talk openly about certain issues with girls and with young people today, because they pick up things on the internet that are often inaccurate or unhelpful. Maybe they could be informed through certain shows, online or televised, designed to capture their attention. Those could be structured like soap operas that illustrate what can happen to a girl when she starts her sex life, explaining it to them in a way they can understand. This would allow them to see what dangers exist, so that they know what can happen once they become sexually active. (Interview 23)

An essential step, alongside the direct and constant education of young people on sex education issues - through content delivered in schools, in communities, and through public campaigns, as well as via age-appropriate sources and channels - is to educate and empower parents on the importance of this topic. Parents can be helped and guided through campaigns and courses that equip them with both concrete ways of approaching the topic of sexual and reproductive health, as well as the necessary knowledge. These resources can be adapted according to the children's ages and can include relevant related topics, such as the risks of a lack of information, as well as the implications and signs indicating the need for specific health services.

3. Continuing training for healthcare staff

Ongoing training of healthcare professionals in empathetic communication skills and cultural diversity awareness is a crucial aspect of improving the relationship between patients and medical staff. The training should cover topics related to the prevention of ethnic and racial discrimination and gender-based violence, thus contributing to the reduction of discriminatory practices and attitudes by ensuring fair and dignified treatment for all patients regardless of ethnicity or socio-economic status.

[Medical staff involved in the provision of sexual and reproductive health services] should attend courses on empathetic communication with patients, courses on understanding different cultures, and courses on preventing and combating gender-based violence, in addition to their specialized courses, undoubtedly. (Interview 40)

First of all, [...] in medical school [...] medicine should no longer be treated only for its scientific side because medicine is also human; after all, we work with human beings. We have a one-semester course on patient communication or some kind of psychology, but it's very impersonal, very dry, and basic. I was looking at my colleagues, and a lot of them are racists, or even fascists. So I was wondering how on Earth do these people get through medical school and become doctors. Perhaps, during the admission, students who want to go into medicine or nursing or midwifery should also take a psychological exam to show whether they have empathy, whether they have compassion towards others, whether they are racist or not and so on. [...] I think that there should be mandatory training in hospitals, even for private doctors, meaning they should be obliged to attend, not just sign up and go if they want. Training on inclusion, diversity and how to implement that in your work as a doctor. (Interview 42)

It depends on who provides this communication or this system of education [of medical staff on empathy, diversity, and communication with patients], but yes, when it comes to staff, as in any other field, there are people who understand more easily, and who have a certain way of expressing themselves, of talking to patients. It is not always the most orthodox, let's say, of approaches, and this is probably also due to the level of schooling they have had, but I can't say for sure. There are also doctors who don't always adopt the most normal tone, so to speak. Yes, it [medical staff training] wouldn't hurt (Interview 37).

In addition to each sexual and reproductive health practitioner's own conscientious responsibility, the institutions regulating these professions should condition their ability to practice on constant and real updating and improvement of knowledge - through constructive, monitored processes aligned with international standards. It is essential to provide specialization and training courses that are accessible, of high quality, aligned with best practice recommendations, evidence-based and accompanied by informative materials and specialized sources in Romanian. These are necessary not only for improving the quality of care in the field, but also for continuing professional development. Standards of practice should also be adapted and revised to include the non-technical skills needed at each level of practice. In both the initial and continuing training of health

professionals, there needs to be a much clearer focus on the importance and development of these competencies.

4. Accessibility and integration of midwifery services

Midwives are not just an essential element in maternal care; they are a resource that, unfortunately, is under-utilized in Romania. Midwives play an essential role in supporting women during pregnancy, childbirth and post-partum care, especially in rural or remote areas where access to healthcare is limited. The recommendations emphasize the need to amend legislation to allow midwifery services to be reimbursed and more effectively integrated into the health system. Establishing and supporting community midwifery clinics would greatly improve maternal and child care, preventing complications and facilitating women's access to quality care close to home.

