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**Sexual and Reproductive Health in Romania and Moldova: contexts,
actors, challenges.**

By

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**Submitted in fulfilment of the requirements for the Degree of Doctor of
Philosophy**

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Abstract

Over the past two decades sexuality and reproduction have proved potent and contested subjects. After the unexpected collapse of the state socialist systems, societies facing uncertainty and dislocation have turned both to the allure of ‘the west’ and to pre-socialist traditional values of family and gender. Along with this, aspirations of moving closer to Europe sits alongside a resurgent nationalist sentiment throughout the region, and it is sexuality and reproduction which has become a particularly contested battleground, as the female reproductive body has become a metaphor for the vitality and viability of the nation-state. Discourses of demographic crisis, calls to produce more (indigenous) children to increase the population and ensure the stability and viability of the state, and proscription of so-called ‘deviant’ (defined as non-heterosexual/non-reproductive) sexualities have all gained in currency as the nations of the region try to establish themselves as sustainable entities following the years of state-sponsored paternalism. At the same time, western nations and donor agencies offer support to redevelop and redesign out-of-date systems and bureaucracies and the opportunity to modernise and enjoy the benefits of capitalism and liberal democracy. A particular focus on developing civil society along with the reform of state institutions widens the social marketplace still further.

It is against this backdrop that policy makers and service providers attempt to develop and provide health services. Public health is a useful barometer of what is happening in society, as it reflects the effects of wider socio-economic and political trends. Within this, the study of sexual and reproductive health is crucial as it also has the ability to illuminate the differential effects of societal change on different groups within society, such as women or those from minorities. It also powerfully illustrates the contestations going on in wider society around meanings of the moral and healthy, as sexuality and reproduction are issues pertinent to the continued reproduction of states and other ‘communities of power’.

This thesis is a study of the experiences and perceptions of service providers in the field of sexual and reproductive health in Romania and the Republic of Moldova. Through interviews with service providers in both state and civil society sectors as well as regional and national authorities and international donor agencies, and an extensive media review of the portrayal of sexuality, reproduction and sexual and reproductive health, opportunities and barriers to providing accessible and responsive services within the contested arena of

two postsocialist countries with much in common historically and culturally but following very different paths in the contemporary period are explored. The continuing importance of sexual and reproductive health as a category of study which can illuminate wider macro-level debates on national identity and vitality, as well as the importance of discursive battles over control of meanings, are amply illustrated in the thesis. In particular the relation between health and morality is extensively explored, and the relevance of an area studies approach to this wider topic is demonstrated. The thesis finds that it is vital to consider sexual and reproductive health services within their wider sociocultural context and that transnationally-funded initiatives do not take full account of the multiplicity of meanings and values underpinning the reactions of target populations to their services; indeed services are often framed as representing an unwelcome invasion of 'alien' morality. Ultimately providers and funders need to take the moral understandings of their target populations very seriously if they are to overcome the considerable opposition to their services.

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My family have been incredibly supportive over the last few years of the thesis, despite me giving up yet another ‘proper job’ in order to return to university, and my in-laws too have showed nothing but interest and support. Most of all I have been so blessed to have Pete’s love, support and patience (not to mention amazing cooking) as I have spent far too much of our spare time working – I can’t thank him enough as I really could not have got this far without him.

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Author's declaration

I declare that, except where explicit reference has been made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature

Printed name

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Introduction

This thesis is an investigation into the development and provision of sexual and reproductive health services in Romania and the Republic of Moldova, in particular the experiences and perceptions of service providers and other interest groups of the contexts in which such services are provided. It aims to consider the range of different actors involved in services and how they negotiate the challenges and competing claims around sexuality and reproduction. It also discusses the competing interests and discourses – local, national and international, lay and professional, state and civil society – around sexual and reproductive health in order to contextualise the services offered. The thesis contends that the power to define, and thus control, what is considered healthy, normal and moral is crucial to understandings of activities ‘on the ground’ and barriers to them. It draws on insights from such varied disciplines as area studies, sociology, development studies, public health and anthropology in order to interrogate the complex processes within which policies and services in sexual and reproductive health are developed. In particular it offers a critique of the underlying assumptions of public health approaches which underpin many services within sexual and reproductive health and highlights other issues, particularly morality, which are under-considered by policy-makers and service providers. As such it contributes to wider work on the sociology of health and illness, and on morality and health, by bringing an area studies approach to the study of these issues in the postsocialist region. This provides an awareness of the importance of both historical and contemporary contexts, an interrogation of interactions between local, national and transnational actors and contexts, using theoretical frameworks from a range of disciplines.

Genesis of the thesis

The original intention of this research was to undertake a comparative study of state and civil society health services in Romania and Moldova. The prospect of two countries with much in common culturally, linguistically and historically, but which in their more recent history had followed different paths, was thought to offer an interesting basis from which to consider the effects of divergent socialist pasts and contemporary issues such as European Union membership (or not, in Moldova’s case) on the development of health policies and services. This appealed to me as a practising health professional with links in both countries and experience in both public and voluntary sectors. I envisaged a study which would investigate the development and provision of state and civil society health

services in each country, considering the extent to which they did or did not complement each other, and then consider the extent to which these processes in each country were differently affected by their various positions vis a vis European Union membership, influence of Russia (and latterly the Soviet Union) and their exposure to different levels of funding and technical assistance from transnational and western organisations and governments following the end of the state socialist period. The study was conceived therefore as primarily comparative, with health used as an example to illustrate these various processes. At the beginning of the research I had not decided to focus on a particular area of health, and I envisaged considering health promotion as an activity undertaken in a number of areas and specialities, which would be narrowed later on making contact with specific practitioners.

With this in mind I visited Romania and Moldova at the end of the first year of the research in order to establish contact with civil society organisations and practitioners who would be willing to participate in the study. As a result of this visit, the majority of practitioners and organisations in both countries I met had a focus on – or at least activities in – sexual and reproductive health, and it was felt that an emphasis on this area in particular would provide focus to the study. An extensive literature review was undertaken on this subject, both in the two countries specifically and also in central and eastern Europe and the former Soviet Union more widely. Questions of gender, historical legacy and power were shown to be of considerable importance alongside the comparative questions originally envisaged.

When the schedule for interview questions was being drawn up, the comparative aspect and questions around funding, partnership and the practical operation of services (such as how decisions are made on which services are provided and who participates in this decision-making process) were designed, and early interviews in Romania included these questions. However it soon became clear that other issues were felt to be of more importance to interviewees, and that certain issues were being raised again and again which had not appeared in the bulk of the literature accessed prior to starting the fieldwork, nor in transnational organisations' literature relating to sexual and reproductive health. In particular the concept of 'shame' (in Romanian, *ruşine*) was used in the large majority of interviews. It became clear that an interesting line of enquiry was emerging, namely, the relationship between health and morality and how this impacts on the design and provision of services. By the time I was preparing to leave Romania to go to Moldova the questions of social policy and service duplication seemed less urgent than this question of health and morality, and I contacted a number of my early interviewees in Romania to ask

supplementary questions around this topic. Early on during my time in Romania it was also clear that it was going to be difficult to contact clients in sufficient numbers to be feasible as a substantial part of the study, and so a sharper focus on the perspectives of service providers was established early on in the research.

Once I had started making contact with practitioners and services in Moldova I soon found that similar issues – including extensive reference to *ruşine* – were being raised there too. Questions of shame around sex education, unwillingness to discuss sexuality and reproduction in the family and reluctance to discuss such matters with health professionals, raised time and again in Romania, were also to the fore throughout my interviews in Moldova. Therefore I began to see the research evolving away from a formal comparison between countries and sectors and towards an exploration of contexts, debates and discourses which affect the design and provision of sexual and reproductive health services. Of course a certain element of comparison has inevitably remained, due in part to different contemporary political and legislative developments and in part to historical legacies, most notably Romania's history during the Ceauşescu era of repressive anti-abortion policies which was not experienced by Moldova as part of the Soviet Union. However the main aim of the thesis is to explore, in two different countries albeit with some similarities, how the issues raised by respondents spoke to wider processes around sexuality, reproduction, gender and welfare in the region rather than in the cataloguing of similarities and differences.

On returning from the field, the wide media review from both Romania and Moldova, which I undertook throughout the following two years building on the media research commenced in the year prior to fieldwork, confirmed the wisdom of this change of focus. Articles abounded which debated sexuality and reproduction generally, sexual and reproductive health specifically and services, from a moral as well as a health viewpoint. This added still more depth to the rich picture built up during fieldwork of the contested contexts in which providers at state, international and civil society levels attempt to provide services.

Background to the thesis

In the state socialist times “[t]he control of demographic phenomena was generally considered vital to the success of development strategies in planned economies” (Kligman, 1998:9). Demography in this context refers to the factors “related to the life cycle of a

population: natality, mortality, longevity, morbidity, the structure of the population by age and sex, mobility (social, economic), and migration (internal and international)” (ibid., p.9). In Romania the aim in strengthening the family, referred to as “the basic nucleus of society” (Romanian Communist Party/Parvu, cited in Kligman, 1998:10) by increasing the birth rate, ensuring a young and healthy population, was to maximise the productive and economic capability of the socialist nation. In the Soviet Union too, policies aimed at “ensuring the continuous, successful reproduction of the Soviet population in politically desirable quantities” (Rivkin-Fish, 2005:96) were prevalent, with concern about below-replacement level fertility rates, particularly in the European USSR from the 1970s (Rivkin-Fish, 2005). In Romania the main policy aimed at meeting these demands for an increased population was the banning of abortion with the infamous Decree #770 of 1966 along with extreme pronatalist messages, restriction of contraception and oppressive surveillance, particularly of women. Constant pro-familial rhetoric linked childbirth to the reproduction of the socialist state, blurring public and private boundaries to the extreme. In the Soviet Union, family breakdown and small families were considered by policy makers to be the result of women’s participation in the workforce, and education and discourse focussed on morality and the promotion of both larger families and traditional gender roles. In both countries these policies resulted in “[t]he public discipline of intimate behaviour [sic]” (Rivkin-Fish, 2005:99). As Kligman (1998:13) forcefully identifies, “[p]olitical demography provided the ideological framework through which vital population growth was to be monitored and guaranteed. The population, simultaneously the subject and object of social experimentation, was to be moulded [sic] with or without its consent into the socialist body politic.”

Against this backdrop, following the collapse of the state socialist systems, a new era of sexual and reproductive politics has emerged and is still emerging, yet links to the socialist past are often close to the surface. In the Soviet Union, sexually explicit publications and media emerged from the late 1980s, with “[t]he media, reveling in the demise of prohibition, [finding] its voice in sensationalism” (Rivkin-Fish, 2005:100). Sexuality and this new frankness about it came rapidly to symbolise something bigger: “the moral status of democratic change” (ibid., p.100). Increased openness – or perhaps more accurately exposure – to debate around issues of sexuality was soon seized upon by conservative politicians and religious leaders who equated it with an imported immorality alien to local values and mores. Also alluding to dwindling birth rates, the so-called ‘demographic crisis’, issues around sexuality and reproduction have been co-opted as symbolically representing the unwelcome penetration of external western values into the national body

politic (Rivkin-Fish 2005a; 2005b). Insecurity about national identity – in the case of the former Soviet Union successor states due to being so recently constituted with complex patterns of population groups and population movements, and in central and eastern Europe with the transition from paternalist state socialism to membership (aspired and actual) of a new ‘bloc’, the European Union – means that arguments around reproductive rights are inevitable and “often directed to concerns about selling the nation to the International Monetary Fund, the World Bank, or the Catholic Church, or all three” (Kligman, 1994:267; see also Gal and Kligman, 2000a). In the cases of Romania and Moldova, the countries under consideration here, the Orthodox Church has proved a powerful obstructive force in the development of legislation and political debate around issues of sexual and reproductive health (Stan and Turcescu, 2007), both forming and feeding into wider debates around national identity, health and vitality.

It is in this context that reforms of health services, prompted and promoted by western transnational organisations and governments, often as a prerequisite to membership of the European Union and other transnational bodies, have taken place. These reforms, both welcomed and contested, add a further layer of debate around who leads and shapes the discourses and contexts within which practitioners are expected to provide services. The area of sexual and reproductive health is particularly instructive to study in this regard as it is able to highlight in microcosm wider social and political processes within the region.

Contribution of the thesis

This thesis contributes significantly to the study of both sexual and reproductive health and civil society within the region. On Romania there have been important studies on the impact of Ceauşescu’s pronatalist policies (in particular Kligman’s (1998) seminal study; also the work of Adriana Băban (2000; 1999)), research on differential access to sexual and reproductive health services (for example Magyari-Vincze, 2007) and epidemiological studies on reproductive health (Ministry of Health et al, 2006). In the former Soviet Union, studies (in particular by Rivkin-Fish, 2005a) into women’s health in post-Soviet Russia have highlighted the efforts at local, national and international levels to meet the demands of negotiating Russia’s neoliberal transition. This thesis builds on these works, but also advances knowledge firstly through its interrogation of multisectoral responses to reform and to the challenging context. The inclusion of local and regional state actors, civil society groups and international actors provides a rich web of experience and perspective and highlights tensions in what should be an uncontroversial goal of improving

services. Secondly the inclusion of Moldova, a relatively understudied and undertheorised country greatly enhances the original contribution of this thesis. Thirdly, although not primarily intended to be a comparative study, the focus on two countries with much in common as well as many differences provides a richer overview of the complexities and nuances of the politics around sexual and reproductive health.

The thesis also contributes to the sociology of health and medicine through its interrogation of public health and medical approaches to sexuality and reproduction in the two countries. It challenges the universalising assumptions of public health and highlights the different (and often unexpected) reactions to public health projects in sexual and reproductive health. The thesis also adds to work such as Peterson and Lupton (1996) which critiques the power of the so-called 'new public health' discourse through its exploration of "public health as a sociocultural practice and a set of contingent knowledges" (Peterson and Lupton, 1996:x), its critique of the ways "language, knowledge and power interact to construct and reproduce our way of experiencing our selves, our bodies and the social and material worlds" (ibid, p.x) and its focus on the cultural and social dimensions of public health (ibid, p.xi).

Perhaps the most significant contribution of the thesis is to the growing body of literature on health and morality (see for example Brandt and Rozin, 1997; Conrad, 1994; Anand et al, 2004). The difficulties experienced by my respondents in negotiating hostile contextual factors, in particular the battles over who has the power to control and define meanings of what is healthy, moral and normal, mean that this study is able to make an important contribution to debates on personal and social responsibility for health and public health ethics.

Thesis structure

The thesis aims to provide an empirical account of contemporary sexual and reproductive health service provision in Romania and Moldova and an understanding of reactions to and experiences of the context within which these services are developed. It demonstrates the limitations as well as benefits of uncritical public health approaches, and explores the interactions of participants in sexual and reproductive health services from different sectors in the two countries and beyond, highlighting how formulations other than epidemiological (such as debates on morality and the production of meanings) inform current services and could be harnessed to develop policy and services in the future.

Chapter 1 provides an overview of the theoretical perspectives framing the study. Consideration of the medical model of health (Nettleton, 1995) and medicalisation provide the foreground for discussion on public health and sexual and reproductive health more specifically. Current theory on health and morality is also discussed, as the overarching body of theory to which this thesis contributes. The chapter concludes with consideration of public health and sexual and reproductive health in central and eastern Europe and the former Soviet Union in order to contextualise the theoretical framework and underpin the context of services which will be explored throughout the thesis.

Chapter 2 considers the institutional context within which services are developed and provided. It outlines the key institutional players having a role in service development. Crucially this does not merely include service providers (state and civil society) but also donors and development agencies, religion and the mass media as key formers of meaning and important actors in the debate around the validity and desirability of services. Within this, historical perspectives on the role and perceptions of ‘the west’ are included to further contextualise the issues faced by contemporary service providers ‘on the ground’.

Chapter 3 introduces the methodological issues faced as I conducted the research both ‘in the field’ and away from it. It also discusses the full research process including choice of locations and research methods, issues of data collection and analysis and ethical issues. The methods used were qualitative (namely semi-structured interviews, observations and media analysis) and were chosen to reflect the information sought and to complement the theoretical frameworks of the thesis.

Chapters 4, 5 and 6 present the empirical data collected in both countries. Chapter 4 outlines the key players involved in forming the context within which services are provided. As well as insights from the main service providers (state and civil society), there is further discussion on the role played by religion and by international donors and agencies in enabling or obstructing the development of a context conducive to providing services.

Chapter 5 then considers the discursive landscape within which providers and policy makers are attempting to develop services. The contested areas of demography and national identity, family, and sexuality are interrogated in order to present the underpinning debates and environment for services, and to provide the context for the discussion in

chapter 6 of the main services which are provided. These services fall into three categories, namely adolescent sexuality and sex education, pregnancy and maternity services, and gender and domestic violence. Material from both respondent interviews and observations and media analysis is infused throughout these empirical chapters in order to highlight the contestation of meanings and values and underpin the thesis' central assertion of the importance of morality to considerations of sexual and reproductive health and the limitations of this being marginalised within a public health approach.

The conclusion summarises the principal findings of this study and discusses their implications both for practice and for further research. It highlights how, alongside the many gains and developments in sexual and reproductive health services in Romania and Moldova, significant barriers remain to the development of services which meet the needs of the population at individual, community and national levels. The findings demonstrate that national and international initiatives enable the development of services but also fail to fully take into consideration wider contextual issues such as a widespread reluctance to discuss sexuality and reproduction and forceful opposition to services in the name of religious and national identity and values.

Chapter 1

Theorising and Contextualising Sexual and Reproductive Health in Romania and Moldova

This chapter outlines the theoretical context in which this thesis is sited, presenting the historical and contemporary background to sexual and reproductive health in Romania and Moldova and engaging with the principal themes which run through the thesis. The thesis explores and discusses existing research and theoretical frameworks drawn from a number of disciplines including sociology, anthropology, feminist theory, development studies, and area studies as well as public health approaches. This sites this thesis within a number of contemporary theoretical debates, most notably those relating to the place of public health approaches to sexuality and reproduction, the gendered impacts of health debates and interventions, the role played by diverse institutional interests in regulating sexuality and reproduction, and the complex links between health and morality. Chapter 2 will look in more detail at the institutional background to the services considered in the thesis, as well as providing more local contextual background to the study. Chapter 1 considers the overarching theoretical frameworks informing the research undertaken for this thesis.

1.1 Theoretical Frameworks

This thesis draws on a number of theoretical perspectives in order to position my analysis within wider research. This part of the chapter will be divided into two main sections in order to outline the theoretical basis for the empirical chapters which will follow. Firstly I will give an overview of some of the debates around public health and medicine relevant to my thesis, drawing mainly on sources within public health but also anthropological and development literature, in order to introduce the ‘macro’ context. This includes a section on health and morality, as an overarching body of theory to which this thesis contributes. Following this a more specific overview of theory around sexual and reproductive health generally and within central and eastern Europe and the former Soviet Union more specifically will be presented. There is also a brief theoretical consideration of the institutions of religion and the mass media, as important players in the wider context within which services are designed and provided. Consideration of understandings of gender is incorporated throughout in order to highlight the gendered and politicised nature of discussions around sexuality and reproduction.

The chapter concludes with a discussion of the concept of postsocialism and a consideration of its ongoing usefulness as an analytical tool in considerations of health services in central and eastern Europe and the former Soviet Union.

1.1.2 Medical models of health

The purpose of this research was to explore the various experiences and perceptions involved in the provision of and access to sexual and reproductive health services in Moldova and Romania. Although not all service providers came from a health background, or worked for specifically health-related organisations, the majority did, and medical formulations and understandings of sexual and reproductive health were vital in the design and delivery of services. This section therefore briefly considers the implications of a medical model of health and medicalisation on understandings of sexual and reproductive health, before discussing some of the issues around public health approaches when considering sexuality and reproduction.

The so-called ‘medical model of health’ can be defined as consisting of five main assumptions: (1) the separation of body and mind (*mind-body dualism*); (2) the body as a machine which can be repaired (*mechanical metaphor*); (3) technological interventions are promoted and sometimes overplayed (*technological imperative*); (4) explanations of disease processes are reduced to mainly biological explanations (to the relative neglect of psychosocial factors); and (5) every disease is caused by an identifiable agent (*doctrine of specific aetiology*) (Nettleton, 1995:3). As such “[t]he body is isolated from the person, the social and material causes of disease are neglected, and the subjective interpretations and meanings of health and illness are deemed irrelevant” (ibid, p.3).

Such an approach to health can be critiqued on a number of grounds, for example that it objectifies the individual through mind-body dualism and the mechanical metaphor, or that it neglects psychosocial determinants of health, and that it reduces medical inquiry still further from the individual to the body to ever smaller parts of that body (organ, cell, etc). The scientific-rationalist view that all phenomena can be diagnosed, explained and treated came to predominate in the west since the end of the eighteenth century (Nettleton, 1995:3), and has resulted in processes including (but not restricted to) reproduction and sexuality being both pathologised and controlled by the medical profession. This has been challenged by feminist scholars arguing that “control of pregnancy and childbirth has been taken over by a predominantly male medical profession” (Nettleton, 1995:28; Williams & 10

Calnan, 1996). The process by which aspects of life such as childbirth are reframed as medical issues is known as medicalisation. This process is of interest for this thesis in that health promotion and education in the area of sexual and reproductive health is provided by both medical and non-medical staff, and are also contested on both medical and non-medical grounds. The implications of medicalisation in this area are therefore important to consider briefly here.

Tiefer (1996, para. 11) highlights how the process of medicalisation involves distinctive values, models, institutions and agents which “exercise practical and theoretical authority over particular areas of life.” She cites Crawford (1980) when stating that many aspects of western society are already medicalised through the standards dominating (for example) notions of appropriate behaviour, gender identity, reproduction, food choices or recreational activities. This has profound implications for medical claims of scientific neutrality. Medicalisation is an important means of social control, with the power to define ‘the health norm’ or what is good and bad in relation to health.

“The ideology of healthy living has acquired the status of a moral code, with public “signs” of unhealthy living ... being severely stigmatized ... The imperative to be healthy produces the final moral element in the biomedical model: the sense of shame a person acquires along with an unhealthy or abnormal condition” (Tiefer, 1996, para. 76).

A sense of blame related to the adoption of an unhealthy lifestyle is now commonplace (Peterson and Lupton, 1996).

Conrad (1992:220) argues that a major aspect of medicalisation lies in the power to define, as it is this which confers greater social control. Such a power is not usually universally accepted, but will depend on support from practitioners, availability of technology, the existence of competing definitions and the presence of challenges to medical definitions. In the context of this research the competing definitions and claims of medical practitioners and organisations working largely within a medical paradigm, and opposing groups such as conservative nationalist, political and religious groups, have led to a polarised debate not only about sexuality and reproduction per se but also around the power to define the ‘normal’, ‘healthy’ and ‘good’. Issues around morality and the power to define are therefore central to this thesis.

Having considered the medical model of health and medicalisation, a discussion of issues pertaining to the specific area of public health, as the medical paradigm underpinning many sexual and reproductive health services, is important here.

1.1.3 Public Health

Public health is a complex and contested concept, and Verweij & Dawson (2007:21) suggest that it can be understood in two ways, as “the health of the public” but also as the collective (i.e. public) interventions designed to promote the health of a population. Both these aspects feature in most influential definitions of public health, such as that by Acheson (1988, cited in Verweij and Dawson, 2007) who defines public health as “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”, whilst the Institute of Medicine (1988, cited in Verweij and Dawson, 2007) defines it as “what we, as a society, do collectively to assure the conditions in which people can be healthy”. Nuffield Council on Bioethics (2007:v) refers to public health as “the efforts of society as a whole to improve the health of the population and prevent illness”, and highlights public health policy’s focus on prevention rather than treatment of the sick, on population rather than individual, and the importance of collective action. Given that traditionally the field of bioethics has a large focus on individual freedom with regards to consent, information and treatment (ibid), the focus of public health on the collective gives rise to an interesting set of ethical issues around who is responsible for ensuring that people live healthy lives.

It can be seen then that the definitions and indeed the concept of public health are far from unproblematic. The concept of collective action or organised efforts of society implies a degree of consensus on what is healthy, and that there are certain groups (in particular, governments and the medical and allied professions) who are qualified to define what is healthy and encourage particular health behaviours, through legislation and through professional discourse and consensus. It is also assumed that what is healthy for one population group is technically equally healthy both for all members of that group and for other population groups. The place of the individual within this amorphous ‘public’ is sometimes difficult to distinguish, and the interests of groups or communities with different views as to what constitutes ‘healthy’, as well as those who do not constitute the majority population, are hidden within the standard definitions and practices of public health which are driving policy at local, national and international levels (MacIntyre et al, 1996; Smith, 2000; Lillie-Blanton and Laveist, 1996).

There is a sense in which the focus and practices of public health can be seen as somewhat contradictory. Despite a focus on the collective, measured through group level statistics such as morbidity and mortality rates, much of the practice of public health is aimed at individual lifestyle behaviours (such as smoking, drinking, dieting, exercising, sexual activity), with the result that “few areas of personal and social life remain immune to scrutiny and regulation of some kind” (Peterson & Lupton, 1996:ix). Discourses of fear, risk and responsibility are employed to encourage particular health behaviours and discourage others, and professional expertise is privileged over lay expertise in spite of the common language of empowerment (Peterson & Lupton, 1996).

