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Pregnancy Experiences of Women in Rural Romania: Understanding Ethnic and Socioeconomic Disparities

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Abstract

Women in rural Romania face significant health disadvantages. This qualitative pilot study describes the structural disadvantage experienced during pregnancy by women in rural Romania, focusing on the lived experiences of Roma women. We explore how women in rural communities experience pregnancy, their interactions with the healthcare system, and the role that ethnic and social factors play in pregnancy and childbearing. We conducted 42 semi-structured interviews with health and other professionals, seven narrative interviews with Roma and non-Roma women and a focus group with Roma women. Data were analysed using thematic analysis. We identified intersectional dimensions associated with women's pregnancy experiences: women perceiving pregnancy as both unplanned and wanted, joyful, and normal; women's and professionals' differing prenatal care perceptions; transport and cost related barriers to care; socioeconomic and ethnic discrimination; and facilitators to care such as social support, having a health mediator and having a doctor. Talking directly with professionals and Roma and non-Roma women helped us understand these many factors, how they are interconnected, and how we can work towards improving the pregnancy experiences of Roma women in rural Romania.

Keywords

Roma; Romania; pregnancy; discrimination; community health

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Introduction

Romania's maternal and child health outcomes have improved significantly since the collapse of communism in 1989. However, communism's fall has arguably led to heightened gender inequality, and Romania's maternal health remains worse than other post-Communist countries (The World Bank Group 2015; Gal and Kligman 2012). Furthermore, reproductive outcomes remain poor for women in rural areas, minority ethnic groups, and women of low socioeconomic position (Logar, Pavli and Maksuti 2015; Magyari-Vincze 2009; Zeman, Depken and Senchina 2003).

The Roma are a marginalised ethnic group that are estimated to be between three and ten percent of Romania's population. Roma women often experience multiple disadvantages and have poor maternal and child health (Surdu and Surdu 2006; The Government of Romania 2015). According to the Open Society Institute's Report on the Status of Romani Women in Romania in 2006, 70% of Roma women reported ethnic discrimination in healthcare, and over 20% reported ethnic and gender discrimination, specifically those in rural areas, with low socioeconomic position, and with little education (Surdu and Surdu 2006). Beyond discrimination, evidence suggests that Roma and other marginalised women in Romania have poor healthcare experiences due to low health literacy, specifically about prenatal health (Nikolic and Djikanovic 2014; Rat 2005; Rorke, Matache and Freidman 2015). These many factors likely contribute to Roma women's poor pregnancy experiences.

Prior studies on health and social issues with marginalised women in Romania and in Europe focus mostly on Roma women (Council of Europe and European Monitoring Center on Racism and Xenophobia 2003; Wamsiedel, Vincze and Ionescu 2012). As negative social phenomena (e.g., poverty) in Romania are often considered synonymous with being Roma, studies have neglected other components of disadvantage (e.g., rurality) that affect pregnancy experience (Colombini, Rechel and Mayhew 2012; Magyari-Vincze 2006; Magyari-Vincze 2009). Additionally, these studies have not considered Roma women to be a heterogeneous group with different experiences based on geography, socioeconomic position, and more. These studies were conducted in urban areas, which have better healthcare infrastructure, more gynaecologists, higher socioeconomic position, and fewer Roma women than rural areas (Magyari-Vincze 2009). Therefore, little is known about the pregnancy experiences of women in rural Romania. Another gap in the literature is the perspective of professionals who provide healthcare and support services within this population. Conducting such discussions prior to interviews with mothers may result in improved understanding of the context surrounding women's pregnancies that cannot be elicited through talking with women alone.