[To make it easier to access the services of a licensed midwife, I would change] the legislation first to allow midwifery services to be reimbursed and second to allow the opening of midwifery practices. (Interview 40)

According to international recommendations, it is essential to define the roles of midwives and to integrate them as experts in sexual and reproductive health, as practitioners with a high degree of autonomy, capable of complementing the care team and being present at all levels of activity in the field. Midwives can collaborate effectively with other members of the multidisciplinary care team, and this integration can make a significant contribution to improving health, preventing complications and reducing maternal and child mortality and morbidity. There is a need to re-establish midwifery training programs in medical schools across the country, as well as to create positions for licensed midwives at each level of sexual and reproductive healthcare both in and out of hospitals, with a priority in vulnerable communities where access to services is often limited. With minimal resources, midwives can provide essential services where they are most needed. Reimbursing the services provided by midwives working outside hospitals - either in collaboration with them through mobile outpatient clinics or in independent practice clinics - could ensure real access to quality SRH services for vulnerable communities.

5. Ensuring access to free SRH services in the community

The gaps in the availability of SRH services close to people’s residences highlight the urgent need to improve the distribution and accessibility of health services in areas not already served by them. This can be achieved both by increasing the number of medical specialists, family doctors, community nurses, and midwives in small or rural settlements and by providing a package of free SRH services. An important recommendation is that SRH services should also be supplemented by the establishment of clinics or dispensaries, as well as independent practice offices in communities, to provide continuous and accessible healthcare to all. In order to ensure equitable access, services should be free or at minimal cost, to avoid women being put in the position of having to forgo essential care due to a lack of financial resources. Providing free or subsidized services, especially in vulnerable communities, can significantly reduce sexual and reproductive health risks, including maternal and child mortality.

First of all, I would provide all women with at least these basic minimum health services. They should have a [gynecological] check-up every year, regardless of whether they have an insurance or not; every woman should benefit from it. [...] (Interview 28)

I would build more clinics... I don't know, dispensaries, like they used to be, I don't know. [...] Yeah, a healthcare network. In the community. Yes. That's available to everyone. And free. Because, after all, that's the most important thing, for it to be free. (Interview 38)

[There should] be more specialized doctors, just like there are in the big cities, they should be

available in the smaller cities too, and patients should have access to more education as well, not just the hospital staff or doctors. It would be helpful to have more information campaigns and free services for those who can't necessarily afford the cost of a consultation. It would be great if these facilities could also solve even certain problems that require more than a simple check-up, as well as offer more resources for consultations and sexual health needs. (Interview 10)

It would be very interesting to have psycho-education centers for women. [...] Sort of like health clinics. Clinics working with the state. Clinics and polyclinics, yes. With, I don't know, breast-feeding counseling. And they should not be private. (Interview 43)

Thus, increasing the number of community health nurses and the use of midwives in the community could contribute significantly to improving access to SRH health services. The provision of these services free of charge would facilitate access and allow for the implementation of measures focusing on prevention, effective monitoring, early recognition of complications and prompt intervention. This would lead not only to a reduction in the number of severe cases and multiple, advanced complications, but also to a reduction in maternal and child morbidity and mortality, while contributing to a more efficient use of health system resources.

6. Access to accurate information on SRHR and related services

A constant theme in the recommendations proposed by the women interviewed is ensuring the provision of accurate and accessible information on sexual and reproductive health, particularly to women from marginalized communities and those without access to formal education. Without accurate information, women cannot know what rights and choices they have, what is happening to their bodies and how to protect themselves from risks. Information can be provided both through sustained and repeated outreach programs in communities and through health services that provide SRH care (e.g., family physicians, gynecologists, maternity health staff, etc.) The information should be not only theoretical but also practical, explained in accessible language and provided by trained personnel who can guide women through the important stages of their sexual and reproductive lives. In addition, essential medical procedures and tests should be clearly standardized and presented in a transparent way to avoid confusion and delays in accessing care.

The provision and popularization of essential information on SRH in an accessible, unified, and up-to-date form should be a common objective across all information channels. It is important that these messages make a clear references to official and reliable sources, not only to combat lack of information, but also to actively counter misinformation.