Cheek (2008:974) highlights how

“[m]any contemporary health and health care discourses are shaped by liberal capitalism, given that this has been an era that has seen the assumptions of liberal capitalism become less an idea than an orthodoxy ... Health has become ... a new form of a badge of honor [sic.] by which we can claim to be responsible and worthy both as citizens and individuals”.

Discussions with service providers in Romania and Moldova and analysis of policy and popular discourses on health show how health has become a loaded term and many different interest groups – governments, medics, NGOs, media, religious groups, to name a few, and the most relevant to this thesis – use it as a way to promote particular judgments on acceptable and unacceptable outcomes. Crawford (2000:226) when discussing the activity of health promotion identifies it as “a collective act speaking to a collective experience. It sets out the symbolic-practical *polarities of conflict*, provides guideposts for making sense of their entanglement, improvises rules for practical action, *including transgressions*, and supplies scripts for *moralizing various outcomes*” (emphases mine). Lipschutz (2004:201-2), discussing global civil society and governmentality, makes a similar point:

“Populations ... are analysed and treated as homogenous collections of people moulded into particular categories and forms ... Individuals comport themselves according to their specific population’s standards of ‘normality’. The right disposition of things is maintained through the standardization of populations within certain defined parameters, the self-disciplining of their own behaviour ... and the disciplining function of surveillance and law ... Taken together, these constrain individuals’ practices to a ‘zone of stability’, or ‘normality’.”

The use of population-based data and evidence from randomised controlled trials

“stand supreme, and studies of the social context and understandings that individuals might have about a prescribed lifestyle don’t count in terms of best possible evidence ... These understandings have been simply transferred to the messy reality that is life and lifestyle for individuals in contemporary society” (Cheek, 2008:979).

As a result health has become another form of discipline where people are praised or blamed for making good or bad, responsible or irresponsible choices, and the regulation of behaviour (by self and others) is at the core of public health activity.

There is a tension between the elevation of the individual in neoliberal thought and the positioning of the individual within a larger society where health is a duty rather than a right. This can lead to interest groups within and outwith health care establishing “new and different forms of control ... [employing] judgments, comparisons and displays as means of incentive, control, attrition and change – based on rewards and sanctions (both material and symbolic)” (Cheek, 2008:981, citing Ball, 2003). Within a neoliberal framework, technologies are employed to “‘govern... at a distance’ ... creat[ing] localities, entities and persons able to operate a regulated autonomy” (Peterson & Lupton, 1996:11, citing Rose & Miller, 1992). In what has come to be known as ‘the new public health’, appealing language of empowerment, participation and community control has been employed which “serves to mask shifting relations of power involving, in particular, a redefinition of citizenship rights and responsibilities” (Peterson & Lupton, 1996:11). The same authors identify the new public health as “if, nothing else, a set of discourses focusing on bodies, and on the regulation of the ways in which those bodies interact within particular arrangements of time and space” (ibid, p.11). People are encouraged to “become more self-regulating and productive both in serving their own interests and those of society at large” (ibid, p.12).

With neoliberal politics in the ascendancy during the 1990s when western governments and donor organisations started to provide aid and technical assistance to the countries of central and eastern Europe and the former Soviet Union, the tension between ideas of the individual and the community often reflected interactions between east and west and the tension between a “socialist rhetoric of egalitarianism and social justice [and] ... the liberal discourse of individual liberty and (economic) opportunity” (Einhorn, 2006/2010:22). It may be then that exploring the tensions inherent in public health services in two countries of the region is a way of highlighting, in microcosm, the wider processes and tensions that continue in the contemporary period in wider society.

Having highlighted that public health discourses have been shaped by liberal capitalist assumptions, it could also be argued that public health approaches can act as “a buffer against rampant capitalism” (Dew, 2007:108) in that through the use of epidemiological data they can point to inequalities in society, lead the critique of unregulated capitalism, and prompt action encouraging greater social solidarity. Given the attempts of both Romania and Moldova to move from a centrally-planned to a capitalist economy, this places health in general, and public health in particular, in an important position practically and theoretically, as the state of a nation’s (or population sub-group’s) health can offer useful insights into the positive and negative impacts of wider contextual and societal influences in that society. One of the problems with this, though, is that the institution of medicine is regarded as both “repository of truth” and “morally neutral” (Dew, 2007:107). However, given that “[p]ublic health is an institution that performs a moral regulatory function in contemporary society, and therefore as an institution is in opposition or conflict with other institutions performing different regulatory functions or fostering individualism” (Dew, 2007:112) the positing of medicine as a morally neutral arbiter of acceptable societal behaviour and outcomes is problematic. This thesis therefore takes as an important starting point the tension between the discourses and practices of the wider health community on the one hand, and on the other, the different voices and interests with a say in, or influence over, the wider factors in society that impinge on what is defined as healthy and how this is regulated and sanctioned.

1.1.4 Sexual and Reproductive Health

That sexuality and reproduction are contested arenas is not a new insight, and the question of why has been extensively theorised. Nevertheless, the fact of this contestation is a crucial foundation to this thesis. As Foucault (1976/1998:33) highlights, “we are dealing less with a discourse on sex than with a multiplicity of discourses produced by a whole series of mechanisms operating in different institutions”. Whilst public health approaches to sexuality and reproduction are sited largely within a modernist and scientific framework assumed to be value-neutral, stable across contexts and thus unilateral (Pigg, 2005), constructivist approaches posit the socially and culturally constituted nature of “sexual identities, desires and practices ... through a complex and unstable interweaving of biology, anatomy, intellect and discourses” (Corrêa and Jolly, 2008:23). In other words “the subtle articulations between the body (the external image), biology (the inside) and social construction and contingencies (the outside)” (Corrêa and Jolly, 2008:24 citing

Petchesky, 2005) interact to constitute understandings and experiences of sexuality and reproduction.

The tension between scientific and constructivist approaches is reflected in the theoretical shift “from models stressing the social regulation of sexuality to those stressing the social production of sexuality” (Pigg & Adams, 2005:5, citing Vance, 1991). As Pigg (2005:43) highlights, “[w]e live in a time when sexuality is being increasingly biologized through international public health projects, while, simultaneously, social theory is prying it away from its association with the physical body”. There is a powerful sense in which this tension is reflected at the local level – it is too simplistic to say that there is merely a battle between global and local, although of course this is an element of the debate. Even within the local context, debates around what constitutes the natural, moral, healthy, locally-authentic (and therefore also the unnatural, immoral, unhealthy and externally-imposed) are often fierce. Whilst agreeing with the constructivist suspicion of universalising explanations and models, and with the call for interpretations at a local level (Pigg & Adams, 2005), ‘local priorities’ (as mediated through the discourses and practices of dominant groups within the local context) can also be exclusionary and reinforce existing relationships of power and control (Corrêa and Jolly, 2008:30). These discourses and assumptions therefore need to be examined and critically interrogated. Understandings of what constitutes ‘healthy’, ‘moral’ and ‘normal’ not only potentially differ between global and local, but also within the different institutional players and interest groups at the local level, often mediated by both historical and external influences.

For the purposes of this thesis, sexual health and reproductive health are largely considered together, partly for ease of use of the shorthand “sexual and reproductive health”, but primarily because both sexuality and reproduction are often linked by the organisations, professionals, institutions and policy-makers who are most influential and involved in framing and providing services. This is both helpful and problematic. On the one hand, linking them highlights that reproduction is more than merely a biological act with a tangible outcome, but is embedded within gendered, cultured, socialised and politicised assumptions and practices. On the other hand, the linking of sexual health to reproductive health has led to a framing of both sex and reproduction as primarily medical matters (Pigg & Adams, 2005:16), as well as institutionalising family forms and public and private domains, and delimiting and proscribing deviance (ibid, p.14). Just as sexuality and reproduction are contested concepts, so too is health, and the ensuing battles as to what is healthy (as well as ‘moral’ and ‘normal’) have politicised sexuality and reproduction

through linking both to national political concerns. “The project of classification ... is often seen as central to the possibility of objectifying sexuality as a biopolitical domain” (Adams and Pigg, 2005:159). In central and eastern Europe and the former Soviet Union this is done particularly through the invocation of notions of national integrity and purity, and of ‘demographic crisis’ – even though in many of these countries population decline is seriously affected by emigration and by a lack of immigration which is not seen as a suitable answer to demographic decline (Gal & Kligman, 2000a:28). It can be seen, for example, that there is a tension between the dominant international development community focus on ‘population control’ (understood in many parts of the world as ‘decreasing fertility’) and the discourses in Europe of demographic crisis and calls to increase the indigenous population. These discourses, as linked to the issue of national integrity and survival, are so powerful that attempts to introduce medical advances and interventions (for example contraception, abortion, fertility treatments or immunisation against the Human Papilloma Virus (HPV), the most common cause of cervical cancer) are popularly derided and protested against in the strongest possible terms (such as ‘national genocide’). The politicisation of these debates, and of the actors within them, is therefore a fundamental concern of this thesis.

In its overarching definitions of sexual and reproductive health, the World Health Organisation (WHO) introduces empowerment and enabling as ideals. Thus, sexual health is defined as:

“the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching, and that enhances personality, communication and love ... [T]he notion of sexual health implies a positive approach to human sexuality, and the purposes of sexual health care should be the enhancement of life and personal relationships, and not merely the counselling and care related to procreation or sexually transmitted diseases” (WHO 1975, cited in WHO, 2001:7).

Likewise, reproductive health (incorporating sexual health, reproductive freedom and safe motherhood) is defined as:

“impl[ying] that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (WHO 1994, cited in WHO, 2001:7).

The language of these definitions implies a holistic view of individuals and their health, their rights to adequate health care leading to a satisfying experience of sexuality and reproduction, and assumes a level of agency by individuals in terms of accessing services. There is a basic assumption of ‘correctness’, of ‘common sense’, in the WHO’s charge that these areas “should be integrated in policy and programme development, service delivery and information, education and communications” (WHO, 2001:7), but this language can also suggest imposition in the responsibility of recipient countries to implement these ideals.

This empowering of individuals through improving access and the range and quality of services is linked explicitly by WHO to measurable outcomes such as a reduction in abortion rates and an increase in modern contraceptive take-up across the larger population, as well as to the language of rights (which, interestingly, is also quantified). Thus the WHO strategy includes objectives of ensuring legislation which conforms with “internationally endorsed reproductive rights” (WHO, 2001:9), the inclusion of the concept of reproductive rights in school curricula and that people are aware of “their right to make free and informed choices on reproductive behaviour” (WHO, 2001:9). There seems to be an assumption that with such a sense of empowerment and enabling, people (particularly women) will actually claim these rights; however it is not specified how these rights will be claimed and there is minimal discussion of barriers to making such claims (see Turbine, 2007a). Education is seen as key to both empowering individuals and larger groups (such as women or young people) and to improving overall health outcomes. This is something with which my respondents broadly accepted and agreed.

Material from the United Nations Population Fund (UNFPA) and International Planned Parenthood Federation (IPPF), two other international agencies involved in supporting and/or funding respondent organisations in this research, also supports the concepts of rights and empowerment. For example,

“[t]he right to sexual and reproductive health implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences. Sexual and reproductive rights provide the framework within which sexual and reproductive well-being can be achieved” (IPPF, 1996:1).

Member organisations are encouraged to develop activities in the field of political activism in terms of rights protection and increasing access and knowledge, firmly within a rights-based approach. UNFPA too commits itself to the empowering role, stating that it:

“promotes the right of every woman, man and child to enjoy a life of health and equal opportunity ... [with] programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect ... UNFPA seeks to improve the lives and expand the choices of individuals and couples” (UNFPA, 2008).

With the involvement of health-oriented organisations such as WHO and UNFPA, public health is to the fore in their approaches. Peterson and Lupton (1996:4) highlight a turning “away from the biomedical emphasis on the individual towards a focus on ‘social’ factors, particularly ‘lifestyle’ ... and ... the adoption of a broad concept of the determining ‘environment’ that includes psychological, physical and social elements”, as well as a focus in some cases on health inequalities. Within this, health education and health promotion are seen as important; thus, health can be promoted in such a way that people are enabled “to acquire and maintain behaviour that promotes their own reproductive health” (WHO, 2001:16). This can be done through education, health, work, community and family settings, through the reorientation of services and policies, through the building of intersectoral partnerships, and through the establishment of supportive environments where “self-protection is an established practice” (WHO, 2001:16). The concept of protection is important – protection from adverse health outcomes such as unwanted pregnancy and STIs, for example – with a focus on health behaviours such as excessive alcohol intake or use of condoms which are, despite the population focus, ultimately a decision for the individual.

1.1.5 Health and morality

In linking morality and health explicitly, I follow theory on the ethics of public health as well as feminist and development literature questioning the ostensibly value-neutral stance of health services. For example, health and morality are often linked through the framing of wellness and health as good and disease and illness as bad. This is then fed through to the societal level with societies referred to as healthy or sick. “[T]he cultural link between health and morality” (Conrad, 1994:387) is underlined through both the medicalisation of “deviance” and the promotion of individual health and lifestyle behaviours. Laws around sexuality and reproduction “mark the political front line between the personal and the

public” (Thomson, 1994:40), whilst contestations and debates around morality and sexuality, and the specific interventions undertaken, “themselves mediate concerns about nationalism, geopolitical relations, and post- or neocolonial identity politics” (Pigg and Adams, 2005:2). As such, “discussions about human reproduction have an enormous power to moralize politics because reproduction is already constituted “as a natural, primal phenomenon involving the most fundamental issues of life and death” (Gal and Kligman, 2000a:29). What is ultimately at stake is the power to define the moral and the healthy, and this has a direct impact on the design and provision of sexual and reproductive health services.

Turner (2003:102) identifies how what she refers to as the “anthropological turn in bioethics” is important in that it “reveals considerable cross-cultural variation in understandings of what constitutes “reasonable,” morally defensible social practices.” She critiques the view common in bioethics and championed by Beauchamp and Childress (1979) that there are four universal ethical principles (autonomy, beneficence, non-maleficence and justice) which transcend culture and provide a general framework for addressing practical issues in health care. In particular her work highlights “how enculturation into particular “ways of worldmaking” leads to quite variable understandings of morally defensible behavior ... [which can] frequently lead to episodes of norm conflict in the health care setting” (Turner, 2003:103). This is important for this particular research in that powerful actors – including governments and transnational donor agencies – have faced opposition in trying to develop and disseminate services which has represented a considerable barrier to their work, yet interpretations of this opposition rarely go beyond frustration, anger and accusations of ‘ignorance’. Turner’s notion of “ways of worldmaking” is crucial in consideration of the different groups working to promote or oppose particular sexual and reproductive health services – given that “[t]he forces acting on the creation of moral perspectives are highly variable by time and place, by politics and economics, by religion and science” (Brandt and Rozin, 1997:3) it is simply not enough to assume a ‘commonsense’ approach to matters of moral agency and moral decision-making in health care provision. The causes of disease and disease patterns are perceived differently by different actors, reflecting powerful moral beliefs, which then “implicitly and explicitly ... affect patterns of social behavior and the organization and delivery of health care” (Brandt, 1997:53-54). Behaviours are formed and constituted by discourse, and the discursive environment in which health services are provided cannot be discounted, given that “[d]iscourses are the scaffolds of discursive frameworks, which order reality in a certain way ... [and] both enable and constrain the production of

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knowledge” (Cheek, 2004:1142). Services cannot afford to ignore the “ways of worldmaking” (Turner, 2003:103), or ways of developing moral concepts, of their opponents. These moral concepts enable actors to “organize, interpret, and make sense of ambiguous and conflicting information, providing a paradigm that gives special coherence to a confusing environment” (Mechanic, 1997:80-81). Understanding the moral domains within which opponents view the activities of service providers and policy-makers may well provide the space within which progress can be made. Recognising that individuals within a society, as well as particular interest groups, hold differing discursive frameworks of what is significant and moral and how they therefore comprehend their lives and the activities of others (Turner, 2003:108; Cheek, 2004:1143) is a vital first step to moving beyond the polarity of the current debates on the morality or otherwise of sexual and reproductive health services.

1.1.6 Public health systems in central and eastern Europe and the former Soviet Union

Having outlined some of the theoretical perspectives and critiques of public health generally, it is important to place public health specifically in central and eastern Europe and the former Soviet Union into context in order both to critique public health theory and assumptions, and to highlight where health services in the region fit into or challenge those assumptions. This is crucial as the understandings of those involved in transforming policies and structures within health care in the region do not necessarily accord with the understandings and expectations of users and practitioners within the system (Rivkin-Fish, 2005a:68-72). This section will therefore consider health care systems and understandings of public health particularly during the state socialist period, in order to contextualise contemporary reforms and debates.

In discussions with health practitioners in both Romania and Moldova, many were keen to point out that the health care system in the state socialist period was not all bad, and in fact they regretted the disappearance of aspects of the previous system, particularly its universal coverage. During state socialism both countries’ health systems were based on the Semashko model,

“based on the principles of universal coverage and services free at the point of delivery ... Central to this system was the state provision of services to all citizens, leaving little or no choice to the user but seeking to achieve a high level of equity” (Vlădescu et al, 2008:22).

Furthermore, “this model is characterized by an extensive infrastructure, curative focus and a large number of professionals” (Atun et al, 2008:20). The curative focus of the health care system in both the Soviet Union and in socialist Romania resulted in very high numbers of doctors and hospital beds per head of population (see Field, 1966 and Tulchinsky and Varavikova, 1996 for the Soviet Union, and Vlădescu et al, 2008 for Romania); however at the same time the sector suffered from “residual principle” funding (Rivkin-Fish, 2005a; Twigg, 2000) whereby health budgets were allocated only after higher-priority sectors (such as industry) budgets had been allocated. This meant that for much of the Soviet period, health care was allocated only around 3-6% of GNP in the USSR (Schechter, 2000). In comparison, by 1989 West Germany was spending 8.2% of GNP on health care expenditure (Kirchberger, 1994).

Ideologically, health care was declared in the Soviet Union by the Commissariat for Health in 1918 to be a state responsibility, free of charge with a preference given to the proletariat, centralised, uniform, involving citizen participation and emphasising preventive medicine (Lane, 1992:352). The high number of physicians (particularly women) per capita was used by the Soviet government to proclaim the success of socialism; however in reality many physicians, particularly in rural areas, faced inadequate training and equipment and the health care system was characterised by systemic neglect (Schechter, 2000:86). In addition the medical profession was deprofessionalised with the removal of professional associations (Schechter, 2000; Rivkin-Fish, 2005a). Other problems of the system included a tendency, institutionalised within medical training, for physicians to specialise early on in a narrow area, meaning that patients were directed to specialists and care was fragmented with no continuity between services (Rivkin-Fish, 2005a:75; Twigg, 2000:54).

Universal coverage was ensured in the Soviet Union through the practice of assigning primary care physicians and facilities based on either residence or workplace (Twigg, 2000:50; Barr and Field, 1996:307). Whilst this largely removed choice from the population, it did provide at least rudimentary coverage of primary care services to even the most rural areas of the country, and provided a basic safety net relied on by the entire population (Twigg, 2000). As Schechter (2000:87) posits, “[t]he social contract between the state and the workers during the Soviet era entailed cradle-to-grave security for Soviet citizens in exchange for their individual freedom. This “bargain” created a society where workers became extremely state-dependent.” The situation was similar in socialist Romania, with service users having little choice in who provided their health care and no private health care providers, but a rudimentary coverage of services across the whole

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country (Vlădescu et al, 2008). Reforms of the health care systems post-1989/91 sought to roll back the influence and involvement of the state and introduce competition into a thoroughly inefficient system in order to improve choice and efficiency. They have in reality in many parts of the region “left health care even more woefully underfunded than in the past, and ... people have suffered from the collapse of universal access and free provision of basic health services” (Twigg, 2000:44). This will be discussed in more detail in chapter 2.

The definitions of public health in the previous section emphasised both the health of a population and collective efforts designed to ensure population health. The place of the individual within this was seen to be somewhat confused, on the one hand being subsumed within the collective and so assumed to be as receptive as any other member to treatment or education, and on the other hand subject to discourses and practices aimed at individual rather than collective health behaviours. Peterson and Lupton’s (1996:ix) warning that few areas of social life remain beyond scrutiny and regulation, although aimed at the ‘new public health’ of neoliberal thought, is starkly reminiscent of health surveillance in state socialism, with its legacy of compulsory workplace gynaecological examinations in Romania (Kligman, 1998) designed to ensure the optimum fertility and reproduction of the population, and compulsory annual checkups in the USSR (Tulchinsky and Varavikova, 1996) to ensure the optimum health and thus productivity of the workforce (Lane, 1992).

The tension between the individual and collective in neoliberal thought is to a large extent also present in the state socialist public health system, and indeed in its ideological underpinnings. Whilst socialist health systems were aimed at maximising the health and productivity of the collective work force, in neoliberal thought too health is often regarded as a duty (Cheek, 2008), with irresponsible individual choices criticised as harmful to the collective good.¹ Moralising discourses around health and health behaviours in the postsocialist context of western technical assistance and support for health care reform then, do not necessarily represent a change, still less a transformation, from one ideology to another but in some sense rather a continuation. Dislocations in provision, funding and access are being experienced, leading to no small level of nostalgia for the socialist past among a population with institutionalised expectations about the role of the state and what it would and should provide (Field and Twigg, 2000:4). What has emerged since the

¹ Recent debates in the UK on the appropriateness of offering surgery to heavy smokers or those who are grossly obese, and whether or not this represents the best and most efficient use of finite health resources are a case in point.

collapse of the state socialist system is a plurality of both providers and interest groups keen to articulate and control discourses on what is ‘healthy’, ‘normal’ and ‘moral’ (Cheek, 2004; Crawford, 2000). It is these competing discourses which represent a significant contextual challenge to the provision of contemporary public health services in central and eastern Europe and the former Soviet Union, including sexual and reproductive health services.

1.1.7 Sexual and reproductive health in central and eastern Europe and the former Soviet Union

The politicisation of sexuality and reproduction in central and eastern Europe and the former Soviet Union is something that feminist scholars (both within and outwith the region) have been highlighting since the 1990s (see for example Kramer, 2007; Gal & Kligman, 2000a and 2000b; Verdery, 1994; Rivkin-Fish, 2005a; Einhorn, 1993 amongst many others). In particular the role of gender generally and reproduction specifically in the project of nation-building, the use of reproduction issues to support claims to wider political legitimacy, and the place of the family in constructions of socialist and postsocialist societies are often cited in accounts of contemporary life to highlight ongoing gender inequalities, the rise of nationalism and the limitations of the postsocialist democratisation project to adequately address the burden of these phenomena. Sexuality as separate from reproduction is considered much less frequently, and is either assumed to be incorporated within the sphere of reproduction or ignored altogether². However the rhetoric of ‘demographic crisis’ as propounded in political and media discourses within the region often explicitly incorporates issues such as rising STI rates and homosexuality alongside discussions of falling birth rates and abortions. This brief overview will therefore concentrate on some of the region-specific literature largely as it relates to gender and reproduction, but acknowledges the fact that the scope of this thesis is wider and contributes not only considerations of gender and reproduction but also of sexuality to analysis of the effects on the political project of nation-building and nation-defining.

Gal & Kligman (2000a) highlight how reproduction is politicised in order to establish both normative and essential notions of ‘nation’ and also how reproduction is invoked as part of the democratisation process. Across the region, debates about abortion and birth control, for example, have been used in different ways to enforce political legitimacy claims. In

² Exceptions to this in research in the former Soviet Union include work by Stella (2007); Omel'chenko (2000) and Healey (2001).

Romania this was done through the immediate post-Ceaușescu legalisation of abortion in order to distance the postsocialist polity from the repressive pronatalist regime that preceded it. In Poland meanwhile, the pervasive influence of the Catholic Church means that abortion, associated with the evils of communism and destruction of the nation, is restricted, and a politician's stance on abortion acts as a proxy indicator of their stance on anything from health and social welfare, church-state relations, or Poland's position within Europe (Gal & Kligman, 2000a and 2000b). Likewise, debates around reproduction impact on the consideration of women as economic actors; for example Dölling *et al* (2000) discuss choosing sterilisation in former East Germany post-reunification as a reaction to the realities of everyday life in an unequal society (see also Kramer, 2007), whilst Verdery (1994:236) highlights the “persistent gendering of power and the workforce ... thus focus[ing] on driving women back into their “proper” nurturant roles”.

In periods of political rupture such as the end of state socialism in 1989/1991 when new and old political actors struggled for control over state forms and institutions, discursive battles over what constitutes legitimate political action are inevitable, and moreover within this process reproduction represents a prime site for the constituting of political authority (Gal & Kligman, 2000a:21). This can be expressed in a number of ways; Gal & Kligman (2000a) highlight four important ones as the recasting of the relationship between the state and the populace, the narrative of nation and nationhood, the use of reproduction as a claim to political legitimacy and state morality, and the constitution of women as political actors. In its analysis of popular and professional as well as political discourses on sexuality and reproduction, this thesis aims to demonstrate how these discursive battles illustrate wider national processes, impact on both local and transnational constructions of sexual and reproductive health, and affect how services are provided, perceived and experienced.

