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Roma Women's Reproductive Health as a Human Rights Issue in Romania

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ABSTRACT

My policy paper addresses the issue of Roma women's reproductive health in Romania as a socially and culturally determined phenomenon. I argue that this is shaped by structural discrimination, cultural prejudices, school segregation and abandonment, poverty, disparities in income distribution and unemployment, inadequate housing and food, lack of clean water and sanitation, lack of official documents and of medical insurance in many cases. As my ethnographic fieldwork shows, these conditions mean that women are subject to double discrimination, but are also agents able to use creative strategies for dealing with all of their private and public burdens, among them reproduction. At the same time, the issue of reproductive health is an issue of human rights, central to general well-being and crucial for achieving equity and social justice.

Reproductive rights of women include the right to access reproductive health care information and services, the right to sexuality education, to bodily integrity, the right to decide on the number of children and the time-spacing of births, and the right to decide on the contraceptive method most appropriate for their medical and social condition. As my primary research proves there are many structural and cultural factors within the health care system that limit the opportunities of de facto use of reproductive rights by Roma women. It also argues that the ethnic blindness of reproductive health policy and the gender blindness of Roma policy fail to serve Roma women properly. This is despite the fact that there are initiatives within the Romani movement in Romania, which aim to enhance women's rights and even discuss reproductive rights. But, on the whole, these initiatives have insufficient authority, prestige and financial resources in order to impose their perspective on (Roma and non-Roma) policy makers.

The stakeholders involved into the issue of reproductive health are the Ministry of Health, the National Agency for Roma of the Romanian Government, non-governmental organizations working in the domain of sexual education and reproductive health (like the Society for Sexual and Contraceptive Education, and the Romanian Family Health Initiative), but also Roma women's rights groups such as the Association of Roma Women from Romania, the Association for the Emancipation of Roma Women, and the Association of Gypsy Women for Our Children. At the same time, this issue is also of interest for the larger community of people dealing with Roma communities, among them Roma health mediators, Roma schools mediators, local Roma experts and other (formal or informal) community leaders.

The recommendations of my policy paper include the need to mainstream ethnicity into public health policy and mainstream gender within Roma policy in order to overcome the effects of discrimination in relation to reproductive rights and access to healthcare of Roma women. As such, they seek to contribute to the general aim of mainstreaming gender and ethnicity in all public policies from Romania. The proposal also aims to empower women within Roma communities and within the Roma movement in order to transform public discourse about women's body, sexuality and related rights into a legitimate issue. And last but not least, these recommendations are focused on excluding the emergence of a racist fertility control, which claims to provide Roma women with reproduction control methods while actually working to "prevent Roma over-population".

1. INTRODUCTION

1.A. Problem definition

Roma women's reproductive health as a human rights issue and a socially determined phenomenon

This policy paper¹ addresses the access of Roma women to reproductive health in Romania as a socially determined phenomenon and as an issue of human rights central for general well-being and crucial for achieving equity and social justice. It does not deal with the health situation of Roma in statistical terms. The report relies mostly on my primary ethnographic research, but in the background it also considers the available secondary sources regarding this situation.²

I subscribe to the definition of reproductive health as "a state of complete physical, mental and social well-being...in all matters relating to the reproductive system".³ In terms of physical well-being the mostly widely used indicators are: fertility rate, infant mortality rate, and maternal mortality rate, the proportion of births attended by skilled health personnel, contraceptive prevalence, and occurrence of abortions, uterine cancer and breast cancer.⁴ As is health in general, reproductive health in particular is socially and culturally conditioned. In the case of Roma communities it is shaped by structural discrimination, cultural prejudices, school segregation and school abandonment, poverty, disparities in income distribution and unemployment, inadequate housing and food, lack of clean water and sanitation, lack of official documents and of medical insurance in many cases. In my ethnographic research, I focused on the ways in which the use of contraceptives and abortion was shaped by Roma women's life conditions, by the cultural conceptions dominant within the investigated communities and by the nature and functioning of the local health care system, but, on another level, also by the existing public health and Roma policies.

Most importantly my policy study treats the issues of reproductive health as part of the problem of reproductive rights, and considers that reproductive rights include:

Women's "right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence",⁵

The right to the highest standard of reproductive health,

The right to have access to reproductive health care information and services,

The right to sexuality education and to bodily integrity,

The right to decide on the number of children and the time-spacing of births,

Women's right to decide on the contraceptive method most appropriate for her medical and social condition.

A whole range of stakeholders are involved in the issue of Roma women's reproductive health. Among them governmental agencies (most importantly the Ministry of Health and the National Agency for Roma of the Romanian Government), non-governmental organizations working in the domain of sexual education and reproductive health (like the Society for Sexual and Contraceptive Education, and the Romanian Family Health

Initiative), but also in the domain of Roma women's rights (like the Association of Roma Women from Romania, the Association for the Emancipation of Roma Women, and the Association of Gypsy Women for Our Children). This is also in the interest of a larger community of people dealing with Roma communities, among them Roma health mediators,

Roma schools mediators, local Roma experts and other (formal or informal) community leaders.

1.B. The importance of the problem

The impact of (the de facto lack of) reproductive rights on Roma women's life and on Roma communities

Reproductive health is defined and recognized by the international community and by the Romanian government as an important dimension of public health. But the human rights discourse has little impact on public talk and practices regarding reproductive health, and there is a limited concern with the poor access of Romani women to health care information and services.⁶ That is why there is a need to raise public awareness about reproductive health as a right within Roma policies and within public health policies, and secondly to consider the social determinants of Roma women's health and access to health care.

Reproductive rights are important because the presence or absence of these rights has a huge impact on how people live and die, on their physical security, bodily integrity, health, education, mobility, social and economic status and other factors that relate to poverty. Reproductive health underpin other goals relating to gender equality, maternal health, HIV and AIDS and poverty alleviation, and are crucial to the achievement of the goals overall.⁷

Women belonging to marginal groups (among them Romani communities) often lack the rights or opportunities to make choices around reproduction even if Romania's population control policy is legally ensuring these rights. Their general living conditions, the racism of the majority population inscribed among others into the public health care system, the pressures coming from their own family members, the existence of different social and cultural norms related to women's body and sexuality, to gender roles and relations, in particular to women's status or to the desired number of children may restrict their options. They may have difficulties accessing family planning services, or preventive medical consultations, or proper treatments of illnesses. They can easily become victims of the use of inappropriate contraceptive methods or of the destructive effects of repeated abortions, or even targets of a racist fertility control. The later argument shows that women's reproductive rights are not only referring to them as women, but are also strongly linked to the rights and the well-being of the Roma communities in general. As usually, in this case, too, women's issues are not concerning only women, but men and the whole community as well, so everybody must have the interest and the obligation to work on the improvement of their condition. On the other hand the advocacy for Roma women's reproductive health might contribute to the mainstreaming of gender into public (health) policies, in particular to generally advocate for women's reproductive rights.

1.C. Statement of intent

Mainstreaming gender and ethnicity in public policies. Ethnicizing reproductive health policy and gendering Roma policy

This paper aims to have a research-based contribution to the development of a reproductive health policy and of a Roma policy, to consider reproductive health as a human right of women and treat it as a socially and culturally determined phenomenon. The ethnic awareness of reproductive health policy and the gender awareness of Roma policy should be based on the recognition of the fact that ethnic and gender differences are not naturally given, but are produced, maintained and turned into inequalities by social and cultural mechanisms.

One of the conclusions of my policy paper is that women's reproductive rights is a highly sensitive issue within Roma communities, within the Roma movement, but also within the public health care services providers. That is why my recommendations are also referring to the need:

to empower women within the Roma communities and within the Roma movement in order to turn the public talk about women's body, sexuality and related rights into a legitimate issue; to exclude the emergence and functioning of a racist fertility control, which claims that it provides Roma women with reproduction control methods while actually is working with the aim of "preventing Roma over-population".

1.D. Methodology

This policy paper argues that (reproductive) health is determined socially, economically and culturally, and that problems related to it are also talking about the lack of reproductive rights, or, at least, about the lack of opportunities to make use of these rights. That is why the framework of my analysis is shaped by a social, cultural and critical approach. Otherwise the analysis is based on a primary empirical research done in the summer of 2004 (in cooperation with the Society for Sexual and Contraceptive Education from Cluj), and between June and December 2006 (with the support of the International Policy Fellowship Program).

As health in general, the state of reproductive health is shaped by the social and economic conditions of Roma women's life, but also by the cultural conceptions/prejudices about Roma women existing within their own groups and within the community of health care providers. I managed to reveal these aspects of the problem by the means of an ethnographic research done within local Roma groups and the local community of health care providers (family doctors, gynecologists, and medical assistants) in the city of Orastie from Hunedoara county. Participant observation and in-depth interviews were the main methods used at this stage of the research. The out-coming results are discussed in Chapter 2.A. The same techniques were used for identifying the perspectives related to the importance, strategies and limitations of representing Roma women's rights within several Roma non-governmental organizations from Cluj, Bucharest and Timisoara. They are presented in Chapter 2.B.

As the access to reproductive health depends also on how politics and policies treat this issue, in order to investigate documents reflecting the reproductive health policy and Roma policy from Romania I also used the method of discourse analysis. The aim was to identify how opened they were towards Roma women's health in particular and Roma women's condition in general. My participation on the Roma Health Conference organized in December 2005 by the Presidency of the Decade of Roma Inclusion in Bucharest made possible to get further ideas about the internal debates on gender-related issues and about the state of affairs in the development of current Roma policies. The out-coming results of this part of the research are presented in Chapters 3.A. and 3.B.