I think it would be… that information [would make it easier to access SRH services] ... Because a lot of women don't know about a lot of things, and, like, I also didn't know, I had to go through three births to understand anything. And even then, I learned it from the doctors. (Interview 31)

There are many young people who don't know their options. When you want to get pregnant, no doctor will tell you what you need to do, and that's what I discovered the first time I got pregnant. No doctor, when you go in, tell you step-by-step what tests you need to do when you get pregnant. They start telling you all sorts of things only after you have lost one or two pregnancies, and after you have looked for a few more doctors or changed a couple of hospitals. I think that there should be a series of clear, well-defined, established tests, posted in every doctor's office, so that every person knows exactly what to do. You go and do those tests, and depending on the result of those tests, you know what other tests to do. Because, for example, I didn't know that I had to have a hysteroscopy, salpingography, tests that nobody tells you about. Everybody just stuffs you with pills, with Duphaston or, I don't know, folic acid to get you pregnant. But until I found a doctor who knew everything and who also knew how to do his job, I had to go through two hospitals, you know. (Interview 29)

[The medical staff should] have more patience, and if they see ... for example, when I went with my two-weeks-old child to the hospital, instead of rushing us, they could have sat me down and explained to me why they have to give the IV to the child, and what are the things that could affect him. (Interview 25)

I think that the greatest need for information and the implementation of programs is in vulnerable communities, especially among those people who no longer attend any form of education, who do not have access to information [...] I think that if we could do sustained, repeated programs, with consistency, with incentives, in vulnerable communities, it would be a very great success. So getting information and education into the community is key. We've had these programs, I just think that in terms of the scale of this phenomenon, we've been a grain of sand in an ocean. (Interview 22)

Well, I think that they should somehow have access to information that is not only theoretical; they should somehow be presented with all these problems and, basically, by specialists in the field. There should be people who can explain it to them in understandable medical terms, in hospitals and maternity hospitals - auxiliary staff, not just doctors - specialists who can talk freely, who can prepare women before they start a sexual life, give birth or after giving birth. I feel that this is still lacking (Interview 23).

[There is a need to] publicize these services to rural women as well ... I mean mass media

coverage. Frankly, I wouldn't even mind hearing an ad on TV saying: "Girls in their 20s and 30s are invited to the Regional Oncology Institute for free HPV testing," because we know that most people have access to TV and could benefit from hearing that. (Interview 43)

7. Eliminating discrimination and ensuring fair treatment based on informed consent

Many of the recommended changes that would facilitate women's access to SRH services point to the need for an equitable healthcare system in which every patient is treated with respect and without discrimination, regardless of ethnicity, social status or educational level. Eliminating racism and prejudice from the doctor-patient relationship would allow real access to quality services for all, including Roma women and women from disadvantaged backgrounds. Empathy and a humane attitude on the part of health professionals remain essential, especially for vulnerable patients, such as pregnant women or young mothers, who often face lack of support and indifference. Increasing Roma representation in the health professions could improve access to care and give patients from marginalized communities the confidence to turn to the medical system. In a more inclusive and humane healthcare system, respect, empathy and equal treatment should become the norm, not the exception.

An important step towards respecting patients' rights would be the development of clear and accessible feedback mechanisms through which women can report abuse, discrimination or difficulties encountered while interacting with health professionals. These channels would help increase transparency, monitor discriminatory practices and hold healthcare institutions accountable. At the same time, one of the solutions proposed in the research is to build partnerships between medical student associations on the one hand, and minority rights organizations on the other. Such collaborations could play a key role in shaping an inclusive medical culture, preventing institutional discrimination and promoting equitable treatment for all patients regardless of ethnicity, sexual orientation, disability or social status.