Verdery (1994:227-8) highlights how in the state socialist period the nation was constructed in such a way that a “quasi-familial dependency ... [or] “socialist paternalism”” ensued; in other words the family and nation became inextricably linked through citizens' dependence on redistributed social benefits from the state. The early Bolshevik pronouncement that “[t]he family must be replaced by the Communist Party” (Probrzhensky, cited by Verdery, 1994:230) indicated the basis of the communist family project, although this was later modified such that the family became the site, in official discourse and policy, for the development of good, moral communists. Although the idea of the state as ‘quasi-family’ has been discredited following the end of state socialism (and indeed during state socialism, when many researchers highlight how the family was often

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viewed as a bastion or refuge from the all-pervasive state) (see for example Gal and Kligman., 2000a:69) nevertheless there is some continuity in discourses about the family as “the fundamental unit of a nation” (Verdery, 1994:251) and as a “prime vehicle for symbolizing and organizing [the] interface [of gender and nation]” (ibid, p.229).

It can be seen then that reproduction – and by extension reproductive health – is an important site for “conceptualizing and implementing a renewed social order” (Rivkin-Fish, 2005a:5). This is as true in the postsocialist era as it was in the socialist period, with the project of democratisation seeing international actors and organisations offering prescriptions designed to address demographic concerns and improve health and health outcomes. Through attempts to modernise both facilities and attitudes of service providers, “global health projects” (Rivkin-Fish, 2005a:7) aim to promote democracy, pluralism and choice in an arena previously characterised by stagnation, the dominance of political and professional hegemony and lack of patient autonomy. Rivkin-Fish (2005a:2) in her research on contemporary Russia suggests that “women’s bodies and selves came to symbolize the unfolding destiny of a nation in demise”. It seems to me that both the ‘modernisers’ and the more traditional voices speaking to the debates on reproduction in central and eastern Europe and the former Soviet Union today are seeking to improve the demographic situation and both public and national health. However, as my research shows, with radically different frames of reference and criteria for defining both what is meant by health and what constitutes a successful outcome, reproduction remains a politicised battleground even today.

Before concluding the chapter, I briefly consider the theoretical basis behind two of the institutional actors influential in debates around the provision of sexual and reproductive health services, namely religion and mass media. The specific characteristics of national religion and mass media in Romania and Moldova are discussed in detail in chapter 2.

1.1.8 Religion

Although the state, civil society and international development agencies are the most obviously important institutional interests in the provision of sexual and reproductive health services, they are not the only ones of importance to my research. Discussions with respondents in both Moldova and Romania highlighted that religion and mass media also played important roles in shaping the context in which sexuality and reproduction are debated and experienced, and it is to these that I now turn. Much has been written on the

role of religion as “a key social force in shaping sexual attitudes and influencing social policy and laws” (Grove, 2006:342), with the “[d]iscourses and actions deployed by dogmatic religious voices and groups ... a major influence in determining the contours of sexual politics in the early 2000s” (Corrêa et al, 2008:53). Alongside the discourses of religion and sexuality, notions of nationalism are often invoked so that religion is positioned as the champion of national tradition, morality and health.

Friedland (2002) suggests that there is logic and reason behind the cultural premises of religion, and that religion needs to be understood on the institutional as well as the social-cultural level. Moreover, the politicising of ritual spaces identifies them with the nation. The fundamental link between religion and nationalism is institutionalised through the use of a common symbolic order (Friedland 2002; see also Dillon 1996:33). Struggles over resources and discourses, which “expand the materiality, the efficacy of those agents and languages that thereby organize ... resources” (Friedland, 2002:383), mean that it is important to examine the use of language in the various debates about sexuality. As Friedland argues, religions use institutional language and logic which extends into the basis for legitimacy, identity and the criteria for the judgment and regulation of behaviour. In an economically fragile society with eroded welfare regimes, localised tensions (Corrêa et al, 2008) and insecurity of identity, religion becomes a credible alternative as a basis for identity and solidarity. McGuire (1990:290) posits, with Bourdieu, that the “struggle over the power to define ... symbols” is both evident, and a major part of political power. Verter (2003:152) also highlights the “struggle for the power to define tastes as a strategy of maintaining or modifying ... social position”, whilst Swartz (1996:82) points out the political basis of the struggle for the right to define religion – a struggle that is going on within as well as outwith religious denominations.

McGuire (1990:285) discusses the traditional dualistic split of mind and body. This dualism is reflected in the ‘battle’ between secular and religious in the debates around sexuality. Sexual and reproductive health and education services are largely targeted towards the individual (even if it is a population-based programme such as screening or vaccination), with language of rights, choices, being informed, the consequences of particular behaviours, etc. Although these services are generally explicit that they are not merely dealing with a biological issue and that psychological and social and emotional issues are all important, it is still largely framed as an individual issue. Religious groups on the other hand seem to have latched onto the idea of the collective psyche/identity much more successfully – making the link between mind, body, *and* society/nation. Through

framing particular activities as sinful, and by then linking this with nationalist concerns, activities and behaviours no longer simply have bodily, individual consequences but also affect the physical and spiritual state of the nation as well. Debates around sexuality seem to be reduced to individual rights versus national concerns/'higher' laws, and the collective concerns do seem to carry some resonance with large parts of the population. This may well be something that secular services and policy-makers need to consider more carefully when designing services and information campaigns.

1.1.9 Mass media

The mass media, through its reporting of events and issues, creates what Charles Taylor (2002, cited in Frosh & Wolfsfeld, 2007:107) refers to as "the social imaginary". In other words, how people imagine their lives and social relationships and interactions is at least partly formed by the media constructions and representations of aspects of society (Frosh & Wolfsfeld, 2007). Erjavec (2001:702) also argues that the mass media plays an important role in both constructing and disseminating normative views of what constitutes 'reality':

"The presentation of reality by news discourse is not reality itself, but reality generated by a general sign-system in relation to social structure ... It both shapes and reflects the dominant notion of what is significant, and therefore contributes to the ongoing process of constructing a dominant ideology through which the audience perceives reality."

The media are thereby involved in constructing a consensus which contributes to formation of national, gendered, racialised and sexualised norms which are used to regulate what is seen as acceptable behaviour and identity.

The process of framing or translating issues from individual stories to public opinion is largely invisible (Kramer, 2007), and is mediated by the social contexts within which the stories are read (Kitzinger, 1990). The messages within media presentations of sexuality and reproduction do not merely consist of their content, but often frame the audience's thinking through omissions, value judgements, use of 'expert' opinion or choice of accompanying images. In this way dominant social values are reflected (Cotrău, 2003), constructed (McRobbie, 1991) and construed (Fairclough, 2003:8), and stereotypes reinforced. The media acts as a mediator between the private domain of the audience and the postsocialist public sphere (Draga Alexandru, 2007), and as such analysis of media

portrayals is important to identify the issues and identities, both dominant and invisible, shaping contemporary discourses about reproduction and sexuality.

The development of the mass media in central and eastern Europe and the former Soviet Union since 1989 has been extensively analysed in terms of the extent to which the media are influenced by state interference or foreign ownership, the extent to which media sources are moving towards western standards of journalism, and the impact of the mass-media on the process of wider democratisation in society and politics (see for example Lauk, 2009; Gross 2004 and 2003; Coman 2004 and 2000). The profession of journalism has also been studied (Lauk, 2009; Coman, 2004), with the differences between professional standards (of neutrality and objectivity) and practice (with journalists close to particular sources of power) highlighted. In general the foreign ownership of the bulk of central and eastern European media organisations is judged not to have led to a 'westernisation' (and implicitly 'higher quality') of reporting standards, with quality reporting often deemed to have been sacrificed to commercial interests (Lauk, 2009). By and large media reporting is deemed to still be largely partisan (Gross, 2003) and with commercial driving forces political debate is often replaced with a focus on scandal and entertainment (Coman, 2000).

In the coverage of sexual and reproductive health and related issues, many of these elements are apparent. Although state influence is not usually overt other than in sources already sympathetic to the political rulers, debates around moving towards more westernised systems and attitudes are common, as is the sensationalism of issues. Given that sexuality and reproduction are inherently social and relational issues, the mass media's role in constructing the 'social imaginary' is crucial in understanding how sexuality and reproduction are understood in wider society. Often issues are presented as the result of a "critical discourse moment" (Brown and Ferree, 2005:10) and both the articles themselves and the responses to them are richly illustrative of current societal normative understandings. Examples of such critical discourse moments include attempts in Romania to introduce vaccinations for schoolgirls against the human papilloma virus (HPV) which generated extensive (and often very negative) media debate, or in Moldova the opposition to a proposed gay pride march which fed into debates about a proposed anti-discrimination law. These cases often highlight polarised views as to what constitutes 'healthy', 'normal', 'moral' and 'national', and the extent to which the democratisation project is actually served by the media.

1.1.10 Postsocialism

This chapter concludes with a discussion on the concept of postsocialism, as another conceptual and theoretical framework within which this thesis actively engages and to which it contributes. With the collapse of the communist regimes in central and eastern Europe and the former Soviet Union, discourses of ‘the end of history’ (Fukuyama, 1992) and ‘return to Europe’ (Roman, 2003/2007; Hann, 2002a; Wedel, 1998) suggested a relatively straightforward transition from one economic and political system to another, with the states and their peoples rejecting the state socialist system and embracing liberal western capitalist democracy. Inherent in this was an assumption that democracy was best promoted through encouraging the growth of the private sector, promoting political transparency and supporting the growth of civil society (more often than not in the form of grants and technical assistance to NGOs) (Wedel, 1998), and that western assistance was best-placed to ensure this (King, 2000a). This was designed not only to transfer know-how and skills, but was also seen as vital in “the quest to bring the former Soviet bloc countries in line with Western expectations and values” (Mandel, 2002:280). However, as King (2000a:158) highlights, “[t]he communist system was institutionally rich but organizationally weak” and increasingly feudal, and as has widely been noted by commentators (for example Hemment, 2007; Hann, 2002a; Wedel, 1998; Sampson, 1996) the so-called transition period was not able to deliver the liberal democracies or flourishing civil societies expected by either the donor states and organisations or the recipient states. What has emerged appears to have been a reaction and adaptation to these processes of ‘enforced’ transition, with an increase in cynicism on both sides (Wedel, 1998; Sampson, 1996) as a result of the unforeseen and unpredicted results of engaging in attempts to promote capitalist democracy. It seems that many advocates of the transition to a postsocialist capitalist democracy did not anticipate that the people of the state socialist countries would make “political judgments over a time span that includes the socialist past as their prime reference point, rather than think ... just about the present trajectory to the future” (Humphrey, 2002:13). Given that the majority of the political classes and senior policy makers experienced life and work under the socialist as well as postsocialist systems, a consideration of the usefulness and validity of postsocialism as an analytical construct remains pertinent. As younger generations with less (if any) memory of the socialist era experience public, private, political and civil life, the usefulness of the category of postsocialism will perhaps wane, but for the respondents in this research the socialist past was still referenced regularly and it was clear that it was still a (if not the prime) significant reference point for their present activities. There have been calls for the

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abandoning of postsocialism/postcommunism as a referent due to a perceived ‘othering’ tendency by western scholars, a removal of agency from ‘eastern’ actors and a “normative gatekeeping role for Western observers who, it is assumed, will be the ones to tell us when the East has actually arrived somewhere other than postsocialism” (Woodcock, 2011:65; see also Mizielińska and Kulpa, 2011:17-18). Nevertheless, given the fact that “[w]hilst 1989/1991 saw the formal end of socialism in the region, it did not mark some clean break or rupture with that socialist (and pre-socialist) past” (Stenning and Hörschelmann, 2008:322), and there is an ongoing need to focus on where countries have come from in order to understand how they are dealing with and reacting to situations in the present. This does not need to imply a cultural superiority on the part of those (including myself) writing and researching within a paradigm of postsocialist studies, indeed by utilising a critical ethnographic methodology the thesis arguably contributes “to a critical, poststructuralist area studies that challenges the universality of western imaginations of the world” (Hörschelmann and Stenning, 2008:345).

1.1.11 Conclusion

In this chapter the main theoretical frameworks underpinning this thesis have been introduced and critiqued. In particular, the concepts of medicalisation and the medical model of health, and public health theories in both neoliberal and state socialist guises have been introduced in order to inform how the empirical data in this thesis are contextualised. In particular the assumptions and tensions between individual and community health (both generally in public health and specifically for sexual and reproductive health) have been explored and provide the basis for the exploration of assumptions underpinning the provision of sexual and reproductive health services in contemporary Romania and Moldova.

This thesis contends that ‘health’ is not a morally neutral or value-free enterprise. In considering the specific area of sexual and reproductive health, itself far from uncontested, the thesis highlights the different interests involved in demarcating the meanings of ‘health’, and controlling the definition of the ‘acceptable’, ‘good’ and ‘moral’. In the specific contexts of Romania and Moldova, the thesis illustrates the limitations of a primarily health-focused orientation to sexuality and reproduction issues (Cornwall et al, 2008:5) that ignores (or at least downplays) pleasure and intimacy. At the same time it illustrates the moral dimensions of health discourse and practice, and shows how an assumed ‘value-free’ stance leads to polarisation of interest groups, delays in implementing

services, and obstructions to the development of services. As Pigg and Adams (2005:1) ask,

“[i]f sexuality is located in dense webs of socially meaningful moralities, then what are the repercussions of the myriad modernizing projects that claim neutrality and objectivity while placing sexuality within notions of population management, human rights, disease prevention, risk reduction, child survival, and maternal health?”

This thesis takes this question as one of its starting points, to interrogate how the differently constructed values and moralities around sexuality, reproduction and health are experienced and interpreted in Romania and Moldova, and questions how a greater understanding and acknowledgement of these constructed moralities and values can enhance the provision and use of sexual and reproductive health services. In placing itself within a paradigm of postsocialist studies, the thesis also questions the extent to which western formulations and ‘solutions’ are relevant to, and translatable in, the Romanian and Moldovan context.

Chapter 2

The Institutional Context

This chapter considers the institutions involved in delivering services, designing policy and driving the overarching debates around sexuality and reproduction, including issues around postsocialism and welfare/care.

Responsibility for health and for welfare provision is inextricably linked to issues of institutions and power. In the contested arenas of both public health and sexual and reproductive health, a multiplicity of interests, values and claims to control the discourses on what constitutes 'healthy' and determine what services are (and are not) provided sometimes cooperate but often compete for dominance. It is this institutional landscape that the first half of this chapter considers, as a basis for the empirical discussion to follow in the rest of the thesis on the providers of services, the context in which they operate and the constraining and enabling forces affecting their work. As well as considering the two main sectors of providers with whom I spoke during the research, namely civil society/NGO and state medical and allied professions, I will also discuss other important institutional players, such as governments, donors, religion and media, as identified by respondents as important in enabling (or hindering) their work. By so doing, "the complex interaction among postcommunist institutions and the communist substrate on which they have been constructed" (King, 2000a:155-6) and the impact of this interaction on sexual and reproductive health services should become apparent.

Following consideration of the institutional background to the study and its participants, the chapter will conclude by providing some more general contextual background to the study, considering the two countries studied in terms of historical, political and social issues in order to place the empirical data which follows in their national context.

2.1 Civil Society

Civil society as a concept, much like the previous discussions on health, sexuality and reproduction, is much debated and contested, and arguably "riddled with contradictions" (Hann, 1996:1). It is commonly defined as "a wide range of associational activity outside of, and usually opposed to, the state" (Hann, 1996:21). The precise boundaries of civil society are unclear, with institutions such as the family appearing in some definitions as separate from civil society whilst placed firmly within it by others (Howell, 2005:1) The

extent of civil society's (however defined) political agency is also contested. For some it exists within a framework defined by existing political institutions, whereas for others it plays a part itself as a political actor in influencing wider political society (Glasius et al, 2004:4).

A primary vehicle of civil society, as viewed by the development organisations and donors so important in providing development assistance to central and eastern Europe and the former Soviet Union in the 1990s and beyond, are non-governmental organisations (NGOs). Their proliferation in the region after the collapse of state socialism was enthusiastically supported by donors who considered them “the connective tissue of democratic political culture” (Wedel, 1994, cited in Hann, 1996:1) and civil society as “a crucial ideological signifier of democratization” (Hemment, 2007:49). This conflating of NGOs and civil society has been problematic in that by being seen in such favoured terms by donors, the focus perhaps inevitably turned to “formal structures and organisations ... [rather than] ... beliefs, values and everyday practices” (Hann, 1996:14). Through civil society being defined negatively, in opposition to the state, and by it being championed by western donors and proponents of democratisation and “idealized as organizations through which people help others for reasons other than profit or politics ... as apolitical participants in a field of otherwise implicated players” (Fisher, 1997:442), a suspicion between state and civil society has been somewhat institutionalised. This can hamper cooperation between the sectors where useful collaboration could conceivably take place, and ignores the more complex reality “on the ground” where often people are moving between sectors or inhabiting and working in a hybrid “both/and” zone (for example, where state workers also volunteer in or manage an NGO) where the boundaries between state and civil society are much more fluid (Kay, 2007). In reality linkages between state, civil society, international agencies and transnational networks mean that discussing civil society or NGOs as discrete bounded entities is complicated (Fisher, 1997) if not impossible.

The proliferation of NGOs in the region from the 1990s, whether in response to the availability of western funds (Pralong, 2004) or the articulation of previously suppressed attempts to associate in interest groups outwith state control, has been remarkable. Many of the organisations have folded following an initial flurry of activity, but many of those that remain active are characterised by an ongoing need to attract and retain external funding – very few of them, even those not totally reliant on western donors, are self-sustaining (Grunberg, 2000:315). Certainly among the NGO respondents who participated

in my research this was largely the case – although some were in receipt of local funding for particular projects, all were to a greater or lesser extent also reliant on grant income from western donors and spoke of needing to take time from their activities both to apply for new funding opportunities and report back to donors on the progress of existing programmes.

2.2 Medical and allied professions

The institution of the medical (and allied) professions is often perceived to be one with a powerful voice in determining policy and services, as well as enforcing the will of the state by ensuring a compliant population. This perception is true of the links between medicine and sexuality – as Foucault (1976/1998:36-7) has it, the proliferation of discourses around sexuality and the emphatic use that doctors made of these discourses seemed to be designed “to ensure population, to reproduce labor [sic.] capacity, to perpetuate the form of social relations: in short, to constitute a sexuality that is economically useful and politically conservative”. Roberts (2006) highlights that although the combination of sex and medicine (as outlined by Foucault) is historically-specific, it is now seen as normative, with biological and pathological ways of thinking routinely applied to sexual behaviour, reproduction, infertility and disease. This can be seen for example in discourses around homosexuality in the state socialist period (Healey, 2001) and continuing into the postsocialist period.

Foucault (1976/1998) highlights discourses as multiplying the legal sanctions against sexuality, with the medical profession playing an important role in reinforcing these sanctions and defining sexual ‘norms’. For example, so-called sexual ‘irregularities’ - defined as non-heteronormative sexualities - were reclassified as mental illness, and homosexuality was only removed from the United States manual of psychiatry (DSM) in 1973 (Roberts, 2006) and considerably later in most post-socialist countries (see for example Human Rights Watch/IGLHRC 1998). By so doing, medicine appropriates the language of morality through its dominant position in defining the ‘normal’ and ‘healthy’. In the postsocialist countries of central and eastern Europe and the former Soviet Union understandings of the nature of non-heteronormative sexualities tended to take longer to filter through to wider society, and legislatively homosexuality was decriminalised in Moldova in 1995 (Immigration and Refugee Board of Canada, 2006) and Romania only in 2000 (Turcescu and Stan, 2005).

Service providers work within the cultural and historical development of the connections between medicine and sexuality. In the state socialist countries of central and eastern Europe and the former Soviet Union, the relationship between the medical profession and the regulation of sexuality and reproduction was forged in a particular political climate that sought to lessen the importance of the individual and promote the importance of the collective. In practice this led to a promotion and idealisation of the role of motherhood, puritanical views and prejudices within education, and a sense of contraceptive fatalism that still lingers (Stloukal, 1999; see also Rivkin-Fish, 2005a; Kligman, 1998). One of the questions this thesis considers is whether service providers today are merely reinforcing this historically and culturally created view of a primarily biological understanding of sexuality and reproduction, or whether some are seeking to challenge and subvert it.

Since the collapse of the state socialist systems in 1989/1991, the medical profession has been involved in, and arguably dislocated by, the project of health care reform. Reform of the health care systems was one of the big priorities of western donor and technical assistance organisations, and this is one area where international and transnational influence has been significant. As far as donor institutions involved in this research (either as respondents or as funders to respondent activities) are concerned, WHO and UNFPA work at the governmental level (often with local NGO partners as well as Ministries), whilst IPPF works with partner NGOs, although again it seeks to influence at the national/policy level. In terms of governmental assistance, the development of health care systems emerged as an important theme in the activities of these international players. Romania's accession to the European Union in 2007 saw health care reform as one of the major preconditions to membership, and Moldova's aspiration to eventual membership has also led their health system (amongst many others) to be subject to the gaze of the international community. The acceptance by both countries of funding and technical assistance from international agencies meant that they both had (and continue to have) their health systems scrutinised at every level. The development of the health system in both countries away from the Semashko model (typified by extensive infrastructure, curative focus and a large number of health professionals) (Atun et al, 2008; Vlădescu et al, 2008) towards more marketised and decentralised systems characterised by the use of health insurance, and a greater emphasis on primary care and preventative services, began in the 1990s, with varying levels of political support and success.

Vlădescu et al (2008:xx) suggest that it has only been in the last few years since 2005 that the Romanian government has really started to take seriously its responsibilities with

regard to stewardship of the health system, and certainly in my conversations with practitioners (in both state and NGO sectors) this was reflected in their agreement that there was still an over-reliance and over-emphasis on curative services in the health system as a whole. Romania introduced a mandatory social health insurance system in 1998 during the brief period in the late 1990s when the Liberals and Christian Democrats were in power; prior to 1996 successive Social Democratic governments had signed a number of decrees covering the reform and financing of the health care system which paved the way to the later reforms. In 2000 when the Social Democrats regained power adjustments to the laws regulating the health care system were made, designed to strengthen and regain control over state resources following the shift to a social insurance system by the Liberals and Christian Democrats. However throughout the period up to 2004, regardless of who was in power, the high turnover of ministers meant that reforms were slow and delayed and priorities not well elaborated. In 2004 with the accession of the new government and the prospect of relatively imminent European Union accession, a new Health Care Reform Law relating to more extensive health care reform, including social and private health insurance and management of the health care system was enacted in 2006 (Vlădescu et al, 2008:23-24). The key organisations within the system are the Ministry of Public Health which is the institution responsible for ensuring the nation's health through engaging stakeholders, regulating services and defining the legislative environment within which services are provided (Vlădescu et al, 2008:25), and the National Insurance House which is an autonomous institution that regulates and administers the social health insurance system (ibid., p.26) through district level Insurance Houses. Within this system public health has a higher profile, with preventive activities at the local level supervised by district public health authorities. However it was only in the 2006 Health Reform Law that the concept of the 'new public health', with its emphasis on community empowerment, decentralisation, evidence-based decision-making and multidisciplinary/intersectoral approaches, was enacted in Romanian legislation, having previously been introduced as part of the National Public Health Strategy of 2004 with the support of the World Bank (Vlădescu et al, 2008:101-102). Whilst international donors were active in Romania throughout the 1990s, by the time of this research in 2007 many had withdrawn (or announced plans to withdraw) from Romania following the accession to the European Union. For more discussion of the experiences of practitioners and organisations trying to provide services within this complex institutional and legislative environment, see chapter 4. In particular, practitioners felt that national policies were often not communicated to them, and that they were swamped with the demands of reporting figures to both the Ministry and the Insurance House.

In Moldova, reforms were delayed in the 1990s due to fiscal constraints (Atun et al, 2008:xvii) rather than due to the political reluctance to reform that characterised Romania in the early 1990s. However, Atun et al (2008:xvii) do highlight that these delays did result in close examination of policies and collaboration with international bodies in Moldova such that initiatives were reformed prior to implementation. Certainly many of my respondents in Moldova did report that, at least at the level of legislation and policy, Moldova's health system was not unsophisticated and policies were good (although their implementation often remained a problem). In the early 1990s Moldova had an extensive network of health facilities and staff, which it attempted to maintain despite the collapse of the economy, although it was consolidated dramatically following the Russian rouble crash in 1998 (Atun et al, 2008:17). This did lead to the stalling of the introduction of mandatory health insurance (which had been introduced in law in 1998), but with the development of legal frameworks and managerial capacity and the success of a pilot scheme in 2003, mandatory social health insurance has been operating nationwide since 2004 (ibid.). The health system is financed via a contract with the national insurance house, whilst primary and secondary care organisation is devolved to the rayon or municipal health authorities (ibid.). The Ministry of Health has overall responsibility for the health of the nation, stewardship of health services and the health reform programme as well as directly funding some programmes relating to 'socially important' diseases such as tuberculosis and HIV/AIDS (Atun et al, 2008:22), whilst the National Insurance House is an independent body, answerable to the government, and is the key actor in the health financing system (Atun et al, 2008:24). Within this system, public health services "maintain a vertical organizational structure and are accountable directly to the MOH through the National Centre for Preventive Medicine" (Atun et al, 2008:91). Within the NCPM is a special section for health promotion; however this remains somewhat underfunded and "the main emphasis of public health services remain the control of communicable diseases and environmental health protection and population health monitoring" (ibid.). Reforms within public health have involved strengthening public health capacity, mainly through the support of international donors (ibid.) (for example, contraceptive supplies at the time of the research were provided primarily by UNFPA without being a part of the national health budget). International donors active in the country include various UN bodies and the World Health Organisation, who are involved in providing assistance to develop legislation and services, and in some cases fund non-governmental organisations to carry out practical activities – for example, one of my respondent organisations was contracted as the 'operational arm' of a UN organisation.