This pilot study addressed the lack of information and knowledge surrounding women's pregnancy experiences in rural Romania and draws on intersectionality theory. Intersectionality was first used to explain the interconnectedness of gender, race, sexuality, and class. The theory posits that these social categories are inextricably linked and the disadvantage that results from these categories must be considered holistically (Crenshaw 1991). Intersectionality theory has recently been introduced in studies with Roma women

(Alex and Lehti 2013; Kóczé 2009). In this study, intersectionality provided a way to conceptualise how current and historical disadvantages related to being rural and/or Roma impact health-related behaviours, healthcare service utilisation, and reproductive outcomes. Our primary objective was to understand the experience of pregnancy for women in disadvantaged, rural communities in Romania from the perspectives of professionals who serve this population and rural women that are often left out of public discourse and decision-making. Specifically, we aimed to better understand: 1) how mothers in rural areas perceive their pregnancy experiences within their family, community, and healthcare system, 2) professionals' perspectives on mothers' prenatal care utilisation and healthcare experience, and 3) whether ethnic and social factors play a role in disparate service delivery. The results of this study have implications for developing programs and policies to improve maternal and child health for rural Romanian women.

Methods

Setting

The research took the form of a two-phase qualitative study. The first phase of the study involved in-depth interviews (IDIs) with professionals throughout Romania. These interviews provided context for the first-hand accounts of recent mothers in phase two. The second phase of the study involved IDIs and one focus group discussion (FGD) with recent mothers in an ethnically diverse rural commune in Cluj County. The rural commune is officially 50% Romanian, 35% Hungarian, and 8% Roma (National Institute of Statistics: <http://www.recensamantromania.ro/rezultate-2/>). We recruited women from the community's two villages: a larger village with a small healthcare centre and public transportation and a smaller village a few kilometres away. We conducted phase two in one commune due to limited resources and a need for community facilitators to ensure community entrée and build trust. The second phase captured individual pregnancy experiences and community level resources and support for new mothers, necessitating both IDIs and a FGD. The IDIs elicited first-hand accounts of individual pregnancy experiences while the FGD prompted conversation about organisational and community support and preparedness for new mothers and discriminatory practices within maternity care. Using both methods provides depth to our understanding of individual and collective experiences of marginalisation (Pollack 2003).

Participants

We purposefully selected key informants based on their experience working with rural Romanian women and recruited them through colleagues in the Department of Public Health at Babes-Bolyai University and World Vision International. Professionals had to be 18 years or older, speak Romanian or English, and have experience working with rural areas and/or with Roma communities (N=49) (Table 1).

We purposefully recruited mothers through a community facilitator in the identified rural community. Women had to have given birth in the past five years, be 18 years or older, speak Romanian or English, and live in the selected commune. However, our FGD included two women whose most recent pregnancy was more than five years ago. All women approached

agreed to participate in IDIs. There were 12 participants in the second phase of the study which consisted of IDIs (N=9) and a FGD (N=6). Three women who participated in IDIs also participated in the FGD (Table 2).

Procedure

We conducted phase one of the study between December 2015 and February 2016. Professionals were interviewed in-person or via Skype. Phase one interviews were conducted in English or Romanian by the lead researcher and a Romanian research assistant. Interviews lasted between 30 and 90 minutes.

Phase two was conducted between April and June 2016. The FGD and IDIs took place in private community settings. Three IDIs were conducted with two participants in a joint interview when women felt more comfortable speaking with the researchers with a friend. The IDIs and FGD were conducted in Romanian by a Romanian researcher and the lead researcher. The FGD lasted approximately two hours and IDIs ranged from 12–48 minutes.

Participants received and signed an informed consent document before the interview. The study was approved by Institutional Review Boards at Washington and Lee University and the Department of Public Health at Babes-Bolyai University.

Instruments

We used a semi-structured interview guide for professionals' interviews. Interview guides were developed with the assistance of maternal and child health experts in Romania and covered women's health in Romania, prenatal care utilisation, gender roles, structural discrimination, and legal frameworks and policies in maternal and child health.

In phase two of the study we used a narrative interview guide for IDIs and a semi-structured interview guide for the FGD. The narrative interview guide focused on women's most recent pregnancy. We led with the question: 'would you please tell me the story of your last pregnancy?' and asked follow-up questions based on women's responses. As participants had young children and many responsibilities, the IDI guide was brief. The semi-structured interview guide for the FGD included questions about community support for pregnant women and new mothers and access to healthcare and other services.