I'd change this racism thing. I mean, make us all equal. That's all. [...] No matter how much education you have as a Roma man or as a Roma woman, you are still Roma in their eyes. (Interview 30)

Doctors should treat patients properly, and no longer differentiate between rich and poor. Treat them all the same. [...] I would be happy if medicine would change, if doctors would actually take care of people. At least our children would have a better life. We have been treated with indifference long enough. (Interview 16)

I would change life, our community, the world, the doctors. I would bring about respect. Wherever we go, we should have respect. (Interview 15)

Humanity. Make the system more humane. [...] Here, [in the German medical system] it doesn't matter if you're white, black, a cleaning lady, or a rector, you get the same food, the same treatment, the doctor welcomes you with the same smile on his lips, asks you 100 times if you're in pain, how much pain, how are you holding up, etc. Here, a nurse has three patients in the ICU for the whole shift. 8 hours spent on three patients. Here, in Romania, a nurse looks after a whole ward. (Interview 28)

I would really wish, if I were to make this change, that the people [in the medical services] would put more passion into helping a helpless, inexperienced person that comes into their office and that they would be a little bit more kind, a little warmer, to put themselves a little bit in that person's situation and to think a little bit about the person who is going through it. I'm especially thinking about the fact that I have been through it, and I am talking about young girls, because it is inevitable that young girls in their 20s and 21s or even earlier become mothers, and it's their first experience. I would like to change their mindset, so that they come to work with their soul, not just for the money, just letting the time pass, treating the people in their care as if they were garbage

bags that they throw in the trash. (Interview 17)

*I wish [...] that we would stop being bad-mouthed and insulted, being told that "you are g*****s, you are peasants, you are filthy." There is water, there's detergent... We wash ourselves. We don't go to the hospital or to the dispensary dirty. That's the biggest possible offense, how can a doctor, a medical professional insult you, especially when you go with a sick child, especially when you go with personal problems... That's what I would like to see change, I would like for us to be treated like any other human being. [...] The doctors should also behave nicely with us, ask us questions, listen to us, and stop insulting us. We don't insult them, they shouldn't insult us either. For example, if you are going with a child that has a problem, or if you go for a personal problem, because maybe you have a problem down there, like any woman, the doctor will tell you, "But that's just how you g*****s are! Go away! You're sick now, but if your man gets on top of you, you're not sick anymore." So we don't want to be insulted, we want to be nicely spoken to. Like, someone told me that we are living off the doctor's back. (Interview 19)*

*Well, in my opinion, if we had Roma medical staff, the situation would be different. People's accessibility would be different. People in my community are meek, and don't have that much knowledge. Because they are stuck in their ways, are older, or don't have access to information. An older person doesn't have access to information like a younger one does. [.] It'd be nice if there were someone that could show you that they want to help you when you turn to them for help. Not look at you from a high horse, like, "Oh my gosh, who are you? A Roma, a g***y, who came to ask for help." No! Someone you can trust; someone you can tell what your problems are. (Interview 5)*

One of the solutions would be to establish a fairly good relationship between student associations, doctors' associations, and minority associations, which defend minority rights. (Interview 43).

[It would require] creating a closer connection between doctor and patient. I mean a feedback system, a follow-up system. A way for that patient to be able to ask further questions. (Interview 43)

In addition to implementing easy ways to provide feedback on care and the experience of accessing the healthcare system, it is essential to emphasize the quality of care from a holistic and humane perspective, with clear quality standards and well-defined measures for situations where staff attitudes or the care provided are substandard or non-compliant. Mandatory publication of statistics on the quality of care, including those generated by patient feedback, could contribute constructively to maintaining a high standard of services.

It is imperative to effectively link the different levels of the multidisciplinary care team, related specialties and the different professions involved. Equally important is the organization of a system of debriefing, follow-up and monitoring, especially for cases with multiple vulnerabilities through integrated case management. All this should be supported by the development and implementation of a clear protocol for integration and collaboration between the services, authorities and institutions involved, at both the local and central levels, to intervene promptly, effectively and responsibly in support of the fundamental right to health.

