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# CHILDBIRTH EXPERIENCE IN ROMANIAN HOSPITALS

## RESEARCH REPORT ON OBSTETRIC VIOLENCE

### Recommendations for improving access to universal antenatal care, evidence-based childbirth practices and women- and child-friendly hospital policies

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Views and opinions expressed are however those of the authors only and do not necessarily reflect those of the European Union or The Netherlands Helsinki Committee. Neither the European Union nor the NHC can be held responsible for them.

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# About us

**The Independent Midwives Association (AMI)** is a non-profit organisation that has been working for over 11 years to support women, mothers, children and families in Romania and to strengthen and promote the midwifery profession.

AMI provides health services for women, pregnant women, adolescents, mothers and newborns, medical services and health system navigation for vulnerable people and refugees; it also carries out activities to protect women's reproductive health rights and to prevent and fight sexual and gender-based violence.

# About the authors

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*I complained of pain and they told me that I was lying.*

*My legs were tied to the delivery table.*

*I was left with the thought that I had survived a slaughter. They butchered me body and soul.*

*A nurse held my hand...*

*The doctor was calm...*

*A woman with a golden heart who encouraged me...*

# SUMMARY

This report is based on quantitative cross-sectional descriptive research carried out in the project "Safe Motherhood - Safe, universal, free, accessible and non-discriminatory care provided with respect for all women who want to become mothers" implemented by the Independent Midwives Association with the support of the Netherlands Helsinki Committee (#NHC) under the Catalyst of Change Program: Protecting EU values by supporting a resilient, engaged and vocal civil society to promote women's rights, environmental justice and the fight against corruption in Eastern and Southern Europe.

The study is based, on the one hand, on the premise that obstetric violence is a manifestation of gender-based violence, which has not been sufficiently studied in Romania, and, on the other hand, on the reality, confirmed by data, that Romania is one of the countries where the number of caesarean sections far exceeds the number of natural births (see data provided by the World Health Organisation - WHO).

The main objective of the research was to find out, for the first time in our country, how Romanian women perceive their experience of the care they received during pregnancy, childbirth and postpartum in Romanian clinics and hospitals over the last 5 years (2018 - 2023). **In this context, we define obstetric violence as any form of physical or verbal abuse, disrespect and mistreatment, lack of confidentiality and neglect during childbirth perpetrated by health professionals that results in unnecessary pain and avoidable complications, and in violations of women's dignity (World Health Organization, 2015).**

The limitations of the study (not so much in terms of the number of respondents, but in terms of sampling) do not allow generalisations to be made.

**However, some conclusions can be drawn from the 5,623 valid responses to the structured online questionnaire:**

a) many of the problems identified in the research are determined by a mixture of cultural and systemic factors;

b) one of these systemic issues that we would like to highlight here is the difficulty or lack of access to paid consultations during pregnancy, which particularly affects low-income women;

c) there is a low level of information/knowledge/awareness among women (even those with higher education - the majority in the sample) about obstetric violence and the different forms it can take;

d) this fact indicates, as we knew from other studies, that issues related to women's bodies, rights, and autonomy are not subjects of interest to be included in school curricula, which raises questions about women's full citizenship, but also about the quality of democracy in Romania;

e) a lack of communication between patients and health professionals contributes to the occurrence of some forms of obstetric violence;

f) health professionals have a somewhat paternalistic attitude, which also paves the way for the manifestation of obstetric violence, an issue that we believe raises questions of professional ethics and deontology;

g) there is a contradiction between the duties and responsibilities of midwives, as laid down in *Emergency Ordinance no. 144/2008 on the practice of the profession of general nurse, midwife and nurse, as well as on the organisation and functioning of the Order of Nurses, Midwives and Medical Assistants of Romania, and hospital practice*;
h) anti-Roma racism persists and manifests itself both among medical professionals and the majority of women.

Moreover, the data in this report (particularly the qualitative data briefly presented) and discussions with health professionals suggest that women's needs, experiences and bodies are virtually absent from medical discourses and practices in pregnancy/childbirth and postpartum. The needs, comfort, and pain of women during childbirth are often downplayed, marginalised, and stigmatised.

At times, it seems as though women and their bodies are valued only insofar as they must deliver healthy babies, with a focus on minimizing risks for doctors. This is reflected in practices such as defensive medicine, the high rate of caesarean sections, restrictive birthing positions, the absence of support persons, and the immediate separation from the baby after birth.

Adequate funding and research, including studies on the causes, extent, and consequences of obstetric violence, are essential to fully address the issues explored in this research and to develop tailored solutions for the Romanian healthcare system.

# INTRODUCTION

The issue of gender inequality is now well documented at local, regional and global level, supported by quantitative and qualitative studies. Some of the most accessible quantitative scientific insights into the dynamics of gender gap perpetuation are provided by gender equality indices (see European Gender Equality Index, United Nations Gender Equality Index, World Economic Forum Gender Equality Index, etc.).

The Indexes, along with much other gender studies research, show that gender inequalities:
(i) are persistent (but not static);
(ii) happen in all areas;
(iii) must be tackled in a multi- and interdisciplinary way in order to be fully understood;
(iv) integrated actions and complex tools are needed to prevent and combat them.

**All studies show that, despite undeniable progress, no country in the world has achieved gender equality in all areas and the pace of change is slow. Moreover, a strong wave of conservatism and resistance to the promotion of gender-sensitive policies, the so-called gender backlash, has recently emerged** (Petö, 2018; Frey et al, 2014; Do Mar Pereira, 2018; Kuhar and Paternotte, 2017; Băluță, 2020; Verloo, 2018, etc.).

Issues related to women's bodies, especially reproductive health and rights, have been and continue to be sources of ideological, political and religious contestation, where women's interests and needs are often ignored, marginalised, misunderstood or defined according to male standards and criteria.

In line with pro- or anti-natalist policies, men's, but especially women's, bodies and experiences have often been politicised, with negative consequences for those affected (Rohden, 2001, 2003; Kligman 2000; Miroiu, Dragomir, 2010).

Despite decades of advocacy, other experiences, such as violence against women or gender-based violence, are hardly considered issues on the public/political agenda worthy of regulation and state intervention.

Gender-based violence became a public and political issue after the 1970s, following the second wave of feminism, the so-called reproductive rights wave. Academic feminism and gender studies as a whole began to generate knowledge in this area, to critically examine the public/private distinction, especially from the perspective of placing family issues strictly in the private sphere, and to provide viable theoretical and practical arguments for the development of effective prevention and response mechanisms.

“The personal is political”, a slogan of second-wave feminism, clearly emphasises the need to move issues such as domestic violence or reproductive rights out of the private sphere and onto the public agenda, where institutional and structural solutions can be found (Pateman, 1998; Lister, 2003; Okin, 1998; Wolf, 2002).

Thus, over time, the need for a gender-sensitive macro-social perspective has emerged, emphasising the relevance of structural and societal factors, as well as gender roles and stereotypes, in the emergence and perpetuation of various

forms of violence against women (Băluță, Tufiș, 20-22).

This includes physical, verbal, psychological, spiritual, economic, cyber, sexual and social violence (see Law 217/2003 on the prevention and combating of domestic violence). These practices are closely linked to power relations in society and the manifestation of gender inequality in various areas - education, health, politics, science, the labour market.

**Obstetric violence** is part of a broader continuum of violence against women that manifests at the intersection of the medical system (in terms of access to health care), socio-cultural norms (often shaped by patriarchal values, stereotypes and traditional gender roles), and the conflicting discourses surrounding the role of the state and the market in the provision of health and reproductive services. It also reflects the ongoing debate about the naturalisation, pathologisation and biomedicalization of women's bodies. (Nisha, 2021; Vieira 2003; Costa, Navarro Stotz, Grynszpan et al, 2007), especially in relation to reproductive issues (Nisha, 2021; Vieira 2003; Costa, Navarro Stotz, Grynszpan et al, 2007).

The most recent research report on the subject (April 2024), commissioned by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM), presents obstetric violence as the result of two major structural crises:
i) gender discrimination;
ii) underfunding of health systems
(Brunello, Gay-Berthomieu, Smiles, Bardho, Schantz, Rozee, 2024).

This report discusses the medicalisation of women's bodies as a product of modern medicine (the pathologisation and biomedicalization of women's bodies as a result of patriarchal constructions), but also the structural, systemic mechanisms that create fertile ground for the manifestation of obstetric violence (including inadequate supervision, insufficient medical staff, inadequate supply chains, poor infrastructure, power dynamics) (Brunello, Gay-Berthomieu, Smiles, Bardho, Schantz, Rozee, 2024).

In our view, the World Health Organization (WHO) definition can be a good starting point for describing this form of violence.

**WHO defines this type of violence as a form of physical or verbal abuse, disrespect and mistreatment, lack of confidentiality and neglect during childbirth, perpetrated by health professionals, which results in unnecessary pain and avoidable complications, and in violations of women's dignity.**
**(World Health Organization, 2015).**

Another useful definition is that proposed by the High Council for Equality between Women and Men, an independent governmental body in France, which in a report published in 2018 states that **obstetric and gynaecological violence is one of the most serious sexist acts in gynaecological and obstetric care and consists of gestures, comments, practices and behaviours performed or omitted by one or more health professionals on a patient during gynaecological and obstetric care, which are formal/institutionalised or informal, characterised by the desire to control women's bodies (sexuality and fertility).**

Such control can take many different forms, which can be categorised into 6 types of sexist behaviour:

- **Failure to take into account the patient's discomfort related to the intimate nature of the consultation**
- **Judgmental comments about sexuality, dress, weight, or the choice of having a child or not;**
- **Sexist insults;**
- **Medical procedures performed without the patient's consent or without respecting her choice or her say;**
- **Procedures performed, or withheld, without valid medical justification;**
- **Sexual violence: sexual harassment, sexual assault and rape (HCE 2018).**

The Independent Midwives Association, in its 'Caring for Mothers' course, defines FGM as “a form of gender-based violence (GBV) that targets women during pregnancy, childbirth and postpartum, violates human rights and evidence-based medicine, and hinders the provision of respectful maternity care” (Tudose, 2022, p. 27). This introduces other elements that give us a clearer picture of the issues surrounding childbirth. This definition draws attention to the fact that obstetric violence is sometimes the result of medical practices that do not take into account scientific developments in the field (see the need for protocols, standards and guidelines, but also for training of medical staff).

**The definition also introduces the concept of respectful motherhood, alongside that of positive birth experience**, namely “the birth of a healthy baby in a clinically and emotionally safe environment. It also necessarily involves the presence of competent clinical staff, the presence of a partner (companion), as well as a sense of control and decision-making autonomy, even when certain medical interventions are necessary” (Tudose, 2022, p. 5).

On the other hand, while innovation and research in this area is progressing, there is evidence that **women continue to suffer various forms of obstetric violence, partly because medical systems are not institutionally built around the needs and bodies of women, but rather around the needs of medical staff and perhaps the needs of the foetus/newborn.**

For a more nuanced approach to this phenomenon, it is worth considering the concepts of "Too Little Too Late" (TLTL), which refers to limited/cumbersome/lack of access to services, resources, information and medical personnel, or "Too Much Too Soon" (TMTS) - high costs, traumatic practices, hypermedicalization, lack of or non-adherence to protocols, both of which have a negative impact on maternal health and, implicitly, on women's health (Miller S., Abalos E., Chamillard M., Ciapponi A., Colaci D., Comandé D. et al., 2016; Khalil M., Carasso K.B., Kabakian-Khasholian T., 2022).

It is also interesting to note the definition provided by Bowser and Hill (2010), who identify seven types of disrespect and abuse to which women are subjected:

- **Physical abuse;**
- **Non-consented care;**
- **Non-confidential care;**
- **Non-dignified care;**
- **Discrimination based on specific patient attributes;**
- **Abandonment of care;**
- **Detention in facilities.**

Violence during childbirth can manifest in various forms, and we believe these definitions offer a nuanced and comprehensive understanding of the phenomenon. They can serve as a foundation for operationalizing the concept of obstetric violence in research, as has been done in various countries and regions.

The need for research into the phenomenon of obstetric violence is also reinforced by the fact that at the 77th session of the WHO Executive Board, which addressed the Sustainable Development Goals (SDGs) on maternal and child mortality, one of the resolutions adopted (PP15) underlines that WHO is aware that one of the causes of maternal mortality and morbidity is related to the stigma associated with abortion, HIV infection and obstetric violence, which tends to be deprioritised, under-reported and poorly known.

For these reasons, the Member States are called upon (OP 1.10.) to address social factors that may be determinants of maternal and child health, including multiple and intersectional discrimination, poverty, gender inequality and their link to obstetric violence, lack of education, and poor access to water and adequate sanitation. In this regard, it is recommended to strengthen multisectoral collaboration and to develop a holistic strategic approach that systematically integrates national and global health architectures (WHO Executive Board, 2024).

It is important to acknowledge that some voices question the use of the term "obstetric violence", arguing that the word 'violence' is too strong, carrying emotional weight that may lead to confusion or unintended negative effects in how it is perceived socially. Moreover, the challengers say, violence would imply deliberate aggression, whereas some forms of neglect or inappropriate treatment are not actually the result of systemic problems (Chervenak F.A. et al, 2024). However, the perspective we take in this report is that any issue, once identified and adequately substantiated, must first be recognized as a problem.

The problem must be clearly named, with clear reference to its specific context. In this regard, starting from the premise that there is a (systemic!) issue affecting the way women experience pregnancy and childbirth in the Romanian healthcare system, we define this problem in its starkest form as **"obstetric violence".** This term highlights the close connection between this issue and other widely acknowledged forms of violence against women, as well as the power dynamics between women and men that operate on individual, institutional, and systemic levels.

The greater or lesser tolerance of different forms of gender-based violence depends to a large extent on the nature of the cultural, political and ideological constructs that regulate women's bodies.

Systemic problems (such as the underfunding of the health system, the contents of medical education, or official malpractice regulations) that manifest themselves in various forms of inappropriate, even abusive, obstetric and gynaecological care are part of a broader societal picture in which, as mentioned at the beginning, gender inequalities persist, placing Romania at the bottom of European rankings in terms of gender inequality.

**The need for such a report** is supported by research on the high prevalence of various forms of obstetric violence (between 25 and 78% - see Martinez-Galiano et al, 2023; Brunello S., Gay-Berthomieu M., Smiles B., Bardho E., Schantz C., Rozee V., 2024; Dominguez, Toro Merlo, 2015; Martínez-Galiano J.M. et al 2021; Scandurra C. et al, 2022, WHO, 2019).

Therefore, the value of this research effort, which aims to provide a more detailed understanding of the Romanian context concerning obstetric violence, is evident.

**We should also highlight that this research report is the first of its kind in Romania, offering a quantitative methodological framework robust enough to provide an initial assessment of the current state of the affairs in the field (covering the awareness and perceptions of the phenomenon, as well as its prevalence).**

**We believe that the findings of this report, in conjunction with other existing viable sources of information, are a first step in informing decisions to prevent and combat such practices in the future.**

# METHODOLOGY

This report is based on a quantitative, cross-sectional, applied and descriptive research, aimed at obtaining information on **(i) how women in Romania perceive this phenomenon.**

Two open-ended questions were also included to collect some qualitative comments on the experience of childbirth in Romanian hospitals.

## Data collection

The questionnaire was drafted using the free Google Forms platform.

**The target group consisted of women in Romania who had given birth at least once in the past five years (2018-2023) in either a public or private hospital.**

**The data were collected between 27.03.2024 and 07.04.2024.**

As a first step, a pilot data collection was carried out in which the questionnaire was filled out by 15 women. The initial link was shared in a closed/private Facebook group for mothers with around 300 members. Their selection was based on the principle of voluntary participation. The final questionnaire was drafted based on the feedback received.

Given the characteristics of the target group, several forms of non-probability sampling were chosen. Thus, a combination of non-probability sampling methods was employed, focusing on the selection of the most accessible participants, and of sampling methods based on the presence and severity of various forms of obstetric violence as identified and defined by specialists, as well as **(ii) the level of women's awareness of these issues.**

The research was based on a structured questionnaire, with closed/pre-coded questions.

The questionnaire was designed and structured in 5 chapters, each one focusing on an important aspect related to the objectives of the study.

**In the questionnaire, we operationalized obstetric violence through 27 items, addressing aspects related to the elements outlined in the definitions provided in the “Introduction”, as well as in the guidelines currently in force in Romania.**

The questionnaire was distributed online to the target population via the social media platforms Facebook, Instagram and TikTok, where it was posted on various open/closed groups dedicated to mothers (the size of the groups ranged from 300 to 45,000), and was posted on the profile of the Independent Midwives Association.

At the same time, the link to the questionnaire was posted on the website of the Association of Independent Midwives (www.moasele.ro), emailed or distributed among acquaintances and other WhatsApp groups through stakeholders who work with mothers: midwives, antenatal educators, health mediators, community support coordinators from other partner associations. Additionally, in the introductory and explanatory section at the start of the questionnaire link, participants were requested to share the

link with other women they knew who had given birth in the past five years. Completion of the questionnaire was considered consent to participate.

The inclusion criterion was having given birth in a Romanian health care establishment within the last 5 years.

**The final number of responses prior to data cleansing was 5,635, of which 5,623 were deemed valid for analysis.** The final number was obtained by eliminating persons who had not given birth in the last 5 years (10 responses) and who had not given birth in Romania (2 responses).

The largest contribution to the 5,635 responses was due to the use of the paid promotion section. Specifically, from 28.03.2024 to 01.04.2024, a paid advertising campaign was active on the Facebook and Instagram platforms, set for "traffic to website", with the aim of maximising the number of link hits. The campaign was set to target the city of residence, age and gender, as well as other more specific indicators that were part of the internal strategy to reach the target audience.

The campaign was displayed across 19 distinct locations on PC browsers and mobile applications: Facebook feed; Instagram feed; Instagram profile feed; Facebook Marketplace; Facebook video feeds; Facebook right column; Instagram Explore; Instagram Explore home; Messenger inbox; Instagram Stories; Facebook Stories; Messenger Stories; Instagram Reels; Facebook Reels; Facebook in-stream videos; Ads on Facebook Reels; Ads on Instagram Reels; Facebook search results; Instagram search results. A second advertising campaign was developed between 03.04.2024 and 04.04.2024, focusing on women up to the age of 32 living in rural areas. The following counties were selected for this campaign: Bihor, Bacău, Brașov, Buzău, Călărași, Dâmbovița, Dolj, Galați, Mureș, Ilfov, Prahova, Vrancea, Ialomița, Sălaj, Vaslui. The remaining technical aspects corresponded to those used in the first paid campaign.

67,604 unique users saw the post at least once in the first strategy and 49,965 in the second. The personnel of the Communications Department of the Association of Independent Midwives managed the collection of the 5,635 responses. The total cost for the entire data collection process via online campaigns was 975,74 lei.

Since non-probability sampling was used, the results cannot be generalized to the entire population. Despite this drawback, we believe that obtaining responses through various forms of non-probability sampling is a valid solution, and that a sufficiently large number of responses allows conclusions to be drawn, even partial ones, which can form the basis for further mixed quantitative and qualitative research.

*Limitations of the free Google Forms platform: Due to the inability to set a maximum number of response options per question, the instruction *"Please choose a maximum of 3 options"* was included within the question to indicate the limit on the number of responses that could be selected.

However, since this limitation was not preset, not all respondents followed the prompt, ending up with some choosing more than 3 options.

## Sample characteristics

With regard to the demographic and general characteristics of the population, 3/4 of the respondents were from urban areas and the average age was 32 (ranging from 18 to 52 years).

Approximately 3/4 of the respondents had a degree, and more than 3/4 stated that they were employed or self-employed and had an average income.

In addition, almost all were of Romanian nationality, married with one or two children. Also, more than 3/4 of the respondents had given birth in a public hospital.

### General information about the sample

| | | N |
|---|---|---|
| **Average age** | **31.58** | **5603** |
| **From urban areas** | **75.5%** | **5623** |
| **Resident in Bucharest** | **19.1%** | **5623** |
| **Births in Bucharest** | **29.2%** | **5623** |
| **Marital status - Married** | **90.6%** | **5623** |
| **Higher education (undergraduate/master/PhD)** | **73.1%** | **5623** |
| **Romanian national** | **94.4%** | **5623** |
| **One or two children** | **93.8%** | **5623** |
| **Employed or self-employed** | **78.7%** | **5623** |
| **Income between 2,101 and 4,600 lei** | **44.5%** | **4423** |
| **Birth in public hospital** | **78.1%** | **5622** |

*Table 1: Demographic and general information on the sample N=5623*

Thus, the information and opinions gathered in this research predominantly reflect the experiences of urban, educated women - average age 32, married, with one or two children, active in the labour market, and mainly earning average incomes - whose childbirth experiences mostly occurred in Romanian public hospitals.

# RESEARCH FINDINGS

## Section 1. Types of childbirth

The first set of questions was designed to provide a general profile of the respondents (Q1- Q11) presented above, followed by a series of questions relating to specific aspects of the birth experience (Q12-Q22), which we discuss below.

### 1.1 C-sections outnumber natural births

Almost 1/2 (46.2%) of the respondents reported that they had an elective C-section (33.7% - elective C-section and 12.5% - emergency C-section without labour - also considered elective).

Just over 1/3 of the women reported natural births (see Q13, Q27). The analysis shows that 1/3 (33.7%) of the women in the sample gave birth by elective C-section, compared to just over 1/3 (37.7 %) who gave birth naturally.

If the 12.5% of caesarean births that occurred without preceding labour are include, the number of C-sections available for critical analysis increases.

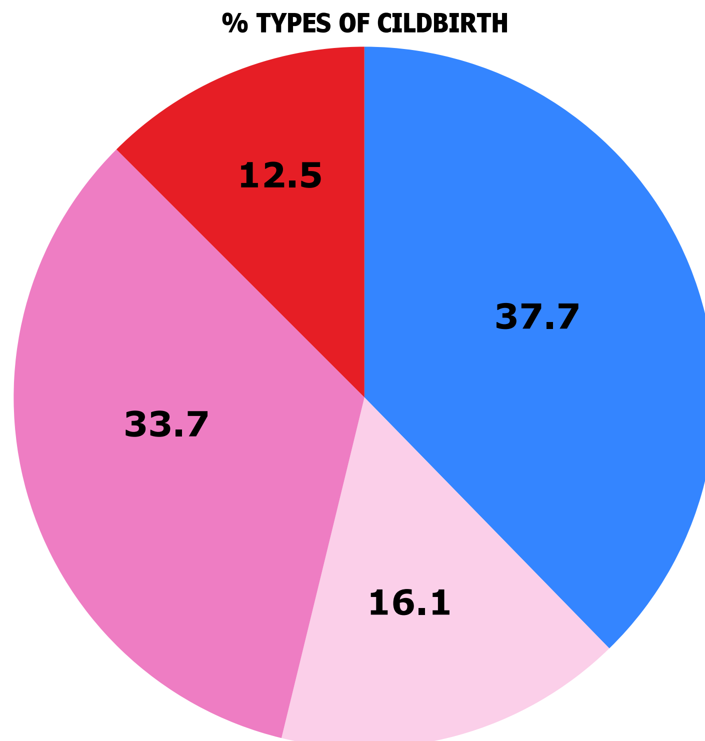


*Chart 1: Types of childbirth. N=5623*

When comparing births in public hospitals with those in private hospitals, some 2/3 (60%) of all births in both cases were by C-sections, the majority of which were elective (32.5% in public and 37.9% in private hospitals).