1.E. Paper overview

The analysis part of my policy paper (Chapter 2 and 3) refers to the causes, manifestations and effects of Roma women's lack of opportunities of de facto using their reproductive rights. It identifies the obstacles of the reproductive health services usage both from the perspective of Roma women's life conditions (2.A.a) and from the point of view of the health care system (2.A.b.). Additionally it shows that the Romanian reproductive health policies (3.A.), and the existing Roma policies (3.B.) are failing to respond to the interests and particular conditions of Roma women, and willingly or not transform them into an underserved and double discriminated group. Unfortunately the few initiatives for militating for Roma women's rights (2.B.) do not have yet the authority to impose a change in the way of thinking about and acting around this issue and to increase its legitimacy and prestige within the mainstream Roma policies.

The recommendation part of the paper (Chapter 4) formulates suggestions for non-governmental organizations and governmental agencies. These are related to the needed changes that might improve Roma women's real access to reproductive rights and reproductive health care information and services. Eventually they suggest the general necessity of mainstreaming ethnicity and gender in the Romanian public policies.

2. PROBLEM DESCRIPTION

2.A. Barriers of Roma women's access to reproductive health care services

2.A.a. Social conditions and cultural conceptions within Roma communities

One of the Roma communities from the city of Orăștie visited during my research was a traditional group whose members considered themselves as travelers and speak Romanes. They are called by local Romanians and other Roma as "corturari". The 40 persons, out of whom 10 are children below the age of 14, are living in 20 households and their houses without utilities (10 houses are having electricity) are situated on a hill (Dealul Bemilor), near the rubbish heap at the periphery of the city. Half of them are having the houses where they live in their properties, while others live together with their relatives. Nobody is employed, none of the children are enrolled into school, only 5% of the adults graduated primary school, and only 7 families are receiving social allowance for which they do community work. Some of them are occasionally working abroad, others are collecting plants during summer, and many do collect scrap-iron. 25% of people above the age of 14 do not possess identity card, and 10% of the total inhabitants do not have birth certificate. Up to other causes, the lack of identity cards is due to the fact that even if their houses were built by them or were inherited from their parents they are not having house contracts with the local administration and until when they are not paying taxes on these houses, identity cards are not going to be issued for those living there, who – moreover – as people without identity cards will not be eligible for receiving social allowance.

Due to the fact that they wear traditional Roma costumes and speak Romanes everywhere are easily identified as "Gypsies" and are exposed to discrimination and negative prejudices. They do have a family doctor, who informs women about the existence of contraceptives and distributes them for free. She thinks that she had the misfortune of becoming the Roma's

doctor due to the fact that she was a beginner in the city, but considers that the “corturar” Roma are more respectful and obedient than the non-traveler Gypsies living in the Digului district. In the last year the community nurse organized a meeting where contraception was discussed in the house of an older woman, the daughter of the former buljubasa.

Today girls marry only around the age of 20, being bought from their families by the groom’s kin; however the negotiations on their marriage might start earlier. Rules on virginity and female purity are very strict, and abortion is considered a big thin and shame on the woman. Parents consider being responsible for their children till they die and the young couples do move in their parent’s house.

Some of the “corturar” families which became wealthy due to their occasional migration for work to Spain or Italy were moving down from the hill into the city, buying houses on the streets nearby, but not part of the Digului district known in the city as the Gypsy neighborhood (“țigănime”).

Formally this community is ruled by a buljubasa, but today he happens to be a man who does not practice the traditional duties of such a leader, so the community is practically not represented by anyone and does not have access to the resources that are supposed to serve the Roma communities’ needs. When I met her, the already mentioned daughter of the former buljubasa, was very eager to take a role in the self-organizing effort of the community, because, as she said, a woman could deal better with this and this group of people is not going to be taken into consideration by anyone till will not have a leader. At her turn she might be empowered and backed up by Roma activists who are responsible for the distribution of resources among different Roma communities. It is a well-known fact throughout the whole city that this community did not benefit from any of the projects that were supposed to improve Roma’s life condition.

A family from this community, whose house was damaged by a huge storm in July 2005, was asking me to take pictures inside their house that might be presented to the mayor. They were supposed to receive some materials of construction to make the necessary reparations, but their repeated tries to approach the local administration was unsuccessful. That’s how and why it happened that, taking with me the photos, I went together with them to the mayor’s office where – after a few hours of being sent from one person to another (my Roma fellows were not allowed to go behind the hall for public relations, I was having some sort of green light due to my identity card) and of hearing all the possible prejudices about how Gypsies are lying and stealing and keep asking for help – we obtained a “firm” promise for delivering the necessary materials in two days. In the labyrinth of local administration I could meet – among others – the (female) director of the Public Service for Social Work, who got very excited when learned about the fact that my research was linked to the issue of reproduction and use of contraception. She exposed very quickly her ideas about the need of making a “campaign of fertility control” among Roma women (campanie de injectare) using the injectable contraceptives, being convinced that the main causes of Roma poverty (and of the troubles that the mayor’s office and she personally has to face day-by-day) were rooted in the Roma “over-population”.

Her discourse and attitude made me aware again of the fact that reproductive policy needs to delimitate very clear the issue of women’s reproductive rights from the issue of fertility control, and has to have mechanisms that prevent the transformation of the policy for reproductive rights into a racist policy of controlling population growth (or of excluding some from the right to procreate). At the same time, this experience convinced me once again about the need to address the issue of women’s (reproductive) rights in the context of the general Roma policy in a way, which reflects a clear standpoint on the relationship between

reproduction and Roma's harsh life condition and makes explicit the fact that the later could not be improved through restricting the growth of population because it has other causes than this.

The other urban Roma community investigated in the city of Orăștie, whose ancestors were brick-makers (cărămidari), were settled down in a ghetto-type location on the margins of the city near the river (in the district called Digului), close to the road that goes up to the hill where the "corturari" are living. The travelers are calling them "băieși", which is a denigrating term that refers to their inability of speaking Romanes and keeping alive Romani cultural traditions. In the total of 125 houses composed of 1-2 premises there are living 800 persons, grouped in 180 families, figures that give a sense about the high density of people living within this cramped space. 50% of the total population is composed of children below the age of 14, and 85% of the school-aged children are enrolled into schools. 135 families are living on social allowance performing community work on the behalf of the city (they are allowed very-very rarely to work in their own district). 15% do not possess identity card, and 2% do not have birth certificate. 10 men are employed as sweeper and 2 got jobs at one private brick-factory. 60% of the population does receive social allowance, 20% declare that they are collecting scrap-iron, almost 5% are collecting plants and 7% do receive pension. The majority of the later are having sick-pension, because, even those who were working 30-35 years were not at the age of retirement when the socialist industries collapsed at the beginning of the 1990s. The whole community has only one source of clean water, 80% of the houses do not have toilets of any kind, and the slop water is thrown out in the mound from the middle of the "street" or into the river (being a permanent source of infections and a cause of several illnesses). But at least 90% of the houses are having electricity.

In this community girls marry early and give birth at an early age, abandoning school at the age of 13-15. As a rule, they do not marry officially and feel free of choosing, but also of leaving their husbands and returning to their parents, together with their kids. Almost every woman from this community is having information about the modern contraceptive methods, but – due to many other reasons – they make several abortions during their life-time. In the spring of 2005 some women from this community were invited to an event organized by the Society for Sexual and Contraceptive Education in order to raise women's awareness about the existence of different contraceptive methods and about their right to choose the ones that are the most suitable for them.

Relationships within this community are structured by several factors, among them by economic differences. Poor people (defining themselves as desperate ones, "necăjiții") are taking loans from the wealthier families (named "cămătarii") and have to pay back the double of the credited amount. Those who are doing better – the families of the very few employed and of the retired people with pension – are proud of being Gypsies, of having a relatively acceptable life despite the fact of being Gypsies and of proving for everyone that a Gypsy is a good worker and a honorable man. They try to isolate themselves from the rest of community and do sustain at their turn the belief in the system of meritocracy within which, as they say, those who are lazy and do not want to work deserve to live in misery, "like a Gypsy". Moreover, they recognize the fact that one of the main obstacles of their inclusion into the Romanian society is rooted in the prejudices that treat them as members of a stigmatized community, and not as individuals who are different than the "stereotypical Roma". They are critical towards Romanians for this reason, among whom, – as they say – one may also find criminals and thefts and people living in misery. One man was even telling me that he is Gypsy for twice: once because he is of Gypsy origin and second because he was born in Romania. In the second part of his statement he was using the category of Gypsy as a general stigma in order to denigrate what's happening in Romania today.

One may observe that the meaning of Gypsiness is shifting from a proudly assumed identity to a stigma, so it functions as a category of classification even within one Roma community and also in the relationship between two different Roma communities. These multiple meanings of Gypsiness probable result from the parallel existence of the desire of self-respect and of the internalized stigmatization, from the ambivalence of identifying with a community and taking a distance from it at the same time, and from the latent will to find always an Other relative to whom one may feel properly. That's how I am trying to explain why someone self-identifying as a Gypsy, at the same time blames Gypsies for being dangerous, or dirty, or lazy or so on and so forth. While being there, we were warned from different directions about the “dangerousness” of the Other: that was stressed by “corturari” about “băieși”, and vice-versa, and within the “băieși” community by “necăjiți” about “cămătari”, and vice-versa.