The experiences of respondents working within these various state and international structures is discussed in more detail in chapter 4. In common with their counterparts in Romania, complaints about excessive and duplicated bureaucracy and a lack of communication of national priorities were common.

In both Romania and Moldova these internationally supported reforms have meant that the health care system has moved to one funded at least in part by a state health insurance system. I asked state respondents in both countries about the impact of the relatively new insurance systems, with somewhat mixed responses. In both countries there was some confusion about whether contraception and other reproductive health services were covered by insurance or not (in Romania one GP insisted contraception was covered whilst others said it was not; in Moldova the same situation occurred over abortion, with one specialist insisting that it was included in the state insurance programme and another lamenting that it was not).

Throughout central and eastern Europe and the former Soviet Union

“[g]lobal political actors such as the World Bank have influenced and continue to influence policy in a residualist and privatizing direction. This is ... tempered for those countries with aspirations to join the European Union by pressures to adopt a social market strategy” (Deacon, 2000:147).

Principles of reform included the introduction of competition and rewards for efficiency, as well as a new role for the state as a legislative and supervisory body in the welfare system financed sustainably from the state budget (Kornai & Eggleston, 2001). In reality, competition has not featured so highly apart from in particular areas such as pharmaceuticals (Deacon, 2000). The majority of welfare and health care systems in the region are financed through payroll taxes (Deacon, 2000), with delivery and choice within the health care system still somewhat limited (Kornai & Eggleston, 2001). Informal payments made to healthcare staff to guarantee a higher quality of care continue to be a common and accepted part of the daily running of health facilities regardless of the formal structures in place to avoid these (see for example Rivkin-Fish (2005a), Gaal & McKee (2005), Ensor & Savelyeva (1998), Belli et al (2004) discussing the practice in Russia, Hungary, Kazakhstan and Georgia respectively). Romania and Moldova are no exception to this general trend (see Bara et al (2002) on Romania and Richardson (2008) on Moldova). The impact of the reformed system, as experienced by providers and users, will be discussed more in chapter 4.

2.3 Donors and Development Agencies

The focus on NGOs, and on the development of civil society more generally as the primary way of introducing democracy and holding the state to account, has already been discussed. I outline here some of the theoretical issues relating to donors and development agencies relevant to this research, before also discussing historical and contemporary attitudes to ‘the west’ .

The process of transition essentially entailed a dissemination of norms from west to east, and the ‘socialisation’ of eastern states in order to prepare them for membership of international organisations such as the EU and NATO.

“As a consequence of the end of the Cold War, the breakdown of the communist systems, and the liberalization and beginning transition to democracy, the constitutive norms of the Western international community became the “standard of legitimacy” for the entire European system of states ... [and] ... ratified the “cultural hegemony” of the West in Europe” (Schwimmelfennig, 2002:7).

The limitations of this exercise, and the assumptions of a one-way transfer of knowledge, skills *and democratic values* from west to east, have been well-documented (for example, Wedel, 1998; Sampson, 1996; Kay, 2000), with King (2000a:157) concluding that “[t]hey underestimated the difficulties of crafting new regimes in multiethnic contexts and overestimated the usefulness of civil society as an explanatory variable”. Whilst the values of “liberal human rights – individual freedoms, civil liberties, and political rights – are at the core of the Western community’s identity” (Schwimmelfennig, 2002:1), the attempts to promote them in eastern countries was not unproblematic. Arguably this is because the assumption of ““true and universal principles’ ... had the unintended effect of sidelining the ethical and methodological dimensions of inducing change” (Rivkin-Fish, 2005a:36). In addition, whilst individual freedoms (for example to make choices about one’s own sexual and reproductive health) were promoted, they were not (and perhaps still are not) tailored to communities with a strongly communitarian history and culture. Furthermore, whilst attention is paid to the importance of the local and of the need to avoid broad-brush programmes which assume all societies and economies will react in similar ways to interventions, paradoxically this has often resulted in local initiatives and attempts at local participation being generated “through a top-down process of planning and organization” (Fisher, 1997:455) by the ‘development establishment’ and by national and international organisations.

Now that many civil society and government institutions have arguably been largely strengthened by the technical assistance, knowledge transfer and financial aid that were received through the 1990s and 2000s, it appears that societies in general are becoming more confident in questioning the west's cultural hegemony. This is particularly the case in terms of religious and nationalist discourses which frame their debates not only in terms of the positives of national culture but also in terms of the encroachment of foreign values. This will be discussed more in chapter 5. Another danger however is that rather than questioning and critiquing the promotion of primarily western models of democratisation and capitalism, the experience of authoritarian rule could result in an expectation of a more powerful external agent providing for all needs (Kay, 2000).

Nevertheless, discourses of the west remain strongly aspirational, with policies promoted as complying with European norms, and services as reaching acceptable European and international standards; indeed, due to the discrediting of the socialist past, the neoliberal agenda was presented "as belonging to the European tradition and, by so doing, ... assur[ing] public acceptance for it" (Ferge, 2001:151). This matches the "return to Europe" rhetoric of the 1990s, when aspiration to belong to western organisations and the "family of Europe" characterised government policy in central and eastern Europe. However, such a situation does hand power to the international organisations somewhat, leading to an asymmetrical relationship between eastern and western actors and institutions.

2.3.1 Historical perspectives on the role and perceptions of 'the west'

Chapter 4 of this thesis considers contemporary perspectives on international influences in a national context. Prior to this, it is worthwhile considering historical perspectives on the international 'other' and its role and place in the perception of people and societies in the region. No region is completely unaffected by the wider international context, nor by historical perceptions and memories, and chapter 4 elucidates notions of aspiration and modernity associated with the notion of 'the west' (as well as opposition to it) which have not emerged in a vacuum. What is happening at the level of cultural production is more sophisticated than a mere 'us' and 'them' formulation. Yet this is perhaps something which is appreciated more at the local level where this cultural production finds its expression than at the international, institutional level where efforts are being made to translate (or even impose) ideas and meanings and methods from one location to another. Comments made by a number of my respondents further demonstrated both aspiration to

be more ‘westlike’ and sophisticated critiques of the shortcomings of many ‘western’ approaches. This tension between aspiration and criticism is something that has marked historical as well as contemporary transnational interactions, and justifies a more detailed consideration here to contextualise my research findings.

In his study of late Soviet culture in Russia, Yurchak (2006:158) highlights the pervasiveness of *zagranița* (literally “beyond the border”) as a construct representing “the peculiar combination of insularity and worldliness in Soviet culture”. The archetypal expression of *zagranița* was ‘the west’, a locally-produced imagining of ‘elsewhere’ which existed whilst the real ‘west’ was largely unobtainable (ibid, p.159). Whilst this imagined west was criticised as bourgeois it was simultaneously framed as promoting the enlargement of cultural horizons – “as long as one learned about the right information and did so with a critical eye” (ibid, p.169). Yurchak highlights that whilst this imaginary west, along with the widespread use of western cultural symbols, could be interpreted “as a sign of resistance to the Soviet state, a desire to flee from it to the West, or a manifestation of Soviet youth’s consumerism and materialism” (ibid, pp.202-3), this interpretation does not take into account the porosity and interconnectedness of local, national and transnational exchanges, and simplifies the sophistication of people’s individual agency. In a large-scale study of Russian youth culture in the first post-Soviet decade, Pilkington et al (2002) develop a similar argument to show how, rather than focusing on a stereotypical view of what ‘westernness’ consists of, Russian young people are using “narratives of the West ... to construct narratives of “self” and “other”” and by doing so “to construct narratives of Russia” (Pilkington, 2002:221). Not only this but, in common with Yurchak’s notion of the demise of the ‘imaginary west’ following the opening up of borders and influence under *glasnost*, Pilkington demonstrates how whilst ‘the west’ remains an important reference point, increasing direct interaction with people and western cultural artefacts, including “their experience as “imposition” rather than “forbidden fruit”” (ibid, p.223, emphasis mine) has caused a repositioning of local ‘selves’ in relation to the western ‘other’. This has led to a seeking “to reauthenticate (parts of) domestic cultural practice, as a means of differentiating itself from an imitative, mainstream other” (ibid). Although these studies largely focus on youth culture, it could be argued that, at a wider level, disappointment following the perceived failure of pro-western reforms post-1989/1991 has led to attempts to revive presocialist traditions as symbols of national identity and authenticity in the face of a perceived onslaught of western values and materialism. As Pilkington (2002:225) suggests, this represents a “disaggregation of positive attitudes towards the West at the socioeconomic level (articulated via the “high

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standard of living” in the West) from negative attitudes at the sociocultural level (evident in references to the West as “spiritually impoverished” or “empty”).” Media articles accessed for this study reinforced this view, with debates about the imposition of undesirable western liberal (and therefore immoral) values and the necessity of accepting ‘evils’ such as homosexuality or sex education as a prerequisite for obtaining the benefits of EU membership. However, among my respondents, positive attitudes towards the west were displayed in discussions on health services and facilities as well as aspiration to more open communication in family and society (considered a western rather than local trait), whilst negative attitudes were expressed more in terms of barriers to organisational agency (for example due to donor priorities) suggesting that the positive socioeconomic/negative sociocultural framing of transnational interactions does not necessarily translate simply in this particular context. Notions of civilisation and modernity continue to pervade local aspirations to western standards by health service providers, and are largely reflected in donor activity.

Development literature more widely, as well as from central and eastern Europe and the former Soviet Union, highlights the often western-centric models applied in non-western settings. As Pigg and Adams (2005:31n18) demonstrate, development itself can be thought of “as a historically situated moment emerging out of colonialism”, and there is always a danger of ‘one size fits all’ solutions imposed on a recipient community. Pigg (2005:47) talks of “international templates always includ[ing] a statement about adapting materials to local cultural circumstances”; however, this suggests that frameworks for passing on correct knowledge and attitudes are largely neutral and universal, and cultural differences are merely “problem[s] of fine-tuning information delivery” (ibid). Similarly, Rivkin-Fish (2005a) in her definitive study on women’s health in post-Soviet Russia found a considerable disconnect between western consultants and local practitioners – ostensible collaborators – in their consideration of local practices and cultural understandings and experiences. International agencies providing technical assistance and funding to develop ambitious programmes aimed at improving health outcomes and influencing policy were found to have “no mechanism for incorporating cultural knowledge ... into the project design” (Rivkin-Fish, 2005a:17), interpreted local problems in different ways from local practitioners (ibid, p.40), and offered “a blueprint for action ... [which] did not lead to ideological change” (ibid, p.49). Such issues were not raised directly by my respondents; however the problems of donor priorities not necessarily coinciding with local ones was mentioned by a number of respondents, and the disconnect between state and NGO perceptions of their own and each other’s work discussed in chapter 4 also suggests the

influence of foreign funding and discourses has not been unproblematic. Indeed, in not filtering down to state national, regional and local levels this has often led to minimal collaboration and little dissemination of ideas beyond the organisation being funded.

Regardless of the nuances and differences between socialist and post-socialist experiences of and encounters with ‘the west’, real or imagined, one thing is clear in both contemporary Romania and contemporary Moldova. The concept of *zaganitsa* as elucidated by Yurchak (2006) has a corollary in the Romanian language with the same literal meaning of ‘beyond the border’, namely *peste hotare*. Although *peste hotare* does not seem over-romanticised in the sense that media accounts of emigré Romanians and Moldovans often portray the harsh realities of life both for those who have gone abroad and those left behind, nevertheless it still seems to exert a strong pull with many people – primarily of working and reproductive age – prepared to take the risk and attempt to experience a better life *peste hotare*. Hundreds of thousands of Moldovans have applied for Romanian citizenship (including a number of the respondents in this study), whilst the Romanian media regularly reports on Romanian doctors and nurses deserting Romania for the promise of better pay and conditions in western Europe. For those left behind, *peste hotare* manifests itself in the desire for better quality equipment and facilities and thus the ability to provide better quality, western standard services.

2.4 Governments and the State

King (2000a:158) notes that the communist system had an elaborate network of institutions throughout society, albeit organisationally weak institutions. The postcommunist system on the other hand can be said to be characterised by institutional confusion, with the state trying to establish its place in relation to neoliberal discourses about the rolling back of the state, a relatively flourishing civil society and the demands of external development agencies. The space between the “institutional density of communist systems” (ibid.) and the less institutionally dense but more pluralistic postsocialist systems is one that is still being negotiated, by both state and non-state providers. This negotiation, including the relationship between the state and civil society providers, is discussed in more detail in chapter 4. Certainly it is difficult to delineate with any certainty the boundary between civil society and the state, with relations often characterised by a more fluid and fuzzy demarcation. Despite the suggestion of separation from the state inherent in the name “non-governmental organisation”, in reality governments and NGOs are often intimately connected “in relationships that are both ambivalent and dynamic, sometimes cooperative,

sometimes contentious, sometimes both simultaneously” (Fisher, 1997:451). Because of the heterogeneity of relationships between governments and civil society, it is difficult to generalise on the impact of NGOs on the state. Whilst some can influence structures and policies, others can contribute to the status quo rather than changing it (ibid., p.452). In this research, the relationship between state and NGO sectors was in some cases a hybrid one, characterised both by cooperation and by the moving between sectors of certain providers. In other cases though the relationship between the sectors was rather more distant.

2.5 National contexts of the thesis

Having discussed some of the main institutional players impacting on sexual and reproductive health services, the final section of this chapter is intended to act as a precursor to the discussion of research methodology and fieldwork contexts in chapter 3. It outlines, firstly for Romania and then Moldova, the historical and institutional context within which the research took place and includes discussion of two more institutional actors, religion and mass media, originally introduced theoretically in chapter 1, as well as historical and contemporary issues in sexual and reproductive health, and civil society. This contextualises the underlying premises of the study as well as the particular research methods chosen.

2.5.1 Romania

Before discussing current issues in sexual and reproductive health in Romania, it is important to outline the history from which Romania has only recently emerged. In 1966 the newly-appointed Secretary General of the Romanian Communist Party, Nicolae Ceauşescu, began a pronatalist campaign to combat the declining birthrate that was relentlessly waged until his overthrow in 1989 (Băban, 2000:227). Decree #770/1966, banning abortion in nearly all circumstances, was the most famous tenet of this campaign, but other restrictive measures such as the halting of contraceptive imports, imprisonment of those who either performed or underwent illegal abortions, compulsory workplace gynaecological examinations, constant pro-familial rhetoric proclaiming the virtues of motherhood and the declaration by Ceauşescu that “the fetus is the socialist property of the whole society” (Băban, 2000:227; Kligman, 1998) led to a direct link between childbearing and “the social reproduction of the Socialist Republic of Romania” (Kligman, 1998:20). This penetration of the state into the most intimate private lives of its citizens was so

pervasive, in effect dissociating the body from sexuality (Cuceu, 2005:199) that one of the first acts of the new government following Ceaușescu's overthrow was to reverse all the legal prohibitions on abortion and contraception, such that legal abortion is now largely considered "a "gift" of democracy" by many women (Băban, 2000:233; Magyari-Vincze, 2007:110). Now any attempt by the state to interfere in private (family) issues, particularly sexuality and reproduction, is "regarded with suspicion" (Gheauș, 2001:186). In the early 1990s, 70-100 abortions per day were being reported by each of the main hospitals in București alone (Kligman, 1995:246). Years of anti-contraceptive propaganda however are taking longer to overcome. This perhaps represents a 'normalisation' of sorts – prior to 1989 Romania had represented an anomaly among its state socialist neighbours as the only country which had outlawed abortion, so the restitution of the right to abortion was more readily acceptable a change for society as a whole (bringing it more in line with its neighbours) than the acceptance of contraception, of which many doctors as well as politicians remained suspicious.

As a result of this history, abortion rates are still higher and modern contraceptive use lower in Romania compared with the rest of Europe (Johnson et al, 2004:185). Abortion rates, although considerably decreasing (684.55 abortions per 1,000 live births in 2006 as opposed to 3,152.59 abortions per 1,000 live births in 1990), remain higher than in other countries of central and eastern Europe except Russia (WHO Regional Office for Europe, nd). During the same period, rates in the United Kingdom were 233.93 abortions per 1,000 live births in 1990 and 276.5 in 2006, whilst Germany's rates were 149.85 abortions per 1,000 live births in 1990 and 177.95 in 2006 (WHO Regional Office for Europe, nd). The use of modern contraception has tripled between 1993 and 2004, but this increase is from 10% to 33.1%, with a further 24.2% of women of reproductive age using traditional methods such as withdrawal (Ministry of Health of Romania et al, 2005:27). This still leaves more than 40% of women using no contraceptive method at all. Contraceptive discontinuation rates are high (Creanga et al, 2007:27), and recent newspaper articles, as well as my interview data, suggest widespread ignorance and misinformation about modern contraception.

During my research many practitioners and managers talked about the lack of education and correct information about family planning, on the part of both lay people and professionals (Băban, 1999:212), and the fact that talking about sexuality is still a taboo subject (Alexandrescu and Tuchendria, 1999:224) with people preferring to gain information informally from friends or mass media rather than from more reliable and

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official sources. Surveys suggest that young people wish to receive sex education in school (Johnson et al, 2004:186), but there is still some resistance on the part of a considerable number of parents to this (Johnson et al, 2004:192). Data from Sibiu (a Transylvanian city where I carried out the bulk of my fieldwork in Romania) and from the capital, București, indicate that many young people are participating in risky sexual behaviours such as multiple partners, becoming sexually active prior to the age of 16³, and unprotected sex (Cioran and Domnariu, 2005:26 for Sibiu; Johnson and Buzducea, 2007:720 for București), and Romania now has one of the highest rates of teenage parents in the European Union (Bearinger et al, 2007). Although sex education is mandated in the national curriculum, delivery is patchy and dependent on the services available in the area, with topics “taught by doctors, physiologists, police officers, parents of disabled children and non-governmental organisations”(Miroiu, 2004:90).

In addition to this, it needs to be remembered that Romania is an Orthodox country (86.8% of the population according to the 2002 census) (International Religious Freedom Report: Romania 2008). The Romanian Orthodox Church has been vocal in its opposition to abortion, family planning and homosexuality (Stan and Turcescu, 2007:172). Although Romanian society appears to be becoming more secularised, the Orthodox Church remains a powerful voice in politics and society, often opposing legislation and initiatives around sexuality and reproduction which it considers too liberal or permissive, such as proposed changes to Article 200 of Romania’s Penal Code regarding homosexuality. In this case the Church was singled out by human rights campaigners as ‘one of the most formidable opponents to decriminalizing homosexuality’ (Stan and Turcescu, 2000:1480). Yet, the end of the “communist regulatory state atheist ethic in 1989” led not only to increased religious moral discourses, but also to a rise in the influence of western popular culture and pre-communist values (Roman, 2003/2007:100-101). Robila (2004:146) highlights that “a secularization of public space and a decline in religious practice” during the communist times still did not manage to eliminate strong religious values and customs. It can be seen therefore that Romania is now something of a melting-pot of influences and discourses, not all of them complementary.

Both state and non-state providers of sexual and reproductive health services have proliferated in Romania since the 1990s. All of the NGO providers I spoke with during the course of my research were primarily (some almost totally) funded by western donors, with

³ The figures are similar to the UK, where nearly one third of young people have their first heterosexual sexual intercourse before the age of 16 (Family Planning Association, 2011)

very few of their activities funded by local or national authorities. In addition, with Romania's accession to the European Union in January 2007 several respondents spoke about their difficulties in accessing funds as donors shifted priorities elsewhere. This reliance on foreign donors has a relatively recent history in Romania. Pralong (2004:237-8) identifies that in Romania prior to 1990 there was very little civil society development due to the extreme penetration of the state into both public and private life. She also suggests that the NGO sector burgeoned in the 1990s as foreign donors, unable to channel funds through local organisations (which largely did not exist at the time), in effect enabled the creation of NGOs primarily in response to the availability of western funds rather than to local need. Although local funding appears to have increased considerably more recently, she contends that many NGOs nevertheless still design their programmes first around the availability of western funds and then identify local needs that may benefit – in other words, NGO legitimacy comes first from the aspirations of civil society in the donor country rather than in Romania (Pralong, 2004:238) (see also Sampson, 1996; Wedel, 1998; Kay, 2000; and Einhorn, 2006/2010 for further discussion of this issue in the region more widely). Certainly the contact with (and reliance on) western sources of funding continues to be problematic, with a disconnect between state and non-state practitioner views on the roles, benefits and credibility of NGOs, and, perhaps more importantly, patchy coverage of services and uncertainties over their long-term sustainability. The vast majority of NGOs are inactive – although the number of active organisations is growing, estimates of currently active groups vary between just 2,500-4,000 out of around 70,000 registered associations, and most of these are largely sponsored by international donors.

In Romania the media landscape is much more developed than in Moldova, with more commercial broadcasters and print news sources, the majority of which are owned by western media groups (Coman, 2000). The identity of news sources is also largely clearer and less eclectic than in Moldova, for example with the best-selling daily *Libertatea* being resolutely tabloid, *Evenimentul Zilei* (formerly tabloid (Carey, 1996) but now a mixture of tabloid and broadsheet elements), and most other national newspapers in my sample aiming for a broadsheet identity.

State television (TVR), which is financed by both tax subscription and advertising, has been criticised for political bias. However private television companies (principal amongst which are *ProTV* and *Antena*) enjoy higher viewing figures than state television (Ulmanu, 2002).

Journalists in Romania, as in much of central and eastern Europe, have had to face the tension between journalistic objectivity and the demands of those who control editorial policy. Coman (2004:47) identifies how journalists in the post-communist era,

“whose ideology was formed in the effervescent environment of the destruction of communist institutions and controlling the new institutions ... believe that the post-communist press was and remains a major agent in the process of building the democratic system and the market economy... [Therefore] the representatives of this profession assume a salvaging role, a militant mission and a special socio-economic status”.

This so-called militant mission has had an interesting effect: by initiating critical discourses around politics and social life, the response by the consumers of these discourses has also become more critical, though perhaps not always particularly sophisticated. Responses to articles are often insulting or aggressive, criticising both the subjects of the article and the reporter. The practice of media reporting then can thus be seen to contribute to an alteration in behaviour in wider society, with the normalisation of a more confrontational discursive environment.

2.5.2 Moldova

Independent since 1991, the Republic of Moldova is the second-smallest republic of the former Soviet republics (King, 2000b:xxvii), and prior to its incorporation into the Soviet Union in 1944 (Eyal, 1990:126) the territory now known as the Republic of Moldova was variously under the rule of Greater Romania, the Russian Empire and the Ottoman Empire (King, 2000b). Its population is over 60% Romanian-speaking, with a significant Russian speaking population, particularly in urban centres, as well as Ukrainians, Bulgarians and Gagauz amongst others (King, 2000b:xxviii). Although in the few years before independence a movement to reunite the country with Romania was prominent, this came to nothing, with a vocal non-Romanian-speaking population objecting to the ideas of closer ties with Romania. The result of this, and the ongoing unresolved issue of the separatist region of Transnistria, is that “Moldovan nationalism ultimately proved to be a rather strange beast: a nationalism that succeeded in gaining an independent state but seemed to fail in making an independent nation” (King, 2000b:3). Both secular media and religious sources regularly debate what ‘nationhood’ means, with discourses of concern about ‘the demographic crisis’ often linked to debates about fertility, sexuality, abortions and family planning. Many of these debates concentrate less on the fact that Moldova is also experiencing a massive movement of working (and reproductive) age people emigrating, to Russia and the west, in search of better paid work and opportunities, although this is

arguably more significant in terms of real demographic concerns about sustainability and viability of the nation.

After its incorporation into the Soviet Union, Moldova was subject to Soviet laws, which although not as draconian as those in Romania, nevertheless had a distinct pronatalist emphasis. Despite a political commitment to social equality and transformation, this was premised on underlying assumptions of gender differences (Ashwin, 2000:11). Official discourse promoted moral purity, though from the 1970s concern with rapidly dwindling birth rates meant that the focus in education became to promote family life and increased rates of childbearing (Attwood, 1990:184; Rivkin-Fish, 1999:804). From 1955 abortion was relegalised, and although officially women were exhorted to bear 3 or 4 children and abortion discouraged, in reality abortion was the only readily-available means of fertility control (Rivkin-Fish, 2005a:92). Sexuality was largely absent from public discourse, with the anecdote from a *glasnost*-era television show, ‘there is no sex in the Soviet Union’, highlighting the absurd gap between what people did and what they discussed (or not) (Engelstein, 1992:786). This reticence about sexual matters appears to have remained and was highlighted by respondents during my research as problematic for their efforts in tackling ignorance, stereotypes and misconceptions.