Data Analysis

We audio-recorded and transcribed interviews. Interviews conducted in Romanian were transcribed and translated into English by a certified translator. Two researchers with training in maternal and child health and familiar with the Romanian context conducted data analysis. As data were collected, researchers independently reviewed transcripts and began conducting thematic analysis. Researchers stopped conducting professional interviews when similar themes arose in interviews and stopped conducting women's interviews when all interested women were interviewed. We took a hybrid inductive-deductive approach to coding interviews. We first identified descriptive codes among professional interviews and expanded our codebook to encompass descriptive codes from professional interviews and/or mothers. We then created granular codes for the text most relevant to pregnancy experiences

and compared codes across interviews to identify emergent patterns. Finally, we identified themes encompassing both professionals' and mothers' narratives and compared them to findings from similar studies related to the pregnancy experiences of marginalised women.

Findings

Perceptions of Pregnancy

Pregnancy as both Unplanned and Wanted—In interviews with professionals and mothers, pregnancies were described as planned and wanted, unplanned and wanted, or unplanned and unwanted. Professionals often conflated the two concepts of pregnancy planning and wantedness, wrongfully asserting that when women did not plan a pregnancy, they did not want it:

I think [Roma families] do not really think about this as a decision, I mean it's part of their daily life and...if it happens it happens, if not, not. So it, this is their life and they are going. (Non-governmental organisation employee 01)

In contrast to professionals' views, women reported that their pregnancies were sometimes planned and wanted. Furthermore, women often wanted their children if the pregnancy was unplanned. One woman spoke about the distinction between wanted and unwanted pregnancies, which were not associated with planning pregnancy:

There is always a difference between a wanted pregnancy and an unwanted pregnancy. You take care of a wanted pregnancy just like you already have the baby. When you don't want the pregnancy...you no longer care. (Mother 01, Roma ethnicity, age 25, four children)

One mother's story showed how blurred the lines of 'wantedness' can be, 'my last pregnancy, I didn't really want this pregnancy but it happened...I felt a regret because I already have five children. And...it is a little harder. But I don't regret the baby' (Mother 02, Romanian ethnicity, age 33, five children). Despite the potential challenges of unwanted or unplanned pregnancies, abortion was often not considered an option. Several professionals and women discussed Roma women's resistance to abortion due to religious and cultural norms.

Joy in Pregnancy and the Importance of Motherhood—Almost all mothers talked about how, even when a pregnancy was unplanned, it was a joyful experience. One mother stated, 'the greatest richness is a child...there is no use in having money and wealth, your house will be empty if you don't have a child' (Mother 03, Roma ethnicity, age 27, two children). While joy was a critical component of women's narratives about pregnancy, the only professional that described pregnancy as joyful were Roma. One was a Roma health mediator, a Roma woman trained by the ministry of health to serve as a liaison between her community and healthcare services. She claimed that, 'for [Roma women], a child always represents a joy...he or she is not a burden even if it is difficult...for them there is no problem' (Roma health mediator 01).

While most did not mention joy in women's pregnancies, they did discuss the importance of becoming a mother in rural areas. Mothers did not discuss this importance, but the

impression of importance may be part of others' interpretation of the mothers' joy. One professional explained that, '[Roma women] have a mission...to be a woman and a mother, to them it's very important' (Social policy expert 01). Professionals claimed that, for these women, womanhood and femininity is inextricable from motherhood.

Multiple and Shifting Roles—Many women and professionals discussed pregnant women in disadvantaged areas as having many roles (e.g., as a mother, spouse, employee) that they juggle and shift between during pregnancy:

The woman's role, it's a very hard role, it's a very hard thing to be a Roma woman. The whole responsibility...they have to be wives, they have to be mothers... (Social policy expert 01)

All of the women we spoke with had at least two children and remained the primary caretaker for their other children while pregnant:

I used the bike until I got eight months pregnant...and I carried the oldest child, I carried her with the bike, I took her to the kindergarten and...during that time we lived farther from the kindergarten...yes [I managed], I didn't have any problem. (Mother 04, Roma ethnicity, age 33, two children)

When discussing the many priorities mothers had, women and professionals alike described the normalcy of pregnancy and how it did not reduce a mother's other obligations. Mothers continued on with all of their responsibilities throughout pregnancy out of necessity.