People from this community do report acts of discrimination experienced whenever they apply for jobs and are declaring their address from Digului street, and/or discriminatory acts encountered by school children. It happens very often that Roma children are let failing a grade for three times to be sent afterwards to special schools where they accumulate even more disadvantages, or it happens that Roma children with high performances are undervalued to be excluded from the group of the leading pupils of their class. But, at least, this community has an informal representative and in the recent past did benefit from some supportive projects assuring different community services. Their representative was a candidate at the last local elections but, unfortunately did not receive enough votes. Moreover – even if he is recognized both by the community and by the local administration as Roma expert, and even if according to the governmental strategy for the improvement of Roma's situation a Roma expert should be hired in the local government – he is only used by the later as an informant about the community and as a mediator in several cases, but is not hired on a paid position and is not involved into decision-making. His wife is hired as a school mediator and the two of them together are committed to make a change in the situation of their community, and would like to get more support in terms of information and empowerment from Roma organizations distributing resources. They are convinced that Roma identity should be assumed proudly, that is why he is teaching the youngsters Romanes, collects money from selling scrape-iron for making them traditional costumes and takes Roma kids to several festivals where they are appreciated due to their dancing and singing abilities. Both of them consider that integration of Roma into the Romanian society should start with their inclusion, and that is why they cannot agree with any phenomenon of segregation wherever it occurs (schooling, housing, etc.). However, special programs and even affirmative action should be directed towards improving Roma's life conditions and empowering them by strengthening their self-esteem and cultural pride. Learning about how identification processes are going on and how the category of Gypsiness is structuring social relations I realized that one of the main obstacles of constructing a positive Roma identity is the ethnicization/racialization of negative social phenomenon (like poverty, criminality, lying, stealing, dirtiness, laziness and so on and so forth) and the internalization by Roma of the practices that are blaming the victim and are naturalizing/legitimizing acts of discrimination against them.

As far as women's reproductive rights are considered (including the right to decide on the number of children and the contraceptive method to be used) they might be assured legally, as it happens in Romania since December 1989, but for Roma women (as for any women belonging to disadvantaged groups) they do not guarantee their de facto access to resources that would ensure their reproductive health. Several factors are responsible for this situation, such as:

- women's and their family's economic condition;
- the nature of gender relations within the community;
- conceptions about women's role in the family and in public life, including their role in sexual relations and their body;
- conceptions about the proper number of children, girls and boys;
- religious belief that might criminalize not only abortion, but the use of any contraceptive method.

In the investigated communities almost everyone had some information about different contraceptive methods. The sources of information were the family doctors, the gynecologists, or women friends and neighbors. The latter and the circulating rumors were having a huge importance in shaping the opinion about the “proper” contraceptive method. Under the conditions of severe poverty – if they decided to use a contraceptive method – women started to take the ones that were distributed for free by the family doctor. In these cases their family doctors were part of the network coordinated by the County Health Directorate and went through courses regarding contraception. But they distributed only some sorts of contraceptives, like particular pills (that were available for free) and injectables. This means that choosing a method was not actually a free choice of women, and the decision was not taken according to their health conditions, but only according to the availability of specific methods. Injectables started to become very widespread. But women were not really informed about its side effects and they got scared about the lack of menstruation, complaining also about headache and wondering if this was not supposed to lead to sterility. On the other hand, the administration of injectables reinforced the cultural prejudices about Roma women within the physician community, as they were considered not being reliable for taking the pills regularly. As intrauterine devices were not available for free, and they might be administered only by gynecologists, Roma women did not consider them as an option. The use of condoms was unacceptable for them because they felt that they were not entitled to impose that on men, or even they considered it a method, which fits the needs of prostitutes.

Under the conditions of this limited access to preventive contraceptive methods abortion remained for very many Roma women “the best”, or at least the “most practical” solution for unwanted pregnancy. Even if they considered it a sin, it was still used as a handy intervention, one which otherwise harmonized with the dominant strategy of going to doctors. As going to doctor (and especially for reasons related to reproductive organs) might be an unpleasant event that is linked to several taboos regarding body and sexuality, and thinking and acting preventively is not really part of the dominant health culture generally in our society (and not only within Roma communities) abortion (as a concrete intervention in case of emergency) is more “favored” than the use of contraceptive methods (which impose, among others, a regular control and supervision, and involve more costs). The act of making an abortion sometimes is considered to be the manifestation of women's power, a moment that is controlled by her, which might be done secretly. Under these conditions its side effects are less or not at all considered.

The case of women who together with their family join some sort of neoprotestant church (and this is a phenomenon that becomes more and more usual within the Roma communities and implies a very strict community control) is totally different in these terms. From their point of view not only abortion, but also the use of any contraceptive method is a sin and – due to cultural reasons – contraception for them is not an available tool for controlling their own bodies and reproduction. Otherwise having many children is considered to be a reason for the proudness and powerfulness of the Roma family and masculinity of a man is judged according to the number of the children he made in a lifetime. Women who have to take care of their family and household, but also of the relationship between family and public

institutions (being in charge with taking children to school, to doctor, or to make the necessary arrangements at the mayor's office) might have other opinions about the "proper" number of children. But in the cases of communities where tradition is strongly shaping people's life and choices, their voice is hardly heard. They might have power to decide (and they do it secretly), but this power lacks authority and is considered an illegitimate one.

The prestige of tradition in the case of a vulnerable community functions also as an instrument of defense in the front of the racist prejudices and practices directed against it. That is why the issue of reproduction control is sensitive in the case of Roma groups (but in fact it is sensitive in the case of any social group during times when it wants to prove its strength through demographic indicators). Moreover, this is why it is important to stress that my policy paper considers reproductive rights as women's rights and makes recommendations for the improvement of women's access to contraceptive methods that assure their health. At the same time it emphasizes that this issue might not be treated separately from the general problem of women's status within Roma communities and should be linked to the empowerment of Roma women within the mainstream Roma movement.

2.A.b. The health care system

Interviews and focus groups were made with those local health care providers who had to deal with women's reproductive health: family doctors, gynecologists, their medical assistants, but also staff from the County Health Directorate, including the community medical assistants. It is to be mentioned that in the city where my research was done there was no Roma health mediator (a possible candidate was supposed to be initiated into this job starting with December 2005) and no centre for family planning. The role of the Roma health mediator was played by a community medical assistant. She was a woman not belonging to the community and did not have much authority nor in the eyes of the community, or in the eyes of the family doctors and gynecologists. Actually she hardly knew about her existence as she was directly subordinated to the County Health Directorate, having her own office, being mostly on the field and lacking the right to administer any medical treatment.

Out of the thirteen family doctors of the city of Orastie only four were part of the network through which contraceptives were distributed for free. The Roma communities were allocated to those who did belong to this network. But due to the huge number of their patients, to the administrative work related to the distribution of free contraceptives and to the fact that they do all this work on a voluntary basis, they do not really have time to offer a serious consultation in family planning. As already mentioned, they mostly advised Roma women to take injectables. On the base of my discussion with them, but also with their patients, I may conclude that besides the material conditions under which these women are living, there are many cultural beliefs and attitudes, which prevent women from the use of contraceptives, such as: the fear of becoming fat (resulting in the rejections of pills); the fear of cancer (resulting in the rejection of intrauterine devices); the fear of the deregulation of menstruation (rejection of injectables); the sexual taboos within the community (and the resulting fear of family and community control); the shyness in the front of medical doctors as stranger; the lack of confidence towards the health care system as part of the un-friendly state authority; the disregard of health under the harsh conditions of poverty; the dominant religious beliefs; the passive role of women in sexual relations (as a result of which men are supposed "to take care", but if they fail to do so, women are supposed to find a solution).

The three gynecologists of the city were working both at the public hospital, and at their own private clinics. Their prestige within the former location was quite reduced both materially

and symbolically. Their private enterprises went pretty well, but obviously Roma women – due to their financial conditions – could not benefit from the services of a better quality offered by this sector. At the public hospital the gynecology section was reduced to a department (the number of beds was drastically reduced due to the reduced number of births) and its material infrastructure was very old. Due to the marketization of the public health care gynecologists were paid according to a strictly defined norm, which did not include, for example, family planning consultation, the administration of intrauterine devices and the abortion on the patient's request. All this work was done on voluntary bases. As Roma women wanted to benefit from abortion services here (because they were more expensive in the private sector) among these physicians one could encounter even an anti-Roma attitude based on cultural prejudices about their „dirtiness”, „excessive fertility” and „stupidity”. But it is to be mentioned that one of these gynecologists (a man) was considered by Roma women whom I talked with as very “nice” and helpful. One of the conclusions I could make regarding what was happening there in the relationship between Roma patients and medical doctors was the phenomenon of ethnicization of particular services. Obviously, there were not only Roma women, but also impoverished majority women who were looking for abortion services in the public hospital. But as usually poverty and all the related and assumed characteristics ended up being considered as a sign of being Romaness, in this case abortion on request and the problems with the use of pills on a daily bases was Romanized as well.

All the mentioned characteristics of the local medical system are obstacles in the real access of Romani women to a health care of a good quality and, as a result, to the opportunities of de facto using their legally assured reproductive rights. They constitute the factors of structural discrimination of women on the base of their sex. In the case of Roma this discrimination becomes a double one, produced at the crossroads of their ethnicity and gender.

2.B. Representing and debating women's rights within the Romani movement

Besides the aspects discussed in Chapter 2.A. the analysis of Roma women's access to reproductive rights needs also to reflect on the extent to and way in which this issue is present on the agenda of the Roma movement. The state of affairs in reproductive rights is reflecting on the one hand the status of Romani women within their communities, and, on the other hand, is strongly shaped by the attention which is accorded generally to women's rights within the movement and within the broader social environment. That is why my policy paper has to refer to this dimension, too.