Of all births in private hospitals, only 29.6% were vaginal deliveries, compared to 39.9% of the births in public hospitals. Therefore, there is a more pronounced trend toward elective C-sections in private hospitals.

**% Types of childbirth by hospital**

| | Vaginal delivery | Emergency C-section (after onset of labour) | Elective C-section | Emergency C-section without preceding labour | Total |
|---|---|---|---|---|---|
| **Birth in public hospital** | **39.9% (N=1754)** | **14.8% (N=648)** | **32.5% (N=1428)** | **12.8% (N=561)** | **100% (N=4391)** |
| **Birth in private hospital** | **29.6% (N=364)** | **20.9% (N=257)** | **37.9% (N=467)** | **11.6% (N=143)** | **100% (N=1231)** |

*Table 2: Type of births by public/private hospitals*

***Comment:*** *The WHO recommends that the number of caesarean deliveries should not exceed 15% of all births in a country.* ***Romania far exceeds this percentage.*** *For example, more recent data show that more than half of all births in Romania were by C-section in 2021 (WHO Statement on Caesarean Section Rates).*[1]

*The high number of C-sections can, at first glance, be attributed to a broad range of women's health issues that necessitate such interventions. However, it is difficult to support this predominantly pathological obstetric profile of women in Romania with other data. The explanations are multiple and should be identified through further research in order to find the right solutions to balance the number of caesarean births (especially, but not only, elective!) and natural births. Romania's recent history, combined with the unique cultural dynamics of the relationship between obstetricians-gynaecologists (OB/GYN) and their female patients - often seen as more personal than professional, with sentiments like "My doctor, whom I trust and want to deliver my baby" - undoubtedly plays a role in this discrepancy.*

*A professional investigation into the underlying causes of the elevated rate of C-sections following the onset of labour is essential to ascertain the extent to*



1 WHO Statement on Caesarean Section Rates

*which these procedures are truly medically justified. The power relations between the OB/GYN and pregnant women, as well as women's motivations for various options are a good indicator to understand the situation, beyond the raw numbers that will be presented below.*

*Last but not least, the particularities of the situation in public vs. private hospitals need to be identified.*

*The current study reveals a high prevalence of C-section delivery in public hospitals. However, a comparison cannot be made due to the limitations of the sample.*

*Informal discussions with physicians indicate an emerging trend of increased requests for natural childbirth in the private system, which requires further documentation in future studies.*

*Furthermore, existing generational and regional differences, along with variations in institutional practices between private and public hospitals, may be adding further nuances to the issue.*

### 1.1 The physician: primary decision-maker in how women give birth

Of the 1,894 women who underwent an elective C-section in the previous 5 years, nearly 3/4 stated that the procedure was recommended by the attending obstetrician, and about 1/4 reported that the planned C-section was their choice (Q14).

| % of women who chose C-section delivery | |
|---|---|
| **It was my choice** | **27.7% (N=525)** |
| **The doctor indicated elective C-section** | **72.3% (N=1369)** |

*Table 3: Who chose the type of childbirth*

As previously stated, the analysis of the data must consider the particular characteristics of the relationship between the gynaecologist and the patient. The doctor is not merely a medical expert; the relationship is more personalised than that of other doctor-patient interactions. In most cases, women have the personal mobile number of "their doctor" whom they can call at any time.

***Comment:*** *From a legal standpoint, the decision to undergo a C-section cannot be a personal choice, since it constitutes a medical intervention that must be recommended by a specialist. Certain informal hospital customs and practices should be examined in detail to gain insights into the underlying mechanisms that facilitate access to C-sections even when they are not absolutely necessary. This can be achieved by e.g. analysing medical records and written motivations for C-sections and correlating them with the actual health profile of women.*

*It is evident that the gynaecologist is in possession of a superior level of knowledge and expertise, which affords them the epistemic privilege to provide informed guidance and recommendations tailored to the individual needs of each patient.*

*What should be analysed and discussed in the system is the substantive compli-*

*ance with the applicable guidelines and the verification of the existence of and compliance with protocols, as well as the knowledge at the hospital level.*

### 1.3 Fear of pain - The main reason for choosing an elective C-section

The most common reason given by gynaecologists for recommending C-section to women (Q15) is a history of previous C-sections (32% said this was the reason their doctor recommended a C-section). Other reasons frequently cited are: cephalopelvic disproportion (large baby/small pelvis: 17,7%; circular cord: 18,8%), presentations other than anterior occipital cranial (forms of presentation:) 11,5%, maternal myopia: 11,6.

Other reasons are also mentioned, but with a lower frequency (thrombophilia, age of the pregnant woman, overdue pregnancy).

As far as women are concerned, the main reason given by almost 2/3 (60%) of the participants in this study for choosing to have a C-section was the fear of pain. Other reasons given were that they had heard traumatic stories about natural childbirth (around 50%), or that they felt it was a safer way of giving birth for them (30%) or for the baby (22%). However, it should be noted that there were several different reasons for choosing a type of birth in the questionnaire, so there may have been more reasons for not recommending a natural birth.

| Top 5 reasons given by women for choosing caesarean delivery (N=525) | |
|---|---|
| **Fear of pain** | **59.8%** |
| **Traumatising stories about vaginal childbirth** | **48.8%** |
| **Because it is safer for me** | **30.1%** |
| **I was told that it is safer for the child** | **22.1%** |
| **Fear of vaginal changes/impaired sex life** | **11.2%** |

*Table 4: Women's reasons for choosing elective C-section*

| Top 5 reasons given by women for their doctor recommending caesarean delivery (N=1369) | |
|---|---|
| **C-section history (scar uterus)** | **32%** |
| **Cord wrapped around the neck (circular umbilical cord)** | **18.8%** |
| **Baby too big or pelvis too small** | **17.7%** |
| **Maternal myopia** | **11.6%** |
| **Different forms of presentation (pelvic, in dystocia, transverse etc.)** | **11.5%** |

*Table 5: Women's reasons for choosing elective C-section recommended by the physician*

***Comment:*** *A C-section is a life-saving procedure. When it is medically necessary and there are scientifically validated medical arguments and practice guidelines, it should be recommended to the woman and performed by an obstetrician.*

***The fear of pain (frequently invoked by women), should not be seen as a "whim". Instead, it must be considered in the context of underlying structural deficiencies of the pain management system, the denial of access of a support person, and lack of free choice of positions in labour and expulsion.***

*It is imperative that the traumas experienced by a generation of women who gave birth in communist Romania (see Miroiu, Dragomir, 2002) not be repeated. In the 21st century, the experience of natural childbirth must not be excruciatingly painful and traumatising.*

***Childbirth is not and should not be a pain test for women***

*Epidural analgesia, for instance, should be available in all hospitals. However, two key conditions must be met to this end: firstly, the hospital must purchase the substances, and secondly, sufficient medical staff must be available (anaesthetists, midwives and nurses) to ensure that the service can be properly and judiciously monitored. A variety of validated non-pharmacological and pharmacological methods are available for the management of labour pain.*

*Hospital facilities are responsible to provide women giving birth with at least the full range of options available at the time, though NICE guidelines suggest that facilities should offer a comprehensive range of choices (Tudose M., 2022).*

*Moreover, the conduct of the medical personnel involved, their capacity for empathic engagement in the provision of psycho-emotional support, and the extent of their knowledge to facilitate the requisite support so that the woman does not perceive childbirth as traumatic, but rather as a physiological process integral to the natural life cycle for women, is also of paramount importance in the alleviation of pain during childbirth.*

*Childbirth is the only physiological process where pain and fear are associated with the feeling of love (Tudose, 2022; Grant, Erickson, 2022). However, the perception of pain varies considerably between individuals, depending on the threshold of excitability and the resilience of the woman in question, which requires specialists to deliver individualized, woman-centred care.*

*Furthermore, childbirth pain is a psychosomatic process, and thus, its therapy should also be psychosomatic in nature. Thus, the provision of psychological support, care and empathy from the medical team can contribute to positive and even memorable experiences for patients, without physical and psychoemotional trauma.*

*If we correlate the "fear of pain" with the second reason frequently given by our respondents for choosing C-section, namely "the traumatising stories about childbirth", then there is an obvious opportunity for prenatal education courses (which should be provided free of charge by qualified staff in any hospital) in which pregnant women may learn about the potential benefits and risks associated with different childbirth*

*methods. Thus, women may make informed decisions and begin to manage their labour pain psychosomatically. It is thus incumbent upon the institution to provide pain management methods and to ensure that the woman is adequately prepared and informed prior to the procedure.*

### 1.4. Financial considerations are not the primary factor in deciding on an elective C-section

The analysis of the reasons why women in this sample choose to give birth in public or private hospitals (Q18) reveals that financial considerations are not the primary factor. Instead, the decision is influenced by the unique patient - physician relationship, and by the informal narratives within the social circles of pregnant women.

For 2/3 of the participants the main consideration is that the pregnancy care OB/GYN works in the public health facility in question; half of them (53%) stated that the main consideration is that “in an emergency, you always go to the public hospital”; and less than 1/3 (about 29%) mentioned financial aspects.

In comparison, financial considerations are not among the top five reasons mentioned for giving birth in the private system (Q19). The primary reasons include the desire for comfort, cleanliness, dedicated staff, the place where the doctor works, and the desire to have the baby with the mother immediately after birth.

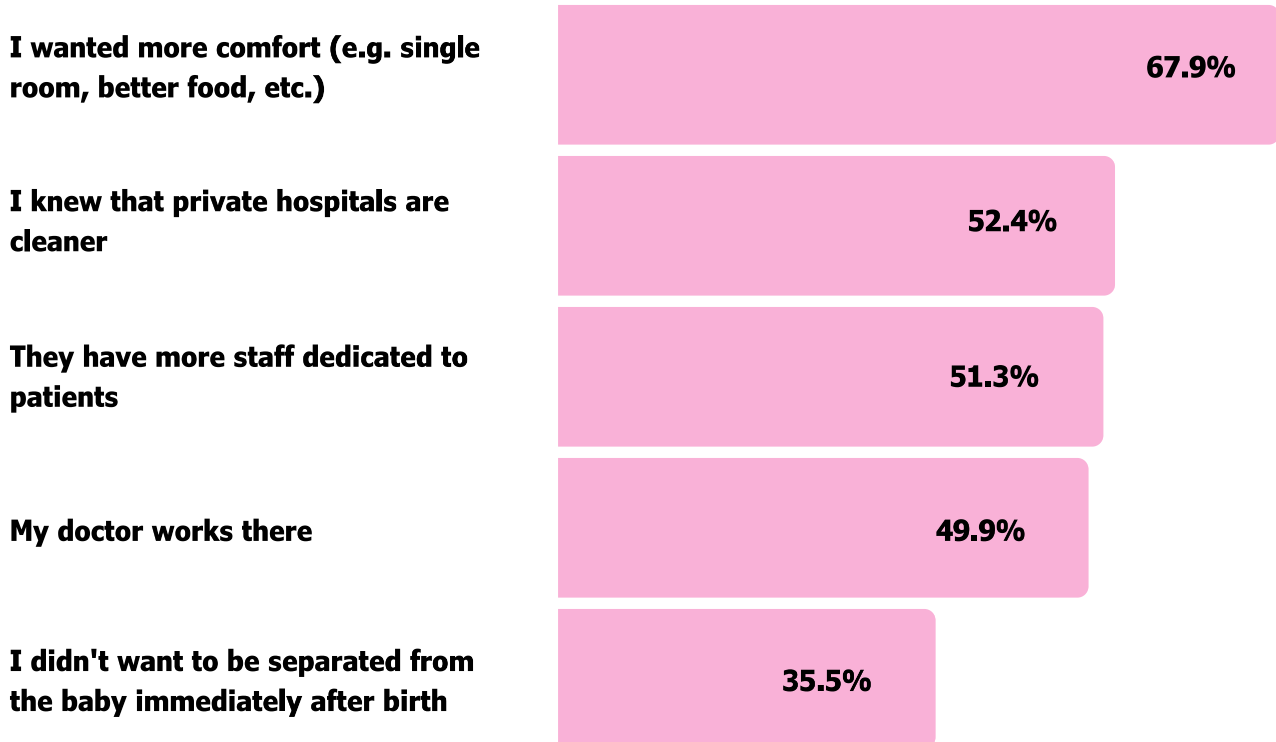


*Chart 2: First 5 reasons for delivering in a private hospital N=1231*

***Comment:*** *However, it is important to consider the above data in conjunction with the fact that the sample comprises women with generally average incomes and higher education It is likely that the financial aspect would have been more relevant for a representative sample of the population, given the high level of poverty in Romania. According to Eurostat data for 2023, Romania has the highest risk of poverty and social exclusion in the EU at 32%.*[2]

## 1.5. Gynaecologist (woman or man) rather than midwife

The vast majority of women (over 75%) were attended by doctors at childbirth, particularly by those who monitored their pregnancy. The reasons why respondents choose to give birth with a doctor (and do so), irrespective of gender, are diverse. Women often indicated the special bond developed with their gynaecologist.

Accordingly, over half of the respondents indicated that they wanted to give birth with the physician who monitored their pregnancy. In 20% of cases, the obstetrician was simply the doctor on duty at the time. It is also noteworthy that the respondents indicated a preference for giving birth in the presence of female gynaecologists. There are few respondents who stated that they gave birth with midwives or nurses, and the reasons for this warrant further investigation. It is crucial to highlight that nurses are not qualified to assist in childbirth, and a more comprehensive analysis of the factors contributing to births assisted by unqualified personnel is necessary.

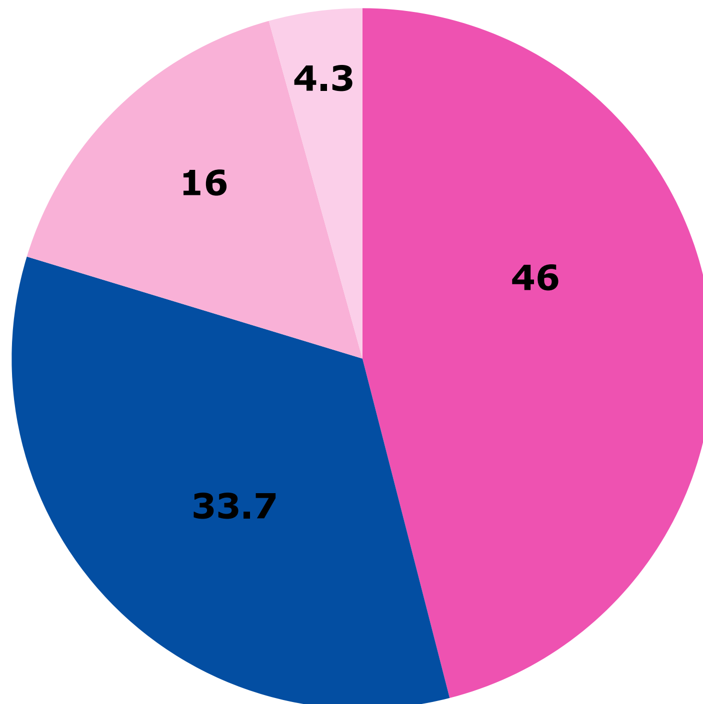


*Chart 3: Healthcare professional attending childbirth. N=5623*

- Woman OB/GYN
- Man OB/GYN
- Midwife
- Nurse



2 Eurostat: People at risk of poverty or social exclusion in 2023

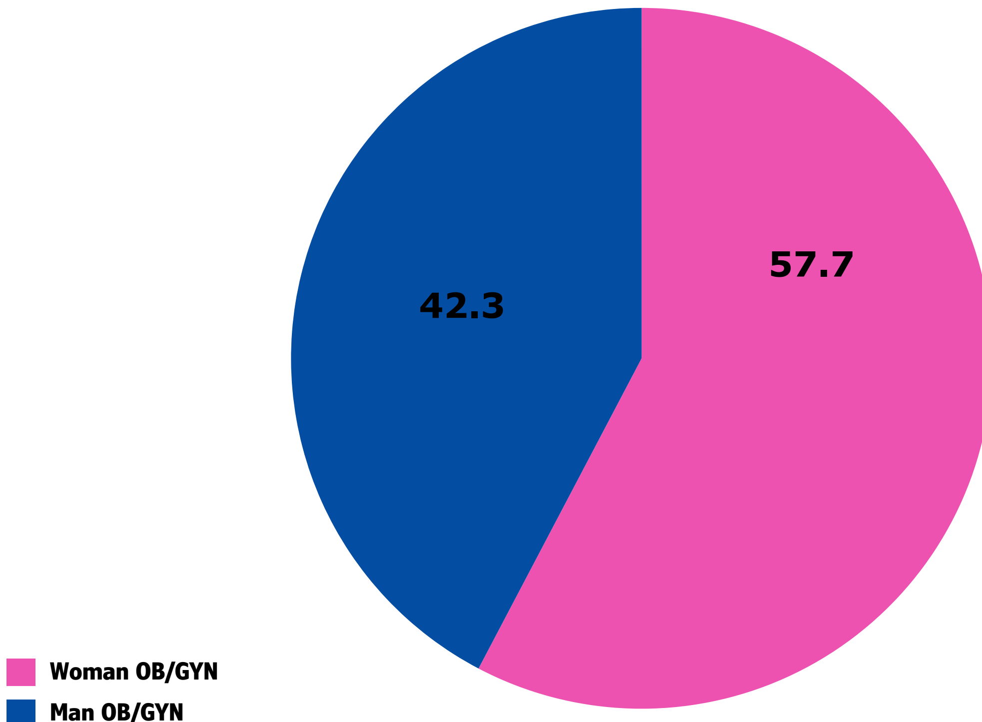


*Chart 3.1: Gender of doctor attending childbirth chosen by woman*
*Situations were excluded where women did not have the option to choose their doctor (such as delivering with the doctor on duty, with another doctor due to the COVID-19 period, and with a doctor recommended by the main doctor). N=4483*

***Comment:*** *A number of hypothetical explanations have been put forth to account for the observed preference of women for female rather than male obstetricians, including the psychological comfort, the perception of a higher level of empathy, and the belief that a female gynaecologist would better understand the birth experience. These assumptions require further investigation and testing in a future study, as this study did not allow for the capture of this dimension of childbirth.*

*The issue of whether OGs should be the sole practitioners involved in the pregnancy and childbirth process, from the initial consultations and examinations to the actual delivery, is a topic that warrants further debate. Legally speaking, according to Art. 7 of EOG 144/2008, the profession of midwife in Romania implies the right to access and exercise a wide range of antenatal and postnatal care activities, such as information, counselling, diagnosis, as well as "care and assistance to the mother during labour and monitoring of the foetus condition in utero by appropriate clinical and technical means; assistance in normal childbirth including, if necessary, performing episiotomy and, in emergency cases, practicing delivery in the pelvic position" (EOG 144/2008).*

*In hospital practice though, despite having the qualifications and a legal framework that allows them a wider range of activities, it appears that midwives are not consistently able to fully leverage their expertise and qualifications.*

*The absence of midwifery in antenatal and postnatal care, the scarcity of midwives in healthcare facilities, the preference of women with financial resources for OB/GYN care during pregnancy, and the lack of awareness*

*about the role of family doctors recognised by the CNAS in perinatal monitoring, collectively influence women's choices in one direction only and perpetuate the dominance of OB/GYNs in perinatal care.*[3]

*Consequently, in Romania, neither the legal provisions on midwifery competencies nor the WHO recommendation pertaining to the so-called "midwife-led continuity of care model" – a model of care in which midwives provide continuous support to women during the antenatal, intrapartum and postnatal periods – are implemented (Sandall et al., 2016).*

## Section 2: Hospital conditions

### 2.1. 2.1 Good and very good relations with medical staff: OB/GYNs and physicians on duty

The results regarding the quality of the relationship between patients and doctors, as well as with other medical staff (midwives and nurses) involved in monitoring pregnancies and in birth, offered an intriguing insight. The assessment of the relationship between the patients and the professionals involved in their care (doctors, nurses, midwives and on duty doctors) yielded positive ratings across all four categories. It is true that the OB/GYNs were the most highly rated, with over half of the participants (57.2%) awarding them the maximum score (maximum score: 10 – very good relationship). In comparison, the nurses were rated the highest by only slightly more than a third (36.4%) of the participants.

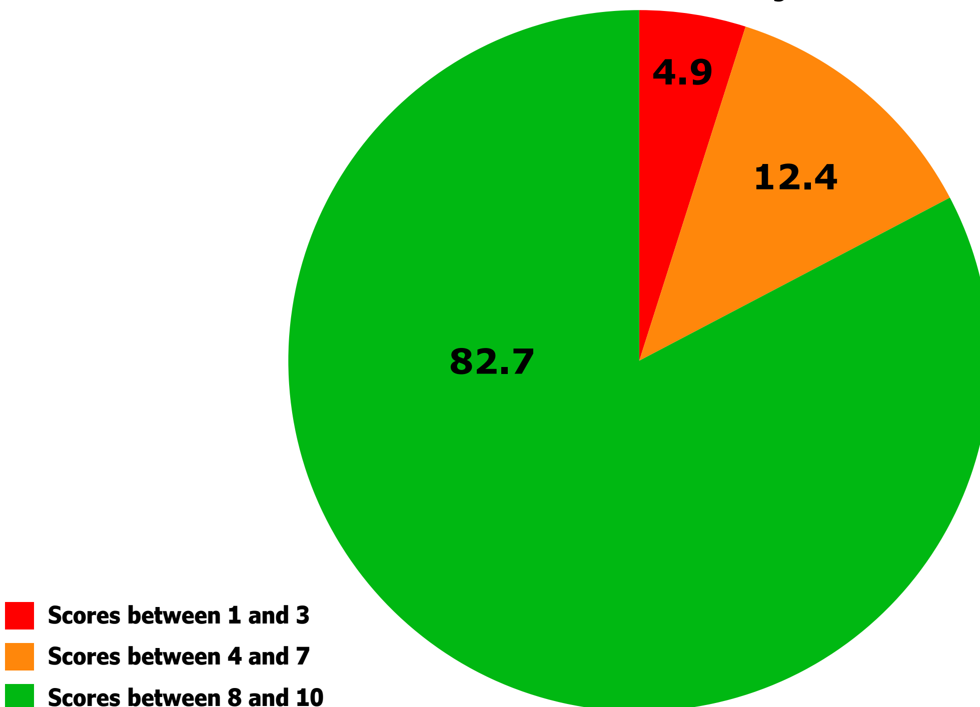


*Chart 4: Scores awarded to doctor attending last childbirth N=5623*

3 RENASC - Report: Assessment of Public Policies on Reproductive Health

Furthermore, if we consider the 8 and 9 ratings, which we also view as indicative of a positive relationship with the doctor during the previous birth, this would bring the total percentage to 82.7% of respondents wo are highly and very highly satisfied with their attending physician.
A total of 274 women (4.9%) indicated that they had a negative relationship with the physician who attended their birth. Of these, 255 (93.1%) had given birth in a state hospital.

