

THE ROMANIAN INITIATIVE PROMOTING PAC

A qualitative study in Romania

Orăștie area, Hunedoara district,

2004

This study was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health of the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-00-00003-00 awarded to the CATALYST Consortium. The Consortium is a partnership between Pathfinder International and its partners, the Academy for Educational Development, the Centre for Development and Population Activities, Meridian Group International, Inc., and PROFAMILIA/Colombia.

The opinions expressed herein are those of the authors and respondents and do not reflect the opinions of the staff of the CATALYST Consortium or of the United States Agency for International Development.

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The Desiree Foundation and SECS wishes to sincerely thank the participants in each of the communities involved for allowing us to interview them and gather the data for these reports. We would like to acknowledge the women, men, and the medical providers for their participation. We also sincerely thank the CATALYST Consortium for their assistance in making this study possible.

TABLE OF CONTENTS:

	<u>Pag</u>
I. INTRODUCTION.....	
II. ROMANIAN CONTEXT.....	
III. METHODOLOGY.....	
IV. PRESENTATION OF RESULTS	
A. MAIN FINDINGS.....	
B. CULTURAL/RELIGIOUS INFLUENCES ON CHILD BEARING.....	
C. COUPLES DECISION MAKING REGARDING NEW PREGNANCY...	
D. EXPERIENCE WITH MODERN CONTRACEPTION, SIDE EFFECTS AND PARTNER INVOLVEMENT IN FP DECISION - MAKING	
E. SATISFACTION WITH PREVIOUS FP COUNSELING.....	
F. PERCEIVED ADVANTEGES AND DISADVANTEGES OF USING ABORTION	
G. SOURCES OF INFORMATION ABOUT BENEFITS OF FP (MODERN CONTRACEPTION)	
H. SOURCES OF INFORMATION ABOUT BENEFITS OF FP (MODERN CONTRACEPTION)	
V. CONCLUSIONS.....	21

LIST OF ABREVIASION

MOH – Ministry of Health

LHA – Local Health Authority

FP – Family Planning

FD – family doctor

CN – community nurse

RRHS – Romanian Reproductive Health Study, 1999

I. INTRODUCTION

The study was conducted as part of the "The Romanian Initiative promoting PAC" project implemented by the Society for Sexual and Contraceptive Education (SECS), with technical assistance and financial support from the CATALYST Consortium, USAID.

Postabortion Care is a critical health care service that can save women's lives. PAC services that are comprehensive, accessible and empathetic are crucial in order to meet the medical and emotional needs of women. Ultimately, the goal of comprehensive PAC services is to prevent both unwanted pregnancies and complications of unsafe abortion.

"The Romanian Initiative promoting PAC" is a pilot project, which aims to go beyond the basic FP training to design a system that could enable women to switch from abortion to modern contraception through provision of quality postabortion family planning services and continuous BCC activities at the community level.

SECS has commissioned the qualitative research to identify the key personal and institutional reasons that stand behind the figures showing that – despite previous interventions – abortion remains an important practice of controlling their fertility for a large number of women. This is why the main aim was to approach the phenomenon in a broader context, i.e. from the point of view of the experiences of women choosing to use or not use modern contraceptives (and risk an unwanted pregnancy), from the perspective of their partners, and as well as from the point of view of the local health care providers.

II. The Romanian Context

Socio-demographic Data¹

Romania is an Eastern European country, with a 21 680 974 population¹; women represents 51.3 % of the population; the drop of the fertility rate to 1.3² combined with the external migration, led to a 1.1 million decline in the total population since 1992.

The Romanian population consists of¹ 89 % Romanians, 7 % Hungarians, 2.5 % Roma³ and 1.5% other.



52.7 % of the population lives in urban areas¹. The literacy rate in the country is 97.4%¹.

Administratively, Romania has 41 districts.

Health system in Romania

At each district level exists a Local Health Authority as representative of the Ministry of Health.

Romania has a medical infrastructure with 42 339 physicians (an average of 18.9 physicians / 10 000 inhabitants or 569 people / physician) and 111 263 nurses (49.7 nurses / 10 000 inhabitants or 201 people / nurse)². There are 446 hospitals, 202 polyclinics (both situated in urban areas) and more that 15 000 family doctors (primary health care in urban and rural area).

Access to health care depends on the coverage by the National Health Insurance System (NHIS). Those covered by NHIS are registered on family doctors lists of patient. The NHIS covers curative treatments. For services related to prevention, the Ministry of Health developed 4 National Programs, out of which there is the “Mother and child Assistance National Health Program”. This Program includes the National Family Planning Program, implemented in collaboration with international donors (USAID, UNFPA) and Romanian NGOs (S.E.C.S.).

For people not covered by NHIS, a newly emerging professional community – the community nurses, ensures their access to the minimal package of medical services accessible for all. This new professional category started to function since 2003. They have a basic nursing background but their training as community workers is in the course of development.

¹ Source: National Census Data, 2002

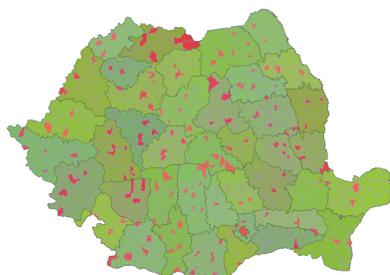
² Source: Romania Reproductive Health Survey, 1999

³ Source: National Census Data, 2002; ethnicity is self –declared; the roma population might be underestimated

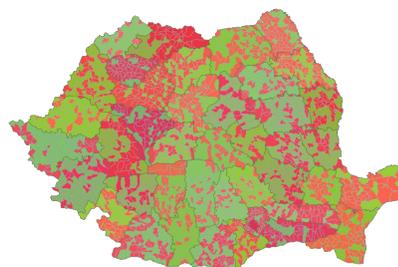
Family planning services - history:

- **After World War II:** Romania developed a liberal policy allowing abortion on demand up to 12 weeks of pregnancy, which was provided in every maternity hospital by Gynecologists. Also, during the period, the general shift in life style occurred from the previous agricultural life (with large family size) to the new industrial one (smaller family); new social norms developed with “better” families having no more than two children.
- **1967:** due to falling birth rates, **the communist régime forbid both induced abortion and modern contraception** (for example, the IUD became illegal both for medical providers to insert and for women to use). Legally, induced abortion remained accessible only for women with four or more children or being more than 40 years old or having medical conditions contraindicating pregnancy. Meanwhile, the country’s isolation stopped access to updated medical information including those referring to contraception (until 1989 there was no training regarding modern contraception for medical providers, for both doctors and nurses). In an environment completely lacking contraceptives, health related education in the educational system and a strongly reinforced law against abortion; the only available option for women to regulate their fertility was use of traditional contraceptive methods (withdrawal and rhythm) and clandestine abortion services, which mostly were unsafe. Despite, these regulations, Romania maintained a low fertility rate, with an average of 2.1 children / family. **The price paid was the very high maternal mortality (169 maternal death / 100 000 live births in 1989)**, mainly due to unsafe abortions
- **1989: abortion became legal up to 12 weeks of pregnancy** in an environment completely lacking contraceptives and basic information about modern contraception, both at the general population level and the medical provider level. **In 1990 4.3 abortions per every live birth were registered (almost 1.000.000 abortions during the year).**
- **1991:** first network of **6 nongovernmental FP clinics** opened by SECS (technical and financial support CEDPA, USAID)
- **1994: The National Family Planning Program** was designed and started to be implemented through coordinated efforts made jointly by the Ministry of Health and NGOs, with significant support coming from the international donors community (USAID, UNFPA).
- **1994:** a network of 241 governmental family planning clinics was opened by the Ministry of Health in urban areas to provide family planning services.
- **1997:** family doctors and their nurses (primary health care) started being trained in family planning in 5 districts.
- **2001:** the major donation of free of charge contraceptives done by UNFPA and USAID, followed by the purchase of contraceptives by the Ministry of Health. The National Logistic System for distributing free of charge contraceptives was implemented.
- **2002:** 13 new districts were included in the FP training program
- **2003:** The Ministry of Health launched “The Strategy in the field of Reproductive and Sexual Health”
- **2003:** the training program for primary health care providers (family doctors and nurses) and distribution of free of charge contraceptives became nation wide (at all districts level).

Romania – Provision of FP services (in red: communities covered with FP services):



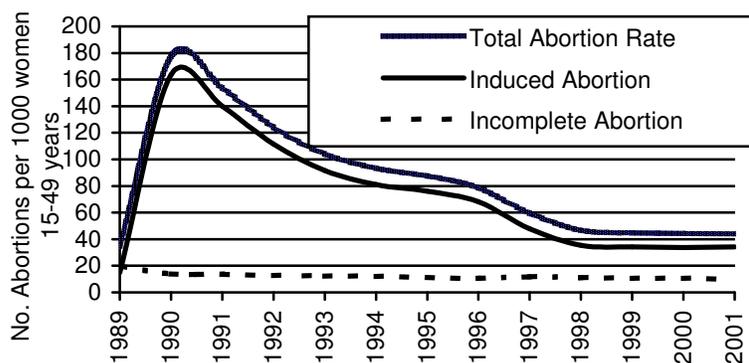
2001(only through FP clinics)



2004 (includes more than 3000 trained Family doctors in FP)

A rapidly expanding network of providers was created, access to free of charge contraceptives for a large segment of the population is ensured, but the use of contraceptives among the population living in rural areas and poor communities continues to be low, abortion remaining the main method of fertility regulation for this population segment.

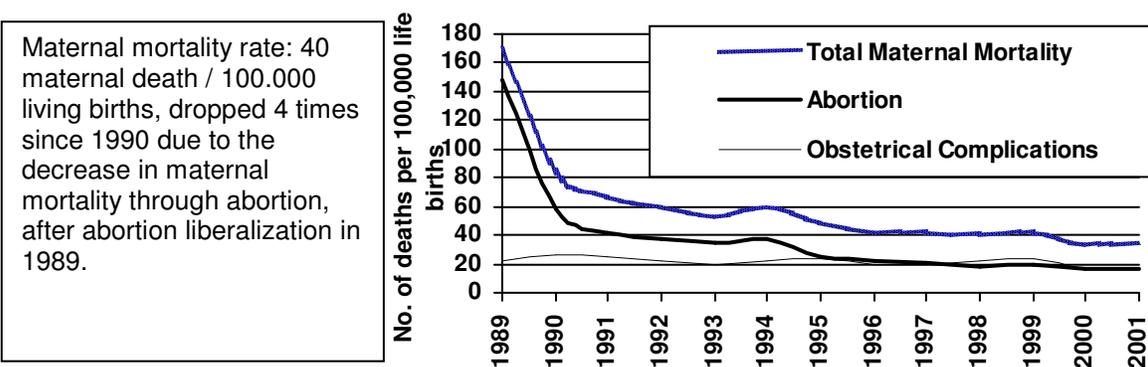
Evolution of Abortion Rate between 1989 and 2001



(Source: CCSSDM/MOHF and SSRR, 1999)

Abortions are provided by Gynecologists in outpatient hospital facilities and private practices. Main techniques are local anesthesia + vacuum aspiration plus curettage, or dilatation + curettage. After the abortion, women rest in the facility for 30 minutes, up to one hour.

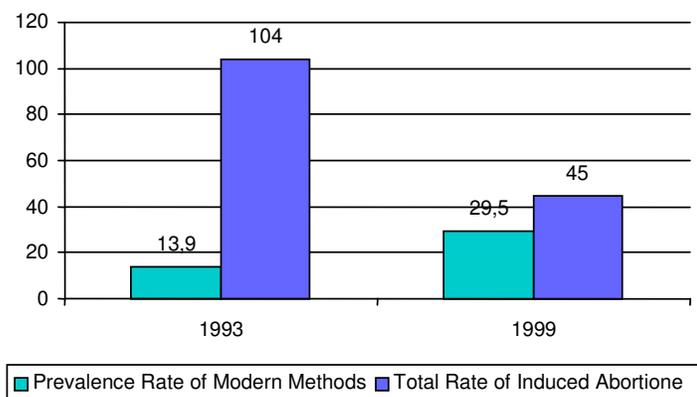
Evolution of Maternal Mortality between 1989 and 2001



(Source: CCSSDM/MOHF and RRHS,

1999)