As in Romania, Moldova is an overwhelmingly Orthodox country, with more than 90% of the population identifying as Orthodox (International Religious Freedom Report: Moldova 2008). The history of the Orthodox Church in Moldova is rather troubled; around 77% of the population in 2005 (Panainte, 2006:97) are members of the Moldovan Orthodox Church which is a Metropolitanate of the Russian Orthodox Church, whilst the numerically much smaller Bessarabian Metropolitanate is under the jurisdiction of the Romanian Orthodox Church (Stan, forthcoming, a.). The Moldovan Orthodox Church, although not an established church, is recognised and appears privileged by the until-recently ruling Communist authorities in Moldova, to the extent that relations between the Church and the state are rather blurred. The Moldovan Orthodox Church enjoys privileged support whilst also being used “to win the support of the electorate” (Panainte, 2006:90). Former President Vladimir Voronin even publicly referred to Jesus Christ as “the first Communist” (Interfax, 2007, para. 2), thereby blurring church-state relations still further.

In addition to the Orthodox Churches, a small but growing number of Protestant groups (Baptists, Pentecostals) and non-Christian religions (Judaism, Islam) also exist. The Protestant groups in particular appear to be ‘punching above their weight’ with a growing

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media presence, and although largely considered an anathema by the Orthodox hierarchy, agreement on matters of sexual morality (particularly abortion and homosexuality, but also sex education and general issues of sexuality) has meant that in this area an unlikely and rather vocal partnership has emerged in the last few years.

Lack of education and correct information, reluctance on the part of families to discuss issues of sexuality and reproduction with their children, and a widespread lack of adequate family planning and other sexual and reproductive health services were identified by my respondents in all sectors as major issues. In addition, at the start of the 2006-07 school year the programme *Deprinderi de Viață* ('Life Skills'), funded by international donors, developed locally and internationally and designed to provide sex education across the national curriculum in schools throughout the country, was withdrawn following protests from conservative religious and political groups, meaning that until now there is no nationally approved sex education programme in schools (see chapter 4 for a more detailed overview of this situation). However, the age at which people are becoming sexually active is rather young, with numerous surveys indicating that the age of 16-18 is seen by many as a good age to become sexually active (Ștefanet and Leșco, 2005:59; Prițcan, 2002:314), whilst condom use by young people is relatively low and inconsistent (Ștefanet and Leșco, 2005:64).

Although use of any contraceptive method by women aged 15-44 is relatively high in Moldova compared to other countries in the region (72% in 2005), urban women are more likely than rural women to use modern methods (48% and 41% respectively), while rural women are more likely than urban women to use traditional methods such as withdrawal (27% and 19% respectively) (NCPM and ORC Macro, 2006:64). There is a similar overall rate of contraceptive use to 1997 (74% use in 1997 and 72% use in 2005), but with an increase in modern contraceptive use and decrease in the use of traditional methods; however this still leaves around 30% of women not using any form of contraception at all (NCPM and ORC Macro, 2006:63). Limited contraceptive knowledge and the availability and tolerance of abortion as a method of fertility control means that abortion rates are high (though declining) – the abortion rate in 1990 was 1,062.87 per 1,000 live births, and 418.82 per 1,000 live births in 2006 (WHO Regional Office for Europe, nd). Maternal mortality from abortion complications also remains high (Comendant, 2005:95; see also Bodrug-Lungu, 2004:177). Both survey data and my own interviews revealed that exposure to family planning information is low, and that opportunities are not always taken

to educate people using health facilities about family planning (NCPM and ORC Macro, 2006:73).

In Moldova there was a considerable burgeoning of NGOs after independence in 1991 alongside the social and cultural organizations inherited from the Soviet times and governmental ‘quangos’ (Cukrowski et al, 2003; Chiriac et al, 2001). However NGOs do not enjoy a wide level of recognition among the public, and collaboration between NGOs and state authorities is reported to be minimal. In fact I spoke with a number of NGOs who did participate in programmes with state bodies, but this did not always seem to be the case across the sector. Issues facing NGO providers seem similar in Moldova to Romania, with a reliance on western partners in order to carry out programmes, and correspondingly minimal state financial support, which is problematic both in terms of the types of services which are offered, and the uncertainty over future funding and ability to continue to provide services. Chiriac et al (2001:315) also highlight the precarious role of NGOs “due to the brittleness of civil society, the everyday frustrations of the populace and a lack of resources,” and there have been government attempts to tighten controls over foreign-funded NGOs.

In general the mass media in Moldova can be characterised as less sophisticated and pluralistic than in Romania. In the former Soviet republics, particularly smaller and less significant ones such as Moldova, considerably less research has been undertaken and written by academics, with much of what has been published written by journalists themselves. Many more media outlets are funded by political parties (Marin, 2001), and so editorial stances are much more obviously partisan. For example, the newspaper *Flux* is financed by the leader of the Popular Christian Democratic Party (PPCD), Iurie Roșca, and regularly features articles detailing the activities and policies of this party even though since the 2009 elections it is no longer represented in parliament. Similarly, despite being privatised in 2005 the former newspaper of the Communist Party (PCRM), *Moldova Suverană*, remains in premises provided by the PCRM and its editorial policy still very overtly favours the party (Lozinschi, 2007). State interference in the media has been more overt in Moldova than Romania – for example, strikes at *Teleradio Moldova* (TRM) in 2002 protested against state interference in appointments and editorial policy (Vitu, 2009) whilst journalists from Romanian-owned *ProTV* and private newspaper *Timpul* have experienced harassment and assaults by the authorities over their professional stances (ibid.).

Despite this more restrictive media landscape, some independent news outlets have emerged, such as the news agencies *Moldova Azi* and *Unimedia*, and the newspapers *Timpul* (national daily broadsheet) and *Jurnal de Chişinău* (local broadsheet, 3 times per week). However, such papers can be classified as “in essence partisans of absolute freedom ... independent but partisan and politicized” (Bogatu, 2007). In addition there is much less foreign ownership of the media compared to Romania – Fagerburg (2007) identifies short-term donor support to media projects, primarily from individual foreign embassies or unilateral agencies such as DFID in the United Kingdom or SIDA in Sweden, but little in the way of long-term support or financing. It is unclear how this situation will develop: *Timpul* ran a poll on its website in 2008 asking if readers would be prepared to access the website on a paid subscription basis (to which the answer was a resounding “no”), yet print runs for newspapers are often small, so income from print news will be unable to subsidise internet sites indefinitely. In 2001 surveys suggested only around 30% of the population bought and read print newspapers, and then not systematically (Ceanu, 2001).

One limitation of the printed press in Moldova is their heterogeneous and eclectic character (Ceanu, 2001) with no obvious market leader and most seeming to contain elements of both tabloid and broadsheet journalism. Nevertheless, with the advent of increased public internet access opportunities for interaction between media and public have emerged and particularly around “critical discourse moments” much public debate is generated.

2.6 Conclusion

The various institutions involved in both the provision of services and as potential barriers to this provision have been discussed in this chapter. The multiplicity of voices around sexuality and reproduction provide a rich and varied context for services but also contribute to barriers and disagreements around who has the power and legitimacy to define what is healthy. Such debates constitute discourses around what is moral, and it is the intersection between morality and health where this thesis finds particularly interesting analyses. These debates touch on issues of power and control – on who has the power to define what is healthy and moral, and on how these tensions constrain or enable services to be provided. They also demonstrate a number of different layers – local, national, international, as well as between state and non-state institutions and interests – all participating in a marketplace of services and discourses which individuals and populations (as well as providers) have to negotiate.

The main aim of this chapter has been to introduce the institutional context within which the services researched take place. Romania and Moldova represent an interesting case study in that they are influenced by state socialist understandings of health yet have experienced extensive input from western donors, technical assistance and discourses. This relatively regionally-specific study then can cast an interesting and critical view on assistance interventions more widely. At the same time the focus on sexual and reproductive health can highlight how the development and provision of services are experienced differentially by different groups of the population (such as young people and women) and can speak to wider processes of democratisation, national identity and demography.

Chapter 3

Methodology

In this chapter I intend to demonstrate how pragmatism, flexibility and reflexivity, as well as prior planning, combined to produce a rich research process and provide a basis from which to collect and analyse a wide range of empirical and contextual data. I have aimed for fairness both in my representations and interpretations, and in a reflexive approach. A concern for both positive research relationships and the protection of the researched (Sampson et al, 2008:921) guided my attempts to engage respondents in this research. The search for ideas and conclusions that might lead to both greater understandings of the contexts and situations from which services are accessed and provided (or not) and to ways in which these understandings could inform the development of more equitable and accessible services was, and remains, a strong motivation. The production of knowledge through this research is not primarily aimed at policy change, as I was anxious throughout the research process that I should not be imposing my own values and beliefs about health services or about gender, sexuality and reproduction onto a system not my own (Hammersley and Atkinson, 1995:20). Nevertheless I do believe that, particularly in a contentious and contested arena such as sexual and reproductive health, with its implications for challenging accepted stereotypes around gender and sexuality, research can have policy (and indeed political) implications and the researcher should not necessarily shy away from this (see Rivkin-Fish, 2004). I chose qualitative, ethnographic methods in order to try to gain as rich and varied material as possible (written, spoken and observed) and to try to promote and ensure fairness and accurate representation for all my research subjects, both those who actively participated, for example by granting me interviews, and those who did not but whose materials in the public realm have provided me with insights into the context in which sexual and reproductive health services are provided and contested. These methods also closely link to my research questions which were intended to explore experiences and perceptions of the context of service provision and how different actors interpret that context.

This study was not intended to produce findings generalisable across a wider area than the two countries studied so much as to represent how various actors perceive, experience and make decisions about which sexual and reproductive health services are used and/or provided, and about the wider context in which these services are used and provided. In this sense I am largely following Hammersley and Atkinson who define ethnography as involving the researcher “participating, overtly or covertly, in people’s daily lives for an

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extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research” (1995:1). However, by placing the research in its wider regional context, as well as drawing on similar studies from other parts of the world, it is hoped that the study will not only highlight issues specific to Romania and/or Moldova, but also suggest issues in the field of sexual and reproductive health provision which have a wider applicability. From this approach more general questions and principles can be drawn out in order to aid the continued refining and questioning of policies and practices, as well as identifying issues that are peculiar to Romania and/or Moldova.

As is to be expected in a study of this nature, once the process of collecting empirical data had begun, changes in focus occurred and my questions were refined and expanded. The more I spoke with more people in both countries, observed services and training sessions, and continued to access media sources and discourses around sexual and reproductive health, the more issues emerged which had not seemed immediately obvious in the pre-fieldwork stage of the research. This enabled me to develop a more ‘bottom-up’ process of data generation and collection, as well as feeding into the process of analysis. I therefore consider this study consistent with the philosophical underpinnings of grounded theory (Strauss and Corbin, 1990), in which theory and observations are generated from the data collected, rather than aiming to prove or disprove a hypothesis generated prior to data collection. By listening to my respondents and observing their work, issues emerged of significance to the subjects, which clearly merited further consideration and exploration as the study progressed. By first identifying issues, it was then possible to consider the meanings that respondents ascribed to these issues, and how these meanings affected their subsequent interactions and choices (Chenitz and Swanson, 1986:5).

As with any retrospective account, the research process represented here is much more neatly ordered than was the case during the research period itself, when opportunities and barriers meant that many of the strands of the process could only be situated and ordered in retrospect. The chapter is ordered roughly chronologically in three main sections. A background section (section 1) discusses my personal and professional background, preparing for fieldwork including the pilot study, initial collection of media sources, and choice of locations and respondents. Section 2 charts the research process, including methodological approaches and decisions, ethical issues, fieldwork, and the widening out of the media analysis across a three year period. The process of analysis is discussed in the final section.

3.1 Section 1

3.1.1 Background

Before considering the background to my methodological choices in this particular study, it is important to site myself as the researcher in the context of the research, as my professional and academic background undoubtedly influenced my desire to undertake this research in the first place, as well as my choice of methods and the theoretical assumptions underpinning it. It is also, I think, contrary to older ethnographic theoretical claims of researcher neutrality, impossible for the research to be carried out entirely separately from my personal biography (Hammersley and Atkinson, 1995:16). My concern therefore is to make my biography explicit so that I can acknowledge my own judgments and values and the effects that these may have had on my analysis and interpretations. Certainly Weber identified “that all research is contaminated to some extent by the values of the researcher” (Silverman, 2001:54) – it is these values which lead to the identification of and emphasis on particular issues in research, and from which the research conclusions are drawn (ibid.).

Professionally, I am a qualified nurse and health visitor. As well as public sector experience in the UK health sector I also worked for some years, both before and after qualifying as a nurse, in the voluntary sector in both paid and voluntary capacities. This voluntary sector experience included working as an English teacher in Romania, and subsequently as an administrator for a charity in the UK which sent trained social workers to Romania and Moldova to provide technical assistance to local and national authorities there to develop child and family support and protective services and policies. I also served for a number of years as a trustee of a small charity involved in community support and development work in Moldova. In addition, whilst working full-time as a health visitor I undertook a Masters degree in Development Management.

My observation from all of this experience is that very often there is a disconnect between the experiences and expectations of service users, service providers and policy makers/authorities/funders, and also between public and voluntary sectors, with respect to policies, services and the management of change. A common consideration in development studies is that development is not clear-cut, with simple prescriptive solutions, but is in fact a very messy business, with multiple actors and contested assumptions, values, norms and meanings (Mackintosh, 1992). There is a lot of waste and

inefficiency, but also much frustration and anguish experienced in the space between rhetoric and reality. This is true in both voluntary and public sectors, at local and international levels, and is experienced not only by potential and actual service users but also by managers and practitioners. My concern in this study therefore was to address how the context in which sexual and reproductive health services are provided mediates and influences these spaces between rhetoric and reality, and how this is experienced and perceived by actors at all levels.

3.1.2 Pilot Study

A year before the main fieldwork period, I spent a few weeks in Romania and a further week in Moldova attempting to make contact with health NGOs and practitioners who would be willing to participate in this study. At this point I had not yet finalised the specific area of health upon which to focus. In Romania I had some experience of wider health services, having the opportunity to interview two general practitioners in Cluj, and attending a hospital Accident and Emergency department in Sibiu as a patient. However, the NGOs with whom I spoke and who demonstrated willingness to participate either had a primary focus on aspects of sexual and reproductive health, or sexual and reproductive health constituted a significant element within their wider work. It was in Sibiu that I encountered two organisations (one contacted in advance and one discovered opportunistically) with a greater or lesser focus on sexual and reproductive health. In Moldova I also made contact with two NGOs in Chişinău, one focused specifically on sexual and reproductive health and education, and the other a Christian medical centre, which among many other specialities also provided gynaecological and obstetric services. Both expressed willingness to participate in the study. It was from this point that the focus on sexual and reproductive health specifically emerged and the choice of research locations was made.

Once the focus of the study on sexual and reproductive health had been clarified, an extensive amount of work was done accessing literature and media sources in order to ascertain some of the contemporary issues to be considered and to help in the development of overarching research questions, as well as specific interview questions. I deliberately kept the focus of this work quite wide (for example including issues such as domestic violence, homosexuality, the early postnatal period and reproductive cancers as well as issues around pregnancy and contraception, and considering education as well as health services) as I am well aware that all too often the term “sexual and reproductive health” is

thought of in lay terms as being about contraception, pregnancy and sexually transmitted infections (STIs) only. I was concerned not to impose my own interpretations on what should or should not be priorities for services, and I also wanted to establish, before I undertook the main period of fieldwork, the main issues considered “talking-points” in Romania and Moldova themselves. This also proved a very useful exercise in learning subject-specific vocabulary which meant that I was able to converse with respondents in a more natural, less stilted way using terms with which they would be more familiar due to their regular exposure in the media. During this period (September 2006-April 2007) I examined two daily broadsheet online newspapers from each country, *Adevărul* and *România Liberă* from Romania and *Flux* and *Timpul* from Moldova, retrieving any articles which discussed issues relating to sexuality, reproduction or sexual and reproductive health.

All of the issues mentioned above arose in the media sources used. In addition, a series of articles in *România Liberă* (2006) discussed the 40th anniversary of Ceaușescu’s infamous 1966 Decree #770 which prohibited abortion, clearly showing how this remained a highly significant issue which continued to have an impact on Romanian consciousness and which then would be important to raise with respondents. The ethical issues arising from this, and the other topics that were to be considered, will be discussed as part of the fieldwork section.

3.1.3 Choice of Locations

Although I always intended there to be a comparative element to this study between the two countries, my concern was more with the various perceptions and experiences of the many and various individuals and organisations in their wider context rather than with a precise comparison of organisations or places. Also, from a more pragmatic and practical viewpoint, the timescale available to me to do the research (five months over summer 2007) meant that I made the decision to build on already established contacts and relationships despite the fact that the locations were not particularly similar. I was largely based in one city in each country; however in both I had the chance to travel and speak with or contact practitioners in other parts of the country. This helped me to reflect on the extent to which the information I was gaining, and the issues and trends that were emerging, were reflective of the situation within a wider context than just a single city.

Studying these two countries has the potential to identify both commonalities and potential differences as the result of social, historical and legislative experience. Whilst both share a state socialist recent history, and prior to that had been incorporated into the same country, Greater Romania, the political and legislative paths taken by each during the state socialist era and subsequently were rather different. The ease of study was facilitated by the fact that I speak Romanian so was able to conduct the research in the same language in both (a few of my Moldovan respondents had Russian as their first language but all were fluent in Romanian). This also helped analysis as terms and concepts used in both countries could be more easily identified.

Undertaking a study in two countries has potential drawbacks as well as potential gains for the research. Much of the literature on comparative studies and methodologies refers to large scale, often quantitative studies using large datasets (Bryman, 2004; Hantrais, 1995; Lijphart, 1971) and highlights the dangers of samples not being like for like and therefore requiring greater methodological compromise (Hantrais, 1995). In this smaller-scale ethnographic study of two countries with a number of similarities, using a grounded theory approach of generating conclusions from the data rather than of testing previous hypotheses, this was less of an issue. However a drawback here was the danger of the comparative element taking on a level of importance that was potentially detrimental to the analysis. My interest is more in how the issues raised by respondents in either country speak to wider processes of welfare, gender and agency in-country and within the region, rather than in straightforwardly cataloguing differences and similarities. My organisation of the analysis along thematic rather than country lines was intended to mitigate against this potential problem, with the research as more of a hybrid in that its aim in collecting data from two different countries was “to act as a springboard for theoretical reflections about contrasting findings” (Bryman, 2004:55).

3.1.4 Romania

In Romania, I spent most of my time in the county town of Sibiu, in southern Transylvania. Sibiu is a historic Saxon town, with a population of c.155,000 people (sibiul.ro, n.d.), of whom around 94% are Romanian, with small communities of Hungarians and Germans (sibiu.ro, n.d.). In 2007 (the year of my fieldwork, and Romania’s first year as a full member of the European Union) Sibiu was also European Capital of Culture. It has always been a popular tourist destination, thanks to the historic city centre and many cultural activities, and maintained strong links with Germany due to its previously large ethnic

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German population. The current Mayor, Klaus Johannis, is an ethnic German and president of the Democratic Forum of Germans in Romania (FGDR) who in 2008 won his 3rd mayoral mandate with over 88% of the vote (*Monitorul de Sibiu*, 2008) and who in 2009 narrowly missed nomination as Romania's Prime Minister. Nationally, the government at the time of fieldwork was led by Prime Minister Călin Popescu Tăriceanu of the National Liberal Party (PNL) whilst the President was (and remains following elections in 2009) Traian Băsescu of the Democratic Liberal Party (PDL).

Sibiu as a provincial town does not have large industrial areas; much of its economy is based on tourism (particularly in the municipality itself, as a historic Saxon town) and service industries. Outwith the municipality much of Sibiu county is rural with small and large farms. It is also a university city, with both private and state universities attracting a large student population. The German population, now very small, was considerably larger during the communist era but the late 1980s and particularly the early 1990s saw most of the German population emigrating to Germany. The city also has a Hungarian population and a small residual Jewish community (although most of the Jewish community were deported during World War 2).

In terms of public health, there is a District Public Health Authority based in Sibiu responsible for public health indicators in the county. There are also a number of non-governmental agencies involved in various elements of health and social care provision as well as statutory health services including a county level hospital providing services for patients throughout the county and beyond. Interestingly during 2007, the year that Sibiu was European Capital of Culture, a number of my respondents remarked how considerable resources were being devoted to cultural activities and refurbishment of the historic city centre, but that there was comparatively much less money available for social and health services. This, along with the withdrawing of international donors from Romania following European Union accession referred to in chapter 2, had a considerable impact on the ability of my respondents to provide services.

As well as interviewing and observing NGO and state practitioners in Sibiu, I also attempted (ultimately unsuccessfully) to interview an NGO practitioner/manager in Cluj (the largest city in Transylvania), and did interview another NGO manager/consultant in the city of Târgu Mureş, also a county town in Transylvania. I also received a written response to interview questions from a GP in rural Sibiu *judet* (county), and observed two lessons in a school in rural Sibiu *judet*. As well as these personal contacts and

observations, I accessed publications from national media, national NGOs, and a national survey undertaken by the Soros Foundation (Bădescu et al, 2007) relevant to my research.

3.1.5 Moldova

In Moldova most of my time was spent in the capital city, Chişinău, which is the largest and most developed city in the country. Its population is just under 650,000 of whom around 68% are ethnic Moldovans (Romanian-speaking) and 14% ethnic Russians, with smaller but significant minorities of Ukrainians, Romanians and Bulgarians (statistica.md., n.d.). Chişinău's mayor, Dorin Chirtoacă, the Vice President of Moldova's Liberal Party (PL), was elected in 2007 defeating Communist Party opponents, and is the youngest mayor of a European capital city. He is seen as a key figure of the anti-Communist opposition, and his uncle Mihai Ghimpu was both Speaker of the Parliament and Acting President of Moldova following the rerun elections in August 2009. At the time of fieldwork the national government was the increasingly unpopular (particularly in the cities) Communist Party, which had been in power since 2001 led by then-President Vladimir Voronin.

Chişinău as a capital city is the centre of industrial development in Moldova, and there is much heavy industry there as well as work in service industries such as hotels and shopping malls. There are a number of high profile universities within the city and it has a large student population (although many of these students are already resident in the city and remain living with their family during their studies). The city is, in common with the rest of the country, experiencing a large out-migration of the population, particularly of working- and reproductive-age people, which has considerable implications for those seeking to provide health services. For example, the health status of returning migrants unable to access health services in the countries in which they may be living and working illegally, and the impact on Moldovan health services, was brought up by respondents.

As well as speaking with locally-based state and NGO practitioners I also had the opportunity to visit some family doctors (*medici de familie*) in a rural area in central Moldova, and also spoke with a number of representatives of national and international organisations. For both Romania and Moldova, my attempts to look beyond the local were informed by the fact that no locality exists solely in a local vacuum, and localities and situations within them shift, are influenced by and themselves influence wider external settings (Hammersley and Atkinson, 1995:41)

3.1.6 Choice of respondents

In both countries my initial intention was to interview practitioners, managers and clients in urban and rural settings and from both state and non-state contexts, in order to explore the extent to which client needs and expectations matched the perspectives of service providers, and the extent to which state and non-state services overlapped and/or complemented each other. However, it soon became clear that in both countries access to rural communities would be extremely limited, and also access to clients in either rural or urban milieux. This was partly due to the timing of the fieldwork – over the summer, most rural communities were working in the fields all day and so NGO services there stopped until the autumn. In fact in August (just after I arrived in Moldova) it was common for nearly all workers to take the month off for their yearly holiday, so it was very difficult to access anybody at all! In Romania I overcame (to an extent) the minimal opportunities to interview clients by being able to observe a number of group education sessions in two NGOs, and also the Soros Foundation survey mentioned above was published while I was still in the country, which covered many issues (such as gender roles, family, sex and contraception, etc) of interest to this study, and I was therefore able to an extent to use this data to add to the data being collected from practitioners and managers. In Moldova I was fortunate to have friends with recent experience of local maternity services who consented to be interviewed for this study, but again I needed to rely on external survey data (such as NCPM and ORC Macro, 2006) in order to supplement the data I was gathering from service providers.

In Romania I spent time with three NGOs based in Sibiu and one in Târgu Mureş. This involved interviewing managers, practitioners and volunteers, and also undertaking observations of education sessions in two of the Sibiu-based NGOs. Also in Sibiu I interviewed a doctor from the county public health authority, three family doctors and a pharmacist, and a consultant at the county hospital who specialised in family planning. I was able to obtain written answers to my questions from a rural village-based family doctor, and I interviewed a Romanian international development consultant who has been involved in policy, advocacy and training in both Romania and Moldova whilst I was in Moldova.