It is also noteworthy that the on-duty doctors, who just attended the delivery, received exceptionally high ratings, though the assumption was that the OB/GYN's who monitored the pregnancy would score high due to the trust relationship established through repeated interactions but also to the possibility to select and/or change the doctor overseeing the pregnancy.

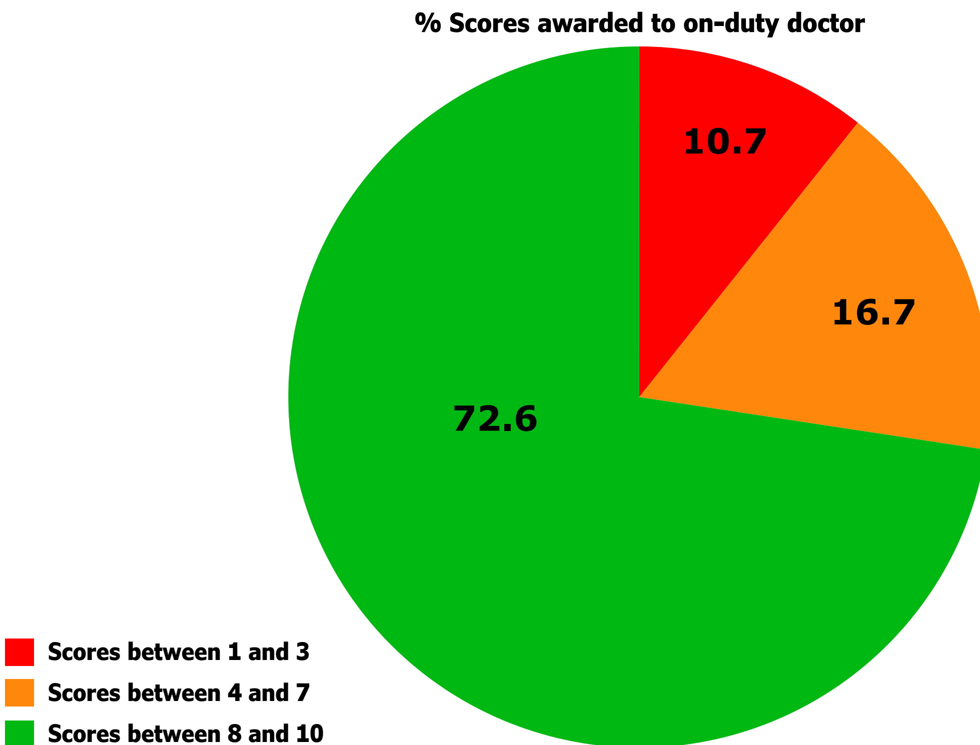


*Chart 5: Scores awarded to doctor on duty at last childbirth N=3455*
**If this was the doctor who also attended the birth, or if you did not interact with the on-duty doctor, do not answer the question*

### Good and very good relations with nurses

The development of very good relationships with the doctors, potentially attributable to the patients' autonomy in selecting them, and the establishment of a robust, trust-based rapport during the approximately 40 weeks of pregnancy, can be further confirmed by the ratings awarded to the relationships with nurses, who engage at varying degrees with pregnant women, particularly postpartum (neonatology nurses).

Thus, only 36.4% of respondents rated the relationship with the nurses as very good (score 10), in contrast to 57.2% who rated their relationship with the doctor as very good (score 10). However, almost 70% of respondents rated their relationship with the nurses between 8 and 10 (10 indicating a very good relationship), which represents a significant percentage.

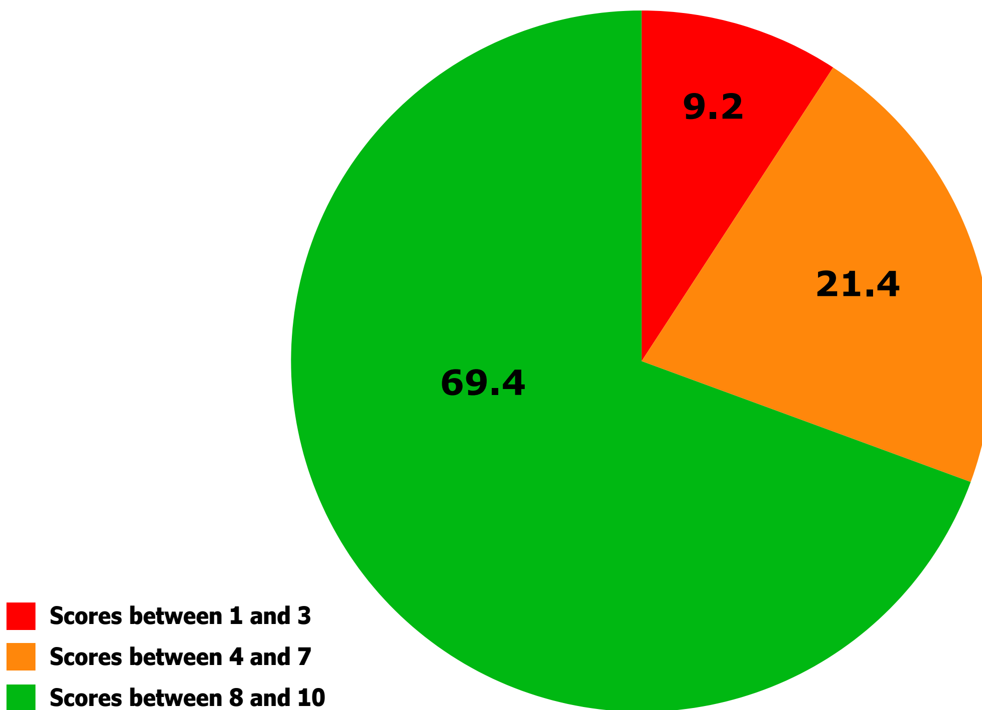


*Chart 6: Scores awarded to nurses at last childbirth. N=5623*

**Almost half of respondents who interacted with midwives during pregnancy and childbirth rated the relationship as very good (score 10 out of 10).**

The trend is also maintained when it comes to the relationship with midwives, almost 3/4 (72.7%) of the respondents stated that they had good (23.8% - score 8 and 9) or very good (48.9% - score 10) relationships and only 10.9% stated that they had bad (5.1% - score 2 and 3) and very bad (5.8% - score 1) relationships with midwives, the remaining 16.4% being distributed between score 4 up to 7 inclusive.

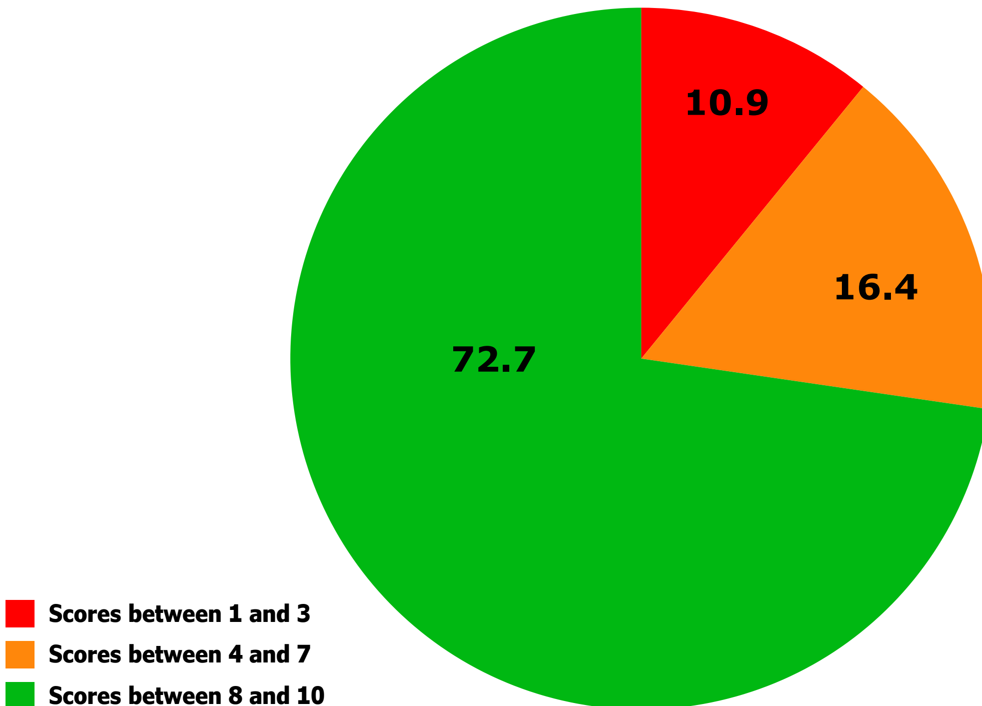


*Chart 7: Scores awarded to midwives at last childbirth. N=3713*
**If none present, please do not answer the question*

***Comment:*** *20% of the interviewees indicated that they had given birth with the on-duty doctor, while approximately two-thirds (67%) had given birth with the doctors who had monitored their pregnancy. This suggests that the majority of these births may have been planned.*
*The high level of satisfaction with the relationship with the OB/GYN can be attributed to the fact that patients who can afford it can select the doctors who will oversee their pregnancy and that, in most cases, the practice (informal in public hospitals but formalised in private hospitals) is to give birth with the same medical professional, even if the legal responsibility lies with the on-duty doctor.*

**In accordance with the Regulation on working time and organisation of on-duty shifts in public healthcare facilities, as set forth in Order No. 870/2004 of the Minister of Health: Article 44 (1) The on-duty schedule for each health facility is prepared on a monthly basis by the management of the respective wards, laboratories and departments and subsequently approved by the management of the health facility. (2) Modifications to the schedule may be made only in exceptional circumstances, with the approval of the head doctor of the relevant ward or laboratory and the management of the health facility. Consequently, in the majority of cases, the OB/GYN provides assistance to a patient he has been following throughout their pregnancy outside of his scheduled on-duty hours, without the need to complete any formalities or obtain the approval of the head doctor since he/she cannot justify the necessity the action. Also, in light of the provisions of Article 100(15) of Law 95/2006 on healthcare reform, as well as Article 90(3) of Decision No. 521/2023 approving the service packages and the Framework Contract regulating the provision of healthcare, medicines and medical devices in the social health insurance system, as amended, which provides that the costs associated with activities conducted in the on-duty room are incorporated into the structure of the tariff per case handled/average tariff per case handled by specialties, the scheduled on-duty doctor is required to sign for the services provided by another OB/GYN doctor in order for the hospital to settle the costs.**

*A closer analysis of the unfavourable ratings awarded to physicians overseeing pregnancies reveals that nearly 2/3 (60.2%) of the lowest scores assigned to the attending doctor were related to vaginal births.*

*These data can be correlated with data indicating that women who opted for C-section did so primarily due to concerns about pain. This, in conjunction with the elevated rate of caesarean births, raises questions about whether we are not dealing with a systemic issue where vaginal delivery becomes challenging, both for medical professionals and for women.*

*The distribution unfavourable ratings awarded to physicians overseeing pregnancies by type of hospital (the overwhelming majority related to public hospitals) also prompts consideration of systemic issues. This indicates a need for further research, particularly given that the majority of doctors typically work in both public and private hospitals.*

*It is therefore important to gain a deeper understanding of the implications of these data, to identify potential explanations and to ascertain their relationship with underfunding, the lack of quality assessment of delivery care and assistance services, protocols, the shortage of midwives with qualifications in physiological obstetrics, the lack of woman-centred care, the use of sub-standard staff, poor infrastructure and other factors.*

### 2.2. Good conditions in public and private hospitals

**The quality of hospital facilities was rated highly. Nearly 3/4 of respondents indicated that they had positive experiences with hospital conditions, with the majority of births occurring in public hospitals (score 8, 9, or 10).** Of the remaining 1/3, 364 women (6.4%) stated that they experienced bad and very bad conditions (score 1, 2 or 3).

Most of these (359) gave birth in a public hospital and only 5 of the women who gave birth in a private hospital rated the conditions (e.g. facilities and/or cleanliness) between 1 and 3.

The proportion of women who rated the conditions in private hospitals as 1–3 was less than 1%, whereas approximately 8% of women who gave birth in public hospitals made the same assessment. It is also noteworthy that 62.9% of women who rated hospital conditions/facilities as 1–3 at their last birth had undergone C-section.

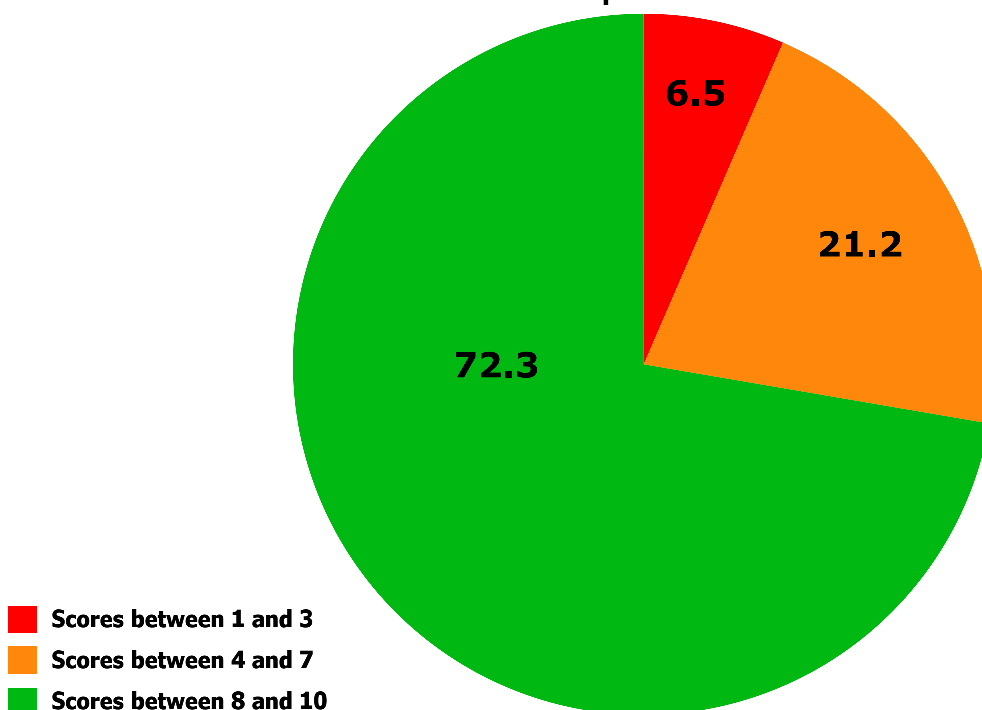


*Chart 8: Scores awarded to hospital conditions at last childbirth. N=5623*

***Intersectional comment: Ratings awarded by self-identified Roma women***

*In order to incorporate an intersectional perspective into this research, respondents were permitted to self-identify as members of a minority or ethnic community.*

*We chose to undertake a more detailed examination of the responses provided by Roma women on their perceptions of their interactions with health professionals and the conditions in hospitals because we thought that this particular area might yield insights into instances of differential treatment. However, the share of respondents who self-identified as Roma was extremely low (0.3%), rendering the raw data statistically inconsequential and precluding any meaningful inferences.*

*Nevertheless, we deem it beneficial to offer the following observations regarding their evaluation of the relationships with medical personnel and the quality of hospital facilities.*

*The majority of ratings of health professionals and hospital conditions are within the 8-10 range, which closely aligns with the ratings provided by the majority women.*

*The most striking differences were observed in the assessment of hospital conditions, with Roma women being the least likely to provide positive ratings. Further analysis of this information would be beneficial in relation to a number of qualitative comments (see Section 6) and, of course, in relation with other studies.*

## Section 3. Experiences in pregnancy and childbirth

### 3.1. Higher likelihood of experiencing obstetric violence in vaginal births

According to the data, women who have given birth vaginally identify the greatest risk of obstetric violence. On average, they ticked-off about a third of the 25 forms of violence identified in the study for this type of birth (29.6%).

The analysis revealed that approximately 25% of the 23 forms of potential obstetric violence were identified as being at risk for occurrence during emergency C-section births that commenced in labour. For planned and emergency caesarean sections without labour, the risk was identified in approximately 20% of the 16 forms of violence tested.

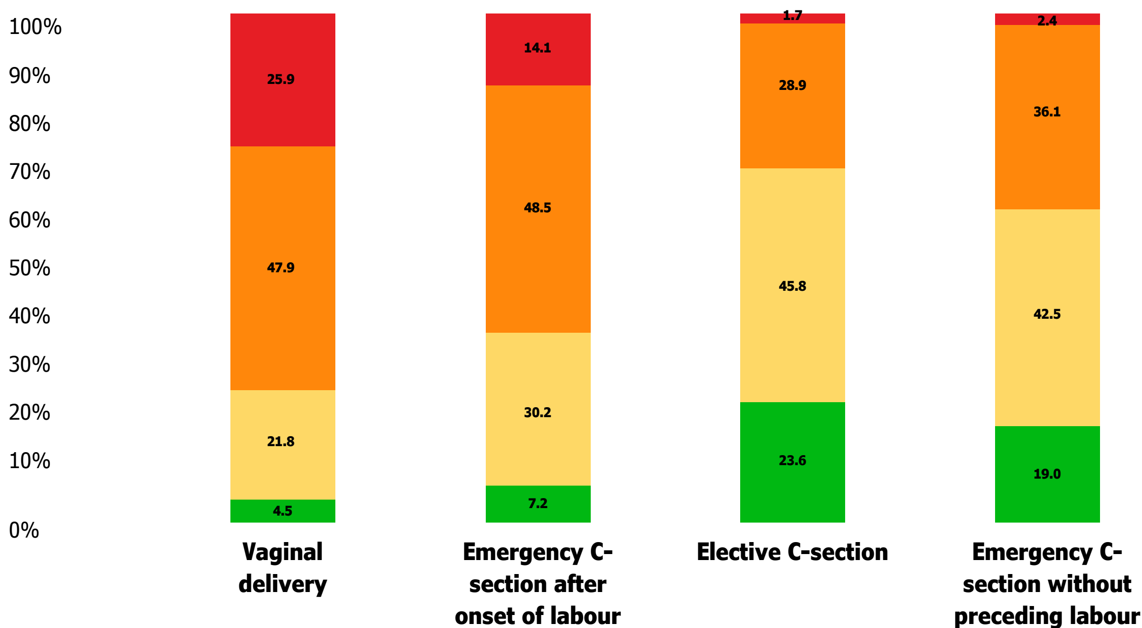


*Chart 9: Experiences of forms of violence N=2119; N=905; N=1895; N=704*

**0 Obstetric violence experienced**
**Between 1 and 3**
**Between 4 and 10**
**More than 10 experiences of obstetric violence**

It can be argued that vaginal birth represents the type of birth in which women are most exposed to obstetric violence. This may be a significant factor contributing to the high prevalence of caesarean births, particularly planned. In particular, the decision to undergo a planned C-section was primarily influenced by concerns about pain (59% of women) and traumatic experiences with vaginal births (48.8%). Comprehensive data on the type of birth and the type of hospital where the birth occurred (public or private) are provided in the annexes.