Perceptions of Prenatal Care

Women's Perceptions of Prenatal Care—Women's conceptualisation of pregnancy as natural and normal influenced their use and expectations of prenatal care. Some women went to prenatal care less frequently than advised due to perceiving pregnancy as natural. However, they recognised that prenatal care could detect potential problems: 'I didn't make exactly all of [the prenatal check-ups] with my second pregnancy, but I did the most important ones' (Mother 02, Romanian ethnicity, age 33, five children). Some mothers we spoke with stated that poorer women in their community did not go to prenatal care because they did not care about their pregnancy:

There were some [mothers] who sometimes asked me: 'Why do you go every month for the check up? Why do you spend money...if you already were there and everything was fine?' ...it's about convenience, [the other women] don't care... (Mother 05, Romanian ethnicity, age 26, two children)

Professionals' Perceptions of Prenatal Care—Professionals expressed varying views on Roma women's prenatal care usage. The majority reported that Roma and other disadvantaged women did not go to prenatal care because they thought pregnancy was natural and normal, but they considered this conceptualisation to be problematic: 'this is one problem... [Roma women] consider that the pregnancy is something natural and they don't have to investigate something during the pregnancy...' (neonatologist 01). Many stated that women did not go unless they experienced complications. Professionals said that this was especially true of mothers with many children:

It's quite hard to say to a woman who has already given birth to five children...
'you really need to go to the doctor because otherwise something would happen,'
...She would laugh at you. (Social worker 01)

Several professionals provided contrasting views, noting that Roma women they worked with attended prenatal care:

Yes, when they are pregnant they are coming to the clinic...sometimes there are high-risk [pregnancies], so they are coming...it is not something for some non-Roma and Roma... (Gynaecologist 01)

Barriers to Care

Transport and Cost—Women reported economic barriers to accessing maternity care including unaffordable transport and health insurance. Women in smaller, more isolated village were a few kilometres from the general practitioner and train station. Lacking transportation complicated their pregnancy, as they relied on others and made compromises regarding care:

[Roma women] are coming for ultrasounds...from near the town...[If] they live in a rural region...it's difficult for them to come ...because they don't have money for a tickets, for bus tickets, for train tickets, not for ultrasounds, because ultrasounds [are] for free. (Gynaecologist 02)

Although all women in Romania have free antenatal care after they register their pregnancy with a physician, they must pay for this first visit if they are uninsured. Women who had insufficient funds were susceptible to delaying care. Another cost for some women was informal payments (i.e. soliciting funds for services that should be free) that providers expected. While informal payments are not restricted to Roma women and others from rural areas, it is more likely to be prohibitive for them:

... many of the doctors still expect some sort of bribe to do their job and for some of these women, it, it's so difficult to...give money for medical intervention, so then they have this experience of being treated very badly in the hospital... (Non-governmental organisation employee 02)

Socioeconomic Discrimination—Inability to pay for prenatal care also prompted discrimination from some providers. One mother described her labour and delivery experience:

If they see that you are poor, and you don't give them [an informal payment], I tried this as well...I was left alone to suffer...but if you give them [money], they will pay attention. (Mother 06, Hungarian ethnicity, age 29, six children)

Another mother reported that she received harsh treatment when she asked to be taken to another hospital. She stated that the nurse made assumptions about her socioeconomic position because she was from the countryside:

...I told them that I don't want to give birth here, and that I want in the other hospital. And the lady asked me in a penetrating voice whether I have a physician

there. She was very...she probably thought that because we are from the country side we don't have. (Mother 05, Romanian ethnicity, age 26, two children)

Ethnic Discrimination—Individual and societal discrimination against Roma women is widespread, especially in healthcare. A variety of perspectives of this were shared by professionals. These ranged from condemnation to espousing derogatory stereotypes about Roma people. One professional reported that while service providers deny discriminating against Roma people, they hold prejudiced beliefs:

...racism is still very important, and it is present in [healthcare]. If you speak... with doctors or nurses...of course there is initially quite a common attitude of denial of any racism or different treatment of Roma women compared to others but when you dig a little bit deeper and you start talking to them about [what] they actually do, how they behave...(Non-governmental organisation employee 03)