In Moldova my contacts were in some ways more diverse, in some ways less so. I was able to speak extensively with staff and volunteers at two NGOs with national scope, and

observe a number of the training activities at one of these. It soon became clear however that many NGOs in the field of sexual and reproductive health are staffed by practitioners who also work in the state sector, and so my interviews with them were very rich in terms of gaining insight into both state and non-state contexts. In nearly all of these cases I interviewed senior staff who had considerable experience both as practitioners (many of them still practising) and in service and policy development at the national level. I also was able to interview two family doctors from a rural health centre, a Chişinău-based nurse and also people from the media and performing arts who were involved in social programmes related to sexual and reproductive health in conjunction with one of my respondent NGOs. In addition I interviewed representatives from international organisations (World Health Organisation and the United Nations) who are extensively involved in this area, and a representative from the Ministry of Health.

Interviews tended to be lengthier in Moldova than in Romania, but I had much less opportunity to observe direct client work there. It is clear therefore that this is less a 'like-for-like' comparison, and more a study on how individual actors react to their current contexts and how this speaks into wider contextual issues such as provision of services or control of discourses. It was ultimately a pragmatic approach, interviewing whoever was prepared to speak with me during the relatively short time available; however the issues that emerged from speaking with such a diverse group of people are I believe significant and cross class, social and professional positions and local, national and international boundaries.

3.1.7 Outline of respondents

Appendix 1 contains a short description of the main NGOs involved in this study. They have not been named as I assured them confidentiality, but assigned a number which will be used consistently throughout the thesis.

Appendix 2 provides an anonymised list of interviewees, outlining their gender, organisation and position within the organisation, as well as whether they worked primarily in state, civil society or other capacities.

Appendix 3 provides an overview of the formal and informal observations undertaken for this study.

3.2 Section 2

3.2.1 The Research Process

This section aims to highlight the issues arising from all of the various research methods used in this study, incorporating issues before, during and after fieldwork and considering not only research techniques and methods themselves but also barriers to research, ethical issues, practical and philosophical issues arising, and further reflections on my own role and position as researcher.

This research was not intended to provide a picture of the epidemiology of sexual and reproductive health issues in either country. There are many official statistical reports (such as NCPM and ORC Macro (2006) in Moldova and Ministry of Health et al (2005) in Romania) which look at factors such as contraceptive use, abortion rates and utilisation of services. However these studies tend to focus on incidence and impact, and do not on their own give insight into either the reasons for particular incidence rates or particular choices, or the experience of providing sexual and reproductive health services. This thesis is an examination of the context in which services are provided and the experiences of those involved in promoting sexual and reproductive health through the provision of direct services and/or education, and therefore a qualitative approach was used in order to examine the constraining factors and opportunities for such services.

3.2.2 Fieldwork

The principal period of fieldwork lasted just over five months, with the period May-July 2007 being spent in Romania, and August-September 2007 in Moldova. After leaving Moldova I spent a further week in Sibiu before returning to the UK, as I had the opportunity to visit a rural school that had been on summer vacation while I was there earlier in the summer. In both countries the main methods I employed were semi-structured interviews (usually with a single respondent, but on occasion with two or more), observation of NGO activities (in Romania these were mostly education sessions with clients, and in Moldova mostly training and media activities with NGO workers and volunteers), reflection using a fieldwork diary, and collection and analysis of media and other literature, such as the health education literature produced and/or used by NGOs.

3.2.3 Interviews

In this section I will discuss a number of issues that required consideration before, during and after the actual period of fieldwork. These will include the selection of respondents and reasons for my choice of respondents, the use of gatekeepers, issues involved in recording interviews, the type of interview methods used, and issues around language and translation.

3.2.3.1 Accessing and selecting respondents

As previously explained, the initial selection of respondents was largely pragmatic, based on the organisations that had indicated an interest in participating in the research during my pilot study the previous year⁴. As a result of this I was able to arrange interviews over the three month period in Romania with managers and practitioners of two NGOs in Sibiu, as well as with volunteers and a group interview with a set of clients. I also participated in an education session with one NGO and attended a five session antenatal course at the other. Staff from both NGOs were helpful in suggesting other people it might be useful for me to meet. Other contacts were made opportunistically – for example, the interview I conducted outwith Sibiu was the result of an opportunistic contact, and during my first week in Sibiu there was a public display on one of the main streets in the city centre where various local NGOs were distributing leaflets and information about their activities. One of these (the local branch of a national/international NGO) included literature on contraception and safe sex, and as a result of this I contacted them and was able to interview the director of the branch and a group of their volunteers. This further led to contact with one of this NGO's board members who was a member of the county public health service, and thanks to her recommendations I was able to interview a number of state employees who would probably have been difficult to access otherwise. 'Snowballing' from previous contacts therefore proved a largely successful recruitment method. Of course it cannot be claimed that the people contacted through this method were representative of the entire population of users or providers of sexual and reproductive health services, as this is a shifting population in any case (Bryman, 2004:102) and this study was intended as a 'snapshot' of how a variety of actors experience and perceive services and the context in which they are provided and used. It nevertheless provided a useful cross-section of people with a variety of experience who

⁴ A more detailed account of the activities and priorities of these groups and individual respondents appears in Appendix 1, and a table of all the interviewees appears in Appendix 2.

were able to explore and shed light on the different issues pertinent to the research. It is also undoubtedly true that without previous recommendation from a trusted source, I would not have had so many successful contacts, particularly with respondents from the state sector (see Thomson, 2001). Of course, not all attempts were successful – one person contacted by a gatekeeper declined to be interviewed, and an attempt to produce extra data via an online survey (offered by an NGO manager who was a member of an online forum of organisations working in a relevant area) produced no response at all. This outlines the difficulty in not having direct personal contact to explain the research – even with the use of snowballing and gatekeepers, with no personal connection to the research there is no incentive to participate and the person making the recommendation may not explain the research in a way that invites participation. Likewise, online surveys conducted without a personal level of contact are easy to ignore, even if the subject is interesting or relevant.

In total 20 interviews took place in Romania with 17 individual and group respondents, a further interview took place in Moldova with a Romanian respondent, and I undertook 21 hours of observations on 15 occasions.

As in Romania, in Moldova snowballing proved a very successful way of recruiting respondents, with one NGO manager in particular being very generous in sharing her book of contacts, resulting in a number of interviews with Ministry, international and other NGO contacts, as well as invitations to observe training sessions and interview a number of the organisation's volunteers, staff and board members. This respondent also enabled me to access media and performing arts contacts involved in their work which provided another interesting angle on the research subject. Four of my other interviews were arranged with or through friends of mine in Chişinău, including the opportunity to visit a rural health centre and interview the doctors there. Indeed, only two of the interviews in Moldova resulted from opportunistic 'cold' contacts, one after I had written to the local author of a journal article, and one after I had met the respondents at an unrelated festival in the city centre and they had shown an interest in my work while we were chatting informally.

However, not all of my attempts to interview my contacts in Chişinău were successful. Most disappointing was the Christian medical centre who had indicated the previous year that they would be willing to participate. I will discuss this in more detail later in the chapter. For now suffice to say that although I met them again and they said that they would be prepared to participate in the study, on learning of my focus on sexual and reproductive health specifically they wanted to know the other organisations to whom I

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would be speaking. I gained the impression that they may have been concerned about being associated with research which also involved organisations with aims contrary to their own understandings of sexuality, abortion and other such issues, as well as possibly some concern about my own personal integrity (although this was never stated explicitly). This also raised the ethical concern for me as researcher as to the extent to which I should disclose the identity of other potential respondents. On the one hand, by using snowballing techniques many of my respondents were known to each other and aware of each other's participation in the research; on the other hand I did wish to preserve anonymity as far as possible and not give opportunities for antagonism or disagreement following publication of my research. Following my meeting with medical centre staff I had minimal contact from them despite several attempts to arrange a time to see them (except once when I required prompt medical assistance myself, when they were very helpful) and reluctantly decided eventually to no longer pursue the contact for this study. Given the emerging importance throughout my other interviews on the role and influence of religion on issues around sexual and reproductive health this was disappointing, although I was able to access some written and media sources which I have used throughout my analysis in order to try to ensure that my discussion does not merely consider the viewpoint of secular respondents.

In Moldova I did 24 interviews with 24 individual and paired respondents, and 12 hours of observations on 4 occasions.

3.2.4 Ethical issues and researcher positionality

Even prior to contacting and interviewing respondents, I had a number of ethical concerns. Ethical approval had been sought and received from the university authorities, but I had found the process of applying for ethical approval rather frustrating. It seemed to me to be compartmentalising ethics into a component 'part' of a larger research process 'whole', as another hoop to jump through prior to undertaking the 'real' research, whereas I was committed to ethical considerations being infused throughout the entire process. It also struck me as a 'one size fits all' approach, with the four ethical principles (justice, beneficence, non-maleficence and autonomy) presumed to provide an undisputed normative and universal framework for ethical research, practice and analysis despite the fact that "different cultural or religious traditions of moral enquiry might endorse distinctive substantive principles, or provide resources for interpreting the four "core" principles in markedly divergent ways" (Turner, 2003:100). Even apparently relatively

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straightforward issues such as gaining prior consent is problematic in central and eastern European settings, with ethics committees often demanding proof of signed written consent, but the research setting being one where respondents can be reluctant to give their signature. I tried to mitigate against this by providing a detailed information sheet about the research aims and objectives, which clearly stated that respondents did not have to answer any questions they did not want to, and could ask me further questions before deciding whether or not to participate. I also provided contact details so that they could also ask questions after the interview had taken place if they wished. I also, at the start of each interview, gave a verbal summary of the aims of the research, in order to make it as clear as possible and to give people the opportunity to decline to participate at any point in the process.

However, even this approach is not without ethical concerns. As qualitative research studies such as this one are rather open-ended, it is not always possible to outline precisely the limits and aims of the research, as during the course of the research questions develop and change (Bryman, 2004:515). Certainly while the broad focus of my study, that of perceptions and experiences of sexual and reproductive health services, remained the same, as themes such as the importance of religion emerged the conceptual basis of the study evolved from a primary focus on health and policy and collaboration (or lack thereof) to include a larger focus on discourse and morality. By framing the explanations of the research around experiences and perceptions I was able to mitigate against the worst of these ethical concerns by not being prescriptive and rigid in the explanations; however the possibility of my explanations therefore being potentially vague and unclear to respondents remains a 'grey area'.

It is also true, of course, that undertaking qualitative research is not a value-free activity (Archbold, 1986). My commitment to a feminist approach to research, defined as the need to acknowledge my personal views (for example on morality, sexuality, religion, reproduction, and family), as well as my professional experience, rejection of the researcher/researched dichotomy and aiming for fairness, consciousness-raising and empowerment (Renzetti and Lee, 1993:177) all have some bearing on my choice of research questions and focus and on my subsequent analysis. I needed to take care not to impose my judgment or opinions on my subjects, and to be aware that not all participants would share or agree with my values and opinions.

Other issues of concern related to the subject matter of my research. Clearly, sexual and reproductive health and related issues are sensitive topics with personal as well as local, national or organisational significance. The history of sexual and reproductive health under the state socialist systems throughout central and eastern Europe and the former Soviet Union is imbued with both imposed values and also very real distress as outlined in chapter 2 (consider for example the history of the decree outlawing abortion in Romania – see Kligman, 1998; *România Liberă*, 2006). This required sensitivity when discussing the history of sexual and reproductive health services in the region and its impact today, as I was talking to practitioners who may well have been practising during the socialist period, and whose personal experiences during this time were not known to me. On the whole people seemed willing to discuss this and other sensitive topics with me, and indeed a few respondents disclosed personal information (such as their own contraceptive use or age of first sexual encounter) which I had not actually sought. I therefore aimed to reassure respondents of my commitment to confidentiality and anonymity when storing data and writing up and interpreting their responses. I also needed always to bear in mind during analysis and writing up that the various opinions, values and interests of both respondents and myself as researcher were constantly interacting with each other and with the wider political and social context (Sieber, 1993:14). This needs to be acknowledged in order not only to generate rich data but also to bring out in the open underlying assumptions and values which may affect the interpretations of the data.

I was also concerned about my position as a western ‘outsider’, particularly that there might be some expectation of me providing useful contacts for respondents and their organisations, or to be seen as a comparatively rich westerner, or that I might be judgmental in comparing what I saw in Romania and Moldova with what I have experienced working in health services in the UK. I was also concerned about possible accusations of ‘cultural imperialism’ as a foreigner researching people from a different country (see Drakulić, 1992; Funk, 1993). Fortunately, generally none of these situations occurred, and although I had numerous off-the-record conversations with respondents about my opinions of their country and systems and how they compared with the UK, this was nearly always in the spirit of genuine interest and curiosity and not with any expectations beyond a friendly conversation. Much more of a personal issue of concern was my feeling that I was ‘using’ my respondents without being able to offer much, if anything, in return – that I needed them much more than they needed me. This is a dilemma articulated by Ries (2000:ix-x) – my respondents would be providing me with information and contacts upon which I would be building my own reputation as a

researcher, but where was the dialogue, the reciprocity? In fact in a number of cases I was able to offer some concrete help – for example help with the translation into English of a website article, or information about possible funding sources for academic study – but nevertheless it did feel somewhat one-sided in my favour. I was constantly striving for a way to undertake my research in a way that was not only non-exploitative but also a positive experience for participants (De Soto, 2000:87), through the opportunity for genuine dialogue with respondents interested in my experiences and perceptions, and also through the opportunity to bring their experiences to a wider audience.

3.2.5 Recording of data

Nearly all of my interviews were recorded, with only four exceptions, three of which were in Romania. One occurred at the very beginning of fieldwork where I had arranged an opportunistic appointment in order to discuss my research with a view to then arranging another longer appointment for an interview and so did not have recording equipment with me. The initial discussion covered so many of the points I wished to discuss in an interview that it was not deemed appropriate to arrange another appointment to discuss the same material. On another occasion the respondent had gained the impression from the ‘gatekeeper’ who had requested her involvement that I would be conducting a questionnaire and so insisted on writing her answers on my interview schedule rather than answering spoken questions. One at the very end of the research occurred when a contact told me she was seeing a friend who was a rural doctor socially that evening and she could ask her some questions on my behalf; I therefore quickly devised a questionnaire with my most pressing questions for that purpose. In Moldova only one interview was not recorded, when the respondent insisted the interview be on record not as the views of their employer but as their personal views, despite the fact that the interview was only arranged due to the respondent’s position in that organisation. In all of the cases except for the one where I was not present, I made extensive notes during and immediately after the interview in order to preserve as many of the points made as possible, and have treated these notes as equivalent in value to the transcriptions of the recorded interviews for analytical purposes. Whilst this is not ideal, as it was not possible to remember every pause or interaction in detail (Silverman, 2001:161), it did in most cases yield enough information to be of value to the overall study.

I did have some concerns that the presence of recording equipment would make the interview setting feel unnatural and possibly be intimidating to respondents. There was

also the issue that by relying on recorded information I might miss significant non-verbal cues or events (Hammersley and Atkinson, 1995:187) when subsequently listening to the interviews. In addition to this, it was not always possible to undertake the interview in a quiet, uninterrupted environment, and so the potential for background noise to disrupt the flow and understanding of the recording was sometimes an issue. I was concerned that some respondents may have felt uneasy at the prospect of being recorded; however I explained that this was to enable me to listen again and clarify concepts that I might not pick up during the interview itself due to being a non-native speaker (all the interviews, with the exception of the very first unrecorded interview referred to above, were conducted in Romanian), and I was able to assure them that their confidentiality would remain respected. Permission was nearly always granted (with the above-noted exceptions), and the recording equipment did not usually appear to have a detrimental effect on people's willingness to talk. I usually took notes during the interviews to supplement the recordings, so that I could further reassure respondents of my commitment to understanding what they actually said.

3.2.6 Interview format

The interviews I conducted followed a semi-structured format, in other words I had a series of topics about which I was interested in ascertaining the respondent's point of view, but the question schedule was not 'set in stone' and I was happy for the respondent to go off on tangents and interpret the questions, in order to establish the issues they felt were important (Bryman, 2004:321). At times not all of the questions were asked; for example, if the respondent talked about a topic as part of an answer to another question, or if it emerged from the earlier stages of the interview that a particular topic was not relevant to their line of work. Although most interviews featured similar questions, sometimes I introduced specific issues tailored to a specific respondent, and certainly as the fieldwork progressed and issues emerged the interview schedule became more sophisticated (and lengthy!). In a number of cases, particularly in Romania, I conducted follow-up interviews with respondents whom I had interviewed early on in the fieldwork, to establish their views on issues that had emerged as the fieldwork had progressed.

In general the semi-structured interview format worked well. In a few cases it was clear that respondents were not used to this type of interview and were expecting closed questions and were taken aback when they realised I wished for longer answers and their own opinions rather than what could be perceived as objective facts. In its most extreme

case, I suspect that this was the case with the respondent who wrote answers on my question schedule rather than engage in a more conversational interaction. However most respondents appeared to feel comfortable with the format of the interviews.

It needs to be remembered though that the semi-structured interview format can also have potential drawbacks. Specifically, the decision to use this qualitative format rather than a more structured and formal method of questioning respondents is in itself a value-based decision (i.e. that I as researcher am more interested in certain types of data – opinions, interpretations, etc – rather than others – statistics, etc), and also the format with the interviewer aiming for a minimal and not overly-directive presence may also create interpretive difficulties for the respondent, who has to work out with minimal input what is relevant (Silverman, 2001:92). I tried to overcome this difficulty by continuing to interact with the respondent – not interrupting, but asking follow-up questions if things were not clear, or commenting on points they had made. This format was deemed most suitable to provide rich data in answer to my research questions. It also reflected well on my theoretical concerns (see chapter 1) that expert medical knowledge should not necessarily be privileged but a rich variety of understandings should be explored.

3.2.7 Language issues

Another issue pertinent to my use of interviews was that of language and translation. With the exception of my first opportunistic interview and the final interview with written answers conducted opportunisticly by a contact (neither of which were recorded) all interviews were conducted by me in the Romanian language, in both countries. Lopez et al (2008:1729) highlight the common belief that researching in a language other than the researcher's first language is potentially problematic due to "the belief that meaning – which is the heart of qualitative analysis – cannot be sufficiently ascribed by an investigator whose primary language differs from the study's participants", and that conducting cross-cultural studies in a language other than the researcher's first language introduces "the opportunity for interpreter bias ... as well as the failure to take regional variations in language and culture into consideration" (ibid, p.1730). Whilst these concerns are important, and I could not take for granted the fact that the linguistic understanding that I was continuing to develop in Romania would be precisely transferable to Moldova, my use of the language of my respondents was, by and large, very useful during both data collection and analysis for a number of reasons. Firstly, as a westerner who spoke Romanian I was something of a novelty, and thus some respondents may have

been more willing to speak with me as although I was taking their time I was not expecting them to also speak my language. Secondly, by enabling respondents to reply in their mother tongue (or, in the case of some of the respondents in Moldova, their second language but one in which they were fluent), they were more at ease and did not seem to worry so much about getting the ‘right answer’, but were more free to express their opinions without filtering it through a second (or third) language. Thirdly, as different respondents had different levels of English (if they spoke it at all), using English would have placed me in an unequal and uneven power relationship with them and might have made them more reluctant to explore topics in detail. Fourthly, it soon became clear as I conducted the interviews and listened to them afterwards that a number of words and phrases were appearing again and again, as answers to a number of different questions, and so I was able to identify important emerging themes early on in the research which informed my subsequent development of the research questions and analysis⁵. If I had been conducting some of the interviews in English these themes might have been translated differently by different respondents and might not have been as obvious to me as early, if at all. Occasionally some respondents would translate a word or a phrase into English for me, to make sure that I understood their meaning, but generally the use of Romanian proved a useful ‘leveller’ in the research process. Conducting interviews in Romanian also meant that I did not have the problems that using an interpreter might have created, of mediating replies through a third party, of confidentiality and of the overall comfort of respondents. My own experience with transcription altering the meaning of the spoken word (see next section, this chapter), as well as other research highlighting the potential limitations of using interpreters (such as Pitchforth and van Teijlingen, 2005) highlighted the advantages of conducting research in Romanian myself.

Being situated as a linguistic ‘outsider’ in terms of my own native language (English) but drawn towards (or, perhaps, allowed into) the ‘inside’ by virtue of speaking the local language well enough to conduct the research, I am mindful of my position as a translating researcher and “the problems of representation and speaking for/with others” (Müller, 2007:207). Although I conducted interviews in Romanian they are reproduced in this thesis in English (with my own translations). I have attempted to overcome any potential difficulties or errors in interpretation by including Romanian words in my thesis where there is no direct English equivalent, and by discussing potential ‘double meanings’ of

⁵ In some cases I asked both friends and research contacts about the use of one particular word (*ruşine*, usually translated as ‘shame’) once I realised that it was being used by nearly every respondent, to try and clarify the nuances and different meanings the word *ruşine* could be invoking.

words, phrases and concepts where they may have arisen. Whilst acknowledging myself as a linguistic ‘outsider’, it needs to be stressed that linguistic ‘insiders’ are “not immune from accusations that they do not represent all sections of communities” (Temple, 2005, para. 4.5) and linguistic difference may “stimulate rather than block communication by focusing on taken for granted assumptions” (ibid, para. 4.4). My interpretations and translations may differ from those of a native Romanian speaker, but also may shed light on assumptions and issues that are so taken for granted by ‘insiders’ they are no longer acknowledged or considered important.

3.2.8 Transcription

I made the decision that my interviews would be fully transcribed so that I could return later to everything that was said and decide during post-fieldwork analysis what issues were particularly important from the interviews. As I had conducted the interviews in a language that was not my mother tongue I arranged for the transcriptions to be done by native speakers, primarily due to time constraints, but also because although my spoken Romanian is good I was not sure that without the visual, non-verbal cues that take place in a face-to-face interaction I would be able to capture everything as accurately as a non-native speaker. I had specified that I wished the transcriptions to be word-for-word, so that I could make the decisions on the interpretation and significance of the data; however on listening to the interviews once they had been transcribed it soon became clear that (particularly in the case of many of the Moldovan interviews) they had been ‘tidied up’ considerably. Sometimes it was just that one word had been substituted for another of the same or similar meaning; at other times points that had been repeated in the interview were only transcribed once; and more seriously in many cases entire sections had been considerably paraphrased. In one case the very important point made by the respondent had been paraphrased in such a way that the meaning in the transcribed Romanian was exactly the opposite of what had actually been said. I had not appreciated before the event the extent to which “[r]esearchers who delegate transcription work to others become distanced from this piece of the process and often are not aware of the decisions made on their behalf” (Tilley, 2003:758). After discovering the extent of the problem, with the original transcriptions to hand, I completely retranscribed the interviews myself, a task that took a considerable amount of time and effort but which was ultimately a rewarding way to immerse myself in the data and remind myself of issues which had arisen. During this process I also noticed other themes emerging which perhaps had not been apparent during the actual interviews themselves, so although it was a laborious process it was ultimately

useful. As Silverman (2001:164) highlights, the process of transcription is not merely “a technical detail prior to the main business of the analysis” – the very process of transcribing the interviews involved detailed listening, thinking and reflection which ultimately benefited my analysis enormously. It also meant that, as the researcher who had conducted the interviews, I was able to make “informed interpretive decisions [and] decide whether the transcript was representative of the taped piece transcribed” (Tilley, 2003:762).

It is also clear that, as with translation and the use of a second language to undertake the research, the process of transcription is not neutral or apolitical. I had initially approached the issue of transcription as “mundane, technical, [and] unproblematic” (Lapadat and Lindsay, 1999:67), but it soon became clear that the very act of transcription is an interpretive one in and of itself (ibid, p.81; Tilley, 2003) and the finished text is a representation of an event rather than the event itself (Lapadat and Lindsay, 1999).

3.2.9 Observations and use of field notes

Although interviews provided much of the data for this study, I also spent considerable time undertaking observations in a number of different contexts. In Romania I participated in an education session on sex, pregnancy, contraception and abortion at one NGO for a group of teenage clients, and also attended a course of classes for pregnant women and their partners led by another NGO, which incorporated both educational elements (instruction about pregnancy, birth and care of the newborn) and aerobics classes for the women. In Moldova the observations were not with clients, but involved participating in two broadcasts on national radio, and observing two training days for the volunteers of one NGO, one on advocacy and the other on the use of drama in peer education. In all cases participants were made aware of my position as a foreign researcher interested in sexual and reproductive health services, which reassured me that I was not being covert in my methods but open, honest and accountable. I also observed a number of ‘state spaces’ such as a family planning clinic waiting room whilst waiting there to conduct an interview.