Due to the increase of availability of FP services and FP information to the general population, an increase in modern contraceptive use occurred (from 13.9% in 1993 to 29.5 % in 1999), concomitant with the decrease of use of abortion:



(Source: CCSSDM/MOHF and RRHS, 1999)

For contraceptive use, the RRHS, 1999, (according to the data contained in the study, completed on a sample representative for the reproductive aged population in Romania, formed by women with ages between 14-44 and men with age from 15 to 49):

- Almost all the population (99%) has heard about at least one modern contraceptive method;
- Approximately 92% of the population has heard about the IUD; 55% of these know how it is used;
- 23,3% of women and 22,8% of men in Romania use modern contraceptive methods;
- 58% of the women and 52% of the men that are either married or cohabiting together without being legally married do not want any more children.
- 72% of the women and 61% of the men would like to receive more information regarding the contraceptive methods
- The rate of modern contraceptives used by married women, 15-49 years of age (%): 29,5
- The attitude of mothers towards the infant, % of unwanted children: 46,5

Training of medical providers:

Medical studies in Romania consist of 6 years after high school, followed by 1 year of internship. There is no formal FP training during this period (some Universities introduced an "optional" course for students, which is not followed by all students). After this period residency varies according to specialty (5 years for OG, 3 years for family doctor).

The FP training is done as a post university, 5 days, basic training. It is done by SECS with USAID, UNFPA support. It includes counseling, contraceptive technology and logistics.

AVAILABILITY OF FP SERVICES AND CONTRACEPTIVE METHODS

Contraceptives are available in Romania:

- Free of charge (through the National MOH program)
- For sale (through pharmacies and family planning clinics; condoms can be purchased also in many types of shops).

The National FP program of MOH distributes contraceptives free of charge through family planning clinics and general practice facilities (family doctors' clinics). To enter the distribution program, the FDs and their nurses go through the 5 days FP basic training course.

The distribution of free of charge contraceptives consists of:

- pills (monophasic),
- injectables (Depo Provera)
- condoms
- IUDs - available only in the family planning clinics (due to Romanian medical regulations)

The criteria for distributing free of charge contraceptives:

- Students
- Unemployed
- Beneficiaries of social security
- Rural area residence
- Women that go through an induced abortion performed in a state owned hospital
- Low income

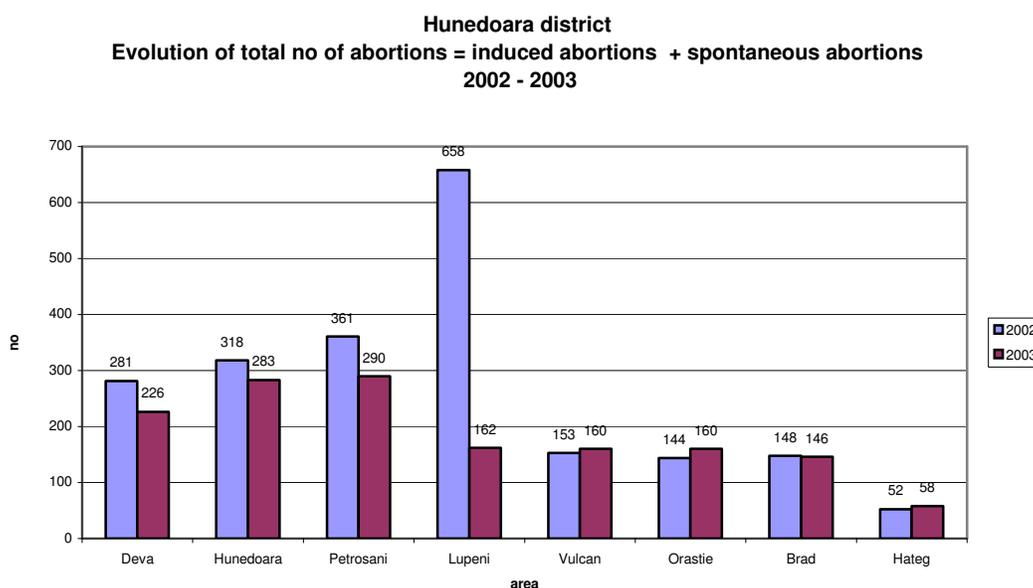
The community nurses do not distribute contraceptives (not even condoms).

Hunedoara district:

Hunedoara district is an average district (stable population 485 712²), with 92.7 % Romanians, 5.2% Hungarians, 1.4% Roma and 0.7 others. The district was included in the FP training program in 2002. Also, it is one the first districts to use community nurses.

The criteria for selecting the area for the research and the program implementation were decided with the Local Health Authority of Hunedoara district: one area in the district = a town and the surrounding rural communities, taking in consideration the following criteria:

- Existence in the area of all three medical structures (hospital, FD, CN)
- Existence of FDs trained in FP and distributing free of charge contraceptives for each community for at least one year
- Number of abortions unchanged during this period of time.



Using these criteria, in the district there are 4 areas where the abortion number did not drop during the past year. Three of these areas either had family doctors trained for less than a year, or there were no community nurses. The selected area became Orastie.

Orastie area:

Orastie has a 40 723³ total population, 69% living urban area (the distribution in urban / rural area is way above the country average). Data from the District Council (office for roma population) shows that there is a roma population of 3939 in the area (9.7 % of the population).

Almost 50% of all family doctors have been trained in FP (at least 1 FD/community) and started distributing free of charge contraceptives in April 2002. Despite this, according to

² Source: National Data Census, 2002

³ Source: Local Health Authority, July 2004

the available statistics – the number of abortions made at the state owned hospital increased from 140 in 2002 to 160 in 2003.