**Note:**
**25 forms of potential obstetric violence were identified during vaginal deliveries;**
**23 in the case of emergency C-sections following the onset of labour;**
**16 in emergency C-sections without prior labour.**

### 3.2. Obstetric violence, experienced more often in state hospitals, but also common in private hospitals

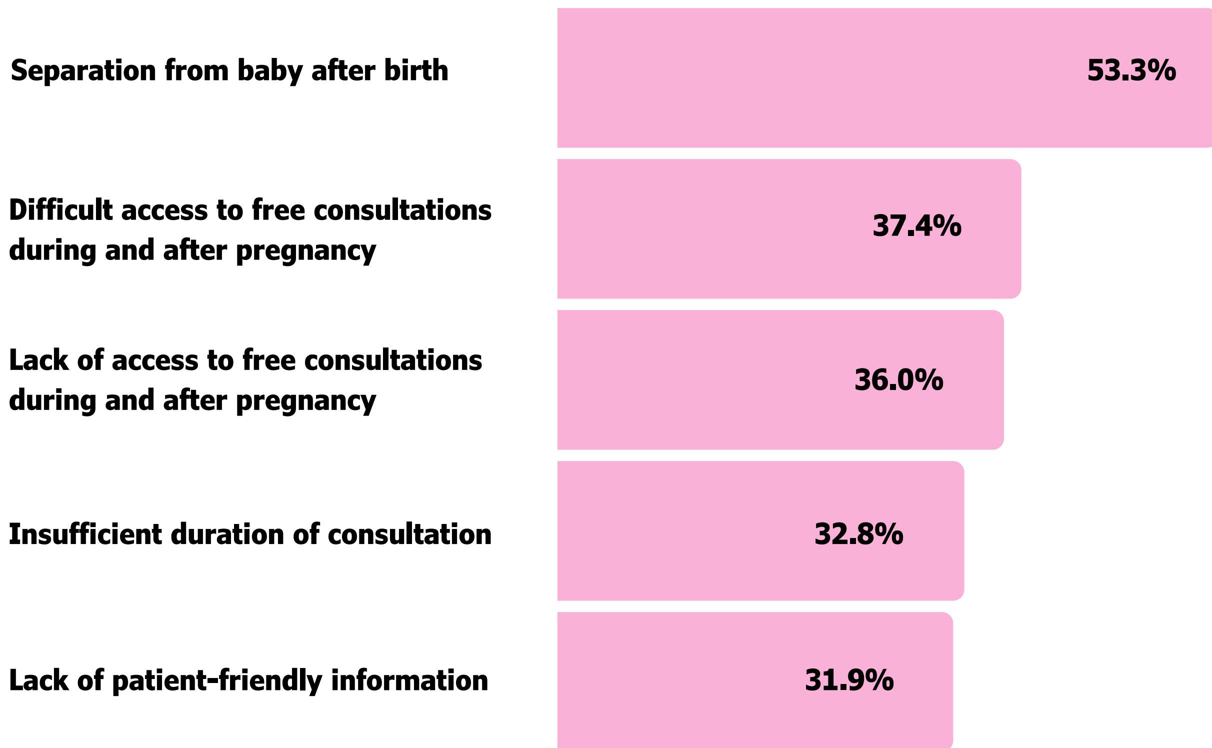


*Chart 10: Top 5 experiences of women who gave birth by emergency C-section without going into labour in a public hospital. N=561*

## % Top 5 experiences of women who gave birth by emergency C-section without going into labour in a private hospital

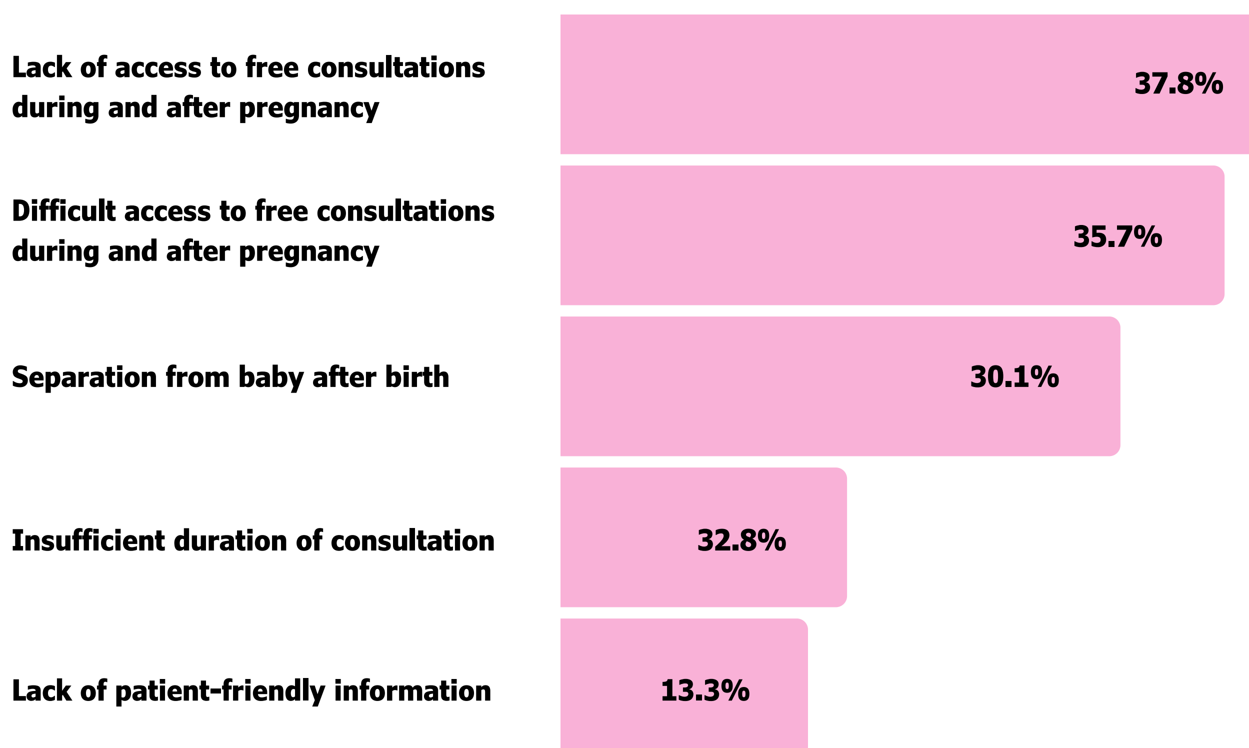


*Chart 11: Top 5 experiences of women who gave birth by emergency C-section without going into labour in a private hospital. N=143*

Consequently, the most frequently reported experiences of women who have undergone an emergency C-section without going into labour are the separation from their babies at birth, the difficulty in or lack of access to free consultations during and after pregnancy, and the insufficient duration of consultation.
**It is crucial to highlight the considerable number of women who reported limited or no access to free consultations during pregnancy. This underscores a significant systemic issue, particularly for already vulnerable women, including those with lower incomes.**

There were notable discrepancies in the responses by type of hospital where the birth occurred.

The findings suggest that public hospitals may not provide the same level of care as private hospitals in terms of consultation time, the quality of information provided to patients, and the separation of mothers from their newborns.

Significant discrepancies were also observed between public and private hospitals with regard to a number of other experiences, including staff attitudes, the administration of medicines without prior information, and the lack of facilities for people with disabilities.

It is noteworthy that both categories of hospitals appear to be similarly vulnerable with regard to access to free consultations (financed by the Single National Fund for Social Health

Insurance - FNUASS). This is a subtle form of obstetric violence associated with access to the medical procedures/services that unambiguously points to systemic shortcomings.

**The same trends were observed in the case of the 1,895 women who gave birth by planned caesarean section.**

## % Top 5 experiences of women who gave birth by elective C-section in a public hospital

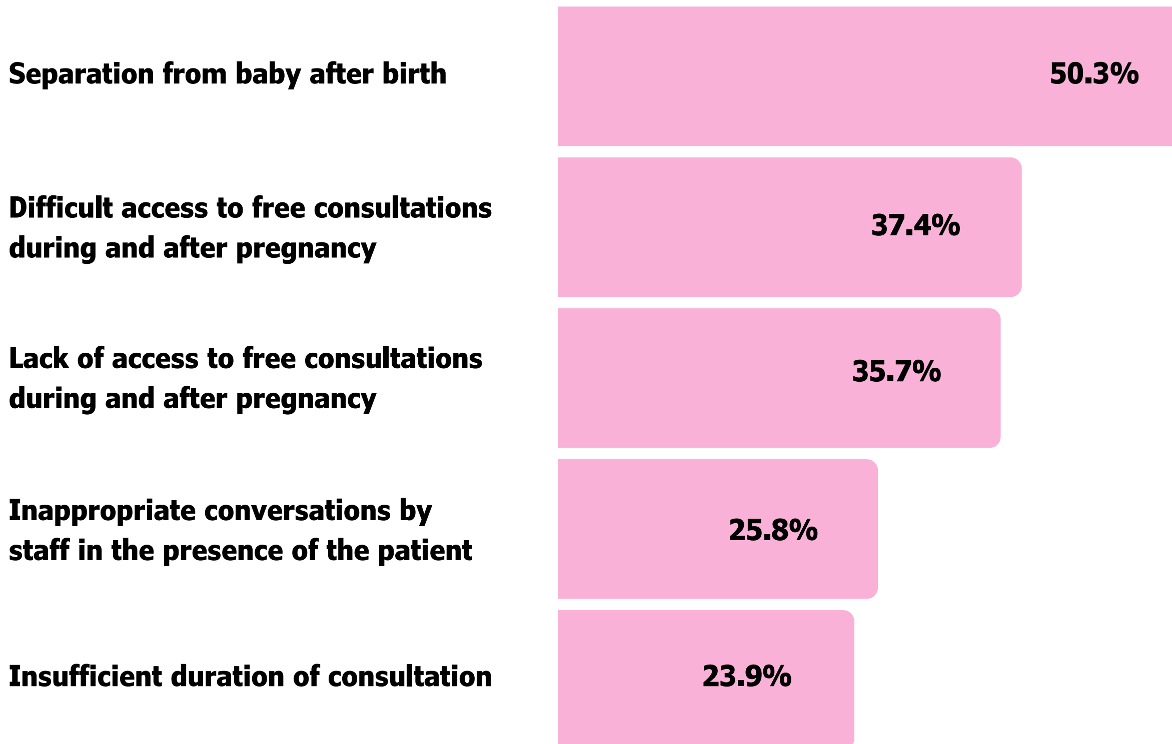


*Chart 12: Top 5 experiences of women who gave birth by elective C-section in a public hospital. N=1428*

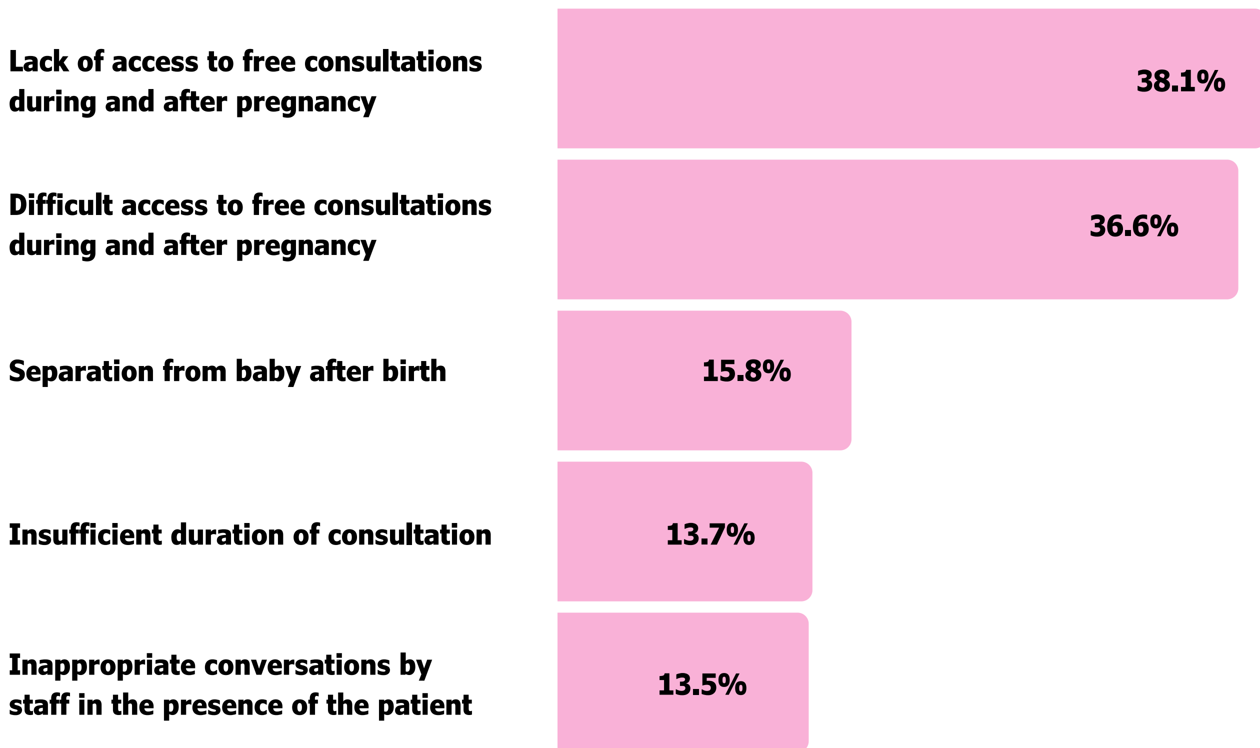


*Chart 13: Top 5 experiences of women who gave birth by elective C-section in a private hospital. N=467*

***Comment:*** *Significant differences are noticeable in the prevalence of obstetric violence between public and private hospitals.*

*A closer examination of the underlying causes of these differences is required, particularly given that many health care professionals work in both public and private hospitals, which raises concerns about the potential for professional ethics conflicts.*

*It is inevitable that the issue of resources, more specifically the issue of money, will arise. The data above demonstrate that women who can afford to give birth in a private hospital, namely those from privileged groups, are at a lower risk of experiencing obstetric violence. Conversely, women who are unable to afford such services, including those from vulnerable, low-income groups, are more at risk of experiencing obstetric violence. This dynamic raises significant concerns regarding equity and social justice.*

## 3.3. Labour - Increased risk of obstetric violence

Relevant differences emerged when analysing births preceded by labour. The absence of the option to have a partner or support person present during labour and childbirth was the most common experience among women who gave birth, either vaginally or via C-section, immediately after labour began. Nevertheless, considerable differences exist between public and private hospitals: in private hospitals this practice is lower by more than 50% than in public ones.

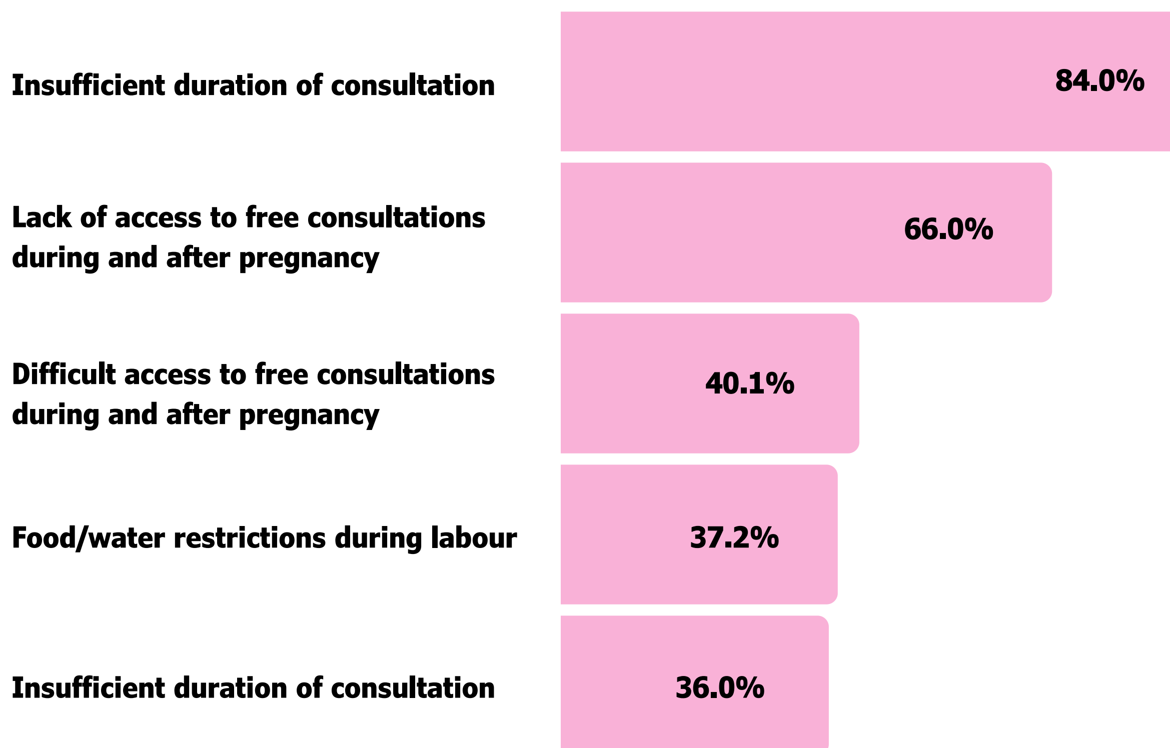


*Chart 14: Top 5 experiences of women who gave birth by emergency C-section after onset of labour in a public hospital. N=648*

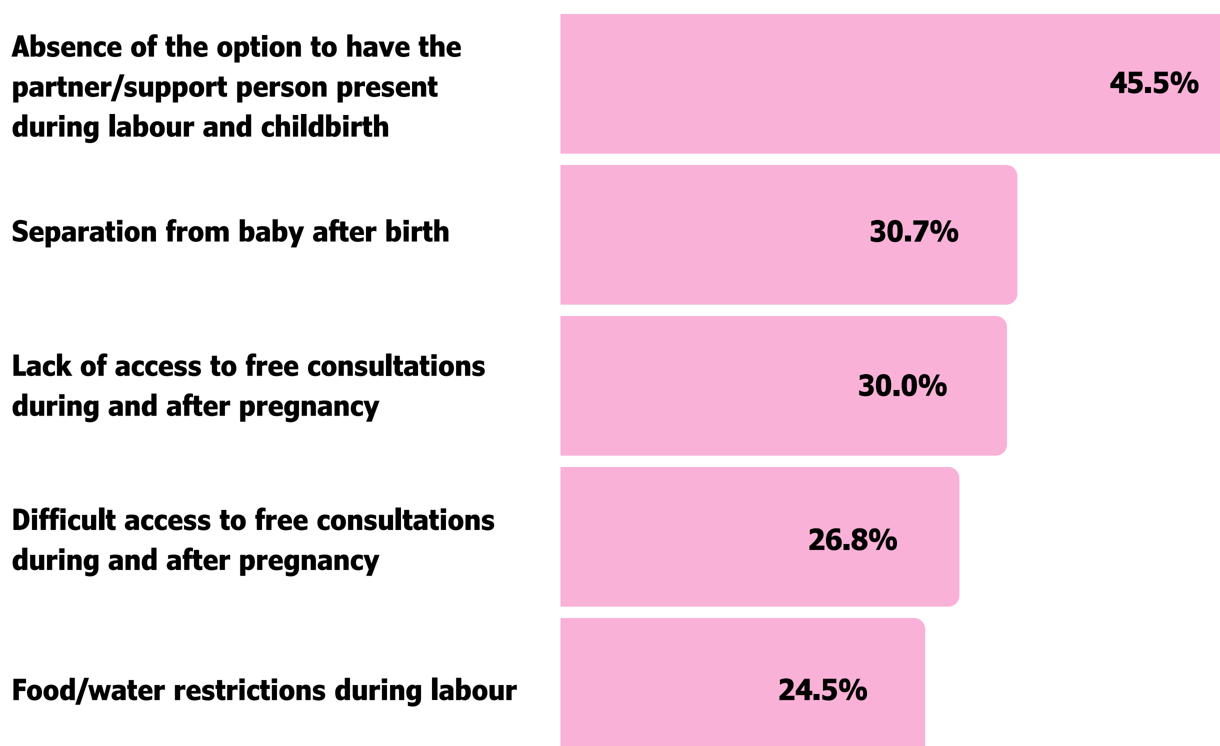


*Chart 15: Top 5 experiences of women who gave birth by emergency C-section after onset of labour in a private hospital. N=257*

The experience of separation from the newborn at the time of birth continues to be identified as a highly traumatic event, even in the context of labour preceded births. However, for vaginal births, this ranks third, after the imposition of a specific position (lithotomy position), a common practice in private hospitals, with over half of the women who gave birth in private hospitals reporting such an experience. The Kristeller manoeuvre (fundal pressure), a procedure not recommended by in Romania[4] and internationally[5] was identified as a frequent practice in both public (45.3%) and private (32.4%) hospitals in Romania.

Furthermore, experiences such as non-consensual procedures, movement restrictions during labour, lack of information, inadequate staff discussions, insufficient duration of consultation, and food/water restrictions during labour are also common in public hospitals (more than 30%), with similar experiences also found in private hospitals, albeit at a lower frequency.

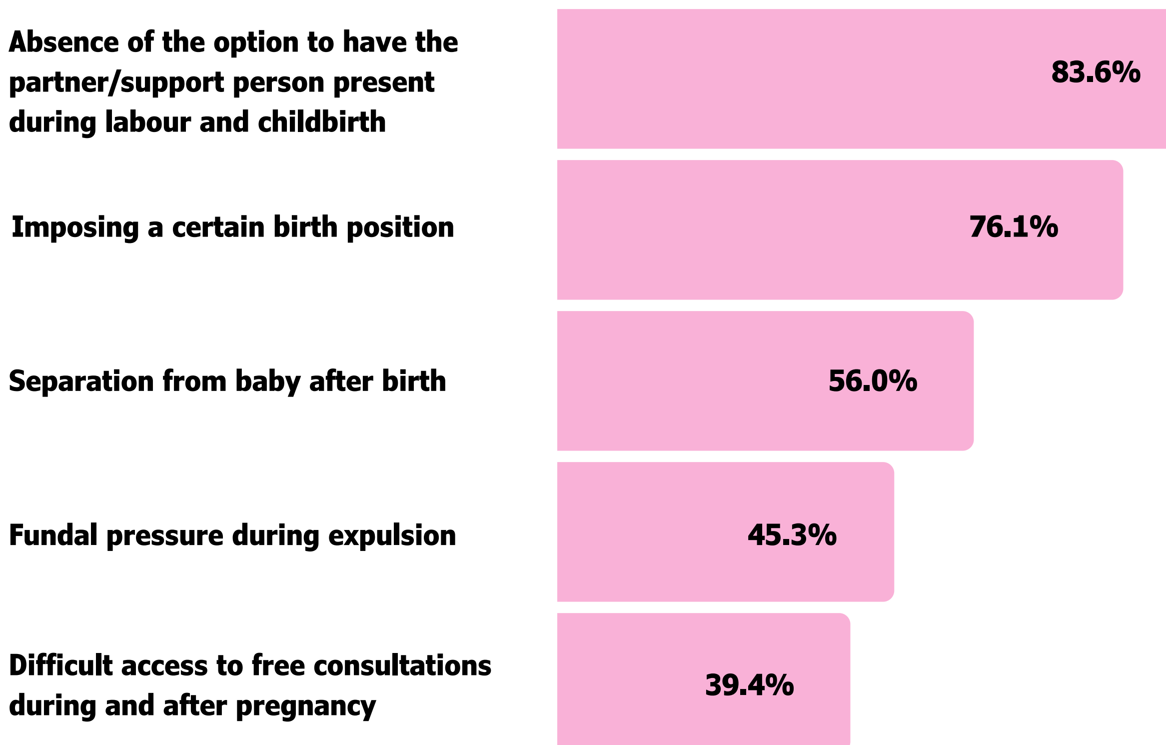


*Chart 16: Top 5 experiences of women who gave birth vaginally in a public hospital. N=1754*

4 Societatea de Obstetrică şi Ginecologie din România: Asistența nașterii în prezentația craniană

5 Malvasi A., Zaami S., Tinelli A., Trojano G., Montanari Vergallo G., Marinelli E. Kristeller Maneuvers or Fundal Pressure and Maternal/Neonatal Morbidity: Obstetric and Judicial Literature Review. J Matern Fetal Neonatal Med. 2019 Aug; 32(15):2598-2607. doi: 10.1080/14767058.2018. (Tudose)

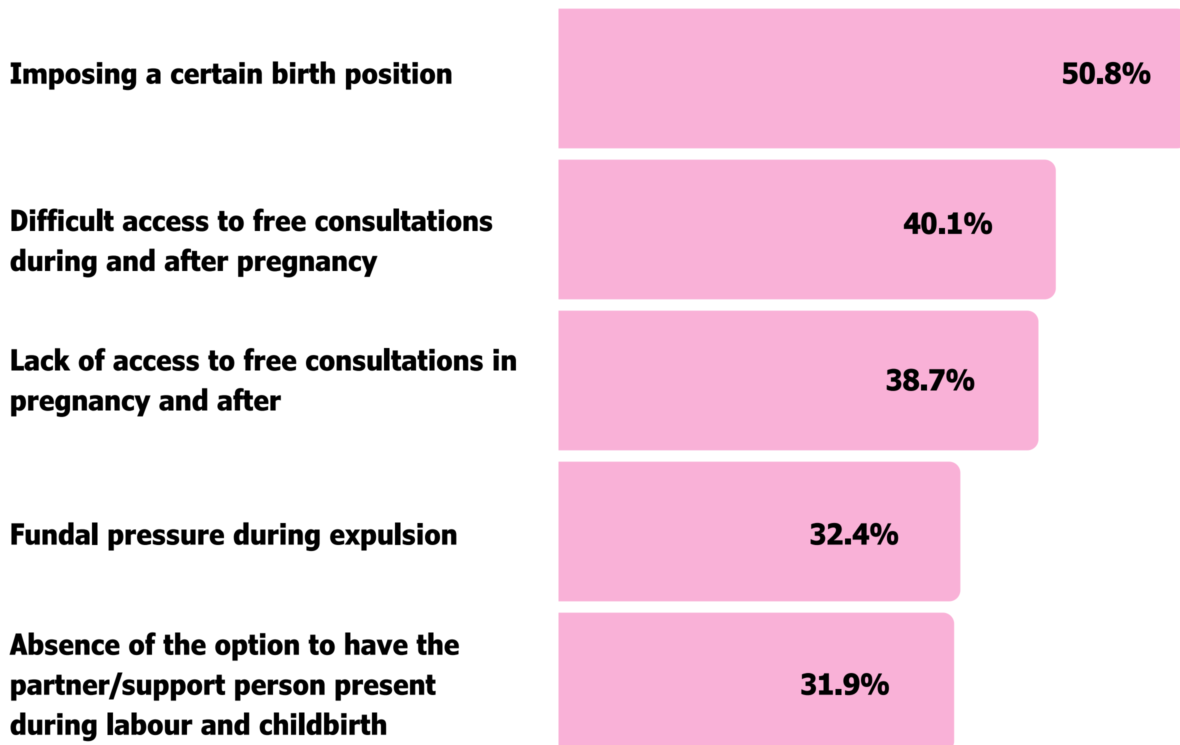


*Chart 17: Top 5 experiences of women who gave birth vaginally in a private hospital. N=364*

***Comment:*** *It thus seems labour, that is typically a normal physiological experience, may in fact become a variable that increases the risk of experiencing obstetric violence. This provides a potential explanation for the high number of caesarean deliveries, particularly planned, but also raises further questions for in-depth research into the factors contributing to this situation, as well as the differences between public and private hospitals.*

*Among them, we could mention that labour involves continuous medical care over a longer period of time, the performance of several medical procedures and can be correlated with negative outcomes, understaffing in state hospitals or insufficient resources (see painkillers, adequate wards etc.).*

### 3.4. Obstetric violence: Commonly experienced but much less recognized

**The recognition of experiences as manifestations of various forms of violence, some of which are more subtle, demonstrates that obstetric violence is a prevalent issue that is often overlooked.** This observation is valid for all the types of childbirth analysed and for almost all the forms of violence covered by the questionnaire.