These observations were not tape-recorded but extensive notes were written up during or immediately after the event in a fieldwork diary about my impressions, observations, feelings and questions. This process added a useful extra layer of richness to the interview data collected, and gave me a way of cross-referencing interviews and observations with my own reflections. I also used the diary to record relevant media material (such as

newspaper articles, or advertisements), and for recording my thoughts and feelings following interviews. Although this necessarily included quite a lot of descriptive material (Hammersley and Atkinson, 1995:175; Silverman, 2001:64) – I aimed for as wide a scope as possible, particularly at the beginning, as I was not sure ultimately what material would or would not be relevant – it also served as a tool for reflection, and the insights into my own thoughts, feelings and fears were useful for considering my own position as a foreign researcher as well as potential biases in data collection and interpretation.

As well as notes about interviews, observations, media and health promotion literature accessed, I also included in my fieldwork diary reports on informal conversations that I had where they were relevant to my topic at large. This included conversations about (for example) the practice in Romania in the month prior to a wedding for both bride and groom to have a blood test for sexually transmitted infections which was discussed in my language class as both my teacher and I were planning our own weddings at the time, or conversations with one of my hosts about differences between her country and mine in terms of the age at which we start talking to our children about sex. I also noted down anything I felt was relevant from the end of interviews, after the tape was switched off, when people carried on talking, as occasionally they would want to emphasise something they had already said or started talking about other issues which were still relevant. It could be argued that the after-interview conversation is a way for respondents to put their own priorities on the agenda, having for the duration of the recording participated in an act structured by the priorities and interests of the researcher (Warren et al, 2003).

This latter activity – the noting down of informal conversations and unrecorded material – is of course not without ethical concerns. As Hammersley and Atkinson (1995:265) point out, even when one's identity as a researcher is explicit, once a level of rapport has been built up it is common for respondents and others to forget this and initiate discussions in a non-research setting about subjects relevant to the research. Their points that as ethnographers carry out research in natural settings their control over the research process is sometimes limited, and that research takes place along a continuum of covert and overt techniques (Hammersley and Atkinson, 1995:266), are useful here in considering the extent to which such data may be used in the final version of the study. My general area of interest was explicit enough to everybody I encountered that the research process would not have been hindered by 'outing' myself as a researcher, even though I was not always able to detail the precise research questions when eliciting consent to participate in the research. Therefore I felt that the conversations I had were useful in enlarging my sense of

the overall context in which the specific people and services I was researching were operating, and that I had been open enough about my research that the very occasional use of (anonymised) informal conversations where they added to data collected during the course of the research was acceptable.

3.2.10 Barriers to research in the field

On the whole I found that people were generally interested in my research and willing to participate in it. However, that is not to say that the process was entirely without difficulty! In this section I will briefly explain some of the issues that arose as I tried to undertake this study.

Firstly, my university in the UK does not have any academic affiliates in either Romania or Moldova. Mostly this was not a problem for me, but occasionally respondents asked me about my academic affiliation and were not satisfied with the answer of the University of Glasgow, and insisted that I must surely also be affiliated with a local academic establishment. At no time did my lack of affiliation with a Romanian or Moldovan university cause a potential contact to decline an interview with me, but I did sometimes feel that it undermined their view of me as a credible researcher. I was usually able to overcome this barrier by talking about my professional background as a nurse, as this usually seemed to satisfy people as to my legitimacy and credibility as a researcher in this particular field.

As previously discussed, in a number of cases I used a ‘gatekeeper’ in order to gain further research contacts. In most cases this was a successful strategy, but I did experience some discomfort and disappointment when, having explained my research to one gatekeeper who appeared very enthusiastic and willing for me to undertake a number of interviews with their clients, when the moment came I was introduced as a foreign researcher who would like to speak to a few people “and it will only take about five minutes” – which was hardly conducive to gaining rich, detailed insights! This was overcome to an extent by interviewing the clients as a group, which meant that the time constraint could be stretched somewhat without inconveniencing the organisation on whose premises the interview took place. In another case, I discovered subsequently that the gatekeeper, who had provided me with a number of very useful contacts, had introduced me as a researcher who was undertaking “a questionnaire”. This meant that with many of those contacts they initially seemed reluctant to move beyond one-word answers, and one was the respondent who

wrote her answers on my schedule rather than being interviewed or recorded at all. I did not experience any obvious attempts to shepherd my research into a particular direction favourable to any of my gatekeepers (Hammersley and Atkinson, 1995:66), but I was aware that due to my reliance on ‘snowballing’, with future contacts generated from previous ones, I was not entirely in control of the ultimate selection of respondents. In practical terms, this meant that my interviews in Moldova featured more managers and policy-makers than the interviews in Romania, for example, where I interviewed relatively more practitioners.

As is often the case in social research in central and eastern Europe and the former Soviet Union (Thomson, 2001), it was rather more difficult than I had anticipated to access rural areas, and the bulk of my research was carried out in urban areas. In both countries I did ultimately have the opportunity to spend a short time in the countryside and observe and interview people there, but this was done in the presence of a gatekeeper (for both safety and access reasons) and could hardly be representative as it was such a short experience. However this in itself could be useful – surveys (such as NPCM and ORC Macro, 2006) show, as did much of my interview data, that it is largely the urban-based population that have better access to sexual and reproductive health information and services, and my experience as a researcher trying relatively unsuccessfully to access rural communities could reflect the problems faced not only by these communities in accessing services and professionals, but also by the service providers who for logistical reasons are more likely to remain in an urban milieu even when they wish to also serve rural locales.

Another barrier which was impossible to overcome was the tradition in Moldova that nearly everybody takes the entire month of August off for a holiday. This meant that it was nearly impossible to undertake any work (I did only one interview the entire month), which contributed much to anxiety levels, as this was the month that I had arrived there, and I only had two months in total to undertake the research. This anxiety also contributed to a sense of culture shock that I had not expected – I knew the country, I was familiar with Chişinău, indeed I had many friends there (unlike in Sibiu from where I had just come, where I only knew research-related contacts), I knew the language and was considerably more confident in my language abilities having just spent the previous three months in Romania. However, my difficulties in contacting anybody or undertaking formal research activities ultimately turned out to be very useful, in that I had more time to observe the culture and general context unmediated by outside opinions. It also gave me time to reflect on the work I had done in Romania and the differences I could observe between Romanian

and Moldovan society, something which proved useful in subsequent activity in Moldova and in analysis of my data from both countries.

3.2.11 Data Saturation

At the beginning of this chapter I sited this study firmly within grounded theory. A primary principle of grounded theory is that data saturation be reached; in other words that enough material is gathered that no new insights are gained but any further information confirms what has already been gathered. Given the limitations of the settings and timing of the research, I felt that overall I had reached data saturation in Moldova, with the length and number of interviews, many making very similar points, giving me more confidence overall in the data I had collected despite the relatively limited amount of time I spent there. In Romania this was more problematic in that I did not have the same access to policy-makers and did fewer interviews overall; however on reviewing my data from both countries the consistency of responses across all respondents suggests that within the limitations of the Romanian field sites I probably would not have gained much more new information here with any subsequent interviews. The addition of the media review to deepen and/or challenge the findings of the interview and observation data helped to ‘anchor’ the analysis of the fieldwork data and ensure that, as far as possible for a five month study, data saturation was reached.

3.2.12 Widening out of the media research

“The mass media does much much more than merely “reflecting” cultural norms and realities. In fact, mass media (of whatever type!) forms and recreates culture. Media and media discourses socialise, in large part; they influence human decisions and behaviour; transmit stereotypes and social models; impose constraints, promote standards and values. The mass-media educates and shows people what is happening with regards to ... gender roles and expectations – the way in which we perceive *difference*.” (Terzi-Barbaroşie, 2007:4, translation mine).

I have already outlined how initially, prior to undertaking research talking to practitioners and others ‘on the ground’, I accessed a few online newspapers from both countries, all of which were loosely categorised as broadsheet newspapers, in order to see what issues relating to reproduction, sexuality and sexual and reproductive health were being discussed, as well as to develop my subject-specific vocabulary prior to undertaking interviews. However, during the period of fieldwork it became increasingly clear that the majority of my respondents acknowledged the mass media had an important (and not

always positive) role in both disseminating health promotion information, not all of which was factually accurate, and in influencing understandings of treatments, risks and debates. A large number of my respondents reported as problematic the fact that the mass media was used by the public as one of their primary information sources, with the potential for the dissemination of stereotypes, myths and incorrect information about reproductive and sexual health issues. As a result of this, I enlarged the scope of my data collection to include a much wider range of media sources for two years following my return from the field, in order to ascertain more accurately popular discourses on reproduction, sexuality and sexual and reproductive health. This process considerably influenced my questioning of my interview and observation data, while in other cases it highlighted gaps between popular/media discourses and the issues and priorities as articulated by respondents. The analysis of the mass media has confirmed Terzi-Barbaroşie's statement (above) that it both forms/recreates and reflects culture and understandings, not just in terms of gender but also of sexuality and reproduction more widely, "both creating the society around it, and reflecting the changes in that society" (Pyykkö, 2007:65).

The bulk of the data collected covers the period between October 2007-September 2009; however I also included the more limited sources I accessed between October 2005-April 2007, giving a total of more than 2,000 media articles. I collected articles from a number of online print and broadcast media sources in Romania and Moldova, as outlined in Appendix 4. Following my interviews with service providers I also considerably expanded my range of sources to include some religious as well as secular sources. I collected not only the articles themselves but also any comments added to them by the public, as this demonstrates how ordinary members of society react to issues as they are reported.

As well as these sources, I also accessed a number of blogs in both countries. As these are mostly personal rather than 'official' sources, I have not included them in my analysis, but found them invaluable in gauging attitudes to debates in different sectors of society (for example, a number of the blogs were explicitly religious, or from members of the gay community). This has therefore informed my overall approach and questioning of my data, although as non-official sources I felt that the authors and commenters would have different expectations of the uses to which the articles would be put than would journalists (Eysenbach and Till, 2001). I therefore have not quoted from them directly. Two exceptions to this were blogs by a young theologian in Romania and a Baptist pastor in Moldova where they did seem to be produced for a national (and wider) audience and put forward more official positions, by actors who themselves have considerable influence and

profile. I therefore analysed these two blogs (*Blogul lui Laurențiu Dumitru* and *Moldova Creștină*) treating them as religious news agencies, as many of their articles relate to current affairs.

In addition to the newspapers and other media sources mentioned above, while I was in the field I accessed two magazines aimed specifically at young people (more specifically at teenage girls), produced in Romania but popular in both Romania and Moldova, *Bravo Girl* and *Cool Girl*. This was because during my research many respondents suggested that magazines were one of the main sources of information about sexual and reproductive health for young people in Romania. As this research is primarily about the experiences of service providers, and also because *Bravo Girl* does not have a web presence separate from its parent magazine *Bravo*, I did not include these teenage magazines in the three year media analysis, but instead restricted my analysis to the paper copies of the magazines I bought whilst in Romania and Moldova. This is outlined in the section on adolescent sexuality in chapter 5. More detailed analysis of the content of resources specifically aimed at teenagers would certainly bear fruit in future research aimed more specifically at this group of service users.

3.2.13 Identity of the researcher

In considering my own place in this research, from its instigation to the ongoing production of meanings and conclusions from the data gathered, I draw on previous literature regarding the positionality of the researcher in relation to the researched. I also make connections with the growing literature, particularly by feminist researchers, on intersectionality, defined as “the relationships among multiple dimensions and modalities of social relations and subject formations” (McCall, 2005:1771); Taylor (2009:191) highlights too that notions of intersectionality have moved beyond initial identification of “crossover points in axes of difference, such as gender, “race”, and class, to more sophisticated attempts at highlighting their mutual construction, embeddedness, and movement, rather than static being”. From the beginning of the fieldwork period I was aware that issues around identity were pertinent not only to my respondents in relation to discussing sexual and reproductive health, but also to myself as the researcher; some of the ways my identity ‘played out’ over the course of the period of fieldwork were quite unexpected.

I draw on a largely constructivist view of identity, considering it constructed and fluid rather than entirely essential; however I am mindful that this approach can mask analysis of both the hardening and crystallization of self-understandings and also the impact of external coercive factors on identity (Brubaker and Cooper, 2000). Nevertheless, the notion of identities on a continuum rather than as fixed positions, and individual aspects and experiences of identity mediated through other social identities (Ganiel and Mitchell, 2006), are influential in my reflections here.

Prior to undertaking fieldwork I was concerned that my position as a western researcher would be a potential barrier in that I might be regarded either with suspicion as critical of local practice, or as a more powerful agent than my status as a PhD researcher merited. In the end neither of these concerns were particularly warranted, and indeed as discussed in the section on use of Romanian language for fieldwork, my position as a Romanian-speaking westerner meant that I was more often seen as quite unusual and accorded generous amounts of time and assistance for my research. Two respondents told me that of all the western researchers they had encountered, my use of their language to help make sure their voice was heard marked me out, whilst another talked of a how a visit by a westerner who was interested in them and their experiences was a different (but pleasant) experience for them.

I was also concerned that my gender might be an issue in the research, particularly when talking with influential men, and was concerned that this could lead to a distortion in how responses to my questions were mediated and expressed – that in contrast to the fear that my status as a westerner might place me in a position of greater power with some respondents, my gender might render me non-threatening, even low-status, with others. Likewise, my professional background as a nurse may have been seen as a threat by local nurses or clients, or as a unifying element granting me a type of ‘insider’ status, whilst at the same time it could have rendered me as lower-status and less credible when interviewing medics in countries where nursing is perceived as subservient to medicine. However, as Karnieli-Miller et al (2009:280) observe,

“[t]he relationship changes according to the researcher’s personality, world view, ethnic and social background, perceptions derived from the researchers’ professional discipline, the qualitative paradigm, the theoretical base of the research, the type of the research and its goals, the research methodology, and the researcher’s own perception of the place and the role of the subject/participant/collaborator/coresearcher in the research process.”

In fact whilst all of these facets of my identity – gender, nationality, professional – mediated responses to varying degrees, these were usually positive, with my ‘westernness’ mediated by my language ability, my clinical background generally providing additional credibility (I was not just a ‘mere’ student) and my academic background doing likewise (I was not just a ‘mere’ nurse). The aspects of my identity which proved most unexpected in mediating responses were my age and marital status (late 30s, preparing to get married, childless) and my religious beliefs (I would self-define as a liberal Christian). Being in a similar position to younger respondents (unmarried, in a relationship, considering my own sexual and reproductive health) yet considerably older rendered me in a few cases as unusual as being a non-native Romanian-speaker.

My religious identity though was the source of the most reflection on my place in my research and my relation to my respondents. As someone with liberal religious beliefs, conservative or dogmatic approaches to faith sit uncomfortably with me; indeed I reject such approaches outright. I often found it easier to relate to respondents dismissive of (or even hostile to) religion and its place in relation to their work, and chose in most cases not to disclose my own religious views. On the other hand, as a Christian I found myself disclosing more about my basic beliefs than I would normally be comfortable doing to the Christian organisation with whom I had met in Moldova during the pilot stage of the research, at some points feeling as though I was tempering my ‘liberalness’ in order to come across as more acceptable to them. In both cases I experienced some cognitive dissonance, even though in both cases I was being truthful, but merely emphasising different aspects of my identity and opinions. As Ganiel and Mitchell (2006:17) highlight when discussing religious identity, “the place we occupy may shift backwards or forwards, as if on a continuum. It encompasses doubts as well as beliefs. It can be changed through the research process itself”, a point which is also made by Valentine (2007:18) when she states “[“w]ho we are” emerges in interactions within specific spatial contexts and specific biographical moments”. In my case the cognitive dissonance I experienced in regard to the issue of religion had a more profound influence on the direction of my research than any of the other aspects of my identity. In particular the experience of being questioned on the Christian nature of my research and the sense of not meeting with approval meant that my own emotions and sense of identity and validity were brought to the fore in a way that I had not expected. Rather than deny or downplay the experience however I was able to acknowledge the role that this experience played in the development of the research and my interpretation of the data (Ganiel and Mitchell, 2006). In particular, despite not ultimately being able to include these Christian respondents in my research, I did make

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sure that religion had a more prominent place in my interviews, and included more religious sources in my media analysis in order that the more conservative religious views were also represented.

3.3 Section 3

3.3.1 Analysis and writing-up

The analysis of the data collected (as outlined above) has not been a discrete part of the research process, but rather occurred before, during and after the fieldwork period (Hammersley and Atkinson, 1995:205). Before starting fieldwork the process of media analysis outlined above provided me with a starting-point from which to develop some of my research questions, and during fieldwork themes started to emerge from even the very early interviews and observations which framed subsequent research foci and my interrogation of the data once I had returned to the UK. The process of reflection in the field, as recorded in my fieldwork diaries, was useful as I tried to make sense of what I was observing and being told, and to make sense of my own position and identity as a researcher. When returning to analyse data once I had left the field, the fieldwork diary proved to be a rich but complex tool. Strathern (1985) reflects on the paradoxes of the field diary when she wonders if not keeping a diary makes the researcher more or less remote from the field; in my case I found it both useful and constraining. It was useful in terms of recording events and reflections which aided subsequent reflection and analysis, but constraining in that sometimes it promoted excessive introspection (what Strathern (1985:26) refers to as “the tedium of connecting everything back to the self”) and an over-focusing on negative experiences. Strathern’s (1985:26) observation that by talking too much about reflexivity we risk “it becom[ing] different from what we are doing” was certainly apposite.

However, on my return to the UK the diaries proved useful in helping me to ‘reconnect’ with my data – as discussed in the previous section on transcription, transcribed interviews are but one representation of the data collected; the fieldwork diary reflections enabled me to discern further dimensions in the data. The diaries also helped to reduce the distance between the period of fieldwork and the period of analysis and writing up, somehow helping to solidify the somewhat dream-like recollections of fieldwork once no longer in the field (Strathern, 1985).

Initially I approached my data in quite broad terms, looking at broad themes that were immediately apparent during the fieldwork period in order to provide an overarching framework from which to view the data. From there I coded the texts (interview transcripts, observation and field notes, proxy sources such as national surveys, and some media and ‘grey’ literature sources) more closely using NVivo analysis software, in order to facilitate the coding and retrieval of large amounts of data and to more easily relate it to wider sources – in effect to facilitate easier administrative management of the data.

The use of NVivo software was both helpful and frustrating, and I did not use it to the extent that I could have due to these frustrations. Much has been written about the “coding trap” in qualitative analysis (Bazeley, 2007) with excessive coding potentially reducing rich data to mere chunks of prose separated from their wider contexts, as well as trapping the researcher in the data unable to see the bigger picture (Richards, 1998). I found the initial coding into categories useful in terms of highlighting important themes and enabling the retrieval of data from the interviews; however particularly in my media review I found that when large amounts of text were coded with one code this slowed the system down to such an extent that manual retrieval of data was often quicker. I also found that just as transcribing an interview into a two-dimensional written account lost some of the feeling of depth of the interview, coding individual chunks of texts exacerbated this and made me feel more remote from the wider context as well as sometimes interrupting the flow of the narrative. I therefore kept the initial coding to facilitate an overview of issues discussed around any particular topic, but reverted to keeping the transcripts and observations/fieldnotes as whole entities in order to preserve their narrative structure.

Coding and analysis of my interview, observation and media data proved useful in developing my arguments within the empirical chapters of the thesis. In many cases the process confirmed ‘hunches’ I already had about the data, for example on the prevalence of debates around homosexuality in the media not being reflected in my interview data, or the large focus of debate amongst respondents on information deficit particularly around sex education. This, coupled with a consideration of the main activities of my respondents, led to a crystallisation of the focus of the thesis and the importance of the consideration of understandings of morality as they pertain to health service provision. This also prompted me to revisit the wider literature on sexual and reproductive health, public health and development interventions and more clearly sited this study’s contribution to the literature on health and morality as well as on welfare, gender and agency in central and eastern Europe and the former Soviet Union.

Consideration of the researcher identity also impacted on the analysis of the data and discussion of background information as outlined in chapter 2. In particular my position as a public health professional did to an extent frame my consideration and analysis of issues such as contraception and abortion/unwanted pregnancy, and moderate my use of language, for example referring to contraceptive methods as ‘modern’ or ‘traditional’. Whilst to a large extent this language reflected the use of such language in demographic and epidemiological reports on contraceptive use, it is nevertheless true that my perspective as a public health practitioner reflects the assumptions about such methods, and I acknowledge that during one of my observations of an education session discussing postnatal family planning I was surprised that ‘traditional’ methods such as withdrawal were presented as valid as well as ‘modern’ methods and felt very uncomfortable with this. However, with all my analysis I have attempted to maintain a tone consistent with mainstream public health consideration of issues around contraception, although I acknowledge the irony of doing this whilst critiquing the supposed values-free and morally neutral stance of public health approaches.

3.4 Conclusion

This discussion of methodological issues is intended to demonstrate how the methods I used for this study were chosen precisely because they were able to help me gather rich and varied data in response to my research questions and theoretical concerns whilst also maintaining maximum reflexivity as a researcher. My concern throughout was not only to gather data, but for my representation of the information entrusted to me by respondents to be treated and presented fairly and accurately, and for the process of reflection and analysis to ensure that my interpretations and conclusions enable the voices of my respondents to be heard.

Chapter 4

Forming the debate: key players

It became clear from an early point in my fieldwork that a narrow focus on ‘public health’, the promotion of a ‘healthy way of life’ (*mod sanatos de viață*) and attempts to improve outcomes (lowering abortion and STI rates, raising safe and modern contraceptive use, etc) was insufficient to capture the intricacies of factors influencing the perceptions of people working in the field of sexual and reproductive health and their clients and shaping their experiences. My observations of how providers and clients were attempting to negotiate the complex social, cultural, political and institutional contexts in which they lived and worked, and my ongoing exposure to debates and discussions about sexuality and reproduction in local and national media, strongly suggest that the context within which sexual and reproductive health services are provided and accessed (or not) is much wider and more complex than formulations around health alone might imply. The prevalence of such concepts as shame in my interviews, and the media (secular and religious) debates about the questionable morality or efficacy of particular health interventions and policies add to the complexity and the contestations around sexual and reproductive health with which services and clients grapple daily.

This chapter focuses on the institutions and actors which form and contest the context within which services are designed and provided. By context I refer not only to the political and legislative context, but also the discursive context of public/lay understandings of health, sexuality and reproduction. For this reason I do not just consider the interests representing service providers such as the medical profession, but also wider interest groups and institutions particularly religion which are also involved in creating and defining meanings around health, sexuality and reproduction and what this means for wider local and national social life. I also consider how these diverse interest groups interact with each other, and how these interactions speak to the thesis themes of the links between health and morality and the implications for service provision. The following chapter will then discuss some of the particular issues which are formed and contested by these institutional and organisational interests in more detail.

This chapter begins with an overview of the two main categories of service providers accessed for this research, namely state providers (doctors, nurses, pharmacists, consultants working in the state health sector as well as local authority and national civil servants) and

non-governmental organisations (NGOs), outlining how providers see themselves and each other. It then considers the importance of religion in the formation of the discursive field within which services are planned and developed. The views of respondents were sought on these different context-creators and their impact on the arena in which services are designed and provided. The interactions between providers and international actors and discourses is then discussed in order to highlight the complexities and problems in providing a responsive sexual and reproductive health and education service, particularly in view of the circulation of a multiplicity of contested meanings.

4.1 Service providers in the state sector: views of their place and role

Originally this research was intended to focus on NGO provision of services; however it is not possible to regard them in isolation and it is important to also consider the wider “local institutional background” (Thomson, 2006:238) among which NGOs were attempting to carve out a space for themselves and their work. Later this section will consider NGO-state interactions; initially though it needs to be made clear that state providers⁶ not only provided a background for NGO services to develop (whether in partnership or opposition to the state services) but also are strong formers of meanings and health beliefs through their pervasiveness in the consciousness of the population. One of the legacies of the socialist past (discussed in more detail in chapter 5) was an ongoing privileging of the medical profession in the state sector.

State providers’ views of where they sited themselves in the overall provision of services and the challenges they faced were explored and revealed both confidence and uncertainty. State services ostensibly work to nationally-mandated priorities – although, interestingly, many respondents in both countries were unable to articulate what national state priorities actually were, and one (a Romanian family doctor) was actually quite hostile to the question, as though consideration of political issues was irrelevant to her work with patients (see Rivkin-Fish, 2004). Another Romanian family doctor talked about being aware of some national priorities but not receiving locally relevant information in order to implement them:

⁶ By state, I refer to those services and practitioners, which come under the auspices of national, regional or local government, i.e. working in the state health and/or education sectors. I differentiate between these and civil society services and practitioners, who can be found in a range of different contexts, for example NGOs, mass media, religious groups, the arts, international organisations, as well as private practices.

I don't know. ... [L]ocal priorities don't reach the surgery. ...I don't receive any information. For example I heard that ...breast cancer screening can be done in the polyclinic, ecography, mammography ...nobody has told me, I don't know anything ... If the state launches a programme like this breast cancer one, if I don't know about it, I can't send many patients because they say it costs, they don't want it, ... they don't have money to pay. But if I know ... the number of the room, if I know the contact person, if I know they don't have to pay, this is very clear, so then I can confidently make this referral, yes? (12RI)

Likewise, two family doctors in rural Moldova with whom I spoke were either unaware of national priorities, or did not consider them helpful in their day-to-day work with patients:

I haven't seen any national priorities.