In the Orastie area the medical system includes:

- A state owned **hospital** (including a policlinic) based in Orastie,
- **23 general practices** in the primary health system both in urban (13) and the surrounding rural area (10)
- **2 private gynecological clinics** (provide counseling and prescription for contraceptives)
- **3 community nurses**

Availability of FP services and free of charge contraceptives:

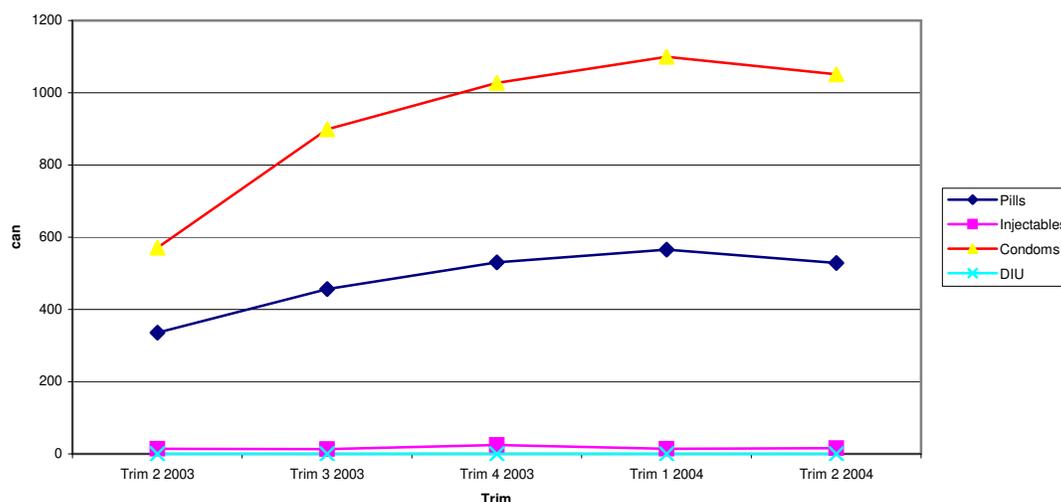
Hospital & policlinic: there are no contraceptives available. Years ago, a family planning clinic was functioning in the policlinic but was closed. The closest family planning clinic is at 30-40 km in the capital of the district.

Primary health care: 12 FDs are trained in FP and are distributing free of charge contraceptives. In the town and each rural community there is at least 1 FP provider: in the urban area 4 FDs (out of the 13 in the town) and 8 FD in the rural area (out of the 10 in the rural area). These FDs provides FP services also for patients who are not on their lists (patients without family doctor or on another FD's list, if that FD is not included in the FP program).

As there is no family planning clinic, for sale contraceptives are available only in the pharmacy.

Free of charge IUDs are not available in Orastie town (the closest family planning clinic distributing free of charge IUDs is at 30 – 40 km, in the capital of the district).

**Distribution of free of charge contraceptives
Orastie area QR 2 2003 - QRT 2 2004**



III. METHODOLOGY

This study was conceived as an exploratory qualitative study in a limited area (one town and the surrounding rural area). The goal of the study was to identify the opinions and practices, of women who had an abortion regarding birth spacing and family planning; their male partners and health care providers involved in reproductive health services.

Four detailed interview guidelines for each case (hospital staff, primary health care staff, community nurses, and women + men) were developed with CATALYST support. Our main principle – mainly in the case of the individual interviews – was to let the interviewees tell their stories by using their own terms, which reflect most properly the complexity of their lived experiences. Each focus group session / semi structured interview lasted one and a half hours using the corresponding guide.

The findings in this report are derived from focus groups and interviews conducted in the area of Orastie, Hunedoara district. Fieldwork took place from July 6 to July 20, 2004. One research team consisting of one professor on cultural anthropology and gender studies and seven members (MA in anthropology / gender studies or PhD students), were responsible for the work.

The participating population included women, which had at least one abortion or gave birth in the hospital of Orastie (and had abortions in their history) during 2003 and male partners, as well as health care providers of sexual and reproductive health services.

A combination of research methods has been used to provide a picture of health system issues and population needs: semi-structured interviews (for women / male partners and 3 doctors specialists obstetric – gynecology) and focus groups for medical providers.

Participants:

A) Medical providers:

The focus groups were organized by LHA who invited participants to the focus groups, taking into consideration professional responsibilities:

Focus groups held:

- 1 group: FDs trained in FP and distributing free of charge contraceptives (4 participants out of 12 trained in the area)
- 1 group: FDs not trained in FP and not distributing free of charge contraceptives (6 participants out of 11 in the area which has not been trained in FP)
- 1 group FDs' nurses (5 participants)
- 1 group: Nurses from the hospital (obstetrics – gynecology) (4 participants out of 8 in the OBY Gyn sector of the hospital)
- 1 group: Community nurses (9 participants – all 3 CNs from Orastie area + colleagues who work in the district of Hunedoara)

Interviews: The 3 gynecologists were contacted directly by the research team (out of the 3 OBY Gyn providing services in the area).

B) Women / male partners:

A meeting took place with LHA and the Director of the Orastie Hospital to get the approval to work with the medical records. The project and the research methodology were presented and discussed. Ethical issues as confidentiality and anonymity were discussed and guaranteed. The study for PAC clients was conducted using the hospital's past medical records.

From the 130 addresses, 53 women (25 from urban area and 28 from rural area) were found and accepted to be interviewed (during the 2 weeks of the field research). 21 male partners of these women were interviewed also (10 from urban area and 11 from rural area).

Consent: In Romania verbal consent is the common norm. Every person interviewed was explain that they are invited to respond to a set of questions that will assist us to learn more about peoples' knowledge, attitude, and practice of Reproductive health services. If they choose to participate, they will be asked to complete a verbal questionnaire. They were ensured that the information provided will be completely confidential, that their name will not appear on the questionnaire and that they will not be identified in any reports. Their name or personal identifying information will never be given to any other studies or businesses, or to any local health providers. Their participation in this project is completely voluntary. Subsequent to this consent, they may refuse to participate in or withdraw at any time.

Use of information: The information is meant to show ways of thinking and behaviors related to contraceptive use / abortion; the research aim is to identify conditions that facilitate or hinder contraception and the changes that could be made in the system in order to ensure access to reproductive health services for all the population.

The 'SAMPLE' and social context: women interweaved in this study do not represent a standard sample, because they were not selected using a sociological methodology and in this sense their group is not representative in the same way a sociological sample would be. But, the number of interviews performed and the in depth discussions with women and men chosen conform anthropological methodology, claims that the experiences and attitudes identified, adequately reflects certain patterns which appears and can be found in similar socio – economic contexts.