The rights based Roma discourse started to explore the gender dimension of racial discrimination and Roma women's situation quite recently. All this begun when the Specialist Group on Roma/Gypsies decided at its 7th meeting in Strasbourg (29-30 March 1999) to request a consultant to prepare an introductory report on this issue, but it was preceded by Roma women's organizational efforts at local levels. The report was made by Nicoleta Bițu.⁸ By then she worked at the Roma Centre for Social Intervention and Studies (Romani CRISS) in Bucharest and acted as an independent consultant on Romani women issues for the Network Women Program of the Open Society Institute. Now she is a senior policy consultant of the Roma Women's Initiative launched by the Network of Women's Program in 1999 (see at www.romawomensinitiatives.org).⁹ If in 1999 it was true that Roma women's associations were not having access to information at international level (as she observed), this is not the case any more. Moreover, the participation of Roma women in different international organizations empowered them to organize at national level. Some young women activists ended up working within international women's agencies, others were getting positions within international women's networks while keeping their local institutional

affiliations, and again others entered into national Roma organizations while being also involved into gender-related programs or even separate NGOs dealing with women-specific issues. But my paper is not aiming to analyze the developments of Roma women's movement, so I am not going to focus in details on it, there are other efforts that are doing this.¹⁰ However, I mentioned these models due to the fact that during my research I encountered cases that represent them. Nicoleta Bițu (whom I could not meet) is one who fits into the first model, Violeta Dumitru and Letiția Mark into the second one, and Mariana Buceanu, Magda Matache and Ioana Neagu into the last one. In the following paragraphs my paper will show how they organized and how the issue of Roma women's health entered into their attention.

Anyway, it is important to observe that organizing at international level was and remains crucial in terms of fighting for women's rights, and in particular for reproductive rights. Because the former is having the potential to empower those local women, who might not have enough legitimacy and authority within their own societies, respectively male-dominated Roma movements. And if this is true in general terms, it might be even more so in the case of reproductive rights, because this is a domain that affects very closely women's condition within their communities, where sexual taboos, virginity cult, arranged and early marriages, and domestic violence shape their position and opportunities.

Altogether, for example, the Roma Women's Forum organized by the Open Society Institute's Network Women's Program and the Roma Women's Initiative in 2003 in Budapest (preceding the conference "Roma in an Expanding Europe: Challenges for the Future", which concluded endorsing the "Decade of Roma Inclusion") had a huge importance in giving Roma women a place at the policy paper.¹¹ The out coming paper expresses very clearly the agenda of Roma women activists: "[they] do not want to create a separate movement of Romani women but rather seek to mainstream Roma women's issues into all levels and structures for both women and Roma". The recommendations of my policy paper are also formulated in this spirit.

The first woman's organization in Romania concentrating on Roma was founded in September 1996 in Bucharest. The Roma Women's Association from Romania (RWAR at www.romawomen.ro) is a nongovernmental, non-profit association directed by Violeta Dumitru. According to the RWAR statute, the main objective and mission of the organization is "to defend the rights of Roma women and support the development and expression of ethnic, cultural, linguistic, and religious identity of its members." The RWAR addresses the following issues: improve women's access to job opportunities; ensure the quality of educational opportunities; provide health care and reproductive health for women; provide social assistance; protect Roma women and children. It sees a possible balance between developing social programs that benefit the Roma community in general and between helping the emancipation of women. Concretely till now it run literacy programs, a program to teach Roma women skills which would enable them to find better paying jobs in the future, and health-related projects. Among the latter the one entitled "Information on contraception and familial planning in Roma communities", and the publication and distribution of the brochure "Information about Birth Control and Family Planning". RWAR is member of the Coalition for Health – Romania, and, as such, it promotes family planning as a strategy for reproductive health and partnership actions with governmental representatives and mass media.

In December 1999 RWAR organized the international conference "Public Policies and Romani Women in Central and East European Countries" with the support of the Open Society Institute. This brought together in Bucharest more than 20 Romani women from Bulgaria, Croatia, Hungary, Macedonia, Yugoslavia and Romania. The conference addressed the participation of Romani women in public life, and issues related to health and education.

The discussions focused on the status of Romani women at different levels of society, the existing resources on national and international level for promoting the rights of Romani women, and elements of a future strategy for Romani women in civil society, governmental and international organizations. Participants stressed the issue of discrimination and racism confronted by Roma women. They identified the following priorities for future work: a broader study and inventory of the projects addressing Romani women; integrating Romani women's issues into the Romani movement, women's rights movement, ecumenical movement, and the agendas of governments and international organizations; lobbying for the inclusion of Roma women's issues into the national strategies concerning Roma, and in the state policies concerning women's rights; increasing the participation of Romani women in decision-making bodies related to public policies concerning Roma and in political life; improving the level of leadership skills amongst Romani women; promoting policies that create more individual choices in relation to migration, family planning, culture and education; strengthening already existing Romani women's organizations, and supporting the creation of new organizations throughout the region. The participants recognized the need for specific measures to ensure equality between men and women and for creating more choices in relation to questions of family planning, domestic violence and prostitution. In order to implement these priorities, the participants decided to create a European network. The document presenting these aims was also signed by Roma activists from Romania: Violeta Dumitru and Mihaela Zătreanu from the Association of Roma Women in Romania, Letiția Mark from the Association of Gypsy Women for their Children, Mariana Buceanu and Nicoleta Bițu, by then working at Romani CRISS (Roma Center for Social Intervention and Studies), Lavinia Olmazu from Aven Amentza SATRA ASTRA, Salomeea Romanescu, school inspector, and Petre Florica, Cristea Mihaela, Osar Mariana, Gheorghe Marinela, Dinca Maria (community health mediators).

The Association of Gypsy Women for our Children was funded in 1997 in Timisoara by its president, Letiția Mark, and it functions as a grassroots organization very much integrated into the life of local Roma communities. She has a long history of Roma activism (started in 1993, when she was among the first militants for the education-related rights), characterized by a permanent struggle in-between local successes and lack of central recognition, and in-between important accomplishments and marginalization. This was probably due to the fact that she was always critical towards the dominant elite, but also due to her “white” appearance, that made many activists not accepting her as “proper” Roma, and – as she said – to being a divorced woman and a single mother, and not belonging to any of the dominant clans within the Roma movement. She never received any support from the national Roma organizations. In October 2005 Letiția Mark was elected as one of the three representatives of the International Roma Women Network (http://advocacynet.autoupdate.com/resource_view/link_366.html) into the European Roma and Travelers Forum. The Network was created in November 2002 to review the health of Roma women in Europe. At the first meeting in Vienna The Advocacy Project worked with the participants to develop their advocacy capacity and brainstorm what networking role they wanted to play at both a regional and international level. This was jointly sponsored by the Council of Europe, the Organization for Security and Co-operation in Europe (OSCE) and the European Union's Monitoring Centre on Racism and Xenophobia (EUMC).

As far as her local activism is considered, the Association led by her aims “to promote the Roma people in Romania’s social-political life with pride, without prejudices, by providing educational and cultural activities for Roma women and children”. Its biggest accomplishment was the establishment between 2000 and 2004 of the Roma Women’s House as a result of a Phare project and a partnership with the City Hall of Timișoara. The team coordinated by Letiția Mark transformed four walls into a warm space where women (and

their children) from the local Roma communities might meet, discuss and benefit of professional support in very many problems, including obtaining legal documents, jobs, health insurance, health education, information on reproduction and contraception, psychological counseling, social assistance and others. Education remains one of the central issues on which the Association is focusing, aiming, among many other things, to empower women by teaching them how to get self-confidence and how not to interiorize prejudices coming both from their own communities and from the larger society.

Romani Criss – Roma Center for Social Intervention and Studies was established in Bucharest in 1993 as a human rights organization, but also as one which campaigns for the design and implementation of public policy for the benefit of Roma communities. Through its (by-then) health department director, Mariana Buceanu Romani Criss had a crucial role in developing the policy for the improvement of Roma's access to health services. But also in implementing one of its major components, the occupation of Roma health mediator, which, in 2002 was introduced into the Romanian classification of occupations. Buceanu had an important role in promoting women into these jobs by defining the criteria of choosing the proper person for this position. Connected details are also discussed in Chapter 3.A. of this paper. My interviews at Romani Criss revealed many problematic aspects of dealing with reproductive health, there were even voices there, which considered that this issue came out as a result of an international pressure.

Magda Matache, the present executive director of Romani Criss was convinced about the fact that changes within Roma communities are going on slowly, and non-Roma, but also modernized Roma should not enforce so rigidly the agenda for change in the traditional communities. According to her opinion there is no Roma women's movement in Romania, but there are charismatic individuals who do a very important work on this domain. This is also due to the fact that women do not really believe in these things, and they do what they do in everyday life not because they like to do that, but because they assume that this is correct. She recognized that there were some pilot projects in Romania, which aimed to teach Roma women about contraceptives, but observed that many women did not want to go to gynecologists, they were ashamed, and the physicians might have been treating them in an embarrassing way, while others did not have financial resources for making such visits to doctors, and overall people did not have the culture of thinking preventively about their health. She stressed: "But anyway, women are open-minded, and we need to continue with making information campaigns both for them and for men. Still, should not forget about the great value that is put within Roma communities on having many children. So the issue of contraceptive methods should be put as an alternative to abortion and not as an alternative to making as many children as they want".

Daniel Rădulescu, in charge with the health department of Romani Criss emphasized that the health problems of Roma women did not differ so much from the health problem of non-Roma women, so they did not need special measures. He considered that the positive discrimination measures were not effective, because they reinforced the existing prejudices. By this he wanted to say that there were no specific Roma illnesses, and the Roma population was not more vulnerable in front of illnesses than the non-Roma one due to its „origins”. However, he recognized that Roma did not have a proper level of health education, and this was a specific problem, which needed to be explained by considering many factors, including racism and discrimination. Radulescu also considered that the issue of reproductive health was a delicate and difficult one. They had a project on this in 2003, but it was difficult to implement it, because in the community of traditional male leaders this was a taboo subject. They realized that women do talk about this among them in secret, but without the acceptance of the community one could not just enter and open up the discussion, so everybody should be careful about not enforcing these projects on communities that are not ready to accept them.