Almost half of the respondents do not recognise the absence of a partner or support person during childbirth, difficult or lack of access to free consultations, and insufficient duration of consultation as forms of obstetric violence.

Likewise, **the lack of choice to have a partner/support person present during labour and birth**, in the case of labour births, even though it was the most commonly experienced form of violence, **was also among the least recognized as an inappropriate practice**.

It should be noted that **even invasive procedures** such as the Kristeller manoeuvre, medical anamnesis during labour, food/water restrictions during labour or unjustified stay in the maternity ward **were not considered as forms of violence by very many respondents (between 20% and 35%).** As might be expected, more subtle forms of obstetric violence, such as those related to access to medical services (paid consultations) or inappropriate discussions by staff, were among the least recognised as unacceptable.

**Last but not least, we were struck by the fact that about half of the respondents were unaware that insufficient time for consultation is a form of violence,** especially since, as we said at the beginning, most of them are women with higher education.

In contrast, the most recognized forms of obstetric violence are:

**Abusive and brutal checks for labour births**
Stated by more than 96% of the respondents

**Inappropriate staff attitudes generally and inappropriate responses to women's pain**
Around 90% of respondents considered this experience as a form of violence

**Lack of privacy**
Recognised by about 90% of respondents as a form of violence

**Lack of painkillers, even when needed**
About 88% of respondents recognised this as a form of obstetric violence

**Non-consensual procedures**
About 86% of respondents recognised this as a form of obstetric violence

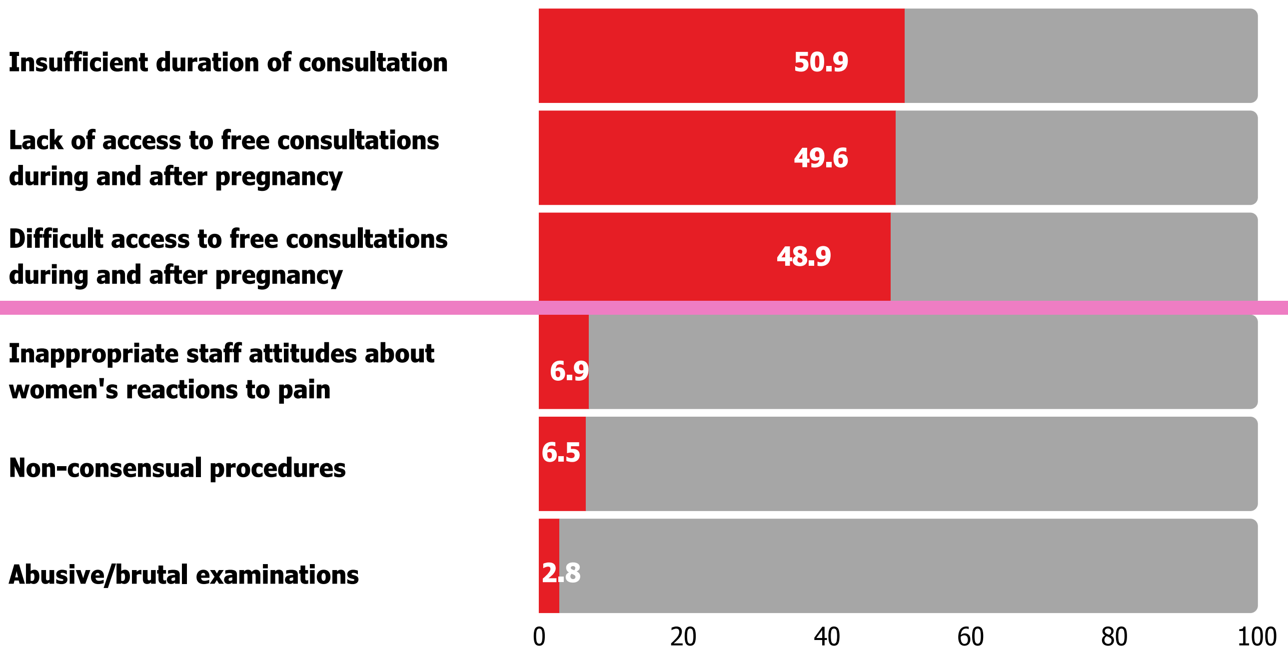


*Chart 18: The first 3 and last 3 experiences of women who have given birth vaginally, which they do not consider as forms of obstetric violence. (Full table in appendix)*

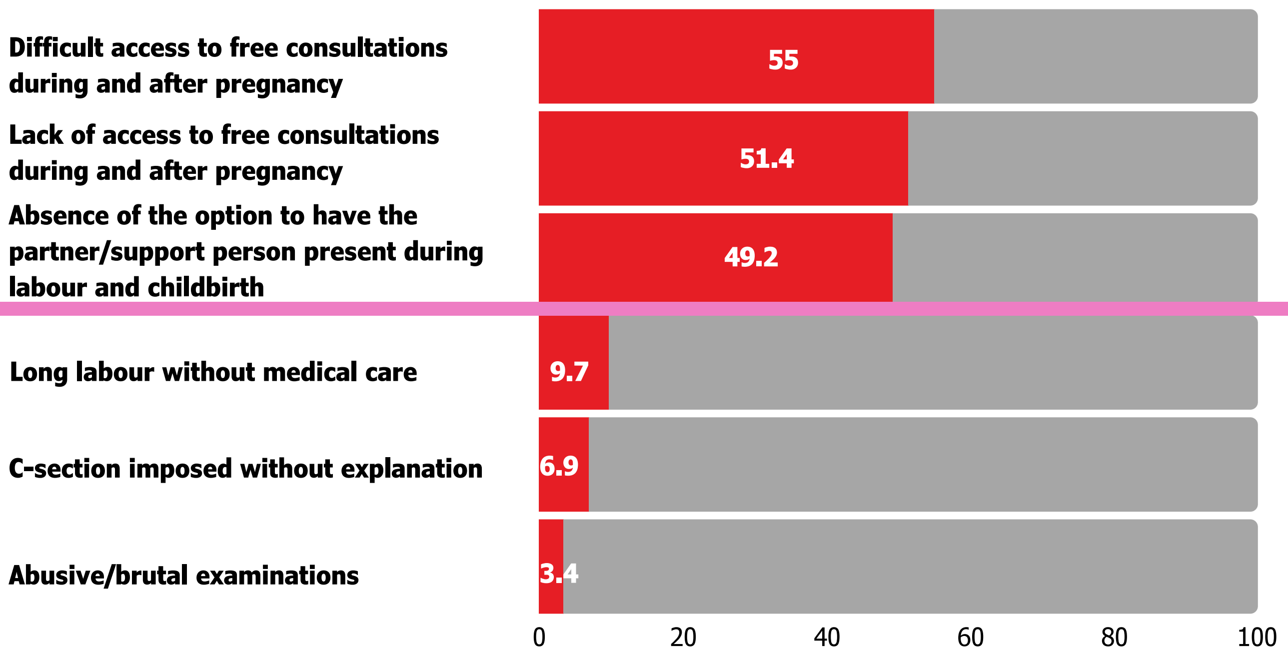


*Chart 19: The first 3 and last 3 experiences of women who have given birth by emergency C-section after onset of labour, which they do not consider as forms of obstetric violence. (Full table in appendix)*

**Do not consider it obstetric violence**

**Consider it obstetric violence**

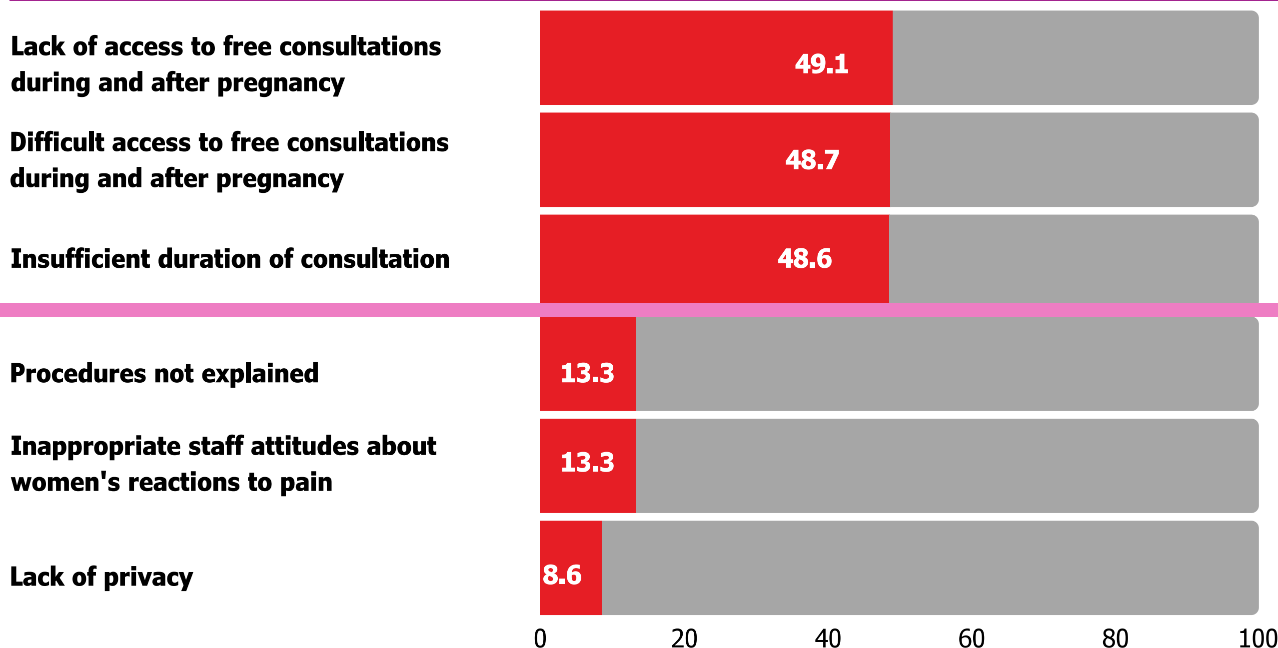


*Chart 20: The first 3 and last 3 experiences of women who have given birth by elective C-section, which they do not consider as forms of obstetric violence. (Full table in appendix)*

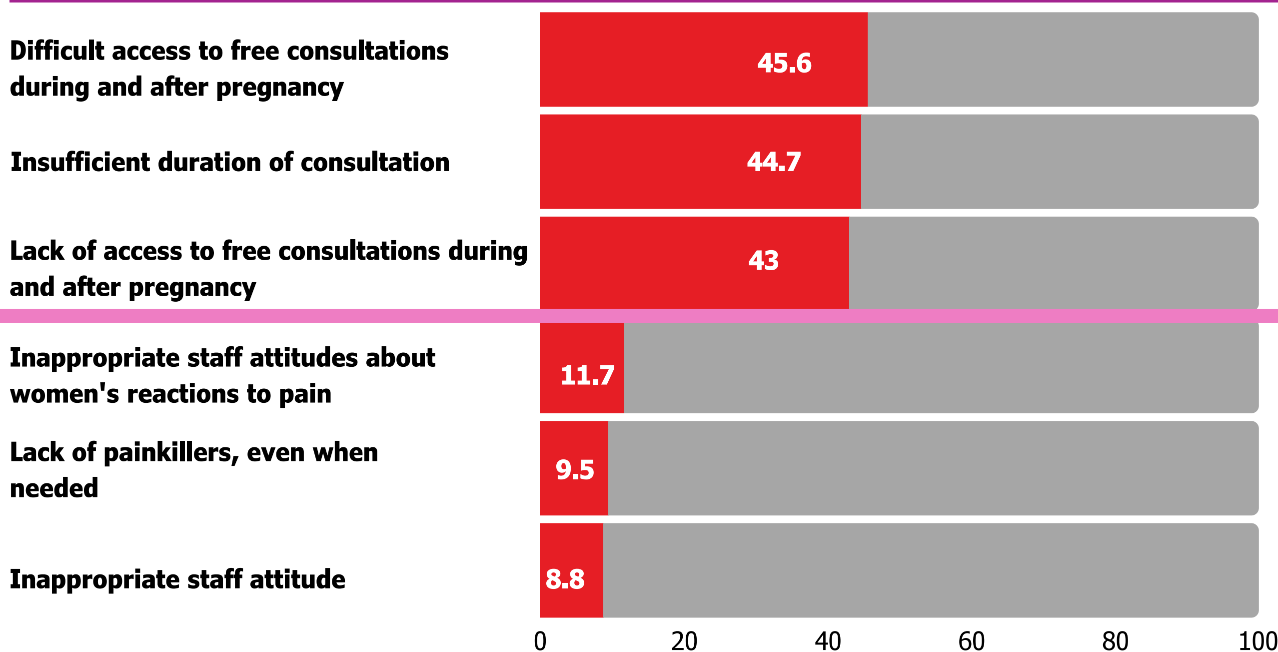


*Chart 21: The first 3 and last 3 experiences of women who have given birth by emergency C-section without preceding labour, which they do not consider as forms of obstetric violence. (Full table in appendix)*

**Do not consider it obstetric violence**

**Consider it obstetric violence**

***Comment:*** *What does the above data tell us?*

***First of all, that obstetric violence is a common experience for women.***

***Secondly, that women in Romania are exposed to multiple forms of violence during pregnancy, childbirth and afterwards, and that the risks of experiencing such abuse are higher for spontaneous vaginal delivery, i.e. those types of births that should be the norm,*** *insofar as pregnancy, childbirth and labour are not diseases but natural stages of life, even if we are talking about significant physiological and emotional changes.*

*It is therefore comprehensible why women tend to be apprehensive about vaginal childbirth and are inclined to accept more readily the increasing medicalisation of this experience, particularly given that the data from this study also demonstrate that doctors (who also hold the epistemic authority) frequently make such recommendations.*

*Furthermore, notable differences were observed between public and private hospitals, with instances of obstetric violence being more prevalent in the former. How might these findings be interpreted and explained?*

*Also, the reduced prevalence of obstetric violence in private hospitals (in the context whereby most medical personnel in public hospitals are also employed in private hospitals) suggests that the issue of obstetric violence is not solely a matter of doctors/nurses midwives normalising and trivialising obstetric violence in general, but attributable to the lack of adequate infrastructure, circuits, protocols, motivation systems, and resources in public hospitals, which provides greater scope for abuse.*

*Last but not least, the limited awareness of the forms of manifestation of obstetric violence among women who are directly affected by it means that bottom-up pressure to implement reforms is unlikely to emerge in the near future unless there is explicit education on this issue. This is particularly relevant given that we still live in societies where violence against women is trivialised and normalised.*

## Section 4. Perceptions of obstetric violence (Q31-Q35)

### 4.1. The term “obstetric violence” is known but not really understood by women

1/2 of all women surveyed said they have heard of the term obstetric violence and 1/3 know what it means.

Overall, the term “obstetric violence” is one that is known to half of the women surveyed, while the other half are unaware of it (Q31).

Additionally, a little more than 1/3 of women (35.6%) indicated that they were aware of the term, whereas the remaining 2/3 (64.4%) either expressed uncertainty or lacked knowledge regarding the specific characteristics of this form of violence (30.6% and 30%, respectively).

In terms of the information received from other women regarding potential instances of obstetric violence, over 1/3 (37.5%) of the respondents indicated that they had been informed frequently, while just under 1/4 (21.5%) that they had heard of such experiences on a regular basis.

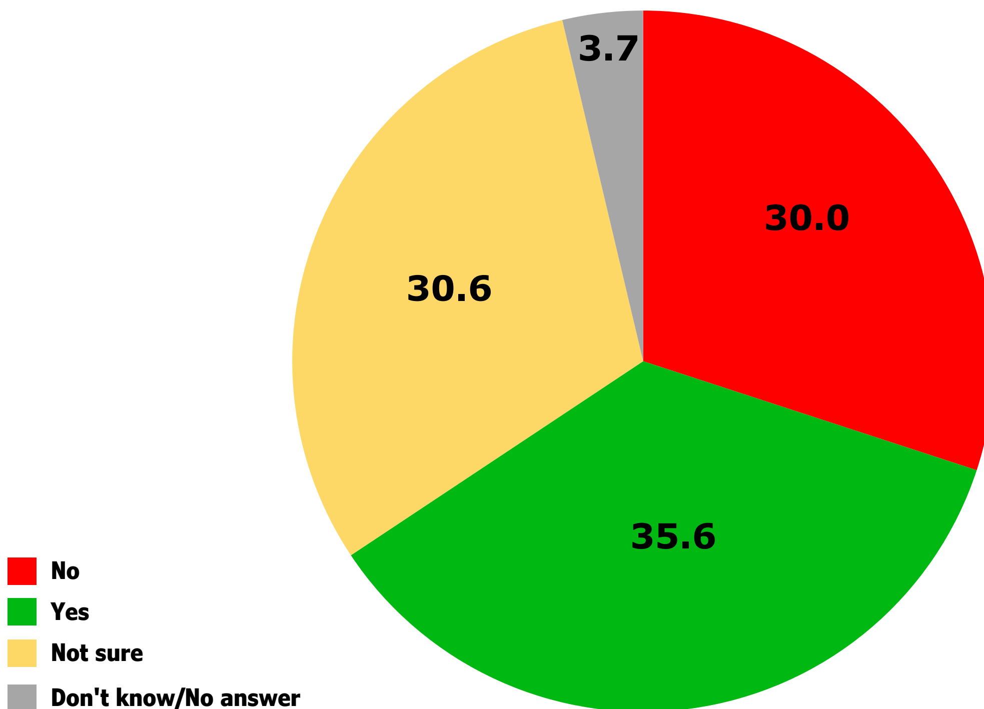


*Chart 22: The extent to which the term "obstetric violence" is known by respondents. N=5623*

***Comment:*** *It is of interest to note the proportion of women who have not heard of this term, or who have heard of the term but are unsure of its precise meaning. This is particularly relevant given that the sample was comprised predominantly of educated women, many of whom with a degree.*

*Significant differences between the two groups of women in terms of their educational backgrounds existed: 46.8% of women with a bachelor's, master's or doctorate degree reported having heard of the term, compared to 34.3% of women who had completed no more than 10 classes. Additionally, 37% of those with higher education indicated that they understood the meaning of the term, compared to only 29.1% of women with minimal/low education.*

### 4.2. Paradox: Though women don't really know what it means, yet have not been victims of obstetric violence

#### Perceptions of childbirth experiences in relation to aspects considered obstetric violence

Once the phenomenon of obstetric violence has been broken down into distinct categories identified and defined by the relevant authorities, the data become more complex (see extended list Q33 and Q35).

A total of 27 statements related to potential forms of obstetric violence were presented to respondents, and the vast majority were identified as instances of violence. The table below illustrates a number of forms of obstetric violence that women reported experiencing to a very large extent.

As evidenced in Table 6, abusive examinations and non-consensual procedures were identified as the most prevalent forms of obstetric violence, with percentages exceeding 80% across all modes of delivery.

The lack of privacy was also rated as a significant issue, along with the fundal pressure procedure and lack of painkillers.

High scores are also found for staff's inappropriate attitude towards women's response to pain.

In natural childbirth, we note that the lengthy period spent in labour without medical care is perceived by many women as a form of obstetric violence.