Demographics of the interviewed women who were using modern contraceptive methods at the time of our study

Out of the 53 interviewed women, 10 declared that they were using modern contraceptive methods at the time of our study: 7 Romanians (5 from urban, and 2 from rural areas), each of them graduating high school (12 grades), and 3 Roma (2 from urban, and 1 from rural areas), each of them graduating middle school (8 grades).

Out of this "sample" 4 were in their 20s, 5 in their 30s and 1 was in her 40s.

4 of the Romanian women were living in households financially sustained by the wages of their partners and their own maternal allowance, 2 of them were in better financial situation due to the fact that both partners earned regular wages. Our "sample" included only 1 Romanian family where they made a living only out of the maternal allowance. The Roma families from this "sample" used to earn money resulted from casual works, and from the social and child allowance.

Demographics of the interviewed women, who were not using modern contraceptive methods at the time of our study

Out of the 53 interviewed women, 43 declared that they were not using modern contraceptive methods at the time of our study. However, out of them 10 declared that they were using some sorts of modern methods in the past, interrupting this usage for several reasons. Out of these 43 women 20 were living in rural and 23 in urban areas.

Out of the 43 women who declared that they were not using modern contraceptive methods at the time of our study, 20 were Roma. Out of them 6 were living in rural, and 14 in urban areas, the majority from the latter category housed in ghetto-type residences without clean water, electricity, sanitation, heating.

The majority of the interviewed Roma women were born during the second part of the 1970s (8 women), or during the 1980s (5 women), so at the time of our study they were in their 30s or 20s. The former ones, usually graduating middle school (8 grades) in the past were having some jobs in the local state owned industries, but with their collapse they became unemployed. The latter ones, usually with 4 grades, never worked for wages, they were “housewife”. Our “sample” included also 3 women below the age of 20 (each of them with one child and pregnant at the time of our meeting), and 4 above the age of 40 (3 of them with 10 and 1 of them with 6 children).

All of the Roma women from our “sample” and their families are living on social allowance (*ajutor social*) and on the child allowance (*alocatia copilului*). At the time of our study their partners were also unemployed; beside the work performed for the local government (as an obligation to receive social allowance) they were working casually at different sites (usually according to the rules of the black market).

Out of the 43 interviewed women who declared that they were not using modern contraceptive methods at the time of our study, 22 were **Romanian**. Out of them 9 lived in urban and 13 in rural areas. Our “sample” included also 1 **Hungarian** woman living in a rural area.

At the time of our study out of these women 10 were in their 20s, 11 in their 30s and 2 in their 40s.

The majority of women from this “sample” (16) graduated high school (12 grades), 6 of them middle school (8 grades) and 1 of them 5 grades.

14 women from the studied cases were living in households supported by the wages earned or by both of the partners, or at least by the wages of these women’s partners and their own maternal allowance. Out of our “sample” 8 women were living in families without any secure income, based on the social and/or on the child allowance, and 1 (divorced) woman was making a living from her medical pension.

Out of these women 10 were having 2 children, 8 were having 1 child, 1 was having 3, 1 was having 4, 1 was having 5 and 1 was having 6 children, and 1 of them was not having any child.

Study Objectives:

- To identify the main reasons that stand behind women’s choice of using or not modern contraception (knowledge, beliefs, norms, customs, values)
- To identify the structure and functioning of local medical system (human resources, the services they offer, and the cooperation within and between different medical institutions).

- To identify the knowledge and attitudes of the medical staff (gynecologists, family doctors, nurses, and medical community nurses) regarding family planning including modern contraception

Findings from this study will allow SECS to adapt its FP training curriculum and BCC activities, both within the project and at a larger scale in its activities implemented all over Romania.

IV. PRESENTATION OF RESULTS

A. MAIN FINDINGS

Following the addresses, we found a world apart, isolated areas within the town of Orastie, certain streets and third category flats, even without water, heating or electric light or rural areas in very poor condition; In some rural areas, especially where religious groups supported from abroad created some sort of “community solidarity”, better conditions were found. Even in the most developed communities, our addresses took us to the most disadvantages families.

Most couples do not plan their future pregnancy, “it just happens”. Most persons stated the need to control the number and the moment to have children (to use “something” not to have more children “than they can take care of”).

Many women have some information regarding the availability of FP services and free of charge contraceptives, but do not access them for many reasons:

- Fear of side effects (Myths and misconceptions)
- Partners disapproval (mostly because of the same fear of side effects)
- Lack of information regarding their right/possibility to do so
- Their doctor not involved in the program
- Money (analyses or transportation)

Misconceptions about modern contraception represent the main reason for not using them.

Most people (women, men) and all medical providers consider abortion as being dangerous for many reasons, but still do not take an action to avoid it.

Often, preventing a pregnancy it is considered to be the men’s responsibility (“to take care” = withdrawal), but if the women get pregnant it is their turn to “solve the problem”.

Male partners has a great role in the decision making process regarding the use of contraception. There is a need to involve more men in the information campaigns regarding benefits of modern contraception.

Medical providers are seen as the most reliable source of information regarding FP.

B. CULTURAL/RELIGIOUS INFLUENCES ON CHILD BEARING

Cultural norms states that women are supposed to become pregnant and give birth:

“...As army is for men, childbearing is for us women...” (women, 34 years, rural area).

Children are considered a joy in the family and generally women and men wants to have children:

“...The house is empty without children...”

“...For the poor people this is the only joy: to have children...”

It is considered to be good to have more than 1 child, either for the child itself (*“...it is good to have 2 children, so they are not alone...”*), either, because of hard life conditions, *“...you cannot know what might happen to them...”* (women having 5 children, roma community).

Sometimes (this is especially the case of older women advising younger ones) it is considered a kind of investment:

“... You are going to have someone taking care of you when you are old...”

Boys are considered better than girls:

“...The boys will help you... with the girls you have to take care of them, what are they doing, it is more difficult...” (men, 25 years, roma, rural community).

Religion recommends as many children as they come. The orthodox religion does not accept family planning and any kind of modern contraception.

C. COUPLES DECISION MAKING REGARDING NEW PREGNANCIES

Based on the findings, couples do not plan and make a real decision regarding a future pregnancy: **pregnancy simply occurs**: *“...the children came one after another...”* or simply *“...God gave us the children...”* (women, rural area), explanation that doesn't have necessarily a religious fundament, but an explanation for their situation, through a divine factor that cannot be controlled.