He considered that the biggest problem was that if a Roma woman went to the family doctor he or she would not have been informing her about her choices, but would have made her an injection, while nobody knew about its consequences and about its risks of leading to sterility.

The Association for the Emancipation of Roma Women was constituted in Cluj in 2000 mostly by young women enrolled into higher education. As its current president, Ioana Neagu mentioned, they encountered all kinds of attitudes among their male fellows, some of them even ridiculed the effort of establishing a women's organization. They knew about the existence of other Roma women's organizations in Bucharest and Timisoara, but had no contact with them, did not even know if they were really functioning, or what were they doing.

They had a campaign on family planning in several communities from the whole county and their strategy was that of presenting the use of modern contraceptives as an alternative to abortion, and aimed to make women understand that they were free to choose on the base of their information. As she said, women recognized the fact that they did not have the financial resources and the personal energies to sustain a big family, but they usually did this after becoming pregnant, so have resorted to abortion. On the base of her experiences, Ioana Neagu was reluctant in defining the main cause that made Roma women not using contraceptive methods. Was that tradition, or religious belief? In any case, she observed that even in communities where women used contraceptives before, after the influence of neo-protestant churches became stronger, they gave this up. Most importantly she stressed that one might not make general affirmations about the use of modern contraceptive methods by Roma women, but might observe that they might have problems in using them correctly, respectively in having the chance of using the most proper ones for their health condition.

She considered that there would be a need for making an education campaign within the community of health cares who have Roma patients, in order to make them aware about the conceptions Roma have about the female body, in particular about the fact that they associate its bottom part with dirtiness, or about male virility, or about the value of numerous children who make a family stronger. More information campaigns should be done within the Roma communities as well, involving both women and men. She strongly affirmed that Roma do not need special laws, but a mentality change, which would eliminate discrimination and internalized prejudices.

My research recognized the potential empowering ability of international organizations towards local women's organizing. However, it should be mentioned that there is a gap between the discourse and practices of international organizations, and those of the local ones, so the latter are still having huge difficulties in implementing these ideas within their national movements, and also within the communities where they work. The lack of financial resources, the lack of primary researches on which policy-making from below should be based, the reduced number of projects dealing with women-related issues, the resistance of central Roma organizations towards deconstructing traditions that subordinate women, the lack of cooperation between Roma and non-Roma women's organizations, and many other factors are responsible for the marginalization of Roma women's organizations. At its turn, at the level of NGOs, this phenomenon is reproducing women's discrimination on the base of their sex and ethnicity within their community and the broader society.

3. POLICY OPTIONS (EXISTING POLICIES)

3.A. Romanian policies on reproductive health

The abolition of the Ceausist anti-abortion law (a law that conferred, among others, the specificity of Romania among the by-then socialist states) was amid the very first issues on which, in December 1989, the new political leaders were focusing their attention. Abortion became legal if performed by a medical doctor upon a woman's request up to 14 weeks from the date of conception, no spousal consent, no mandatory counseling, no waiting period was required. One could suppose that – through this – “women's issues” were to be included among the priorities of the new regime. But this was not going to happen.

It was true that through this change women gained the formal right of controlling their body and reproduction. The fact that women really used this right is reflected by the following figures. In 1990 the number of registered abortions increased to 992.300 (from 193.100 in 1989), but the number of maternal death resulted from abortion decreased to 181 (from 545 in 1989). But it was also true that – through it – the new power achieved high popularity and for many years to come had not improving the medical system in a way in which this could have increased the access of women to modern contraceptive methods that might have assured their reproductive health. In 1993, when the first Reproductive Health Survey was made in Romania, only 57% of the married women were using contraceptive methods. 43% were using traditional methods (coitus interruptus, calendar) and only 14 % used modern methods. Repeated in 1997, the survey showed a change, the percentage of women using modern contraceptive methods increased to almost 30%.

A real concern with women's interest would not have turned the respect of women's right to control their body into the celebration of abortion as the gift of democracy. Instead it should have mean the development of a whole health care and educational system within which women – as responsible and accountable individuals – could decide on the most proper contraceptive method that might assure their own wellbeing. So, the very first change on this domain (which wanted to be recuperative) was actually a sign of excluding women as reproducers from those priorities of the new regime which were considered to be solved in a way that was concerned with the real interests of the involved individuals. Viewed from this point of view (too), the social order of the post-socialist Romanian “transition” is showing signs of exclusionary practices on the base of gender, which are observable from other perspectives as well.

Eventually the international pressure (like the loan agreement between World Bank and Romanian government in 1991, the financial support coming from the United Nation's Population Fund in 1997, and the need to harmonize the national legislation with the European on), and the local civic initiatives structured around it forced the Romanian national governments to introduce on their agenda the issue of reproductive health. As a result, some formal structures were constituted across the health care system and (but only in 1999!) family planning was integrated into the basic package of services provided to the population. The Strategy of the Ministry of Health on the domain of reproduction and sexuality (developed with the technical assistance of the World Health Organization and supported by the United Nations Fund for Population) was launched in 2003, as a result of which courses on family planning for family doctors and the distribution of free contraceptives started. The Strategy provided the framework within which the related legislation could have been developed. An important role in this process was and still is played by the Society for Sexual and Contraceptive Education (SECS), a nongovernmental organization with a centre in Bucharest and with several focal points across the country such as that from Cluj covering

many Transylvanian counties. SECS is currently involved in training the medical staff from primary health care level to become family planning providers, and provides technical assistance for Local Health Authorities to implement the national family planning program. This program aims to create an expanding network of medical providers in order to ensure the access to free of charge contraceptives for a large segment of population. SECS recognize that the use of contraceptives among the population living in smaller towns and rural areas continues to be low, abortion remaining the main method of fertility regulation for this population segment. SECS was involved in 1996 in the creation of the Coalition for Reproductive Health that – as part of its POLICY project – published a booklet entitled “Sănătatea Femeii – sănătatea națiunii” (The Health of Woman – the Health of the Nation), a title which suggests that a public talk in today’s Romania on women’s (reproductive) health is not treated explicitly in the (feminist) terms of women’s rights but in the context of the well-established national discourse. The latest booklet published by SECS entitled “Fiecare mamă și copil contează” (Each Mother and Child Counts) is aiming to make available information about contraceptive methods for a large segment of population, but – at least according to its title – is not addressing (and empowering) women as autonomous subjects located in particular social conditions, but as human bodies centering on their reproductive function.

Ultimately, in 2004 the Law regarding reproductive health and the medically assisted human reproduction was elaborated in Romania, which defines the issue of reproductive health and health of sexuality as a priority of the public health system, and discusses about these issues in terms of rights, but its discourse is mostly couple (family) than women-centered. As stated, these new regulations aim to reduce the number of unwanted pregnancies, of illegal abortions, of maternal mortality and abandoned children. By now, each woman who decides to make an abortion has to be informed appropriately in order to take a decision, doctors have to prove that they did this informing and women have to express their decision in a written form, and free provision of post-abortion contraception should be provided. Moreover, women should have yearly free access to one Papanicolau test.

The liberalization of abortion, the establishment of the family planning network, the provision of free contraceptives through the family doctor’s system, the above mentioned Strategy and Law, and the Law on violence against women, reflects the progresses achieved since 1990 in Romania. But still a lot should be done till all these formal provisions would function in reality and make a change in the reproductive health situation of women.¹² Furthermore, none of the mentioned documents and underlying policies are considering the particular situation of Romani women, so one may conclude that they are not aware (or do not care) about the existing ethnic inequalities, and about the social and cultural factors that transform Roma women into underserved category regarding the access to reproductive health, too. That is why my recommendations are structured – among others – around the recognition of the need for a change in this domain.

However, the problem of access of Roma to healthcare was addressed in a way in Romania, but in a broader context. The counselor of the minister of health and a representative of Romani Criss developed and presented in 2004 a strategy entitled the National Health Policies Relevant to Minority Inclusion. This program aimed to develop and strengthen a network of community nurses and Roma health mediators in order to improve Roma’s health condition and to involve different Roma representatives in finding solutions for these issues. Its goals are: “to implement the National Health Programs in 100% of the Roma communities, with special focus on preventive programs, health promotion, and health of child and family”; “to guarantee the access of 100% of the Roma communities to the primary medical, and pharmaceutical services, corresponding to the EU standards”; “to promote intercultural education among all categories of medical personnel nationwide”; and “to facilitate the

including in the health insurance system of the Roma not meeting the current legislative criteria due to objective reasons (lack of ID, poverty)". The regulations regarding the sex of the health mediator are promoting Roma women, but no emphasis is put here on Roma women's particular health problems, in particular on the obstacles of their access to health services, however they are recognized on the international scene. For example, the Organization for Security and Co-operation in Europe, the European Monitoring Centre on Racism and Xenophobia, and the Council of Europe was coordinating a joint project in 2003 that was arguing for the need of involving Roma women in developing policies specifically for women and to build better access to healthcare for Roma women and their communities alongside the principle of equality, non-discrimination, and participation. 13

Scholars and activists addressing the access to healthcare of Roma¹⁴ – besides the high rates of illness, lower life expectancy, and higher infant mortality – are also emphasizing that Roma women begin childbearing at a young age, and are having less access to preventive sexual and reproductive health information and care (including gynecological care, family planning and natal care). Among others, they stress the following reasons for this situation: Roma women tend to postpone attention to personal well-being in the interest of attending family care and the home (so obtaining contraception for themselves is among the last on their list of medical priorities); they are dominated by a feeling of shame when seeking help, especially if this requires a break in social codes of modesty; there are Roma customs that prevent women to seek care during or after pregnancy; under the circumstances of unequal gender relations women feel little power to choose when, with whom and with what form of protection, if any, to have sex; women are having fear of seeking medical care because they fear violence, abandonment or ostracism from their partner, family and community; and last, but not least, the stereotypical view that Roma women do not think of future, and other gender and ethnic stereotypes might cause health care workers not to offer family planning information and services, or provide information only on certain type of contraception. Recognizing that the effects of discriminatory healthcare are felt disproportionately by women (because it's women who typically bear principal responsibility for family health care and maintain the contact between Romani communities and public health services) it is urgently needed to include Roma women's perspectives and experiences into policies devised on the behalf of Roma, and – I would add – into policies devised on the behalf of women.