Furthermore, professionals drew a distinction about the discrimination faced by Roma women who were viewed as more 'traditional'. Professionals defined women as 'traditional' based on darker skin colour, clothing, speech, hygiene, gender roles, low education, low income, and their engagement in jobs such as craftsmanship. One of them stated:

Because when you have a, a traditional Roma who comes to the hospital, it will immediately attract all the attention...especially if the person is dressed in a traditional dress and is speaking Romani. (Academic researcher 01)

Professionals reported how some of the behaviours and characteristics of 'traditional' Roma women prompted harsh treatment from providers. A professional described internal conflict reconciling providers' discrimination and women's behaviour. Despite denouncing discrimination, he expressed the belief that Roma women bear a degree of personal responsibility in avoiding this treatment:

This [discrimination towards Roma] is a taboo subject; I could talk about the pros and cons of how health discrimination is seen. In a certain way, I give credibility to the society... that it generates for discrimination. So, people are coming, I understand them, you want to go to the physician, to a medical practice, you get yourself cleaned up so that the physician receives you. So, you contribute to your own...discrimination. (Local government policy worker 01)

A consequence of the pervasive ethnic discrimination against Roma women was reduced access to healthcare. Several professionals and mothers described physicians who refused to care for Roma patients: 'then there is the refusal of medical practitioners to assist Roma, even if they have a list...the family physician says that she is busy' (local government authority 01). Limited options for providers paired with anticipated and previous experiences of discrimination led to delayed care seeking, which reinforced physicians' discriminatory behaviours:

When you go to the physician just when it is paramount, well...then the physician simply can't do anything. But...[this] is also the physician's fault, because...the stereotype towards Roma within the Romanian society is very high. (Local government policy worker 01)

Discrimination also impacted the quality of care women received during labour and delivery. One participant described how women were often sent to an inferior ward if they were Roma and poor:

In [one hospital] there still exists a huge ward, big...where there are only Roma women...the lady that was assigned to take me to a ward, she probably saw [my last name] ... and she took me. (Roma health mediator 02)

While segregated maternity wards are illegal, hospitals have been able to avoid the legal repercussions from their practices:

Roma women [were] in a separate room [from] non-Roma women and the doctors explained to us that they have two rooms...one room without [a] doctor...and [in] that room are those persons who participated [in prenatal care] ...in the other room is a doctor...and it's for those persons who [were not in prenatal care] ... Roma [who didn't go to those check-ups], [were] in the second room... (National government employee 01)

Facilitators of Care

Social Support—If women could not afford to pay for their first prenatal visit, social support became critical in caring for their pregnancy and sometimes enabled them to seek care. Mothers and professionals discussed both women's level and quality of social support as influencing their pregnancy experience:

The network of mothers, like a secret society...if one physician was good...well that's set! Everybody will go to [that physician] ...because my friend was at the same one. This is how it happens. (Mother 06, Hungarian ethnicity, age 29, six children)

Women also talked about emotional support they received from spouses and other family members that made pregnancy easier to cope with:

The women are very [close] to each other...I think strong relationships [with] the other women [within] their families. And they help each other...they are a natural network in helping each other. (Social worker 01)

However, professionals discussed how informal support could take the place of prenatal services or healthcare advice. Women also sometimes discussed this replacement of formal services:

Most of the women have the family around them and the family [advises] them most of the times and they consider that this is enough... they take it as medical advice.(Gynaecologist 03)

Having a Health Mediator—Another source of social support and medical advice was their Roma Health Mediator. Roma Health Mediators focus much of their time on pregnancy and family planning and work with women to increase health literacy around prenatal care:

At the beginning, there was a low rate of accessing [prenatal care], but I believe that now, 80% of the persons I have counselled or worked with, I believe now they can handle on their own... (Roma health mediator 02)

With the Roma Health Mediator's knowledge of the healthcare system, they also helped uninsured women overcome transportation and monetary issues by accompanying them to visits and advocating for them:

The first [prenatal visit] must be paid, and [Roma women] don't have money... I tell them, 'you call me and we set up an appointment together and we'll go to the physician,'... We receive the paper, the medical certification that she is pregnant, and...we go to the Insurance House...they give us [insurance] for pregnant women...without a certification from the physician none of the uninsured women will benefit. (Roma health mediator 02)

Another role of the Roma health mediator is to create mutual understanding between patients and providers. When patients experience discrimination from healthcare providers, the mediator can intervene:

[The Roma women] end up complaining to the health mediator and the mediator will make an appointment... for her to go to the medical practice. She feels confident with the mediator because, 'I will go with the mediator and then somebody will definitely receive me.' (Local government policy worker 01)

Having a Doctor—One of the Roma Health Mediators' primary roles for pregnant women is to connect them with general practitioners. Many women talked about their pregnancy experience in conjunction with having or not having a doctor who referred them to a gynaecologist. Having a general practitioner is women's gateway into the healthcare system and insurance during pregnancy. While women recognised this, they were not able to go due to various barriers (i.e., transportation). Women's delivery experience was particularly influenced by them having a gynaecologist who advocated for them:

And I said yes, I do have a physician [at the good hospital] and I told [the nurse] the name of the physician and then she suddenly changed the tone of her voice: 'Of course, we'll go there.' And that's how I got there, with an excellent physician. (Mother 05, Romanian ethnicity, age 26, two children)

Discussion

This study describes results from a pilot project assessing the experience of pregnancy for women in rural Romania. We identified several key themes that impacted on women's pregnancy experiences including differing conceptualisations of pregnancy and prenatal care use between women and professionals, the significance of barriers related to socioeconomic and ethnic discrimination, and the importance of support from social networks and health mediators. By interviewing a diverse group of professionals and rural women, we can appreciate how women's pregnancy experiences are nuanced and uniquely informed by their socioeconomic and sociocultural situations.

Using the framework of intersectionality, we found that gender, poverty, rurality, and ethnic identity played a significant role in rural Romanian mothers' pregnancy experiences. Along the axis of gender, mothers and professionals discussed the challenges rural women faced managing their roles of mother, spouse, and employee. Mothers had to maintain the same level of activity late into pregnancy which may have implications for healthcare utilisation and prenatal health. Poverty and rurality severely limited mothers' healthcare utilisation. Specifically, women faced transport and economic barriers to accessing care, as well discrimination based on low socioeconomic position.

Ethnic identity, particularly Roma identity, acted as a barrier to care for Roma and non-Roma women. For example, some characteristics that made someone appear as a 'traditional' Roma were common among women in rural disadvantaged areas even if they did not self-identify as such. These women, Roma and non-Roma, had the same access to and utilisation of prenatal care, so they often experienced the discrimination and mistreatment that Roma women face. This confirms research which found that women say they often face discrimination from providers not by how they ethnically identify but by the ethnicity the provider perceives them to be (Reitmanova and Gustafson 2008). Discrimination based on race and gender is a common experience for Roma women, which often resulted in poor quality care (Colombini, Rechel and Mayhew 2012; Watson and Downe 2017). Both professionals and mothers reported that women that expected poor treatment avoided care, which reinforced service providers' and others' negative views towards these women, creating a cycle with negative consequences for pregnant women. Providers then formed negative views of these women, seeing them as incorrectly viewing pregnancy as natural and their views as being indicative of low health literacy, which other studies have shown (Janevic et al. 2011). Intersectionality theory provided a useful framework for understanding the interconnected nature of women's identity categories and their effect on women's healthcare utilisation, access to care, and treatment from medical providers.

Our study adds to literature by highlighting the distinctions between planned versus unplanned and wanted versus unwanted pregnancies (Borrero et al. 2015; Aiken and Potter 2013). Although many women did not plan their pregnancies, they reported that they wanted and found joy in them. Their views contrasted with professionals' who often conflated unplanned pregnancy with ambivalence. Our findings, while novel to Romania, are consistent with research with low-income and minority populations, which show that women often report happiness about pregnancy regardless of intentions (Aiken and Potter 2013; Borrero et al. 2015).