**% Women who consider the issue to be obstetric violence by last type of birth**

| Examples of obstetric violence | Vaginal delivery (N=2119) | C-section preceded by labour (N=905) | Elective C-section (N=1895) | Emergency elective C-section (N=704) |
|---|---|---|---|---|
| Insufficient duration of consultation | 43.1 | 42.4 | 44.3 | 45.2 |
| Lack of access to free consultations during and after pregnancy | 42.9 | 38.7 | 43.7 | 44.7 |
| Difficult access to free consultations during and after pregnancy | 42.6 | 38.7 | 43.3 | 44.7 |
| Lack of patient-friendly information | 56.6 | 55.4 | 56.4 | 58.7 |
| Lack of privacy | 80.2 | 82.1 | 78 | 77 |
| Procedures not explained | 80.1 | 79.3 | 76.5 | 78.3 |
| Inappropriate staff attitude | 80.7 | 83.2 | 78.2 | 80.3 |
| Abusive/brutal examinations | 88.2 | 90.8 | 86.9 | 84.7 |

| | | | | |
|---|---|---|---|---|
| Non-consensual procedures | 87.8 | 89.8 | 84.9 | 83 |
| Fundal pressure during expulsion | 78.4 | 78.9 | 72.3 | 70.9 |
| Lack of painkillers, even when needed | 78 | 79 | 77.2 | 75.7 |
| Medicines given without information/specific consent | 77.6 | 76.6 | 73.4 | 72.4 |
| Absence of the option to have the partner/support person present during labour and childbirth | 52.2 | 47.8 | 45.6 | 51.8 |
| C-section imposed without explanation | 79.2 | 78.8 | 74 | 73.9 |
| Movement restrictions during labour | 76.5 | 73.5 | 61.9 | 60.2 |
| Separation from baby after birth | 71.4 | 69.1 | 63.5 | 67.5 |
| Food/water restrictions during labour | 57.7 | 54.6 | 41.7 | 43.2 |
| Refusal/delay of C-section on medical grounds | 63.7 | 74.1 | 58.4 | 55 |
| Long labour without medical care | 81 | 82.5 | 77.7 | 75.7 |
| Medical questionnaire/anamnesis during contractions/delivery | 56.8 | 58.3 | 47.9 | 45.5 |
| Unjustified prolonged stay in the maternity | 48.3 | 47.8 | 49.4 | 46.9 |
| Assistance at childbirth by untrained personnel | 70.7 | 74.8 | 72.6 | 72 |
| Imposing a certain birth position | 75.5 | 72.2 | 59.7 | 58.8 |
| Inappropriate staff attitudes about women's reactions to pain | 82.6 | 82.5 | 79.7 | 79.7 |
| Communication in a language unknown to the patient | 53.2 | 56.7 | 55.2 | 56.5 |
| Lack of disability accommodations | 67.2 | 66.6 | 65.1 | 66.1 |
| Inappropriate conversations by staff in the presence of the patient | 58.3 | 58.3 | 57.6 | 59.5 |

*Table 6: Percentage of women who consider the issue to be obstetric violence by last type of birth*

Asked whether, based on their personal experiences, they considered themselves to have been victims of obstetric violence, approximately two-thirds of the women answered in the negative, therefore do not perceive themselves as victims of obstetric violence. Only 16.2% of respondents indicated that they had been victims of obstetric violence, while 15.4% were unsure whether their experiences fell under this term (Q35).

On the other hand, let's not forget, the vast majority of those who felt that they had been victims of some form of obstetric violence (almost 90%) did not officially report these abuses (see Q36).

***Comment:*** *While approximately half of the women surveyed had heard of the term "obstetric violence", many lacked an understanding of its precise meaning and did not perceive themselves as victims. However, when the concept was broken down into specific items, a significant proportion of women identified a range of potential forms of obstetric violence.*

*Even seemingly softer aspects of the topic (poor information, insufficient duration of consultation or the fact that the partner does not have access to the birth) were pointed out by respondents as problems that can be categorized as obstetric violence - proof that there is a need for information in this area.*

## Section 5: Reporting obstetric violence (Q36-Q39)

### 5.1. Reporting obstetric violence - doesn't make sense or I don't know how/where to report

To a very large extent, women did not report cases of obstetric violence because they did not trust the relevant institutions and did not believe that those would take action (reasons 1, 4).

Also, a large proportion of almost 1/2 (more than 45%) reported inaction due to lack of information or lack of time and energy.

**Top 5 reasons why women did not report obstetric violence (N=804)**

| Reason | % |
|---|---|
| **No one would have taken any action anyway** | **55.6%** |
| **I didn't know what to do** | **46.4%** |
| **I had no time and energy** | **45.8%** |
| **I don't trust the health and justice systems** | **43.2%** |
| **I was afraid that someone might hurt my baby** | **21.9%** |

*Table 7: Top 5 reasons for not reporting obstetric violence*

***Comment:*** *The findings indicate certain issues that warrant further investigation.*

***Distrust of institutional support*** *points to a wider societal problem.*

***The lack of information on the procedures in force****, on what can be done in such situations, indicates a lack of institutional communication.*

***Lack of time (and energy)*** *can be seen in the context of physical, emotional and psychological overload of mothers in the pre- and postnatal period, perhaps also correlated with reduced male participation in the first months after childbirth.*

*The fact that almost 22% of women stated that they did not report instances of obstetric violence due to concerns for the safety of their child can be interpreted from the perspective that women are so focused on the well-being of their children that they prioritize this over their own physical and psychological health in situations of obstetric violence.*

## Section 6 - Women's voices are heard. Some respondents' narratives

This report does not cover the qualitative component of the research study. Recognizing the paucity of women's voices and experiences in public discourse, particularly those pertaining to abuse, we included two open-ended questions in the questionnaire where respondents were allowed to describe, in their own words, **the most unpleasant and the most pleasant experiences** they had in the hospital during pregnancy, childbirth, and postpartum.

**Very many women answered these questions (4,083 gave details of negative experiences and 4,142 described positive experiences).**

**The contrasts between the responses are striking.** While the most unpleasant experiences are detailed accounts of various forms of obstetric violence, the harshness of these experiences is certainly unrecognisable even to an experienced reader. In contrast, the most beautiful experiences are described as absolutely banal, natural and normal aspects that, in a settled society that respects its citizens equally, should never appear exceptional.

The fact that a significant proportion of respondents felt compelled to recount their negative traumatic experiences is indicative of a need for greater openness and space for dialogue and debate on these issues.

**For these reasons, we deemed it beneficial to include excerpts from their testimonies, obtained through the two open-ended questions, which we have grouped under a few broad themes pertinent to the subject matter of the report.**

*Note: The testimonies have been edited strictly for grammar, without changes in content and meaning.*

## 6.1. Lack of empathy and inadequate language by medical staff

*"The nurses who were taking care of the babies were bad-mouthing both the baby and their moms."*

*"Before I had the baby, the doctor on duty, who was a resident, spoke to me very harshly because I had gained a lot of weight during pregnancy. He looked at me disapprovingly and told me that I was going to have a stillbirth. Because he told me that I was having a stillbirth, my blood pressure went up a lot, reaching 18, and they had to struggle with anaesthesia because I couldn't stay still."*

*"Nurses and midwives. They are incredibly inhuman!"*

*"The neonatologist and midwife had a disagreement right after the expulsion, and the gynaecologist was sewing me up while they were having a verbal disagreement each on each side of me."*

*'"Didn't you see how you gave birth?", "Of course the little girl is still traumatized." "Why do you keep asking me when you can see the baby and how she is?" (That was if she came to the door at all). And things like that. The nurses in neonatology were nasty to their coworkers, "Come on, ask me if you want to stay with the baby so I can hear you." When I was still breastfeeding: "Come on, don't bother, you can give him more in 2 hours, that's it, we've got work to do here." All mothers were afraid of being nasty to their children. And with Roma women they were horrible, "Can't you count? How many millilitres if you subtract 30 from 100?"'*

*"Mean side comments during intense labour, Miss (editor's note - used by the speaker to designate a woman physician) talked down to me; though I needed explanations, they gave me none at my level of understanding... I waited on the examination table with my legs up, naked, while other people came in and out of the room, they examined me without announcing what exactly that thing means (I mean dilation), I would NEVER EVER give birth in a public hospital again. Natural birth at 4380 g, asked for epidural and I was not given it. I felt abandoned. It is true I had thrombocytopenia, but still, to torment you like that is inhumane. The staff were not empathetic at all."*

*"At the second birth, the doctor slept soundly in the emergency room and I was in pain for 8 hours during which I was not dilating at all. At 2 o'clock in the morning I arrived at the maternity ward with dilation 6 and with the same dilation I gave birth with the nurse, because the doctor didn't even bother to see if I was still alive or not. I gave birth with the amniotic fluid already green and the baby was under supervision because he swallowed some of it, it was already quite late... After the birth and until the discharge I didn't receive any visit from the doctor on duty, I wasn't even checked if the stitch was ok, and I had a perineum rupture after a 6 cm dilated birth."*

*"The lack of empathy and inappropriate behaviour of the nurses/nurses. The midwife who actually climbed on top of me and was pushing with her elbow, the doctor who also monitored my pregnancy and who agreed with this procedure, and moreover, she even told me off and said that I had to endure it because I chose to give birth naturally."*

### 6.2 Induced need for C-section, brutal examinations

*“The insistence of the doctor who monitored my pregnancy (private) for C-section delivery for no reason.”*

*“During labour, the on-duty doctor came in and tried to make me choose C-section, even though I was very determined to have a vaginal birth. Although I attended check-ups every month during pregnancy and the doctor told me that everything was fine, the on-duty doctor told me that the baby had a nuchal cord and that my placenta was calcified, misinformation that he gave me just to change my mind about vaginal birth.”*

*‘Condescending attitude of the midwife and doctor. Remarks like “And yet you want to give birth naturally?” during labour, with dilation 5 or, “Oh, thanks for not keeping us here all night.” First childbirth, admitted at 4 PM with dilation 1 and natural labour at 7:30 PM same day. I don't know what they gave me and shortly before expulsion I had to ask 4 times for painkillers. Afterward, the midwife kept scolding me for not massaging my belly properly, even though both my hands were numb, and kept saying it's none of her business, I need to massage, but I couldn't, I was out of steam. The brutal removal of the placenta - the main doctor stuck her hand in 4 times, and the stitching of the episiotomy was excruciating.’*

*“The midwife tried very insistently to convince me to have a caesarean birth, telling me that I had not dilated, that the baby's heart stopped beating, that labour would surely last at least 24 hours.”*

*“Episiotomy without consent, forbidding the father's presence during labour, separation from the baby, lack of lactation training of neonatology staff, pressure to induce labour, unnatural, non-gravitational birth position, lack of breastfeeding support, pressure to use formula milk, pressure to use epidural anaesthesia, false diagnosis of umbilicated nipples, inappropriate comments about my body, unnecessary medicalisation of labour by amniotomy without informed consent.”*

*“The most unpleasant experience was the endless insistence of gynaecologists to impose C-section on me. No one had any well-founded medical argument, because I'm a doctor myself and I know when I'm being played. I was turned down by doctors in 2 hospitals, the most wonderful being SUUB, where virtually every doctor I approached, starting with Mrs. Cristoiu, refused vaginal birth. Some didn't even offer arguments. Just no. Either C-section or nothing.”*

### 6.3. Devaluing emotions / dramatizing grief/lack of autonomy

*“Treated like rubbish. I was treated like a dog.”*

*“Mocking jokes about my pain tolerance threshold and screaming during labour. Bed restriction during labour and expulsion.”*

*“I've been asked why I want painkillers; I'd better pray it's over soon.”*

*“I am left with the thought that I survived a slaughter. They slaughtered me, in soul and body.”*

*"The most unpleasant was the feeling of being treated badly (less than friendly lines, attitude as well)... There were moments of maximum vulnerability, when it seemed to me that the respect f o r me was zero, I was just a woman come to give birth on their terms."*

*"The on-call doctor, a man, was very arrogant, spoke superior, ignored what I said and treated me as if I knew nothing about childbirth, about anything, a totally unfriendly attitude, especially when you arrive at the hospital with high dilation, just to avoid such behaviour as long as possible in labour."*

*"In pregnancy and pre-pregnancy, the doctors at the private clinic to which I had a subscription were superficial in their approach and expeditious, even rude when they found out that I would not give birth privately. At the birth, at the state, the midwives were insensitive, treating the birth (which for me was traumatizing) as nothing and devaluing my emotions. Then, in the maternity days, it was a barrage of doctors, nurses, nurses, each with their own opinions and advice, often conflicting, leaving me, a newborn and new mother, to judge what was right and wrong and feel guilty about everything."*

*"The midwife and the nurse told me to stop screaming while I was dilating because my cervix would rupture, but they didn't actually want to hear us screaming in pain."*

### 6.4. Position at birth, on table, leg-strapped

*"My legs were tied to the birthing table. And I had a very large episiotomy at my first birth, even though it was known I was delivering prematurely and the baby is tiny (2.5 kg). And 5 years later I have pain down there."*

*"At the time of expulsion she effectively pulled the baby out of me, not having the patience to come all natural, which resulted in tearing the vaginal wall and stitching without anaesthesia."*

*"The position in which I gave birth, even though I was crying and saying I couldn't give birth on that bed on my back and with my knees up."*

*"The fact that there's only the gynaecologic table position and leg-strapping option."*

*"Tied to the TNS for 10 hours without being allowed to move, I resisted and was scolded. I was being walked on in the bathroom."*

*"The fact that during the contractions I was forced to stay in bed and not move on the grounds that we needed to monitor the baby's heartbeat. And while I can understand this to a certain extent (although I could have had the machine if I was sitting on a ball), I can't understand why they come with a bunch of paperwork for signatures or explain things to you about what the baby will be given after birth (vaccine) right during contractions. You're also put in a room with 5 other moms where visitors come in and you can't rest at all - the day after the C- section."*

### 6.5. Refusal of painkillers/ignoring or minimizing pain

*"Refusal of nurses to give reassurance after caesarean section and their lack of help when getting out of bed after caesarean section."*

*"I gave birth to 3 babies naturally, I had ruptures, cuts downstairs and I was not given anaesthesia although I asked for it at the time of stitching."*

*“When I complained of pain and was told I was lying; When I asked for painkillers and was told I was addicted to them, and that I shouldn't ask.”*

*“At the time of the preparations nothing was known about my history, as a result the on-call anaesthesiologist on duty tormented me live for 30 - 40 min. for catheter placement, during which time I was screaming in pain and was told that I was being comforted. Eventually he gave up and just did the spinal anaesthesia, saying they would give me morphine so I wouldn't be in pain afterwards.”*

*“I had my emergency 'hot' C-section around 2pm. I stayed in the ICU until 4pm, when I started to feel everything... and ask for painkillers. Then I was taken to the ward. No one, but no one even gave me a painkiller the whole time... I was saying I wasn't given anything, and one nurse even told me that I wouldn't know what a painkiller looked like so don't believe me that I wasn't given one... I had the energy just to cry... As a n u r s e myself, but I couldn't have that attitude towards anyone. It wasn't until the shift change that I was given a painkiller... The nurse on the next shift was trembling when she read me the sheets where it was clearly written that I had been so many hours without painkillers... During that time I went from whimpering to delirium and hallucinations. It was awful. Nurses kill you, not doctors.”*

### 6.6. Separation from child

*“The fact that my baby was taken from me because he swallowed meconium and had to be suctioned and taken to the incubator.”*

*“After I came back from lunch in the ward, I felt sick, I threw up and then I barely looked up and asked the nurse on the floor to consult me. The reply was quite aggressive, that I am a first timer and old and I certainly don't give birth that fast, but after I got on the table, I was 7 cm dilated, she didn't prove to call the delivery room and take me there. At 3:10pm I entered the delivery room, at 3:48pm my baby boy came into the world. I had him on my chest for 2 minutes and then the hours that followed I could hear his crying and I wanted so much to get to him, but after the birth, with the ice on my tummy and the sanitization of the room I was in I was left alone… very lonely.”*

*“I had the baby 7 hours after delivery. (During the caesarean I had him held next to my head for about 2 min.).”*

*“Residents attending C-section without informing me, the neonatology nurse slammed the baby for fear of pooping on it, they didn't put my baby to the breast after they took it out, they rushed me to take it off.”*

*“The fact that I was separated from the baby for almost 24 hours after the birth was awful. I recovered very quickly from the anaesthesia, waking up every hour without being able to sleep more because my body was ready to respond to the baby's needs. After 12 hours I had very strong anxiety about this separation. The medical staff refused to bring my baby in to see me because they had already brought him in a few hours after delivery. In the future I would opt to give birth privately to have the baby almost sooner.”*

### 6.7. Ethnicity matters - discriminatory representations and stereotypes related to birth

*"In my case there were quite a few, but the minor colleague was left to struggle because, according to them, she's just a gypsy and that's how they yell.... The girl was cut with scissors by the nurse that by the time they went to check her, the child was coming out... She started shaking afterwards when she saw scissors. That's not normal. It IS still discriminating and she was a child too..."*

*"The midwife who was on duty that night left a bad taste in my mouth, she treated me super nasty because I was ethnic!!!"*

*"The most unpleasant experience was when the resident doctors in triage were ironic at my pain and when they inserted valves for control, just because I was changed in the face from the pain. Then, after I gave birth, another resident doctor discriminatingly asked me 'What am I doing', referring to a certain ethnicity and name belonging to a certain ethnicity, disregarding my name or the fact that I am Romanian, did not look in my chart to see my name and ethnicity."*

*"I ended up in the ER, with bleeding, where I was considered to be of a different ethnicity (Roma), because it was summer and I was tanned, so the gynaecologist behaved unacceptably to me and to the next patient, who was indeed Roma."*

*"When I gave birth, there were several other women in the labour room, including a 16-year-old Roma girl. They scolded her like a child because she was screaming in pain and people were calling her at home until o n e point, then they took her phone and hung up."*

*'"The nurses talk very badly to Roma people on the grounds that they don't get their check-ups during pregnancy"! This pregnant woman had gone into labour and w a s screaming in pain in the hospital emergency room, and the medical staff were saying to her face "There's nothing wrong with him coming back today."'*

*"I didn't have any bad experiences, but at the time when I gave birth, a lady of ethnicity 2 gave birth and they were not nice to her at all, they were even very nasty and disrespectful in the way they spoke/(behaved) with her."*

*'On the evening I was in the ICU, there were two cases of births with problems (a premature birth and a birth where the baby had its genital organ inside). In both situations the doctors on duty spoke very badly... about the premature birth: "If you needed the seventh child, that's it, assume, the baby has problems." There was a Roma mom at the other birth, the mother was told in a raised tone: "Send the baby to Iași, you stay here, don't take so much time to think!". Mommy was very frightened and was told to her face to think the worst and assume the worst. The baby is 1 year + now and it's a very good idea. Ugly, very ugly!'*

*"Women of a certain ethnicity in the parlour after childbirth, who always disturb the peace by talking very loudly on the phone almost all the time, thus affecting the need for rest."*

*"I've been in the ward with ethnic people and their hygiene left something to be desired!"*

*"I was in a ward with Roma people. I had to change 2 wards in 3 days to have peace of mind and hygiene, because*

*I did not choose to stay in the spare. On the second day of hospitalization, my dressing was not changed during surgery."*

### 6.8. When ok becomes exceptional

*"The most enjoyable experience during labour was the interaction with the charge nurse, a golden woman who continually encouraged and praised me. She empowered me to deliver vaginally without anaesthesia."*

*"The nurses asked me if I would like a suppository to help with postpartum pain, offered me cold packs for the episiotomyarea and glycerine suppositories."*

*"The on-call doctor, with whom I gave birth and whom I met then, took an interest in me afterwards, gave me her phone number, we continued to write to each other."*

*"The doctor was calm throughout the birth and followed my case even after delivery."*

*"A midwife on the first shift was with me the whole time in labour and supported me, which encouraged me to have a natural birth."*

*"A nurse held my hand."*

*"During the birth and afterwards, I had care, involvement, I got the necessary information, everyone was dedicated to the job."*

*"The midwife/nurses behaved nicely, they didn't bad-mouth me, as I have heard in other cases."*

*"During the caesarean birth, the anaesthesiologist stood at my head and encouraged me (I was at risk of haemorrhage and losing my uterus) and told me everything that was going on (that they took the baby out, that they are cleaning me now etc.)".*

*"After delivery, in recovery on the first day, the nurses were very kind and caring."*

*"I was in labour and a nurse about my mother's age came and caressed me, said warm words..."*

*"I felt empathy, that I had PEOPLE with me."*

*"We had air conditioning and TV, the nurses were nice and helpful. I guess it makes a difference which doctor you're born with, which doctor you're with..."*

*"My doctor listened to me, supported me, and explained to me whenever necessary why a C-section (foetal distress) was needed, even when all I wanted to do was go home. Besides that, the whole birth experience was super."*

*"On one of the admissions, a nurse took very good care of her patients and came to check my IV without waking me up. It was nice to see such a dedicated person who asked for nothing in return."*

*"Empathy of medical staff during labour and delivery. Breastfeeding support."*

*"I was able to stay in any position I wanted in labour and even under water in the shower."*

*"The staff behaved exemplary, they didn't bully me, offend me or make jokes at my expense. I liked the fact that I received attention, the room I stayed in after giving birth was very clean. I had*

*many facilities like bathroom in the room, TV, and the baby stayed with me throughout my hospitalization."*

*"I was in labour and a nurse about my mother's age came in and stroked my forehead and encouraged me as if I was her own child."*

*"The midwives acted as if I was their daughter. I never thought I would find such warmth in a state hospital."*

*"The most pleasant experience is that everyone is super nice to me and the baby without accepting money."*

*"Everything was superlative in a state hospital!"*

*"The most pleasant experience was that they let me give birth naturally and then brought the baby into the ward quite quickly, after about 3 hours and encouraged me to breastfeed."*

*"My husband was by my side and I wasn't separated from my baby for a single moment."*

*"They put the baby on my belly immediately after my expulsion (at my request!)."*

*"During labour it was quiet, nobody bothered me and I was able to concentrate on the baby, so it was an easy birth."*

*"At my second birth, I was lucky to have a nurse who taught me how to breastfeed my baby."*

*"I was visited very often by the doctor, the neonatal nurses very, very nice".*

*"I did not miss anything in the hospital, the hospital was well equipped, including toilets were hygiene items, as is normal, food ok, nothing special, attentive staff, not expecting attention, helped most of the time when asked."*

*"The fact that the doctors behaved great, the nurses were respectful,*
*the staff in neonatology gave me support in taking care of my baby, I got help with breastfeeding, I got a kit with baby products at the end, I had the possibility to stay alone in a room that I didn't pay a lot of money for. The food was tasty, the nursing staff encourage the mother to take her baby to her room as soon as possible (in the case of surgery, when the mother feels up to it), I received moral support from all the nurses, no one insinuated money and I didn't see it accepted, they bathed in the ward a couple of times a day, they showed me how to bathe the baby and came as soon as I asked for help."*

***Comment:*** *It is notable that the most positive experiences reported by participants were those in which they received appropriate treatment.*

*Concurrently, the most unfavourable experiences recounted involved a multitude of circumstances characterised by abusive, unprofessional, unethical, inhumane and even degrading conduct.*

*Also noteworthy is the contrast between the most positive experiences during pregnancy, childbirth and postpartum (which essentially encompass standard care that should be the norm in both public and private hospitals, where patient-centred care should be provided) and the negative experiences (which encompass a range of obstetric violence forms).*

*The women identified a number of issues related to experiencing some forms of obstetric violence and expressed a preference for what the literature refers to as a "positive birth experience", more specifically "giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and competent clinical staff [...] If intervention was needed or wanted, women wanted to retain a sense of personal achievement and control through active decision-making" (Tudose, 2022; Downe S, Finlayson K, Oladapo OT, Bonet M, Gülmezoglu AM, 2018; WHO, 2018).*

*It is also noteworthy that the lower expectations regarding public hospitals were occasionally contradicted by the women's responses. Some women also described positive experiences in public hospitals, indicating that the key factor was the attitude of the medical staff and their conduct during interactions with the women.*

*In this regard, it must be mentioned that the open answers received indicate that the unmet needs of women in their interactions with the medical system are not primarily related to hospital conditions and physical infrastructure. Rather, they pertain to the lack of empathy, respect for autonomy and human dignity, which are directly related to the relationship with medical professionals.*

*Last but not least, the open-ended responses provide insight into women's perceptions of discrimination, stereotypes, and ethnic prejudice in the medical system.*

*When medical professionals treat Roma women differently due to stereotypes and prejudices, it is a significant issue. However, it is also important to consider the relationship between Roma women and other patients. Many majority women have reported negative experiences interacting with Roma women on the ward and their families.*

# CONCLUSIONS

The research primarily identified a number of issues related to the perceptions of women who had given birth at least once within the past five years (2018 - 2023) with regard to the specific health services they had received during pregnancy, childbirth and postpartum.