3.B. Strategy of the Government of Romania for Improving the Condition of the Roma

In Romania, in the 1992 census 409.723 people out of a total population of approximately 23 million identified themselves as Roma, and in the 2002 census the number of those self-identifying as Roma increased to 535.140, but unofficial estimates of the actual figure of Roma in Romania range between 1.8-2.5 million. Due to the large Romani population in Romania and the extremity of the situation of Roma there, many international organizations are focusing their attention on this issue. For example the European Roma Rights Centre has made Romania a priority country since beginning activity in 1996, and the European Union has been strongly critical of Romania's treatment of its Romani population. In its Regular Report on Romania's Progress towards Accession of November 8, 2000, for example, the European Commission stated that, "Roma remain subject to widespread discrimination throughout Romanian society. However, the government's commitment to addressing this situation remains low and there has been little substantial progress in this area since the last regular report."

The current situation of Romani communities should be viewed in the context of the socialist and pre-socialist legacy, too. Roma people were enslaved for a long period of time (the first

records of their enslavement in the provinces of Wallachia and Moldavia date from the mid-fourteenth century and they were liberated only by the second half of the nineteenth century) and even after continued to live on the margins of rural and urban communities. During the communist regime they were not recognized as national minorities, half of the Roma workers were employed in rural areas, the practice of their traditional jobs was on the limit of legality, and a state decree from 1970 identified them with the “dangers of social parasitism, anarchism and deviant behavior” being followed by measures aiming to eliminate nomadism. All these transformed Roma people (living in approximately forty “nations”, some of them keeping old cultural traditions and speaking Romani language) into a culturally undervalued and socially excluded category, whose “problems” – on the top of all these – were identified as problems of social underdevelopment, of “culture of poverty” and not as issues resulting from forced de-ethnicization and related structural racism and discrimination.

As many reports on the situation of Roma present, after the collapse of the Ceaușescu regime in December 1989, anti-Romani sentiment broke out in a wave of collective violence against Roma. Under the pressure of international organizations and internal Roma activism the “Strategy of the Government of Romania for Improving the Condition of the Roma” was published on April 25 2001, by the Ministry of Public Information. Since then the Strategy went through monitoring process both at the central

and local level, and reports are emphasizing the following.¹⁵ The document includes a commitment to ensuring the conditions necessary for Roma to have equal opportunities in obtaining a decent standard of living, as well as a commitment to the prevention of institutional and societal discrimination against Roma. The Strategy includes as “sectorial fields” of action “community development and administration”, “housing”, “social security”, “health care”, “economics”, “justice and public order”, “child welfare”, “education”, “culture and denominations” and “communication and civic involvement”. The overall time-frame of the Strategy is ten years (2001-2010), with the medium-term plan of action having a target of four years. While the general aims of the Strategy are for the most part noble in sentiment, there is a considerable lack of detail in the plans. For example, the goal of “including the Roma community leaders in the local administrative decision-making which affects the Roma” is to be welcomed, but the means of realizing this aim are not stated. The sections of the program on “Justice and public order” and “Education” are particularly weak. Revealed is the image of a passive state, viewing discrimination as solely the effect of laws, unwilling to act to address discriminatory acts, content to “observe” human rights without acting to guarantee that they are respected by all. Other measures implicitly rehash the prevailing view that Roma are to blame for the unsatisfactory human rights situation in Romania. Provisions on education are basically flawed. Similarly, the development of a family planning and contraceptive program within the set of targets to be achieved in health care suggests a lack of sensitivity in approaching the issue of Romani women and health care (see Action nr. 112, p.23). Another fundamental question raised by the Strategy in its present form is the question of resources. Nowhere in the Strategy document is the issue of funding addressed.

The “Decade for Ethnic Roma Inclusion” (an initiative of eight Governments in Central and Southeast Europe started as a joint initiative of the World Bank and the Open Society Institute) was launched in Romania in February 2005. Its activities will continue the above described National Strategy for Improving Ethnic Roma Situation and are focusing on increasing the access to education at all levels and to basic medical services, on the valuation of the Roma cultural heritage and on the improvement of living conditions in areas populated mainly by ethnic Roma. Starting with July 2005 Romania has the first Presidency of the Decade of Roma Inclusion, and obviously the National Agency for Roma of the Romanian Government plays a major role in this. Its aim is to give substance to the concept of Roma inclusion, and, among others, to coordinate the process of sharing the best practices in terms of Roma policies. At this point Romania is given as an example due to its program on Roma health mediators.¹⁶ But debates about its efficiency, results and limitations – related to broader debates about the advantages and disadvantages of affirmative action (in Romania called “positive discrimination”) – become more and stronger. The National Agency for Roma – also on the base of the difficulties encountered by the implementation of the already mentioned Strategy – considers that its time to link the mainstreaming and targeting strategies, and even more, to emphasize mostly the former as the proper one for ending the isolation of Roma. They consider that Roma do not need special treatment, because special treatment reinforces dependency and isolation, and re-produces the prejudice according to which Roma issues are a set of problem separated from the rest of the society. Instead, they propose for the Decade to develop the concept of mainstreaming and the resulting policies, which are supposed to be based on the conviction according to which the role of promoting inclusion belongs to all state authorities, and the agency for Roma should have a coordinating role making sure that Roma are taken into account in each areas of public policy.

Neither the Strategy, or other documents reflecting the basic orientation of Roma policy in Romania are taking seriously the issue of gender relations and of the unequal power relations between women and men within the Romani communities, and do not reflect on the types of discrimination experienced by Roma women in the Romanian society. That is why the need

for a gender aware Roma policy should be strongly emphasized. This should address the Roma-woman-specific types of discriminations, both those coming from the outside of Roma communities, and those generated within them. For sure, issues like those related to childbearing, mothering, abortion, use of contraception and reproductive health are ones through which the hardships of Roma women are lived out as particular experiences which are required to be addressed explicitly. The recent orientation towards mainstreaming mentioned above could be used within the Roma movement to argue for the need of another mainstreaming, that of gender into Roma policies. But I would say that this does not replace altogether the policy of targeting Roma women's special needs with affirmative action measures, mainly because the implementation of mainstreaming policy would take a very long time and because women militating for women's rights are hardly involved into policy making.

The Conference on Roma Health organized in December 2005 in Bucharest – on which I participated due to my International Policy Fellowship grant – proved that central Roma agencies consider that they should not overemphasize the issue of women's reproductive health as international agencies do mostly due to the forced sterilization cases in Slovakia. I realized again that, obviously, reproductive rights are a highly sensitive issue within the Roma communities and movement. However, this is not only because they might be instrumentalized for the sake of actions against Roma reproduction and, misused, might be transformed into an alibi for fertility control. But this is also due to the fact that some Roma leaders interpret them in the terms of an attack against Roma traditions regarding the “proper” number of children or to women's role and sexuality, or, moreover, as an assault against the unity of the movement. The fears regarding the assimilation of reproductive rights with fertility control are completed by the suspicions around the risk of treating family planning (alongside with sexual disease) as a Roma issue and around reproducing the negative prejudices about Roma. In this context it was affirmed: it is not acceptable that if Roma families are having four children, the latter are considered to be unwanted ones. We should not forget that infantile mortality within Roma communities is of 16% and the Roma minority could maintain itself due to the fact that we dared to make five or six children, or more. Suspicions regarding the need of statistics disaggregated on the grounds of ethnicity (not to talk about gender) were formulated in the same context. From the side of the international organizations the following perspective was formulated: The reaction to the so-called “overemphasis” of women's reproductive health was probably due to the fact that in the first part of the day the participants discussed this issue. It is not that reproductive health would not be important, because, for example maternal mortality in the case of Roma women is of 28%. The problem is that this is discussed in wrong terms, due to which reproductive health is associated with family planning, and with forced sterilization and fertility control. We should define reproductive rights more broadly and consider them alongside the right to work, the right to non-discrimination, and the right to have decent living conditions. Even if – as mentioned at Chapter 2.B. – there are Roma women's initiatives in Romania that militate for women's rights, their voice was not heard at this meeting. The issue of reproductive health as reproductive right was formulated as such by representatives of international organizations. They were those who also emphasized: Roma health mediators are a way to empower women. But seemingly there was no consensus on this among the participants of the conference. However, initially, when this institution was established, the decision regarding the sex of Roma health mediator was taken on the base of the following arguments:

woman is the one who maintains contacts with the gadje world (mayor's office, school, doctors), she takes the children to doctors and send her husband as well, even if she is not taking care so much of herself, and when she would think about buying contraceptives, she would better think about using that money for the sake of her children

in terms of health issues one may enter most successfully into the community through women, because they take care of their families; due to the fact that health mediators are supposed to inform the community about their rights and their access to medical information and services it is good if they are women, because in this way they may contact women easier

through health mediators it is possible to identify women's needs, and also to promote women in public roles, while recognizing their role in the family, in the community and in the broader Roma movement.

Within this context the debate about Roma health mediators is important because it is linked to a series of other issues, like: women's role in Roma communities, women's presence in the Romani movement, advantages and disadvantages of affirmative action, negotiations between and within governmental agencies and Roma non-governmental organizations, the governmental involvement into solving the problems of Roma communities. That is why it should be within the focus of policies regarding Roma women's reproductive rights.