Generally, sexual relations happen as a sexual pleasure for the couple (mostly men's), without any connection with planning a future pregnancy.

Usually sexual relations occur at the men's initiative and the women accepts it:

“...I never refused him. This is what supports the family. You do not refuse it even if you are not in the mood for it. It never happened to me to initiate it my self...” (women, 30 years, rural area).

Usually men considers that that it is their role (and right) to initiate sex but they are not forcing their partners to do it:

“...Usually, I, being a men, initiates sex, but it is up to her to agree or no...” (men, 25, roma, rural community)

In few cases (2), where women were involved in abusive relationships, they had to accept (fear of physical violence): the men initiates sex and has sex and it does not matter if she wants it or not:

“...I hate him: using me for so many years, like an animal...” (women, widow, rural area)

For the very few cases that planned to have a child, different reason were mentioned as factors that made them decide to have children; usually, the child is a mean to achieve something:

- Usually it is soon after marriage or after getting into a new relationship that women (more often than men) consider becoming pregnant (**as a fulfillment of they becoming mothers or somehow a recognition of their relation ship**). These are young, childless women or with one child, regardless of their material conditions or ethnic group. The partner would have preferred initially to postpone due to the economical conditions (to have a job, a house of their own). These are achievements difficult to reach for these couples so eventually men accept it.
- **A mean to get married: to convince their partner / their parents to accept a marriage** “...the key to marriage...” or “...we run away with the boy we love even if parents doesn't want to allow us...”: if the women gets pregnant the men has to marry her (or move together even if not going through a formal marriage) and parents has to accepts a relationship they disagree with.
- **To improve a relationship** (reason given by both women and men): some persons stated that they thought that having a child will solve their problems (like “...my husband was drinking and cheating on me and I thought that a child will bring him home...”, women); these are statements made by people describing an anterior relationship and they got separated after some time.

Sometimes it was the male partner who wanted to have a child and the women agrees with it to please the partner:

- “...I was happy that I gave him a child and now I don't use contraceptives because he wants another one...”(women)
- “...My husband wanted a son...” (women who did not want to have many children but gave birth to three daughters so continued to get pregnant hoping that the next one will be a boy)

According to the interviews, if planning a future pregnancy, both partners have to agree with it. Either the women initiate the discussion or get convinced, but the final decision (to get pregnant) belongs to the women.

Only in 2 cases, abusive relationships, the men let the women pregnant in purpose to keep them next to them (they took the decision without the women's “approval”).

None of the women or men interviewed mentioned advantages for postponing first pregnancy (or doing so). In this group, getting married and getting pregnant (not necessarily in this order) is a way of life: some couples talked about and decided to have a child soon after marriage, for most couples pregnancy it simply occurred.

One woman stated that she used a contraceptive method to space her children, after her first child: “...I thought it is no good to get pregnant again so soon...” (women, 30 years, rural community).

Most frequently, women and men take in consideration limiting their children; more exactly they take in consideration the disadvantages if they do not limit **because of economical conditions**: when they realize that they have difficulties to provide **basic needs** for the children they have (food, clothes) they consider they have to do “something” to prevent a future pregnancy.

Even in this conditions, some couples disregard any contraceptive method: one women explained that she has 7 children, 2 of them in state custody, she had not seen them for many years, if she will have more children she can send them also to the same place.

When planning future pregnancies (or limiting them), only very few of the women and men interviewed took in consideration children's future and well being (1 case in our sample)

"...We have 3 children... and you have to educate them, education costs money and we cannot afford another one..." (women, urban area)

In conclusion, pregnancies are not planned, they usually "happen". Most of these couples do not think about "planning" until they start avoiding a new pregnancy in order to limit their children, due to very precarious economical conditions.

D. EXPERIENCE WITH MODERN CONTRACEPTION, SIDE EFFECTS AND PARTNER INVOLVEMENT IN FP DECISION – MAKING

Personal positive experience:

Women who **use modern contraception** (although a small number in our group, 10 out of 53) are very satisfied with it. They emphasize that these methods provides them **protection, freedom, control:**

- *"...Life is hard; at least with them (contraceptives) we can protect ourselves..."* (women using pills)
- *"...I am very satisfied with this method, since I take them, I feel better..."* (woman using pills)
- *"...I feel better to know that I do not depend on him..."* (woman using pills)
- In one case the women referred also to an **increase in her personal sexual pleasure** *"...he uses condoms and with them I also get to feel well..."* (woman using condoms)

Personal negative experience:

Women that started using contraceptives and dropped out, complained about the side effects:

"...I got fat..." (woman that took pills)

"...I took them and I lost weight..." (woman that took pills)

"...I had terrible menstrual disorders..." (woman that used injectables)

It is usually side effects of contraceptive methods that make women stop using a certain method. Personal negative experiences are related to minor side effects occurring during the 3 first months of use. Without appropriate counseling women could not understand and accept these side effects and also had no other contraceptive alternative.

Community rumors about others' experience:

More that personal negative experience with modern contraception, all women and men not using modern contraception relates on a lot of misconceptions about side effects that are circulating in the community, influencing their decision to use them:

"...A women in the next village had an injection not to have children and she died..." (many women stated same rumor)

"...A women had an IUD and she got cancer..." (men)

"...She took pills and had a huge hemorrhage..." (woman)

"...People say that they can harm your health..." (women, men)

"...People say you can get fat..." (woman)

Indeed in the area one women died of cervical cancer (and had used injectables some times ago); everyone in the community got convinced that injectables were the cause of cancer.

These rumors and misconceptions are very strong in the community; as women and men are convinced that contraceptive methods are dangerous, they do not go to a medical provider to ask questions about them.

Medical providers confirmed *"...women consider less dangerous to have an abortion than risking the side effects of modern contraception..."*.

Partner involvement in FP decision making and support:

Male partners play a major role in the decision making about using or not one method or another and even in procuring the method.

Usually, couples using modern contraception, discussed about using a method and the partner agreed with it. In one case where the women "felt ashamed" to procure the method she sent the husband to the FD and *"...the doctor explained him how to take them..."* (pills).

When the male partner opposes the use of modern contraception it is mainly because of its potential believed harmful side effects; these couples are usually using withdrawal (most used method among these communities).