The limitations of the study (not so much in terms of the number of respondents, but in terms of sampling) do not allow generalisations to be made. It is our intention that the data presented be employed primarily as a resource to enhance the efficacy of policies within this field, and subsequently as a tool for empowerment of women, particularly those from vulnerable groups.

We are reserved regarding any interpretation that could be perceived as partisan or as promoting of specific categories of services, all the more so as such services could require resources that vulnerable women usually do not have.

In this sub-chapter, we present a series of conclusions regarding the potential causes of the situation. Additionally, we propose a set of recommendations for medium- and long-term solutions to specific issues. These recommendations can be subjected to further analysis and evaluation through more comprehensive studies.

**The main conclusion of this report is that many of the problems identified in the research are determined by a mixture of cultural and systemic factors.**

Doctor X, pregnant woman Z or midwife Y are not to blame for the deficiencies in the system.

The systemic shortage of medical staff results in a lack of time for information on the part of the medical team or, in some cases, leads to the failure to apply procedures related, for example, to pain management (such as epidural analgesia), procedures that require adequate supervision for a longer period after administration. The observation that instances of obstetric violence are less prevalent in private hospitals leads us to conclude that this does not necessarily indicate that doctors, nurses, and midwives are in general inclined to condone such violence. Rather, it suggests that in public hospitals, deficiencies in infrastructure, communication channels, protocols, guidelines, motivational systems, resources, or a combination thereof, create a greater opportunity for abuse to occur. For instance, malpractice insurance does not extend to the risks associated with abortion procedures, a fact that contributes to the reluctance of some doctors to perform such procedures. Additionally, the limited role of midwives at all stages of pregnancy and childbirth can be attributed to regulatory ambiguity. While legislation allows midwives to provide autonomous activities and services, the ambiguity persists in practice.[6]

In accordance with the national law that transposes the relevant European Directive (Directive 2005/36/EC, as amended by European Directive 2013/55/EC), the prevailing principle is that midwives are to act independently in the absence of a doctor. In practice, however, doctors are ultimately responsible for all aspects, sign

6 Art. 7 of EOG 144/ 2008 on the practice of the profession of nurse, midwife and medical assistant, as well as on the organisation and functioning of the Order of Nurses, Midwives and Medical Assistants of Romania

everything, are accountable, so delegation is difficult, the primary reason being the absence of direct contractual agreements with CNAS and the medical services provided by midwives not being reimbursed through FNUASS.

**The midwife's presence equates de facto with guaranteeing effective access to health and prevention services to women, pregnant women and newborns.** Midwives can provide a range of services, including family planning, ante-, peri- and postnatal health and medical services, education and prevention for adolescents, prevention of gender-based violence, pre- and postnatal education, immunization and healthy lifestyle education, all autonomously and in accordance with the specific relevant legislation mentioned above.

A low level of information, knowledge and awareness exists among women with regard to obstetric violence and the various forms it can take, even among those with higher education, who constitute the majority of the sample. The reasons are, of course, diverse.

On the one hand, schools do not typically address such topics, which could be incorporated into existing curricula such as civic education (human rights education), sex education, health education, and even anatomy.

Raising awareness about obstetric violence can also be achieved through information and awareness-raising campaigns aimed at the general public or by introducing the topic in childcare courses (which can be accessed free of charge in maternity hospitals).

There is also a **lack of communication** between patients and health professionals that contributes to the occurrence of some forms of obstetric violence (see informed consent, adequate language).

Against a backdrop of poor communication - insufficient, not personalised, not adapted - a series of informal, often negative stories are perpetuated and reinforced at the system level, particularly in state hospitals, about the perceived dangers and negative effects of natural childbirth on women's intimate lives, and the misfortunes that occur in hospitals.

What could be the explanations for this, especially given the clear differences in this respect between public hospitals (which report greater lack of communication) and private hospitals, since often the same doctors, nurses, and midwives are in attendance in both?

One potential cause may be **the shortage of personnel in public hospitals** relative to the number of patients coupled with an overload of tasks and limited time for medical staff to engage in consultations and dialogue.

Moreover, a more detailed examination of the further education college and university medical education system is warranted.

Does the training curriculum cover communication between healthcare professionals, patients, and caregivers?

To what extent are doctors, nurses, and midwives trained to meet the needs of patients in general and pregnant women in particular? To what extent do obstetrics and gynaecology courses cover topics related to the need for autonomy and respect for human dignity throughout the entire medical process

or related to birth giving as a positive experience beyond the medical procedures? To what extent is gender mainstreamed in courses that provide a nuanced and complex critical perspective on women's needs and interests?

**Another conclusion** that can be drawn from the research is that **medical professionals may exhibit a paternalistic attitude**, which, from our perspective, is a matter of professional deontology and ethics.

Paternalism can be defined as a manifestation of professional responsibility and authority in relation to patients when the professionals believes that they are acting in the client's best interests and have the requisite professional authority to do so (Miroiu & Blebea, 2002).

In fields where epistemic authority is highly professionalised, such as medicine, it is relatively straightforward for patients to lack access to the information required for informed consent, which can result in a lack of self-determination - this is evidenced by the high number of caesarean births and the role of doctors in shaping this state of affairs, as detailed in this report.

From an ethical standpoint, paternalism contravenes the principle of individual autonomy and should therefore be avoided wherever possible, all the more so in the context of childbirth, which, in most cases, is a normal physiological experience and, as such, a matter of personal choice for the woman in question. The practice of paternalism can be mitigated through the provision of accurate and comprehensive information to patients, the presentation of decision alternatives, and the offering of recommendations, elements that may also serve as crucial foundations for the maintenance of trust in professional relationships (Miroiu & Blebea, 2002) - see the correlation with the underreporting of abusive situations, which can too be interpreted through this questionnaire.

This is, of course, a working assumption that would be worthy of further investigation in order to gain a deeper understanding of the factors that contribute to the observed imbalance between C-sections on demand and natural births.

Moreover, the data in this report (including the briefly presented qualitative data) and discussions with health professionals suggest that **women's needs, experiences and bodies are virtually absent from medical discourses and practices in pregnancy, childbirth and postpartum.**

It often comes down to what the doctor says, to what is deemed beneficial for the baby and, to a much lesser extent, to what is/isn't beneficial for women (for their physical and mental well-being).

**Nevoile, confortul, durerile femeilor care nasc par a nu fi elemente cu adevărat importante în sarcină și naștere.** They are often downplayed, marginalised, and stigmatised. At times, it seems as though women and their bodies are valued only insofar as they must deliver healthy babies, with a focus on minimizing risks for doctors. This is reflected in practices such as defensive medicine, the high rate of caesarean sections, restrictive birthing positions, the absence of support persons, and the immediate separation from the baby after birth. In our view, it can be seen as another example of the power dynamics

between expert and patient, which, in this case, disregards the needs and experiences of women (whether genuinely or ostensibly acting in their best interests).

**From this perspective, obstetric violence can be viewed as a manifestation of gender-based violence.**

Finally, the research **report identifies at least two types of intersections** that give rise to significant concerns, namely **class and ethnicity.**

**The first category of concern pertains to class** or income level, which is particularly pertinent in view of the considerable number of women who indicated that they lacked or encountered significant difficulties in accessing free consultations during pregnancy. These responses unambiguously highlight a systemic issue where access to health services is constrained, with the brunt of the impact borne by women who are unable to afford paid consultations, particularly those from low-income backgrounds.

It is imperative that the underlying causes of this issue be investigated and addressed with urgency, as they have the potential to directly impact maternal and child health.

**The second intersectional factor is ethnicity.** Ethnicity remains a significant factor, and the status of Roma women in Romania is still marred by pronounced stigma. Although, unlike in the case of class, the available quantitative data on ethnicity is not statistically significant, the qualitative findings from this study vividly illustrate the harsh realities faced by Roma women. These findings reveal that they endure a range of stereotypes and prejudices, often resulting in discriminatory, inhumane, and degrading treatment. It is clear that securing adequate funding for research, including a thorough investigation of the root causes, prevalence, and consequences of violence against women in obstetric care, is crucial for developing effective solutions.

# RECOMMENDATIONS

- To reduce the incidence of obstetric violence, the healthcare system must be strengthened by incorporating medical personnel with expertise in sexual and reproductive health. This will ensure women, pregnant women, and newborns have effective access to essential healthcare and preventive services. Additionally, training and empowering existing medical staff is crucial. This will heighten their awareness of potential violations of patients' rights and underscore the importance of respecting patients' decisions.

- There is a clear need to implement paid antenatal education programs, such as “Parents' School”, to provide patients the necessary information, education, and support, such as to empower them to fully understand their rights, choices, and decisions related to sexual and reproductive health.

- To effectively monitor and address obstetric violence, a form of gender-based violence, it is essential to establish a legal and regulatory framework aimed at preventing and combating this issue. This requires amending and supplementing Law No. 202/2002 on equal opportunities and equal treatment for women and men, specifically by listing and defining various forms of gender-based violence, including obstetric violence.

- Integrating a gender perspective into doctors' codes of ethics and professional standards is crucial, especially in specialties like obstetrics and gynaecology that address the specific needs and conditions of women and girls. Research indicates that gender inequalities persist in healthcare, leading to a significant gender health gap. Gender impacts the incidence and treatment of certain pathologies, as well as the allocation of resources, access to services and other related aspects. It is therefore our contention that the prestige, reputation and epistemic authority of the profession of obstetrician-gynaecologist, as well as that of midwife or nurse cannot be thoroughly developed without a gender-sensitive approach that must be achieved by assuming an interdisciplinary perspective and by working closely with gender experts.

- To increase the number of pregnancies monitored in the public system, boost the rate of vaginal births, enhance breastfeeding rates, and reduce maternal and infant mortality, it is essential to amend Law 95/2006 to include midwives as providers of medical and health care services reimbursed by FUNASS.

- It is crucial to implement the 'Baby-Friendly Hospital' program in all maternity hospitals in Romania through a collaboration between the Ministry of Health, the National Authority for Quality Management in Health, and NGOs.

- It is essential for the Minister of Health to issue an Order to integrate midwives in staffing standards for obstetrics and gynaecology, labour and delivery wards, and rooming-in care. Reconfiguring postpartum and neonatology wards will support the implementation of rooming-in care.

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# ANNEXES

## Percentage of women who have underwent the experience in total births by hospital type

| Potential experiences for women who gave birth by emergency C-section without going into labour (N=704) | Total women who underwent the experience | Public hospital (%) N=561 | Private hospital (%) N=143 |
|---|---|---|---|
| Separation from baby after birth | 48.6% (N=342) | 53.3% (N=299) | 30.1% (N=43) |
| Difficult access to free consultations during and after pregnancy | 37.1% (N=261) | 37.4% (N=210) | 35.7% (N=51) |
| Lack of access to free consultations during and after pregnancy | 36.4% (N=256) | 36.0% (N=202) | 37.8% (N=54) |
| Insufficient duration of consultation | 29.3% (N=206) | 32.8% (N=184) | 15.4% (N=22) |
| Lack of patient-friendly information | 28.1% (N=198) | 31.9% (N=179) | 13.3% (N=19) |
| Inappropriate conversations by staff in the presence of the patient | 26.0% (N=183) | 30.8% (N=173) | 7.0% (N=10) |
| Inappropriate staff attitudes about women's reactions to pain | 23.2% (N=163) | 25.8% (N=145) | 12.6% (N=18) |
| Inappropriate staff attitude | 22.6%(N=159) | 26.0% (N=146) | 9.1% (N=13) |
| Procedures not explained | 17.9% (N=126) | 20.3% (N=114) | 8.4% (N=12) |
| Medicines given without information/specific consent | 16.1% (N=113) | 17.5% (N=98) | 10.5% (N=15) |
| Lack of privacy | 12.2% (N=86) | 14.4% (N=81) | 3.5% (N=5) |
| C-section imposed without explanation | 11.5% (N=81) | 12.5% (N=70) | 7.7% (N=11) |
| Lack of disability accommodations | 11.2% (N=17) | 12.5% (N=17) | 0.0% (N=0) |
| Lack of painkillers, even when needed | 8.9% (N=63) | 10.9% (N=61) | 1.4% (N=2) |
| Communication in a language unknown to the patient | 5.8% (N=41) | 7.0% (N=39) | 1.4% (N=2) |
| Unjustified prolonged stay in the maternity | 5.7% (N=40) | 7.0% (N=39) | 0.7% (N=1) |

*Table 8: Percentage of women who gave birth by emergency C-section without going into labour and who underwent the experience by type of hospital (public or private)*

## Percentage of women who have underwent the experience in total births by hospital type

| Potential experiences for women who gave birth by emergency C-section without going into labour (N=1895) | Total women who underwent the experience | Public hospital (%) N=1428 | Private hospital (%) N=467 |
|---|---|---|---|
| Separation from baby after birth | 41.8% (N=792) | 50.3% (N=718) | 15.8% (N=74) |
| Difficult access to free consultations during and after pregnancy | 37.2% (N=705) | 37.4% (N=534) | 36.6% (N=171) |
| Lack of access to free consultations during and after pregnancy | 36.3% (N=688) | 35.7% (N=510) | 38.1% (N=178) |
| Inappropriate conversations by staff in the presence of the patient | 22.7% (N=431) | 25.8% (N=368) | 13.5% (N=63) |
| Insufficient duration of consultation | 21.4% (N=405) | 23.9% (N=341) | 13.7% (N=64) |
| Lack of patient-friendly information | 19.0% (N=360) | 21.4% (N=305) | 11.8% (N=55) |
| Inappropriate staff attitudes about women's reactions to pain | 18.6% (N=353) | 22.9% (N=327) | 5.6% (N=26) |
| Inappropriate staff attitude | 17.0% (N=323) | 20.9% (N=298) | 5.4% (N=25) |
| Medicines given without information/specific consent | 13.7% (N=260) | 16.1% (N=230) | 6.4% (N=30) |
| Procedures not explained | 12.7% (N=241) | 14.6% (N=209) | 6.9% (N=32) |
| Lack of painkillers, even when needed | 8.7% (N=164) | 10.9% (N=155) | 1.9% (N=9) |
| Lack of privacy | 8.6% (N=163) | 10.0% (N=143) | 4.3% (N=20) |
| C-section imposed without explanation | 5.9% (N=111) | 6.7% (N=95) | 3.4% (N=16) |
| Lack of disability accommodations | 5.2% (N=21) | 5.9% (N=19) | 2.4% (N=2) |
| Unjustified prolonged stay in the maternity | 4.8% (N=91) | 6.2% (N=89) | 0.4% (N=2) |
| Communication in a language unknown to the patient | 3.9% (N=74) | 4.6% (N=65) | 1.9% (N=9) |

*Table 9: Percentage of women who gave birth by elective C-section and who underwent the experience by type of hospital (public or private)*

## Percentage of women who have underwent the experience in total births by hospital type

| Potential experiences for women who gave birth by emergency C-section without going into labour (N=905) | Total women who underwent the experience | Public hospital (%) N=648 | Private hospital (%) N=257 |
|---|---|---|---|
| Absence of the option to have the partner/support person present during labour and childbirth | 73.0% (N=661) | 84.0% (N=544) | 45.5% (N=117) |
| Separation from baby after birth | 56.0% (N=507) | 66.0% (N=428) | 30.7% (N=79) |
| Difficult access to free consultations during and after pregnancy | 36.4% (N=329) | 40.1% (N=260) | 26.8% (N=69) |
| Food/water restrictions during labour | 33.6% (N=304) | 37.2% (N=241) | 24.5% (N=63) |
| Insufficient duration of consultation | 31.3% (N=283) | 36.0% (N=233) | 19.5% (N=50) |
| Medical questionnaire/anamnesis during contractions/delivery | 30.8% (N=279) | 35.5% (N=230) | 19.1% (N=49) |
| Lack of access to free consultations during and after pregnancy | 30.7% (N=278) | 31.0% (N=201) | 30.0% (N=77) |
| Inappropriate conversations by staff in the presence of the patient | 29.8% (N=270) | 34.1% (N=221) | 19.1% (N=49) |
| Lack of patient-friendly information | 29.3% (N=265) | 32.6% (N=211) | 21.0% (N=54) |
| Inappropriate staff attitudes | 27.4%(N=248) | 34.1% (N=221) | 10.5% (N=27) |
| Inappropriate staff attitudes about women's reactions to pain | 25.6% (N=232) | 31.9% (N=207) | 9.7% (N=25) |
| Procedures not explained | 21.1% (N=191) | 23.1% (N=150) | 16.0% (N=41) |
| Long labour without medical care | 20.4% (N=185) | 26.2% (N=170) | 5.8% (N=15) |
| Movement restrictions during labour | 20.0%(N=181) | 23.1% (N=150) | 12.1% (N=31) |
| Medicines given without information/specific consent | 17.2% (N=156) | 19.0% (N=123) | 12.8% (N=33) |
| Abusive/brutal examinations | 16.0% (N=145) | 18.7% (N=121) | 9.3% (N=24) |
| Lack of privacy | 15.1% (N=137) | 18.4% (N=119) | 7.0% (N=18) |
| Refusal/delay of C-section on medical grounds | 12.8% (N=116) | 16.7% (N=108) | 3.1% (N=8) |
| C-section imposed without explanation | 11.3% (N=102) | 12.3% (N=80) | 8.6% (N=22) |
| Lack of painkillers, even when needed | 8.5% (N=77) | 10.8% (N=70) | 2.7% (N=7) |
| Communication in a language unknown to the patient | 6.0% (N=54) | 7.1% (N=46) | 3.1% (N=8) |
| Unjustified prolonged stay in the maternity | 5.7% (N=52) | 6.3% (N=41) | 4.3% (N=11) |
| Lack of disability accommodations | 2.0% (N=4) | 2.9% (N=4) | 0.0% (N=0) |

*Table 10: Percentage of women who gave birth by emergency C-section after onset of labour and who underwent the experience by type of hospital (public or private)*

## Percentage of women who have underwent the experience in total births by hospital type

| **Possible experiences for women who gave birth vaginally (N=2118)** | **Total women who underwent the experience** | **Public hospital (%) N=1754** | **Private hospital (%) N=364** |
|---|---|---|---|
| Absence of the option to have the partner/support person present during labour and childbirth | 74.7% (N=1583) | 83.6% (N=1467) | 31.9% (N=116) |
| Imposing a certain birth position | 71.7% (N=1519) | 76.1% (N=1334) | 50.8% (N=185) |
| Separation from baby after birth | 49.0% (N=1038) | 56.0% (N=983) | 15.1% (N=55) |
| Fundal pressure during expulsion | 43.1% (N=913) | 45.3% (N=795) | 32.4% (N=118) |
| Difficult access to free consultations during and after pregnancy | 39.5% (N=837) | 39.4% (N=691) | 40.1% (N=146) |
| Medical questionnaire/anamnesis during contractions/delivery | 33.9% (N=719) | 35.5% (N=623) | 26.4% (N=96) |
| Lack of access to free consultations during and after pregnancy | 35.4% (N=750) | 34.7% (N=609) | 38.7% (N=141) |
| Non-consensual procedures | 32.0% (N=677) | 34.9% (N=613) | 17.6% (N=64) |
| Movement restrictions during labour | 32.0% (N=678) | 35.4% (N=621) | 15.7% (N=57) |
| Lack of patient-friendly information | 31.0%(N=656) | 33.9% (N=595) | 16.8% (N=61) |
| Inappropriate conversations by staff in the presence of the patient | 30.9% (N=654) | 33.2% (N=583) | 19.5% (N=71) |
| Insufficient duration of consultation | 30.8%(N=653) | 33.9% (N=594) | 16.2% (N=59) |
| Inappropriate staff attitude | 30.6% (N=649) | 34.8% (N=610) | 10.7% (N=39) |
| Inappropriate staff attitudes about women's reactions to pain | 29.3% (N=620) | 33.4% (N=585) | 9.6% (N=35) |
| Food/water restrictions during labour | 28.3%(N=599) | 30.1% (N=528) | 19.5% (N=71) |
| Medicines given without information/specific consent | 27.5% (N=582) | 30.3% (N=532) | 13.7% (N=50) |
| Long labour without medical care | 26.5% (N=561) | 30.7% (N=538) | 6.3% (N=23) |
| Procedures not explained | 21.9% (N=464) | 23.7% (N=416) | 13.2% (N=48) |
| Lack of painkillers, even when needed | 21.7% (N=460) | 25.8% (N=452) | 2.2% (N=8) |
| Abusive/brutal examinations | 15.3% (N=325) | 16.8% (N=294) | 8.5% (N=31) |
| Lack of privacy | 15.1% (N=320) | 16.9% (N=297) | 6.3% (N=23) |
| Unjustified prolonged stay in the maternity | 8.1% (N=172) | 9.0% (N=157) | 4.1% (N=15) |
| Assistance at childbirth by untrained personnel | 5.5% (N=117) | 6.2% (N=109) | 2.2% (N=8) |
| Communication in a language unknown to the patient | 4.5% (N=96) | 5.3% (N=93) | 0.8% (N=3) |
| Lack of disability accommodations | 3.3% (N=15) | 3.4% (N=13) | 3.0% (N=2) |