4. CONCLUSIONS AND RECOMMENDATIONS

4.A. Conclusions

4.A.a. The policy problem

My initial project defined the policy problem as the lack of real access of Romani women to reproductive health, asking how a gender conscious Roma policy and an ethnic aware reproductive policy might serve it better. But now, in the light of my fieldwork experiences I would like to emphasize another aspect of this issue. Since last year, when I visited the same settlement, the access of Roma women to free contraceptives increased, the injectable became the most wide-spread fertility control method that is "suggested" and administered to Roma women by family doctors.

I am observing here the risk of turning the women-centered reproduction policy (which aims to assure that women, including Roma women, are really using their reproductive rights as a right to control their own life and body, including the right to decide on the contraceptive method that is the most proper for their health and lifestyle) into an instrument of structural (and hidden) racism by which one may "prevent" the Roma "over-population".

In my research proposal I was emphasizing that the policy recommendations to be made are going to have a contribution to the development of a (reproductive) health policy aware of ethnic differences and inequalities as produced by the social and cultural system, and able to overcome the effects of discrimination in relation to access to healthcare for Roma. Now I would like to add to this that this policy would need to function in a way that excludes the risk of becoming a mechanism, which reproduces racism by practicing and hiding it under the surface of a "humanitarian aid" (claiming that it provides Roma women with reproduction control methods while actually is concerned with "preventing Roma over-population").

4.A.b. The context of the problem

The context of the real access of Roma women to reproductive health understood as reproductive right is composed by several social, economic and cultural factors, among them the following:

The general life conditions of Roma communities (including a whole set of social and economic problems, starting from the lack of proper housing, through the non-access to education, to unemployment), under the conditions of which the concern for Roma women's reproductive health is defined as a luxury and non-important issue even by women themselves and under which circumstances even Roma women are internalizing the "explanation" according to which population growth is the casual determinant of poverty.

The mistreatment of Roma communities as a cultural group by the majority population, using "culture" and "cultural difference" to legitimate discrimination and negative prejudices against Roma (women) as if these would be the "natural" consequences and not the structural causes of Roma's life circumstances.

The gender regimes dominant within Roma communities, including power relations between women and men, and cultural conceptions about Roma women's role in family and larger community, about women's body, sexuality, childbearing, abortion, contraception and so on and so forth.

The ethnic-blind reproductive health policy (including the National Strategy of Reproductive Health and Sexuality adopted by the Ministry of Health in 2004 as the strategy in the field of public health) and the actual functioning of the medical healthcare system which turns Roma women into an underserved social category, and/or, moreover, exposes them to the risk of being treated as instruments for a racist "Roma fertility control".

The actual functioning of the gender-blind Governmental strategy for the improvement of the situation of Roma from Romania (adopted in 2001), which, generally speaking has many insufficiencies (like not assuring the presence of a Roma expert in the local administration), and which, in particular, neglects Roma women's needs and interests reproducing their status of minority within a minority group.

The malfunctions of the communication and cooperation between central and local Roma organizations and experts, as a result of which local people might not be supported properly in their efforts to get information and resources for their activities on the behalf of their immediate communities.

The marginalization of Roma women's activists within the larger movement for Roma rights, the lack of authority and prestige of women's issues, including women's reproductive rights within the mainstream Roma policies.

4.B. Policy recommendations

4.B.a. Principles guiding my policy recommendations

Women's right to reproductive health (as part of reproductive rights) is a human right, so every woman must be able to use this right regardless of her ethnicity, age, social position and sexual orientation.

The application of the principle of equality between women of different ethnicity in terms of access to reproductive health is not enough in order to counter-balance the structural discrimination to which Roma women are exposed, so there is a need of affirmative action measures that could really assure equal opportunities and equal outcomes in this domain (too). The medical services provided must be based on the respect of human dignity and individual choice of those seeking for (reproductive) healthcare regardless of their ethnicity, and – as far as Roma women are concerned – healthcare providers must avoid racist practices that subsume contraception to the aim of “preventing Roma over-population”.

The well-being of Roma communities is part of the welfare of the larger community within which they live, so it is not only the responsibility of the former to “integrate”, but also the duty of the later to change its discriminatory attitudes towards Roma.

The principle of equity and participation should guide the involvement of Roma women (and not only activist Roma women) on decision-making at different sites (including family, doctor-patient relation, different central and local governmental institutions, Roma organizations, and so on and so forth).

4.B.b. Expected changes

The improvement of the (reproductive) healthcare policy and system in order to respond to the needs of the underserved Roma women (including the anti-racist cultural education of healthcare providers and of other authorities whose jobs are linked to Roma communities, ex. of those working at the Public Service for Social Work of the local government).

The treatment of the issue of access of Roma women to reproductive health as an integral and important part of the conditions under which Roma communities are living and on which strategies of improvement should be applied,

The avoidance of explaining poverty through population growth but instead – while respecting Roma women's reproductive rights – identifying the social and cultural factors (including racism), which exclude Roma communities from elementary resources necessary for a decent life.

The empowerment of Roma women as a result of which they might be enabled to claim their (reproductive) rights within their own communities and within their broader social environment (among others, empowering their self-organizing capacities, increasing their participation on decision-making at different levels, and eventually mainstreaming their activities within the larger Roma movement).

4.B.c. Policy recommendations

My policy recommendations might be subsumed under a larger heading, which refers to the need of mainstreaming ethnicity and gender into the Romanian public policies. This idea reflects the recognition of the fact that Roma women's issues (among them their reproductive health understood as reproductive right) are an integral part – on the one hand – of the broader problems faced by Roma communities and – on the other hand – of the larger issues faced by women from Romania.

Roma women's issues should be treated as such because otherwise their solutions would be only partial and not efficient enough. That is why there is a need for mainstreaming ethnicity or ethnicizing public policies, which means the necessity to analyze each public policy (including reproductive health policy) from the point of view of its impact on different ethnic groups living under different social conditions. On the other hand, there is a need for mainstreaming gender, meaning that public policies (among them Roma policies) should be gendered, or, differently put, should be assessed from the perspective of their impact on both women and men.

Subsumed to these broader aims, I am formulating the following policy recommendations related to Roma women's reproductive health understood as a human right.

General recommendations (for governmental agencies, for non-governmental organizations working on the domain of Roma rights and reproduction/sexual education/contraception, for donors)

The reproductive health policy should be aware of ethnic differences and of the inequalities between women of different ethnicity, in particular of the social and cultural factors that turn Roma women into underserved categories. This links the issue of reproductive health of Roma women to rights regarding proper housing (including satisfactory sanitation infrastructure), education and employment, and to the right of living in dignity, of not being exposed to different forms of cultural devaluation and social exclusion.

The reproductive health policy should include mechanisms of self-control in order to eliminate those factors that expose Roma women to the risk of becoming the subject of racist manipulations, and in order to avoid the transformation of the free distribution of contraceptives among Roma women into an instrument of institutionalized "Roma fertility control" governed by the "fear of Roma over-population". A clear and explicit distinction should be made at each time between fertility control and reproductive rights.

The policies responding to the health needs of Roma should be mainstreamed into national health strategies and services, which, at their turn should be gender sensitive.

The policies responding to the needs of Roma women should be mainstreamed into the national strategies of promoting Roma rights and women's rights, including reproductive rights.

A balance between policies of mainstreaming and targeting should be assured in order to guarantee equal opportunities for Roma (women). For this there is a need to integrate the special measures intended to reach equal access to health care (and reproductive rights) of the underserved categories into the policies, which generally aim to ensure equal access to well-being on each domain of life.

The position of Roma mediators, including health mediators (who should be sensitive towards the particular needs of Roma women, too) needs to be strengthened within the institutions of local authorities (including medical institutions), in order to not being used only as sources of information about the community, but to act as empowered individuals able of taking

decisions and controlling the available human and financial resources needed for the community development projects.

More primary research (both quantitative and qualitative) should be done on Roma (women) with the involvement of Roma (women), in order to produce more data on which effective policy-making should be based. The advantages and risks of the disaggregated statistics by ethnicity, sex, rural/urban should be considered from this point of view, too.

Special recommendations for governmental agencies

For the Committee of Anti-Discrimination and Committee for Equal Opportunities:
should enforce the application of the Law of Equal Opportunities and of the Law of Anti-Discrimination in the domain of health care and in particular in the domain of reproductive rights
should give attention to the field of health care for Roma in their monitoring and recommendations
should consider how discrimination works at the crossroads of ethnicity and gender, in particular how Roma women, for example, are prevented from their access to a (reproductive) health care of a good quality
implementation of complaint mechanisms and provision of legal assistance to those in economic need should be assured

For the National Agency for Roma of the Romanian Government:

a bigger attention should be paid to permanent contact and communication with Roma NGOs at local levels, in order to assure effectively that they really have access to information, services and funds needed for different community development projects
a stronger support should be given to Roma women's organizations and initiatives as a proof of de facto recognizing the role of women in the community and within the Roma movement

the participation of Roma women in the decision-making processes regarding Roma women's rights (including the right to reproductive health) should be increased, and generally speaking the needs of Roma women should be included into the mainstream Roma policies

the recognition and enforcement of Roma women's reproductive rights within the strategies regarding Roma rights

For the Ministry of Health and public health care providers:

- a culturally sensitive and anti-racist curriculum should be introduced into the education of physicians, including knowledge about taboos within Roma communities regarding women's body and sexuality
- a bigger emphasis should be put on the permanent education of health care providers in the domain of contraceptives
- material and symbolic support should be given to physicians involved in family planning counseling

- mechanisms that would enforce the cooperation within the community of health care providers (between family doctors, gynecologists, medical assistants, health mediators) should be implemented
- a stronger commitment of physicians towards patient's rights should be assured, in particular towards the rights of vulnerable and underserved groups, including Roma and, of course, Roma women, for example related to their right to choose the contraceptive method most appropriate for their medical condition
- efforts should be done to train medical professionals belonging to Roma communities, an objective that links the issue of reproductive health of Roma women to the issue of access to education at all levels (including medical high schools and universities)
- besides the ethnic perspective, the gender perspective should be also introduced into the development and implementation of national health strategies.
- Special recommendations for non-governmental organizations

Cooperation between Roma and non-Roma women's organizations, local Roma experts and mediators, and NGOs working on sexual/contraceptive education should be strengthened. Together they should coordinate at local levels several programs, aiming to break the barriers between Roma women and health care providers, while considering the particular social and cultural background of the communities within which they work. Their aim should be the empowerment of Roma women, both as caregivers and as patients. They could provide, for example:

- health and sexual education for both women and men within Roma communities
- information on patient's rights and reproductive rights
- culturally sensitive education of health care providers and authorities.