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Annex 1a. Female users of SRH services - socio-demographic profile

Interview No.	Residence	Age	Formal education	Occupation	Civil status	No. of children	Ethnicity	Family physiciandoctor	Compact community
1	Urban	46	Primary	Part-time employee	Single	2	Roma	Yes	Yes
2	Urban	41	Unfinished highschool	Housewife	Married/ partnered	2	Roma	No	Yes
3	Urban	33	Secondary	Housewife	Married/ partnered	1	Roma	Yes	Yes
4	Urban	40	Primary	Housewife	Married/ partnered	2	Roma	Yes	Yes
5	Urban	36	High School	Full-time employe e	Married/ partnered	2	Roma	Yes	Yes
6	Urban	24	High school (without baccalaureate)	Part-time employe e	Married/ partnered	1	English	Yes	No
7	Urban	35	Unfinished high school	Housewife	Married/ partnered	1	Roma	Yes	Yes
8	Urban	42	Unfinished high school	Housewife	Married/ partnered	2	Roma	Yes	Yes
9	Urban	23	University	Part-time employe e	Married/ partnered	0	Roma	Yes	Yes
10	Urban	23	University	Part-time employee	Single	0	English	Yes	No
11	Urban	40	Vocational education	Housewife	Married/ partnered	3	Roma	Yes	Yes
12	Rural	19	Secondary	Housewife	Married/ partnered	2	Roma	No	Yes
13	Rural	29	Primary	Housewife	Married/ partnered	5	Roma	No	Yes
14	Rural	34	Secondary	Housewife	Married/ partnered	6	Roma	Yes	Yes
15	Rural	41	Secondary	Housewife	Single	3	Roma	Yes	Yes
16	Rural	46	Unfinished high school	Full-time employee	Married/ partnered	3	Roma	Yes	Yes
17	Urban	25	High School	Full-time employee	Married/ partnered	1	Roma	Yes	Yes

Nr. Interview	Residence	Age	Formal education	Occupation	Civil status	No. of children	Ethnicity	Family doctor	Compact community
18	Rural	44	none	Housewife	Married/ partnered	14	Roma	Yes	Yes
19	Rural	40	none	Housewife	Married/ partnered	4	Roma	Yes	Yes
20	Rural	30	none	Housewife	Married/ partnered	2	Roma	No	Yes
21	Urban	45	University	Full-time employee	Divorced	5	English	Yes	No
22	Urban	43	University	Full-time employee	Married/ partnered	1	English	Yes	No
23	Urban	48	University	Full-time employee	Married/ partnered	4	English	Yes	No
24	Rural	35	Vocational education	Housewife	Married/ partnered	3	Roma/ Hungarian	Yes	No
25	Urban	23	Vocational education	No occupation	Single	1	Roma	No	No
26	Urban	23	University	Student	Single	0	Hungarian	Yes	No
27	Rural	37	Vocational education	Full-time employee	Married/ partnered	3	English	Yes	No
28	Urban	42	Primary	Housewife	Single	3	Roma	No	No
29	Urban	39	High school (without baccalaureate)	Full-time employee	Married/ partnered	3	Roma	Yes	No
30	Rural	35	Secondary	Housewife	Married/ partnered	3	Roma	Yes	Yes
31	Urban	32	none	Housewife	Married/ partnered	2	Roma	Yes	No
32	Urban	34	Primary	Housewife	Married/ partnered	2	Roma	Yes	No
33	Urban	38	High School	Full-time employee	Married/ partnered	1	Roma	Yes	No
34	Rural	44	Primary	Retired	Married/ partnered	1	Roma	Yes	No

Annex 1b. SRH service providers - socio-demographic profile

No. Interview	Profession	Residence
35	General Nurse, public hospital	Urban
36	Community nurse, town hall	Rural
37	Primary obstetrics-gynecology, public hospital	Urban
38	General Nurse, public hospital	Urban
39	Social worker, public hospital/social service provider	Urban
40	Midwife	Urban
41	Public social service provider (Social Assistance Department)	Urban
42	Family medicine resident, public hospital	Urban
43	Family medicine resident, individual family medicine practice	Urban

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