"...There are free of charge contraceptives but I prefer to take care..."
(*withdrawal*) (men)

The female partners of these men considers that contraception it is men's responsibility

"...The doctor told me that there are free contraceptives but I think it is the husband's responsibility to take care..." (women, roma community)

Usually these couples consider withdrawl as being a very efficient, no costs, easy to use and reliable method.

In some cases the partner opposed the use of contraceptives because he wants another child:

“...I wanted to use them and the doctor told me that he can give me free of charge but my husband wants another child...” (woman that got convinced to have another child to please the partner)

In the very few (2) abusive relationships where the men takes alone the decision to have another child, without women’s consent, he also disagrees with use of modern contraception *“...He wanted to get me pregnant in order to keep me with him...”*.

It is usual that “taking care” (withdrawal) is the male partners responsibility, but if the women get pregnant is “her turn” to solve the situation.

The negative personal experience (or rumors about others’ experience), the side effects related to contraceptive use lead to drop out and women / couples do not search anymore another modern contraceptive method. These negative personal experiences are usually related to: either women used “something” (usually pills), without counseling and got scared because of side effects, either their counseling did not include explanations related to side effects, or their counselors did not explain to them the available alternatives.

E. SATISFACTION WITH PREVIOUS FP SERVICES

Out of the 10 women using modern contraception at the time of the study, only two were getting their contraceptives from the family doctor (and one of them did not went herself to the doctors, send the partner who received the counseling on how they have to be used). Both of them considered themselves as being satisfied with the contraceptive supply, even if they did not understood much of it:

“...I do not know everything about this method but it is for free...” (women, 26 years, rural community)

Two women were breast-feeding but their doctor already initiated the discussions for FP/ using a contraceptive method:

“...The doctor already talked to me and he will give me contraceptives when I will finish the breast feeding...” (mother having a small infant, 30 years, rural community)

Some women complained about **quality of services**, as the main reason that stopped them to use modern contraception:

“...You had to wait a long time to get to the doctor...” (women, 19 years, urban area)

“...I went once to request an IUD insertion. They told I should come when it is my period. I came back when I was during my period they told me I should come other time. I had other 2 pregnancies after that, one child and one abortion...” (women, 30 years, urban area)

Cost & geographical distance issue:

Even if contraceptives are distributed free of charge, lab analyses asked by doctors on this occasion are not for free.

"...For our patients we know if they are healthy so we do not send them to lab analysis but for other people we have to send them..." (medical provider, rural area).

IUD free of charge is not available in the area, only in another town, 30 km away, which involves transportation costs. Even if the women get a free of charge IUD *"...the women should pay for the insertion and 200.000 lei (aprox. 7\$) could be prohibitive for some women (families that relies only on child support, which is also 200.000 lei/month...)"* (medical provider)

Many women talked about "recommendations" they received from doctors over time, banning them from using a certain method:

- *"... After cauterization the doctor forbade me to use condoms (and get pregnant, for at least one year..."* (woman)
- *"...The doctor said I should make my children quickly, one after the other one..."*
- *"...The doctor said he couldn't insert an IUD because I gave birth many times and my uterus is weak..."*
- *"...The doctor said I couldn't take because of...my glands, heart, varix, etc..."*

Most women consider satisfaction in terms of "getting the free product" and do not take in consideration quality of services. Nevertheless, quality of services may represent a barrier to access FP services.

F. PERCEIVED ADVANTAGES AND DISADVANTAGES OF USING ABORTION

Most women and men and all medical providers considers abortion "to be wrong", both for health risks and for moral consideration.

The vast majority of interviewed women admitted that they had at least one induced abortion; their opinions regarding abortion are related to their personal experience but also on the community's cultural/religious influences:

Perceived advantages:

The mainly perceived advantage of abortion is that it represents an immediate solution to a problem: *"You can get rid of an unwanted pregnancy"*.

People consider that confronted with an unwanted pregnancy it is a better solution to have an abortion than having a child you cannot support: *"if you do not want it (the child) it is better to have an abortion than to have him suffer"*

Also, for special categories (like women having more than 4 children) it is free of charge so for these women it is easier to make an abortion than to complicate their lives with using a contraceptive method.

A special consideration is for a woman in abusive couple relationship: the partner used to beat her and opposed her using contraceptives, trying to get her pregnant to keep her with him; when she was pregnant she would go and ask for an abortion without him knowing it!

Also, some women considers abortion as being less dangerous than risking side effects of contraception

Perceived disadvantages:

Almost all women & men and all medical providers consider abortion as having many disadvantages and risks:

- **Abortion is a danger for women's health, even for women's life:**

"...Abortion is dangerous for a women's health, they (women) should be informed what to do not to get there..." (men)

"...I know a young women who tried many things to abort and she died..." (woman)

"...In my village died a young women, my age, after an abortion..." (woman)

- **Abortion is a religious sin:**

"...It is like if you were killing a person..." (woman)

"...It is a sin..." (men)

"...I am criminal mother..." (woman)

- **Abortion can lead to psychological trauma:**

"...Women can suffer for a long time, they are more sensitive..." (men)

- **Abortion can jeopardize the couple relationship:**

"...After it (the abortion) my marriage didn't worked well any more; it was because of i...t"(1 woman)

Special consideration for post partum and breast-feeding women: many women said having an abortion soon after having another child: women received no counseling regarding return of fertility after birth, if they are breast-feeding or not, and when it is necessary to start a contraceptive method. Women rely on breast-feeding up to 1 year, and most of pregnancies occurred during this time end up with an abortion.

In the context of not using contraceptive methods, abortion is seen as the only concrete and reliable solution under the women's power and control. Especially if the women belong to the free of charge criteria established by the MOH (student, or already has 4 children, etc) and this alternative is perceived as easy to use, free of charge, not dangerous.

On the other hand, addressing medical services for an abortion (instead of looking for contraceptives) is part of a certain "health culture" dominating this group: health is defined by lack of disease and you go to the doctor for treatment but not for prevention, also expecting a concrete intervention from outside the situation.

Thinking in terms of “risk” or “sin” about abortion, seems a “luxury” for certain cases. These considerations are minimized in front of a situation when they have to take a decision and control their lives.