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ENDNOTES

¹ As a policy study this paper wants to inform the policy-making process by carrying out primary research into a specific policy issue. As such it is issue-driven, it includes much primary research data, it formulates general recommendations and information on policy issues and it targets mostly other policy specialists from non-governmental organizations and governmental agencies.

² Among others, the report *Breaking the Barriers – Report on Romani women and access to public health care* (2003) shows that Roma have lower life expectancies, higher infant mortality, a high rate of sickness, and low rates of vaccination. In Slovakia, for instance, the life expectancy of Roma women is 17 years less than for the majority population; for men, it is 13 years less.¹⁰ Infant mortality rate for Roma has also been found to be notably higher than national averages throughout Europe. The author shows that the poor living conditions both cause and further exacerbate illness by impeding access to preventive care, proper nutrition, hygienic materials and medications. In Romania we do not have statistics disaggregated by ethnicity and within ethnicity by sex on the base of which one might have an overview of Roma health situation in the terms of reproductive health. A quantitative research done in 2003 on a Roma sample including 1.511 households and 7.990 people gives only some information regarding that, in particular related to knowledge about and use of contraceptive methods. See in Sorin Căce - Cristian Vlădescu, coord., *Starea de sănătate a populației Roma și accesul la serviciile de sănătate* (The health situation of Roma and their access to health services), 2004. Out of the investigated subjects 48% heard about at least one contraceptive method (51,4% of men, and 42,9% of women), while on the national level 99,6% of women and 99,7% of men were having information about contraceptives. 25.8% of the interviewed persons declared that they used at least one a contraceptive method, 30.9% declared that they never used anything, and 43.3% refused to answer to this question (they mostly were above 35 years). The most frequently known and used methods were: preservatives, pills and *coitus interruptus*. Only 9.1% declared that used abortion in the case of an unwanted pregnancy. Besides these specific data the results show that the average age at death in the case of Roma was 53.4 years (respondents were asked to declare the number of deaths within their families during the last five years), and the most frequent causes of death were: cardiac diseases (24.5%), cancer (15.5%), accidents (9.7%) neurological affections (5.2%), oldness (5.2%), and pulmonary problems (3.8%). Asked about their health situation during the last two weeks, they declared that 29.5% of the adults and 27.3% of children were confronted with illnesses. The most frequent diseases were affecting the cardiovascular system (2.6%), followed by the diseases of the digestive apparatus (1.8 %) and those of the breathing system (1.6%). In the case of children the leading diseases were affecting the breathing apparatus (14.2%), followed by different infections (1.3%) and affections of the nervous system (1.2%).

³ The agreement on this definition was achieved at the International Conference on Population and Development (ICPD) held in Cairo in 1994 (see about this at www.unfpa.org/icpd/icpd_poa.htm#ch7). In 1995, the Fourth World Conference on Women, held in Beijing, affirmed the definition of reproductive health and rights agreed at the ICPD, and also called upon states to consider reviewing laws which punished women for having illegal abortions.

⁴ Addressing the population and reproductive health issues and trends in Central and Eastern Europe and Central Asia, UNFPA emphasizes the following, but without offering ethically disaggregated data: the rapid rise in rates of HIV/AIDS and sexually transmitted infections — the rate of increase during 2002 was among the fastest ever experienced anywhere — especially among young people, and in the eastern parts of the region; inadequate access to quality services for counseling, diagnosis and treatment of STIs is increasingly recognized as a constraint on the whole region; the need to address the reproductive health needs of young people, ensuring access to information and services to help them adopt healthy behaviors; the continuing incidence of recourse to abortion; the large discrepancy between the life expectancy of males and females in numerous countries; negative population growth rates in many countries; the ageing of the population throughout the region; the rise in trafficking of women and girls; high maternal mortality rates. See in *Country Profiles for Population and Reproductive Health* (2003).

⁵ See Paragraph 96 of the Beijing Declaration, 1995.

⁶ The National Strategy of Reproductive Health and Sexuality developed in 2004 (as mentioned in Chapter 3.A. of this paper) introduces the perspective of rights into the discussion about reproductive health. But this remains only a theoretical approach, which is far away of what is happening in reality, and even more far away from treating Roma women's status. Not only because the mechanisms of monitoring the implementation of rights are not functioning, but also because people (as patients) still have to learn about claiming their rights on this domain, too.

⁷ See in Eldis Health Key Issues, Guide on Sexual and reproductive health and rights at www.eldis.org/health

⁸ She wrote many reports and policy papers related to Romani women, the most recent ones were: *Romani women in the European Union: Realities and Challenges* (November 2005); *National Action Plans and Equality for Roma Women. A Report to the International Steering Committee of the Decade of Roma Inclusion* (January, 2005). In the latter she observes that “we asked for the mainstreaming of Romani women's issues, not for separation, but instead of gender awareness within all sectors of the action plans, we see nothing but superficial and token mention of women's issues. Our recommendations ... were ignored”. Bițu called the attention of the Steering Committee to work with the Roma Women's Initiative to figure out how to address issues of women and gender before the Decade launch.

⁹ The report entitled *The Situation of Roma/Gypsy Women in Europe*, 1999 stresses that their life is often characterized by a conflict between the traditional culture and modern developments, but one always has to consider the particular Roma group to which women belong to. It gives an overview of the international activities related to Romani/Gypsy women issues and of state policies in favor of them, and she concludes that Spain has the most advanced policy on this domain. The paper talks also about the participation of Roma women in the public and political life and observes: women have to work three times more than the others in order to gain respect from the males, which is even worse when they are single.

¹⁰ See for example the analysis of Isabela Mihalache (2003), who talks about “the process of the emergence of a ‘consciousness’ among Romani women about the realities of a patriarchal culture”, but also about the fact that “it is extremely difficult for Romani women activists ... to embark on a road full of risks and insecurities – the road of activism against oppression from within the community.” Her personal position is very clearly put (“I refuse to accept traditions that imprison people and do not allow them their freedom”), but it is one that is not easy to assume exactly because of the repressions coming from the mainstream movement that is having a different interpretation of preserving traditions.

¹¹ The out coming report was entitled “A Place at the Policy Paper”, and included a series of recommendations related to women's education, economic empowerment, sexual and reproductive rights, and grassroots leadership and political participation.

¹² Indicators and analysis on this are provided among others by the Eastern European Institute for Reproductive Health.

¹³ The outcomes of this research was published under the title *Breaking the Barriers – Report on Romani women and access to public health care*, by OSCE, The European Monitoring Centre on Racism and Xenophobia, and Council of Europe, 2003. The project was administered by the Council of Europe and overseen by an advisory group consisting of representatives of the Council of Europe, OSCE HCNM, OSCE Office for Democratic Institutions and Human Rights, the European Union's European Monitoring Centre on Racism and Xenophobia (EUMC), and the World Health Organization Regional Office for Europe. In the course of this study, two independent experts were engaged to conduct country visits and individual interviews, Anna Pomykala assisted by Mariana Buceanu.

¹⁴ Corinne Packer wrote largely on this issue. See, for example: *The Health Status of Roma: Priorities for Improvements*, in Human Rights Tribune, Volume 11, N° 1; or: *Roma Women and Public Health Care*, in Sexual and Reproductive Health in a Multicultural Europe. The European Magazine for Sexual and Reproductive Health, No. 55/2003, at <http://eumap.org/journal/features/2002/sep02/romwomenprior>.

¹⁵ Materials of the Strategy and its evaluation might be read in: *Strategy of the Government of Romania for Improving the Condition of the Roma*, at http://www.riga.lv/minelres/NationalLegislation/Romania/Romania_antidiscrim_English.htm; *O necesară schimbare de strategie. Raport privind stadiul de aplicare a Strategiei guvernamentale de îmbunătățire a situației romilor din România* (A necessary change of strategy. Report regarding the application of the Strategy of the Government of Romania for Improving the Condition of the Roma, by the Resource Centre for Ethnocultural Diversity, 2004, at www.edrc-ro; *Monitorizarea implementării la nivel local a Strategiei pentru Îmbunătățirea Situației Romilor din România* (Monitoring the implementation at local level of the Strategy of the Government of Romania for Improving the Condition of the Roma), by the Resource Centre for Ethnocultural Diversity, the Open Society Institute Budapest and EUMAP, 2004, at www.edrc-ro, <http://www.romacenter.ro/noutati/index.php?page=8>; *Report on the Implementation of the Strategy for the Improvement of the Situation of Roma Community from Romania*, 2002, <http://www.eumap.org/reports/2002/content/07>.

¹⁶ The results of a recent policy research coordinated by Marta Schaaf were just published under the title *Mediating Romani Health. Policy and Program Opportunities*, Open Society Institute, Network Public Health Program, New York, 2005.