*Table 11: Percentage of women who gave vaginal birth and who underwent the experience by type of hospital (public or private)*

## Women who delivered vaginally (N=2119)

| | **Au trecut prin experiență** | **Nu o consideră violență obstetrică** |
|---|---|---|
| Absence of the option to have the partner/support person present during labour and childbirth | 74.8% (N=1584) | 44.8% |
| Imposing a certain birth position | 71.7% (N=1520) | 18.5% |
| Separation from baby after birth | 49.0% (N=1039) | 20.0% |
| Fundal pressure during expulsion | 43.1% (N=913) | 22.0% |
| Difficult access to free consultations during and after pregnancy | 39.5% (N=838) | 48.9% |
| Lack of access to free consultations during and after pregnancy | 35.4% (N=750) | 49.6% |
| Medical questionnaire/anamnesis during contractions/delivery | 33.9% (N=719) | 36.3% |
| Movement restrictions during labour | 32.0% (N=678) | 13.9% |
| Non-consensual procedures | 32.0% (N=678) | 6.5% |
| Lack of patient-friendly information | 31.0% (N=656) | 35.4% |
| Inappropriate conversations by staff in the presence of the patient | 30.9% (N=654) | 36.4% |
| Insufficient duration of consultation | 30.9% (N=654) | 50.9% |
| Inappropriate staff attitude | 30.6% (N=649) | 11.7% |
| Inappropriate staff attitudes about women's reactions to pain | 29.3% (N=621) | 6.9% |
| Food/water restrictions during labour | 28.3% (N=599) | 35.7% |
| Medicines given without information/specific consent | 27.5% (N=582) | 12.4% |
| Long labour without medical care | 26.5% (N=561) | 10.0% |
| Procedures not explained | 21.9% (N=465) | 11.4% |
| Lack of painkillers, even when needed | 21.7% (N=460) | 11.7% |
| Abusive/brutal examinations | 15.4% (N=326) | 2.8% |
| Lack of privacy | 15.1% (N=321) | 7.2% |
| Unjustified prolonged stay in the maternity | 8.1% (N=172) | 30.8% |
| Assistance at childbirth by untrained personnel | 5.5% (N=117) | 15.4% |
| Communication in a language unknown to the patient | 4.5% (N=96) | 26.0% |
| Lack of disability accommodations | 3.3% (N=15) | 26.7% |

*Table 12: Percentage of women who delivered vaginally and underwent the experience, but do not consider it as obstetric violence*

## Women who gave birth by emergency C-section after the onset of labour (N=905)

| | Lived the experience | Do not consider obstetric violence |
|---|---|---|
| Absence of the option to have the partner/support person present during labour and childbirth | 73.0% (N=661) | 49.2% |
| Separation from baby after birth | 56.0% (N=507) | 24.3% |
| Difficult access to free consultations during and after pregnancy | 36.4% (N=329) | 55.0% |
| Food/water restrictions during labour | 33.6% (N=304) | 38.5% |
| Insufficient duration of consultation | 31.3% (N=283) | 49.1% |
| Medical questionnaire/anamnesis during contractions/delivery | 30.8% (N=279) | 38.0% |
| Lack of access to free consultations during and after pregnancy | 30.7% (N=278) | 51.4% |
| Inappropriate conversations by staff in the presence of the patient | 29.8% (N=270) | 29.3% |
| Lack of patient-friendly information | 29.3% (N=265) | 35.8% |
| Inappropriate staff attitude | 27.4% (N=248) | 10.1% |
| Inappropriate staff attitudes about women's reactions to pain | 25.6% (N=232) | 11.2% |
| Procedures not explained | 21.1% (N=191) | 11.5% |
| Long labour without medical care | 20.4% (N=185) | 9.7% |
| Movement restrictions during labour | 20.0% (N=181) | 14.9% |
| Medicines given without information/specific consent | 17.2% (N=156) | 12.8% |
| Abusive/brutal examinations | 16.0% (N=145) | 3.4% |
| Lack of privacy | 15.1% (N=137) | 12.4% |
| Refusal/delay of C-section on medical grounds | 12.8% (N=116) | 17.2% |
| C-section imposed without explanation | 11.3% (N=102) | 6.9% |
| Lack of painkillers, even when needed | 8.5% (N=77) | 13.0% |
| Communication in a language unknown to the patient | 6.0% (N=54) | 22.2% |
| Unjustified prolonged stay in the maternity | 5.7% (N=52) | 30.8% |
| Lack of disability accommodations | 2.0% (N=4) | 25.0% |

*Table 13: Percentage of women who gave birth by emergency C-section after onset of labour and underwent the experience, but do not consider it as obstetric violence*

## Women who gave birth by elective C-section (N=1895)

| | Lived the experience | Do not consider obstetric violence |
|---|---|---|
| Separation from baby after birth | 41.8% (N=792) | 25.0% |
| Difficult access to free consultations during and after pregnancy | 37.2% (N=705) | 48.7% |
| Lack of access to free consultations during and after pregnancy | 36.3% (N=688) | 49.1% |
| Inappropriate conversations by staff in the presence of the patient | 22.7% (N=431) | 33.9% |
| Insufficient duration of consultation | 21.4% (N=405) | 48.6% |
| Lack of patient-friendly information | 19.0% (N=360) | 33.3% |
| Inappropriate staff attitudes about women's reactions to pain | 18.6% (N=353) | 13.3% |
| Inappropriate staff attitude | 17.0% (N=323) | 14.6% |
| Medicines given without information/specific consent | 13.7% (N=260) | 13.4% |
| Procedures not explained | 12.7% (N=241) | 13.3% |
| Lack of painkillers, even when needed | 8.7% (N=164) | 16.2% |
| Lack of privacy | 8.6% (N=163) | 8.6% |
| C-section imposed without explanation | 5.9% (N=111) | 14.6% |
| Lack of disability accommodations | 5.2% (N=21) | 38.1% |
| Unjustified prolonged stay in the maternity | 4.8% (N=91) | 36.3% |
| Communication in a language unknown to the patient | 3.9% (N=74) | 31.1% |

*Table 14: Percentage of women who gave birth by elective C-section and underwent the experience, but do not consider it as obstetric violence*

## Women who gave birth by emergency C-section without going into labour (N=704)

| | Lived the experience | Do not consider obstetric violence |
|---|---|---|
| Separation from baby after birth | 48.6% (N=342) | 24.3% |
| Difficult access to free consultations during and after pregnancy | 37.1% (N=261) | 45.6% |
| Lack of access to free consultations during and after pregnancy | 36.4% (N=256) | 43.0% |
| Insufficient duration of consultation | 29.3% (N=206) | 44.7% |
| Lack of patient-friendly information | 28.1% (N=198) | 24.2% |
| Inappropriate conversations by staff in the presence of the patient | 26.0% (N=183) | 31.7% |
| Inappropriate staff attitudes about women's reactions to pain | 23.2% (N=163) | 11.7% |
| Inappropriate staff attitude | 22.6% (N=159) | 8.8% |
| Procedures not explained | 17.9% (N=126) | 13.5% |
| Medicines given without information/specific consent | 16.1% (N=113) | 15.9% |
| Lack of privacy | 12.2% (N=86) | 12.8% |
| C-section imposed without explanation | 11.5% (N=81) | 17.3% |
| Lack of disability accommodations | 11.2% (N=17) | 35.3% |
| Lack of painkillers, even when needed | 8.9% (N=63) | 9.5% |
| Communication in a language unknown to the patient | 5.8% (N=41) | 17.1% |
| Unjustified prolonged stay in the maternity | 5.7% (N=40) | 20.0% |

*Table 15: Percentage of women who gave birth by emergency C-section without preceding labour and underwent the experience, but do not consider it as obstetric violence*

## County of last birth

| No. | County | No. | % |
|---|---|---|---|
| 1 | Alba | 50 | 0.9 |
| 2 | Arad | 52 | 0.9 |
| 3 | Argeș | 36 | 0.6 |
| 4 | Bacău | 481 | 8.6 |
| 5 | Bihor | 190 | 3.4 |
| 6 | Bistrița-Năsăud | 37 | 0.7 |
| 7 | Botoșani | 64 | 1.1 |
| 8 | Brașov | 285 | 5.1 |
| 9 | Brăila | 37 | 0.7 |
| 10 | Mun. București | 1643 | 29.2 |
| 11 | Buzău | 86 | 1.5 |
| 12 | Caraș-Severin | 7 | 0.1 |
| 13 | Călărași | 20 | 0.4 |
| 14 | Cluj | 472 | 8.4 |
| 15 | Constanța | 172 | 3.1 |
| 16 | Covasna | 22 | 0.4 |
| 17 | Dâmbovița | 38 | 0.7 |
| 18 | Dolj | 136 | 2.4 |
| 19 | Galați | 101 | 1.8 |
| 20 | Giurgiu | 2 | 0.035 |
| 21 | Gorj | 18 | 0.3 |
| 22 | Harghita | 63 | 1.1 |
| 23 | Hunedoara | 31 | 0.6 |
| 24 | Ialomița | 27 | 0.5 |
| 25 | Iași | 254 | 4.5 |
| 26 | Ilfov | 29 | 0.5 |
| 27 | Maramureș | 106 | 1.9 |
| 28 | Mehedinți | 6 | 0.1 |
| 29 | Mureș | 196 | 3.5 |
| 30 | Neamț | 43 | 0.8 |
| 31 | Olt | 10 | 0.2 |
| 32 | Prahova | 162 | 2.9 |
| 33 | Satu Mare | 30 | 0.5 |
| 34 | Sălaj | 71 | 1.3 |
| 35 | Sibiu | 161 | 2.9 |
| 36 | Suceava | 107 | 1.9 |
| 37 | Teleorman | 13 | 0.2 |
| 38 | Timiș | 214 | 3.8 |
| 39 | Tulcea | 15 | 0.3 |
| 40 | Vaslui | 80 | 1.4 |
| 41 | Vâlcea | 20 | 0.4 |
| 42 | Vrancea | 36 | 0.6 |

*Table 16: Number and percentage of women by county of last birth*

# QUESTIONNAIRE ABOUT BIRTH EXPERIENCE

This questionnaire is part of a research project initiated by the Association of Independent Midwives in Romania. The project's principal objective is to identify women's perceptions regarding their experiences of pregnancy and childbirth care in Romanian hospitals and clinics. The questionnaire is addressed to women who have given birth at least once within the past five years (2018 - 2023). It anonymous, and the information collected and processed will be used exclusively for research purposes. Based on the results obtained, a series of recommendations will be formulated to enhance the quality of care and women's experiences during pregnancy and childbirth in Romania. The research report will be made available on the website of the Independent Midwives Association.

The questionnaire should take approximately 10-15 minutes to complete. If you feel uncomfortable with any questions, you may withdraw at any time. By completing the questionnaire, you consent to having your responses included in the survey.

Please forward the questionnaire to other women you know who have given birth in the last 5 years. Thank you!

**I. General information**

Q1. Have you given birth in the last 5 years?
1. Yes
0. No (end questionnaire)

Q2. What is your age? Please write your age in figures (e.g. 31)

Q3. Where do you live? I live in an
0. Urban area
1. Rural area

Q4. Which county are you from?

Q5. In which county did you last give birth?

(Q6). Marital status
1. Single
2. In a relationship
3. Married
4. Divorced
5. Widow

Q7. What is the highest level of education you have completed?
1. No education
2. Primary (grades 1 - 4)
3. Lower secondary (grades 5 - 8)
4. Upper secondary (grades 8 - 10)
5. High school (completed 12 grades)
6. Further education college
7. University
8. Master/Doctorate

Q8. Which community do you belong to?
1. Romanian
2. Roma
3. Hungarian
4. Other:

Q9. How many children do you have?
5. No children
2. 2
3. 3
4. ≥ 4

Q10. Do you currently have a job?
1. Yes
2. I am self-employed
3. No
4. No, but I get welfare support
5. No, but I get unemployment benefit

Q11. In which income category does your NET salary fall?
1. Up to 2.100 RON (minimum income)
2. Between 2.101 and 4.600 RON (average income)
3. Over 4.601 RON (above average income)
4. I do not wish to answer

Q12. Thinking about all the experiences you've had with childbirth, pregnancy and pregnancy termination:
1. How many vaginal births have you had?
2. How many caesarean births have you had?
3. How many abortions/miscarriages have you had?
4. How many abortions on demand have you had?
5. How many fertilization treatments have you had?

Q13. Now thinking strictly about your last birth (in the last 5 years), how did you give birth?
1. I had a vaginal delivery
2. I had a vaginal delivery with forceps
3. I had a vaginal delivery with a vacuum extractor
4. I had an emergency C-section (after labour started)
5. I had an emergency C-section without going into labour
6. I had an elective C-section

Q14. Why did you give birth by elective C-section?
1. I chose to have a C-section
2. The physician recommended an elective C-section

Q15. Please tell us the reason(s) for which the doctor recommended an elective C-section. Please choose a maximum of 3 options.
1. Baby too large or pelvis too small
2. Cord wrapped around the neck (circular umbilical cord)
3. Overdue pregnancy (over 41 weeks and 3 days)
4. Vaginal Streptococcus B present in tests
5. Intrauterine growth restriction
6. Different forms of presentation (pelvic, in dystocia, etc.)
7. C-section history (scar uterus)
8. Low amniotic fluid
9. Maternal myopia
10. To be able give birth with the doctor
11. Because I have thrombophilia
12. Because of my age
13. Because the pregnancy was achieved by IVF
14. Other:

Q16. Please tell us why you chose an elective C-section. Please choose a maximum of 3 options.
1. Fear of pain
2. I was told that it is safer for the child
3. Because is safer for me
4. Fear of vaginal changes/ impaired sex life
5. Traumatizing stories of vaginal childbirth
6. Want to choose his/her birthday
7. My doctor doesn't deliver babies, does only C-sections
8. Because all my girlfriends gave birth that way
9. For tubal ligation
10. Other:

Q17. In which type of hospital did you last give birth?
1. In a public hospital
2. In a private hospital

Q18. Why did you choose to give birth in a public hospital?
Please choose a maximum of 3 options.
1. The doctor I used to see works there
2. I don't see any difference between public and private hospitals
3. I didn't have enough money to give birth in a private hospital, although I wanted to
4. I gave birth prematurely and the indication was to give birth in this public hospital
5. Because in case of complications, you still end up in a public hospital
6. Other:

Q19. Why did you choose to give birth in a private hospital?
Please choose a maximum of 3 options.
1. I wanted more comfort (e.g. single room, better food, etc.)
2. I knew that private hospitals are cleaner
3. They have more staff dedicated to patients
4. So that my partner/support person could be with me at birth
5. Because they accepted a birth plan
6. I didn't want to be separated from the baby immediately after birth
7. My doctor works there
8. Other:

Q20. Thinking back to your last birth, with whom did you give birth?
1. Female obstetrician-gynaecologist
2. Male obstetrician-gynaecologist
3. Midwife
4. Nurse

Q21. What was the main reason for giving birth with that particular obstetrician-gynaecologist?
1. He was my doctor in my previous pregnancies
2. It was the recommendation of my acquaintances who have given birth before
3. I had no choice; this was the doctor on duty at the time
4. I searched the internet/press for the best obstetrician-gynaecologist
5. It was the doctor who monitored my pregnancy
6. Other:

**II. Hospital conditions**

Q22. Please think about the relationship you had with your gynaecologist at your last birth. Please score from 1 to 10, where 1=a very bad relationship and 10=a very good relationship

Q23. Please think about the relationship you had with nurses at your last birth. Please score from 1 to 10, where 1=a very bad relationship and 10=a very good relationship

Q24. Please think about the relationship you had with the midwife/midwives at your last birth. Please score from 1 to 10, where 1=a very bad relationship and 10=a very good relationship. If none present, please do not answer the question.

Q25. Please think about the relationship you had with the doctor on duty at your last birth. Please score from 1 to 10, where 1=a very bad relationship and 10=a very good relationship. If this was the doctor who also attended the birth, or if you did not interact with the on-duty doctor, do not answer the question.

Q26. Please think about the conditions (e.g. facilities, cleanliness) you had in the hospital at your last birth. Please score from 1 to 10, where 1=very bad conditions and 10=very good conditions

Q27. Please tell us again how you gave birth last time
1. I had a vaginal delivery
2. I had an emergency C-section (after labour started)
3. I had an elective C-section
4. I had an emergency C-section without going into labour

**III. Experiences in pregnancy and childbirth**

Q28. Which of the following situations/experiences did you go through while you were pregnant, during childbirth or immediately after? Please answer with “Yes, I experienced this” if you have been through the situation/experience or “No, I did not experience this” if you have not.

| No. | Statements | 1. Yes, I experienced this | 0. No, I did not experience this |
|---|---|---|---|
| 1 | I had consultations done in a hurry | | |
| 2 | I had no access to free consultations during and after pregnancy, though I wanted | | |
| 3 | I had difficult access to free consultations during and after pregnancy | | |
| 4 | I was not given enough information and/or the information provided was not to my understanding | | |
| 5 | My privacy/personal space was not respected (other people were present at the consultations) | | |
| 6 | I had tests and various procedures done without sufficient information | | |
| 7 | The doctor/midwife/nurse's language was often upsetting, condescending, insulting, discriminatory | | |
| 8 | I was subjected to abusive/brutal/unsanitary check-ups (violent vaginal/rectal digital examination, touching, hitting) | | |
| 9 | I was subjected to procedures without my consent (such as episiotomy) | | |
| 10 | I was subjected to fundal pressure during expulsion | | |
| 11 | I was not given pain medication even though I asked for it (like epidural anaesthesia) | | |
| 12 | I was given medication without my consent/without clear information (such as cervical ripening substances) | | |
| 13 | I did not have the option for my partner/support person to be present during labour and delivery | | |
| 14 | I was given a C-section instead of natural childbirth without sufficient explanation | | |
| 15 | I was not allowed to move during labour and was forced to stay in bed | | |
| 16 | I was not allowed to keep my baby with me immediately after birth | | |
| 17 | I was not allowed to eat/drink water during labour | | |
| 18 | I was refused/delayed C-section, even though there was a medical reason | | |
| 19 | I was left alone in labour for a long time without medical care | | |
| 20 | I was questioned for history and/or newborn record (or other) while giving birth or having contractions | | |

| No. | Statements | 1. Yes, I experienced this | 0. No, I did not experience this |
|---|---|---|---|
| 21 | I was hospitalized in the maternity ward for a long time for no reason | | |
| 22 | I was assisted at birth by unskilled personnel | | |
| 23 | I was forced into a birthing position/to give birth on the gynaecologic table lying on my back | | |
| 24 | The hospital staff had inappropriate reactions (joking/ scolding me) to my reactions to pain | | |
| 25 | The hospital staff spoke in front of me in a language unknown to me | | |
| 26 | I was not provided accommodations for my disability | | |
| 27 | Hospital staff were talking to me in front of me about other cases or were having personal conversations | | |

Q29. Please tell us briefly what was the most unpleasant experience you had in hospital while you were pregnant, at or after childbirth.

Q30. Please tell us briefly what was the most unpleasant experience you had in hospital while you were pregnant, at or after childbirth.

**IV. Perceptions of obstetric violence**

Q31. Have you ever heard the term "obstetric violence"?
1. Yes
0. No
99. Don't know/No answer

Q32. Do you know the meaning of the term "obstetric violence"?
1. Yes
0. No
2. Not sure
99. Don't know/No answer

Q33. Next, please answer the following situations/experiences with "Yes" if you consider it to be an instance of obstetric violence or "No" if you do not consider it to be an instance of obstetric violence.

| No. | Statements | 1. Yes | 0. No |
|---|---|---|---|
| 1 | Insufficient duration of consultation | | |
| 2 | Lack of access to free consultations during and after pregnancy | | |
| 3 | Difficult access to free consultations during and after pregnancy | | |
| 4 | Lack of patient-friendly information | | |
| 5 | Lack of privacy | | |
| 6 | Procedures not explained | | |
| 7 | Inappropriate staff attitude | | |
| 8 | Abusive/brutal examinations | | |
| 9 | Non-consensual procedures | | |
| 10 | Fundal pressure during expulsion | | |
| 11 | Lack of painkillers, even when needed | | |
| 12 | Medicines given without information/specific consent | | |
| 13 | Absence of the option to have the partner/support person present during labour and childbirth | | |
| 14 | C-section imposed without explanation | | |
| 15 | Movement restrictions during labour | | |
| 16 | Separation from baby after birth | | |
| 17 | Food/water restrictions during labour | | |
| 18 | Refusal/delay of C-section on medical grounds | | |
| 19 | Long labour without medical care | | |
| 20 | Medical questionnaire/anamnesis during contractions/delivery | | |
| 21 | Unjustified prolonged stay in the maternity | | |
| 22 | Assistance at childbirth by untrained personnel | | |
| 23 | Imposing a certain birth position | | |
| 24 | Inappropriate staff attitudes about women's reactions to pain | | |
| 25 | Communication in a language unknown to the patient | | |
| 26 | Lack of disability accommodations | | |
| 27 | Inappropriate conversations by staff in the presence of the patient | | |

Q34. How often did you hear about or meet women who had such experiences?
1. Never
2. Rarely
3. Not rarely, not often
4. Often
5. Very often
9. I don't know exactly

Q35. Thinking about your experience, do you think you have been the victim of obstetric violence?
1. Yes
0. No
2. Not sure
3. Don't know/No answer

**V. Reporting obstetric violence**

Q36. Did you report the case(s) of violence you experienced in hospital during your pregnancy?
1. Yes
2. No
3. I do not wish to answer

Q37. Where did you report the case(s)?
1. Hospital management
2. College of Physicians
3. ANMCS – National Authority for Quality Management in Healthcare
4. Police
5. Mass-media
6. NGOs
7. Other:

Q38. Are you happy with the outcome of your complaint?
1. Yes
2. No
3. I haven't received the result yet

Q39. Why you did not report the violence? Please choose a maximum of 3 options. [only asked if Q36=2]
1. I don’t trust the health and justice systems
2. I was afraid something bad would happen to me
3. I was afraid that someone might hurt my baby
4. I was ashamed of other people's opinions
5. I wanted to, but I was discouraged by family/friends
6. I didn't know what to do
7. No one would have taken any action anyway
8. I had no time and energy
9. Other:

Q40. If there's anything else you'd like to let us know, please do so in the space below.
If you would like to report a situation of abuse, please fill in your contact details below so that we can get in touch with you at a later time. Your details will be used exclusively by the Independent Midwives Association.

Q41. How did you find out about the questionnaire?
1. Website
2. Facebook
3. Instagram
4. TikTok
5. Online groups
6. Friends/family
7. Other source:

Thanks for your cooperation and your time!
The research results will be available on the website of the Independent Midwives Association.

**Independent Midwives Association**

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