We found that mothers and professionals had differing prenatal care perceptions. Women viewed pregnancy as a normal condition that did not necessitate much medical attention, so they often went less than advised. This supports other research with low-income, minority ethnic women, which found that women often view pregnancy as natural and thus underutilise care (Lia-Hoagberg et al. 1990; Aiken and Potter 2013). However, mothers recognised the importance of prenatal care to their child's health and many went to some appointments. Some professionals claimed that women's limited prenatal care use was negligent and misinformed, exemplifying the misunderstanding between both groups.

Additionally, when women do not attend recommended care, their communication with providers is minimal, perpetuating this disconnect (Janevic et al. 2011; Watson and Downe 2017; Strickland and Strickland 1996). These findings indicate the need to improve communication between women and providers to mediate their perspectives.

Given the lack of communication between women and providers, professionals and women described the importance of Roma Health Mediators in navigating healthcare. Community health workers have been shown to increase healthcare access, knowledge about available services, and healthy behaviours (Andrews et al. 2004). Prior research with Roma women in Europe has found the Roma health mediator program to be particularly successful at increasing women's access to and use of care by changing harmful underlying mechanisms (i.e., discrimination), and through improving mutual understanding between patients and providers (Watson and Downe 2017). We found that mediators were engaged in informing women about prenatal care's availability and importance, accompanying women to appointments, and buffering the impact of discrimination. Importantly, non-Roma women that we spoke with benefited from these women's work as well. While this does not mean that all women in poor, rural areas benefit from the programme, it does showcase how women in this sociocultural environment may benefit from such services as they are often treated similarly by healthcare providers. In Romania, the Roma health mediator program, while effective, was decentralised in 2009 and has since experienced difficulties related to funding and local political will (Wamsiedel, Vincze and Ionescu 2012). One initiative now links mediators with community health nurses to provide social and health services for Roma and non-Roma women in rural areas (Norway Grants, 2016). Our findings suggest that expanding this initiative throughout Romania would be beneficial to other marginalised women in rural Romania who also experience difficulties when accessing maternity care (Kóczé 2009).

Limitations

Limitations to our study exist for both phases. In phase one, not all professionals conducted the interview in their native language, which may have prevented us from collecting rich data. However, we worked with the translator when analysing interviews conducted in professionals' second or third language to ensure accurate analysis. Also, professionals had varying levels of experience in rural communities, so their statements may not have been relevant to the setting of the women's interviews. In phase two, we had a small sample of mothers in one commune, some IDIs were short, and we did not interview women who only spoke Romani, which reduces our ability to transfer our findings. There was selection bias in which women spoke to us because we used a community leader to ensure community entrée.

Conclusion

Improving the pregnancy experiences of women in rural Romania necessitates an in-depth understanding of the social and structural environments where their pregnancies occur. We found that women and professionals had differing perspectives on pregnancy and prenatal care use, and that women experienced significant discrimination within the healthcare system. However, when mothers had social support, including positive experiences with

service providers and Roma Health Mediators, they developed better relationships with the system. This highlights the need to continue programs such as the Roma health mediator programme and to link women to care early in pregnancy. Using the lens of intersectionality, our study captured the importance of women's socioeconomic position, rurality, ethnicity, and gender, which should be explored in future studies within and outside of Romania. Talking with professionals, Roma, and non-Roma women gave us an in-depth perspective on rural women's pregnancy experiences and how best to work with communities to improve maternal health in rural Romania.

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Table 1

Professionals' demographic characteristics

Sector	Number
Healthcare workers	10
Academics	4
Social workers	10
Policy makers	6
NGO	19
Gender	
Male	16
Female	33
Experience (years)	
0–2	8
3–5	3
6–8	11
9–11	5
12+	22

Table 2

Demographic characteristics of mothers

Demographic Characteristic	Range
Age	24–39 years
Marital Status	9 Married
	3 Cohabiting
Years in locality	6–33
Years of Education	0–12
Ethnicity	7 Roma
	4 Romanian
	1 Hungarian
Pregnancies	2–6
Travel time to General Practitioner	5–90 minutes
Travel time to Gynaecologist	0.5–3 hours