Partner’s acceptance is not necessarily important for the decision of making an abortion (even if we found a situation where he took the decision). Usually, the partner is either “convinced”, either – especially when this woman’s decision represents an act of resistance toward an abusive relationship, “*the partner doesn’t even have to know*”.

G. SOURCES OF INFORMATION ABOUT FP (MODERN CONTRACEPTION)

Women & men information about availability of services/commodities:

Most clients interviewed heard about the distribution of free of charge contraceptives:

“...Doctors distribute now free of charge contraceptives for poor people...”
(women, men).

Even though women and men who do not use modern contraceptives heard about the availability of FP services/contraceptives, many did not know that they can benefit from it:

“...They (the contraceptives) are not free for everyone...” (woman)

For many cases even if they knew that free of charge contraceptives were available they did not consider that they were having the right to request them, or because of their limited access (as their doctor being not involved in the program) thought that they could not do so.

Sources of information about FP:

Most women and men consider **medical providers (Oby Gyn, Fds and nurses, in this order)** as being the most reliable source of information.

Some women did not want to go to a doctor. They either discussed with **friends** “*...my colleagues told me and I started to use them (contraceptives) myself...*”, either decided alone: she “*...read **books and magazines** and went to the pharmacy and bought contraceptives...*” (woman, urban area).

Who should provide population’s information and counseling?

Even though most women and men consider medical providers to be their best source of information, medical providers (even if they do provide services) do not consider their role as being so important in informing and educating the population:

The hospital staff considers the FDs and the school to have the responsibility to inform the population: “*...We try to counsel them but it is sometimes useless because they were not informed before coming to us...*”. Also, family doctors should be involved and the nurse from the policlinic, but not the hospital nurses “*...who are busy and does not*

have the time, also they and not interested any more in these subjects and it is difficult to change their opinions..." (Oby Gyn).

The FDs considers that it is for the school to inform the young people (and it is not clear who should inform the rest of the population).

Also, medical providers states that especially in the urban area, *"...people have more information (from magazines, TV, internet), when they come to the clinic ask questions about side effects..."*.

H. MEDICAL PROVIDERS

Scientific evidence that medical providers are acquainted with to make decisions:

A) Medical providers not involved in the FP program:

All 3 gynecologists received FP information during their residency training (10 - 12 years ago). One of them also participated in a training course provided by SECS (also 10 - 12 years ago). No recent information since the initial training. They admitted that they are not acquainted with up dates regarding contraception and requested to be included in the first FP training course *"...to up date their knowledge, they are aware that probably many things changed..."*

The FDs and their nurses who are not involved in the distribution of free of charge contraceptives program have not received training in FP (at all). Neither the community nurses. Their opinions are based more on "cultural knowledge".

None of the medical providers had access to recent reference materials in PF.

B) Medical providers involved in the FP program:

The FDs and their nurses were trained by SECS using a 40 hours basic family planning curriculum. During the training, participants receive the "Essentials of Contraceptive Technology", edited by John Hopkins Univ. (Romanian version, done by SECS). No follow up was organized after the training (the training took place more than 1 year ago)

Preference of a FP method over another:

Medical providers not trained in FP (gynecologists and maternity nurses, family doctors and nurses, community nurses) expressed clear preferences (biased) toward one method or another:

The doctors' method of choice is the pill (even though they consider a lot of "contra indications" for their use: age, varix, obesity) and *"...who cannot get used to take pills on a daily basis should use an IUD..."*. These providers heard about injectables, but *"...had many patients with menstrual disorders because of them, up to complete amenorrhea and women got scared..."* (so they do consider injectables as being dangerous for health).

The nurses consider IUD to be more convenient (“...*easy to use*...”). Also they consider that “...*people do not want to use condom because it causes inconveniences*...”.

The community nurses did not express preferences about one FP method, but considered that they do know almost nothing about any method.

FDs trained in FP are less biased, affirm that they are willing to counsel and distribute any method, but they state “...*people do not want to use condoms*...” (so they distribute only pills, or vice versa).

Post abortion counseling:

No post abortion counseling is done at any level (hospital , FD clinics or community nurses). Usually women receive verbal recommendations of what to do after an abortion. Sometimes, Oby Gyn “recommends” the use of a method and they prescribe a contraceptive, the client has to purchase it from the local pharmacy. Usually after an abortion women do not go to the FD clinic; sometimes they talk with the community nurses or FD s nurses (if they happen to pass by).

Referrals among medical structures:

There is no formal, functioning referral system between the different medical structures; both gynecologists and FDs complained about the lack of collaboration among them. Providers do not reinforce messages given by another medical provider.

The community nurses collaborate with 3 FDs and with 1 nurse from the hospital. Apart these 3 FDs, some doctors heard about the existence of community nurses but did not know them (some did not even heard about them). Also, no doctor or nurse knew what the community nurses’ responsibilities are.

IV. CONCLUSIONS

The study carries important implications for the current and future efforts in improving access to FP in order to avoid unwanted pregnancies and therefore the risk of abortion, including unsafe abortion. Most people (women, men) consider abortion as being dangerous but not necessarily action is taken to avoid it.

- To maximize access to FP services, all FDs should be trained in FP service provision.
- Information on where and how to find FP services, and the criteria to access free of charge contraceptive should be included in the IEC activities
- Due to prevailing rumors and misconceptions, women and couples do not use FP methods and rather risk unwanted pregnancies. The information campaign should focus on benefits of modern contraception and dispelling of rumors and misconceptions.
- Male partners' involvement should be taken in consideration. Both the information campaign and the organization of services should target men also (not only women).
- Considering the population' major fear of modern contraception' side effects, and the respect for the medical opinion, efforts should be made so that all medical providers communicate same messages (need to train also staff from the hospital, OBY Gyn, to ensure coherence of messages and correct management of side effects)
- Medical providers skills to provide postabortion counseling at all levels (hospital staff + primary health care) should be improved; initial supply of contraceptive methods should be provided in the abortion department
- Information campaign should include advantages of postponing first pregnancy after 19 years of age, and spacing children 3 to 5 years apart.
- The relationship among different medical providers should be reestablished and a formal referral system should be introduced.
- As the population considers medical providers to be the most reliable source of information, nurses should be involved in providing information for the population in the IEC campaign.