Some things were elaborated, ... But in principle so that we can help someone, not really. (16MI)

The strong impression with which I was left in both countries was that many state service providers felt that the needs of the population and the problems in the system were so great that despite their high standards of training and knowledge, they could not offer all the services to meet the needs of the population. Typical problems cited as detrimental to their ability to provide a good service included a lack of time and resources to offer education or counselling in a private and confidential space, identified here first by a pharmacist and then by a family doctor, both in Romania:

... if there was a counselling room in the pharmacy ... then there would be more questions. (07RI)

I can't do this [i.e. family planning counselling] myself because time doesn't allow me when there are [family] planning doctors who only do this. So, time here is very short, I want to be able to do something else but I can't as I need more time. (09RI)

In Moldova, these resource constraints were also linked to other 'aspirational' issues – as well as wanting better facilities, some respondents also looked towards becoming more like other countries, as articulated by a senior gynaecologist:

What would be better? We develop our services more like what happens in civilized countries, we introduce new methods of treatment, new methods of preventing illnesses, new methods of contraception, new methods of infertility treatment, new methods of educating young people about reproductive health. (17MI)

In both Romania and Moldova internationally supported reforms have meant that the health care system has moved to one funded at least in part by a state health insurance system. I asked state respondents in both countries about the impact of the relatively new insurance systems, with somewhat mixed responses. In both countries there was some confusion about whether contraception and other reproductive health services were covered by insurance or not. In Romania one GP insisted contraception was covered whilst others said it was not; in Moldova the same situation occurred over abortion, with one specialist insisting that it was included in the state insurance programme and another lamenting that it was not.

It was also considered by many respondents in both countries, particularly those in Moldova, that the system worked better for some groups (particularly the elderly and children) than others:

It's not really interested in that [reproductive and sexual health], it's mainly orientated towards the chronically sick, elderly and children. But the problems of reproductive health, not really, not really, that's to say even these contraceptives come from donations. (16MI)

I could probably give you two responses ... my professional position and my personal position. From my professional position ... probably the introduction of medical insurance is a progressive step. It has changed things for the better, it has increased access to basic medical services for the population and access ... is much better than 5 years ago ... Especially for mother and child health very many things are now free. And mothers, pregnant women, children up to 5 years are insured to have some basic medicines absolutely free. I consider that this is a positive step. Personally, I don't have faith in this system ... I would be happy to see alternative models of service to improve the quality of both state and private services. This is my personal opinion, because there isn't a concurrent system in the country, an effective or constructive system. ... I think things will get better, but at the moment probably it's very important to create alternative forms for insuring reproductive health, in other words perhaps also private forms, non-governmental forms, ... to monitor and respect quality standards. (23MI)

However, despite the insurance system guaranteeing free basic medication for certain groups, this is not always communicated to the beneficiaries – for example one of my contacts in Moldova, who was heavily pregnant, told me she only found out from a friend who was a nurse that she was entitled to claim free prescriptions for iron supplements. She had not been told this by her own doctor who had continued to charge her for the prescription.

The issue of insurance for returning migrant workers was also raised in both countries by my respondents. In Moldova where migration of the reproductive age population affects a significant proportion of the population (Atun et al, 2008), migrants are often working abroad illegally and so not entitled to health insurance in their country of work. As a result when they return to Moldova they often require treatment for conditions such as STIs that are in a more advanced state, creating additional pressure on the local health services. In Romania too there were calls for screening for returning migrants:

And I spoke with a colleague who is also a family doctor about this issue of AIDS on her caseload, and I learnt that the majority have come from abroad. So they could do screening on people returning from working abroad where they've had unprotected sex ... to make this test obligatory. (12RI)

Another issue relating to health care reform discussed by respondents included the fact that in Romania curative treatment still appears to be a priority over preventive health services.

... there isn't the necessary budget for continuing these activities, because they always consider that other areas are more important than ... reproductive health, because this is considered more prevention, ... the biggest amounts [of money] are always given to treatment and others, the main cause of mortality for example in Romania is cardio-vascular disease so that's where government finance is directed, not to reproductive health which is a type of prevention. (02MI)

However even in Moldova, where services are being reoriented towards preventive services and primary health care (Atun et al, 2008) and where most of my respondents in the state sector were positive about this reorientation, the reform has not been unproblematic. One respondent from the Ministry of Health reported:

... preventive medicine is the priority, and most money has gone there ... more money than to hospitals (*staționari*). In the hospitals there is less money ... out of 100%, 60-70% goes to primary medicine and the rest to hospitals. ... But ... actually in the hospitals there is a very difficult problem, because ... since the Soviet times there hasn't been money for repairs, for equipment. And now everything is older, and needs to be renovated, but the [Insurance] Company gives money just for salaries, for treatment, for patients' food, ... but for repairs and equipment it doesn't give money, the government has to give money, but the government has few possibilities for this, medical ... equipment is very expensive. ... in this sense it is difficult, it's bad. We want much more. (13MI)

Respondents also talked about the issue of political will (or lack thereof) regarding sexual and reproductive health issues, all of which suggest that the reforms demanded by donors are more complex and ahead of political will. In Romania sexual and reproductive health

was not thought to be a priority and was also considered a taboo subject even at the political level:

... here there are many issues they need to tackle and so this work of prevention is neglected ... There aren't big priorities, we're on a more secondary level because there are these priorities around restructuring the hospitals ... Here there are very many ill people, you understand? ... many diabetics, very many people with mental health problems, very many elderly ill people ... very many with Hepatitis C ... over 2 million registered. So, they need money to follow them up, and so those who are thinking about having a child or not having a child, that's their problem. Understand, that if they undertake a health programme which includes sexual health as part of it, I tell you that they will be too embarrassed to discuss it. (11RI)

In Moldova on the other hand it was felt that although legislation was advanced, politicians were unwilling to discuss or promote sexual and reproductive health as the extreme demographic problems facing the population are potentially politically damaging, as well as because it is still considered a shameful and taboo subject:

From the legislative point of view, the Republic of Moldova seems to be a model country, with legislation in reproductive health ... It's all there, ... but all at the declarative level. I believe that the priorities and involvement of politicians need to be much more concrete. Politicians in the Republic of Moldova are afraid of discussing reproductive health, they're afraid of debating the demographic problems in the Republic of Moldova, they're afraid of officially discussing ... about sexuality, about HIV-AIDs, about STIs, about responsible sexual behaviour. And, politicians from the Republic of Moldova are afraid, they don't have a position ... on ... these fundamental rights in reproductive health. we've tried to, we've asked the President of the Republic of Moldova many times to give an anti-HIV-AIDS message, for the population, for the youth. We've not succeeded. He doesn't want to. And, it's the same thing with the other politicians. They don't get involved. Because, reproductive health, sexuality is considered a shameful thing, a taboo thing and they don't want to discuss it. Political courage doesn't exist among our politicians. (11MI)

Another health system issue highlighted by a number of respondents was that of increasing salaries for staff to increase motivation of staff (and through that, quality of services), and to combat corruption. One Moldovan respondent discussed the ongoing problem of unofficial payments for health care:

Not to mention poor and limited access for poor women, despite the ministerial decision since 2005 that abortion with medical or social indications is covered by insurance, the decision was taken by the Ministry, but it's still not working, today people are still paying for everything, even adolescents, even poor women, and they continue to pay in effect twice: so partly to the [Insurance] House or the hospital, and partly to the doctor. (12MI)

Also linked to this is the lack of funding for equipment and facilities. Concerns about inadequate training, equipment and facilities, screening and reporting were expressed in both countries. Certainly some respondents considered physical conditions in hospitals and clinics as a significant barrier to accessing services, such as this international agency director from Moldova:

To start with, not all clinics have basic equipment and the basic necessities, to provide these services. ... they don't have the necessary space according to the requirements ... the doctor is not able to discuss "face to face" with the client, the nurse or midwife is also there ...the door opens, they go in, they leave ...we can't ... talk about confidentiality. Basically that's probably the biggest difficulty at the moment ... Their salaries are very low, minimal, working conditions are pretty basic, pretty unattractive for medical professionals.
(11MI)

Along with overall poverty levels (particularly in rural areas) the previously-mentioned issues of inadequate information and education can be added to reasons for ongoing difficulties and reluctance in accessing services.

4.2 State providers' views of NGOs

Despite the acknowledged constraints within the state health sector, however, in general it seemed that many of the state sector respondents did not consider NGO providers fully able to bridge the gap between the needs of the population and the ability of the system to meet those needs, as their 'reach' and focus was perceived as too limited. This is a common problem, for example research by Flynn (2006:251) in Russia identified state sector migration organisations viewing NGOs as "supplementary, unprofessional, and insufficiently informed" even whilst in some cases acknowledging the part they did have to offer in overall provision.

State respondents in this study tended to view NGOs with caution. Few were overly critical, but several expressed doubts about the quality, professionalism and professional status of NGO workers and programmes. It was also felt that because NGOs specialised in particular areas this left gaps in service provision. This was particularly true in Romania, where there was less cross-over between state and NGO sectors. In Moldova on the other hand many of the people to whom I spoke, particularly in urban centres, had experience of working in both state and non-state sectors simultaneously leading to a more fluid understanding of each sector and closer working between the two. Some of my Moldovan respondents for example worked in a state-run hospital but also volunteered with an NGO,

or managed an NGO based in a state facility and also participated in government-level reviews of health services, leading to a hybridisation of ‘social security, which [was] both connected to *and* dissociated from local and regional state actors, policies, and welfare regimes’ (Read & Thelen, 2007:11). In Romania I was aware of a similar arrangement with doctors working in the mental health field in both state and NGO services in Cluj, another Transylvanian city, but none in sexual and reproductive health services. In both countries, interactions between state and NGO providers were usually on a referral basis (generally state family doctors referring clients to the NGO, or NGOs referring people with more complex medical issues to state specialists). State-NGO interaction also took place at an official level with formal agreements from local or national authorities allowing NGOs to undertake particular activities (such as sex education classes) in state facilities such as schools. One NGO in Romania reported a positive collaboration between them and the police service on a domestic violence awareness campaign; this appeared to be down to the development of an individual positive relationship between an NGO and a particular police force rather than something that happened ‘across the board’. On the other hand, a state sector family planning consultant in Romania reported previous collaboration with her service, NGOs and a western consultant, but once the programme had finished no further work was done and she felt that she was left to ‘pick up the pieces’ and carry on with no further support.

Doubts about the roles, credentials and priorities of NGOs led to a reticence on the part of state respondents to fully endorse NGOs and their work. This respondent (from a Romanian county-level public health authority, who interestingly was also on the management board of a local NGO) considered that NGOs had the potential to specialise in particular issues and provide a good service, but at the same time was cautious about their professional credentials:

...because of the fact that they are concentrated, they don’t have the number of preoccupations that we in relatively large governmental organisations have, they can concentrate better on this subject ...So, categorically from this point of view, they could have a bigger impact. ... On the other hand, I don’t know what is the exact professional training of the people who work in these [organisations] ... I don’t know if everyone has the ability ... (04RI)

Another respondent (a family doctor in urban Romania) felt that NGOs did not work in areas that she considered a priority:

I know about an NGO... or two which do exercises for pregnant women, I know about one or two NGOs which give out information, a centre for AIDS

information ... but I don't know of an NGO which for example talks about contraception ...so one helps pregnant women, one ill women or ... a couple ill with AIDS yet I say that really still in Romania the main problem is that of contraception. (12RI)

In fact one local NGO did provide education about (though not provision of) contraception; however this work was either not known by state providers, or (in one interview with a state provider) criticised as giving a different message to those who were providing the service and raising client expectations beyond the ability of the state services to meet them.

In Moldova too there was a perception among some state providers that NGO provision of services was ad hoc, uncoordinated and of limited quality and impact, as highlighted by a gynaecologist who had experience of working in state, non-governmental and international services:

... many NGOs have very poor quality programmes ... many of them have programmes that are not generally adapted to the needs ... there is an absolute and total lack of cohesion between their activities. One says one thing, one says another and all the rest of it. (23MI)

In addition to this, several respondents were unable to name any local or national NGOs working in their area, and a number complained of a lack of publicity by local NGOs. These examples highlight a lack of coordinated and systematic information-sharing between sectors resulting in less collaborative work and fewer referrals.

4.3 Civil society providers: views of their own roles and those of state services

The (sometimes tenuous, sometimes quite strong) links between state and civil society providers have been shown above to be quite complex. No organisation in either sector works in a vacuum, and despite attempts at independence the civil society groups all identified the facilitative role of the state in enabling them to function – for example by providing contracts for particular work, or authority, recognition and validation of their activities. It could therefore be argued that, far from being a separate private domain, civil society is thus placed within a public sphere dominated by the state and thus subject to the gendered, unequal power relations that operate within that sphere (Einhorn, 2006/2010:68).

Unsurprisingly, NGO respondents in this research were more positive than their state sector counterparts about their contribution to sexual and reproductive health awareness, education and services. They also had a more positive view of their collaborations with state authorities. Many highlighted their qualities of flexibility, the ability to adapt to needs more quickly than state organs (who are constrained to a large extent by bureaucratic requirements), and the quality of their services, as shown by two quotations from NGO managers, firstly in Romania and then Moldova:

One of the advantages would be that we think more flexibly and adapt more quickly to the needs of beneficiaries. For a [non-governmental] organisation it is much easier to try a project, do it for a year, if it needs changing to modify it; for a public [i.e. state] organisation it's a bit harder to do this ... (02RI)

... taking civil society with state organisations, it's powerful because it is a bit more credible to the population ... people go [to an NGO] because of the quality of the service and people here then understand that it is possible ... to have a correct attitude towards them, to be informed, and to have some quality services ... (05MI)

The next respondents, firstly a Romanian NGO manager and secondly a Romanian development consultant, highlighted the benefits of western funding and involvement, aligning themselves with what they saw as progressive western values, comparing them to state services (with the implication that these are less advanced and less progressive), and remarking on the perceived better standards of staff, services and equipment, also linked to ideas of progress and modernity:

... I think that ... the first thing that is a difference with state services [is] the ... training that we have done ... courses, especially based on principles that come from the west, courses on human rights ... (02RI)

In general services by non-governmental organisations are better developed, financed by international organisations and right from the start were built to modern standards, modern implementation of services and were always well equipped with equipment, with good quality contraceptives, medical training, medical personnel were very good ... and the model in the public sector was based on the non-governmental model. (02MI)

Ideas of progress and modernity as aligned with notions of 'the west' can be rather pervasive (Drazin, 2002); my research too illustrates how notions of progress (as measured in levels of democratisation, comparisons with western services in standards and improvements in sexual and reproductive morbidity) reflect cultural constructions of east/west oppositions and positionality (Gal and Kligman, 2000a:21).

Most NGO respondents were able to give examples of working with local and national state bodies in order to undertake certain activities, for example as mentioned above education authorities had to grant permission for NGOs to undertake educational activities in schools, whilst others collaborated with the police on domestic violence campaigns. One of the NGOs in Romania received many referrals from local family doctors and gynaecologists who were aware of its services. These are all examples of the enabling state, without which the NGOs would struggle. However, at the practitioner level, the differences in perceptions between state and non-state providers about which was the more professional, responsive and inclusive sector was quite striking. NGOs highlighted their flexibility, openness and progressive approach as positives, while state providers considered NGOs ‘niche’, something of a luxury, and still felt that it was the state services which should and did offer the bulk of services relating to the actual needs of their constituent groups (such as providing comprehensive medical assessment prior to prescribing contraceptives).

4.4 *Deprinderi de Viață* – the battle for a nation’s youth

Before going on to discuss the specific institution of religion, I wish to present broader issues around the relationship between health, morality and nation. This will be done in this section in the specific context of Moldova when the sex education programme *Deprinderi de Viață* (‘Life skills’) introduced into the national curriculum was withdrawn in the 2006-7 school year, and in the next section with a discussion of the unsuccessful HPV vaccination programme in Romania. The case study of *Deprinderi de Viață* highlights the links and conflicting arguments around health, morality and nation, and is referred to on several occasions in this thesis.

Although a very specific case study, the situation in Moldova with regards to sex education is useful in that it highlights in microcosm a number of the key issues of this thesis. It was also mentioned many times by most of my Moldovan respondents and so bears elaborating here. In 2005 *Deprinderi de Viață* was piloted in 35 schools throughout the country. This course was funded by international donors such as the UN, WHO and World Bank to the tune of \$2 million and aimed to provide a comprehensive personal and social education to all age groups, covering areas such as anatomy, hygiene, health and nutrition as well as sex and relationships. The course was by and large well received by teachers, pupils and parents, and following successful evaluation of the pilot by the Ministry of Education in 2006 the course was rolled out nationally as a compulsory part of the national curriculum.

However there was an immediate outcry from conservative political and religious groups, who claimed it was promoting abortion, promiscuity, narcissism and homosexuality, that it encouraged pupils who would not otherwise be curious about sex to experiment and engage in sexual acts sooner, that it encouraged pupils to talk about sex and relationships with people other than their family (in other words that the course attacked the family and undermined family values and authority), as well as representing the imposition of unwelcome western values on Moldovan society. As a result of this outcry the programme was withdrawn from the curriculum by the Ministry of Education, in the midst of what respondents described to me as ‘a national scandal’. The role of the national church and of some conservative politicians in ensuring the course was abandoned was mentioned by most of my respondents as a considerable barrier to developing safe and high quality sexual and reproductive health services throughout the country. The example of *Deprinderi de Viață* demonstrates the power of conservative forces in influencing public health and education policy processes in Moldova, a power which has been successfully utilised subsequently to the period of this research, for example with the withdrawal of another book about sex education for children, “*Sexul povestit celor mici*” (‘Sex explained to the little ones’) in December 2010 (*ProTV Moldova*, 2010).

Although the *Deprinderi de Viață* manuals are still technically available in school libraries, there is now no compulsory sex education in the Moldovan curriculum.

In spring I remember when I was in Cimișlia with the pro-health campaign with our young volunteers, and at a school the head teacher responsible for education problems was very indignant at the fact that [*Deprinderi de Viață*] was withdrawn. And there ... the school director, the administration ... with the parents and with the young people ... decided that it would remain as an optional course ... And they took the manuals and they are stocked in school libraries. And great if someone says that there are manuals, you can go and take them, but there are schools here children don't know that the manuals are stocked in the libraries. It depends on the localities. (25MI)

Added to this was the oft-lamented ‘tradition’ of not talking about sex in the family as it was considered a taboo subject, something shameful. Young people were therefore reported by my respondents as getting the bulk of their information from friends and mass-media, with research (Ștefanuț and Leșco, 2005) suggesting that health professionals rank quite far down the list of whom young people trust and go to in order to gain information about sexuality and reproduction. This led to the widespread circulation of myths and inaccurate information which health promoters were keen to counter.

Deprinderi de Viață is important as it highlights a number of issues linking health, morality and nation. Fears about out-of-control, rampant sexual activity fed into debates about the so-called ‘demographic crisis’ in terms of numerical decline (fewer births due to increased abortions, STIs and homosexuality as well as greater knowledge and uptake of contraception) and also debates around national identity. The course was framed by opponents as a western imposition, as not reflective of Moldovan national values and identity, and moreover a danger to the spiritual and moral basis of the family and the nation. It linked discursively with and very closely illustrates media reports of ‘demographic crisis’ and the danger of the imposition of western values and sexual mores to the reproductive health and capacity of the nation.

It also highlights the limitations of a public health approach to sexuality and reproduction. One of the potential problems with any public health approach is that particular behaviours and ‘lifestyles’ are targeted whilst others are relatively neglected. Whilst the public health focus on both efficiency and greatest reach on the one hand, and on health needs and inequalities on the other is laudable, it is not unproblematic for services – both state and non-state – with limited and finite resources, who are working to the agendas not only of local need but also of donor priorities.

4.5 HPV vaccination campaign in Romania: a ‘national failure’

Similar to the above example of *Deprinderi de Viață* in Moldova, in Romania the example of the failure of the HPV vaccination campaign illustrates the power of conservative forces to influence both government policy and public responses to it. Alongside the introduction of this campaign in the countries of western Europe, the Ministry of Health of Romania under then-Minister of Health Eugen Nicolăescu planned to introduce the campaign throughout Romania for school girls in their final year of primary school during the 2008-2009 school year. However, the numbers taking up the vaccine were very low with less than 10% take-up (*Cotidianul*, 2008a) amid accusations of experimentation and eugenics, as evidenced in the public comments after media articles about the vaccination programme.

Although there were institutional conservative voices against the programme, the reactions against it appeared to have a wider public resonance, feeding into an apparent suspicion of vaccinations within Romanian society. Later in the programme it was reported that more than 70% of parents were refusing consent for their children to have the vaccination, and there were numerous reports of a case in England where a young girl collapsed and died

after having the vaccination (*Jurnalul Național*, 2008c) (the subsequent finding that she had had a previously unknown heart condition which was the actual cause of death was much less widely reported). The Ministry of Health subsequently admitted that the information campaign prior to the programme had been insufficient and blamed this for the poor uptake of the vaccine, however by this point the damage had been done and subsequent programmes have not been much more successful than this initial one. The Ministry however did not appear to actively engage with the objections about experimentation but rather relied on the damage-limitation exercise of increased information about the vaccination to increase further uptake. This has not had the desired effect, and suggests, as with the *Deprinderi de Viață* case in Moldova, that whilst politicians and policy-makers do not engage with the very real fears of large segments of the population, however unjustified these fears may be, the impact of public health policy and uptake of public health initiatives will be limited.

4.6 Religion

As well as state and NGO sector providers (as the main respondents in this study), as countries where institutional religion plays a key role in forming and complicating the landscape within which services are developed it is important to consider the role of religion in forming and challenging the discursive field. As previously discussed both Romania and Moldova as majority Orthodox countries experience a vocal and powerful (and largely conservative) religious influence which permeates throughout society. This influence appears to place family as the prime site for the wellbeing of the whole society and nation, with so-called ‘non-traditional’ forms of sexuality (in particular homosexuality and adolescent sexuality) a major locus of blame for the perceived threats to a ‘healthy’ society. The melding together of discourses of health and morality has proved very potent, and provides another layer of context in which sexuality and reproduction are experienced and services are provided.

4.6.1 Respondent views of church and religion

My interviews showed mixed views on the influence and benefits (or not) of religion in respect of views towards sexuality and reproduction and how these impinged on services. Many respondents discussed the church in largely negative terms, but some more neutral and even positive issues also emerged during discussions.

Of the respondents who explicitly talked about the church and religion, half of the Romanian respondents (5 out of 10) and two thirds of the Moldovan respondents (10 out of 15) described it in terms of what it was against (*împotriva* or *contra*). This accords with my impressions of religious media in the two countries, where diatribes against sexual and reproductive issues as abortion, homosexuality and the vaccine against human papilloma virus (HPV) infection join doom-laden warnings against biometric passports and the European Union. In Romania the church was largely reported to be against abortion and family planning. This can be demonstrated here by this quotation about an Orthodox-based charity, ProVita, from a Romanian NGO manager who was talking in the context of a question about the ongoing influence (or not) of the communist pronatalist policy:

There are still very many principles of this type [i.e. pronatalist], even some sayings: ‘However many children God gives you, that’s the number you have to have’ and, really, priests were very often against abortions and unfortunately even against contraception. ... they are very vehement even ... against contraceptives, they came with slogans like ‘The pill equals death’. (14RI)

By contrast in Moldova (probably due to its very recent history with the *Deprinderi de Viață* course) it was sex education that was considered by my respondents as the main object of the churches’ disapproval. Interesting analyses emerged about the power and politicking of the church and the extent to which the church had knowledge about that which it opposed. For example, this manager from a multinational donor identified both politics and power (in the context of a question about church influence in the countryside) as important when considering church opposition to *Deprinderi de Viață*:

Two years ago we introduced in Moldova a course, ‘Life Skills’. Unfortunately it had let’s say a not very successful end. It was piloted in 35 schools in the Republic of Moldova, and afterwards, when the next year it was introduced into school, it was boycotted by church adherents, you know, and some politicians. In fact they used each other, the church and the politicians ... it was a purely political game. ... What we saw here, what happened with ‘Life Skills’ ... a significant opposition with very big influence. And ... often a power with pretty powerful decisions. And, especially in the countryside, so when the problems with ‘Life Skills’ began it was taken to the patriarchal⁷ level. (10MI)

This rural family doctor on the other hand was indignant about the perceived ignorance of the religious opposition to *Deprinderi de Viață*:

Last year we introduced the ‘Life Skills’ course into schools. And it was about reproductive health, the development of sexual organs. Then parents rose up, religious representatives rose up, saying ‘Look what they’re promoting here, they’re promoting abortion’. ... Please, I saw a manual, and I didn’t find anything like that

⁷ In this instance ‘patriarchal’ was referring to the structure of the Orthodox Church.

... So, without opening it, without reading it, without studying it, already they were prejudiced and stopped a really really important work. (16MI)

Analysis of media sources demonstrates that in Moldova once an issue reaches the political sphere the church is then mobilised. In 2005 the church organised against sex education as this was a current political issue. By 2008-9, current opposition was less against sex education and more against homosexuality due to the proposed new anti-discrimination law which includes 'sexual orientation' in its remit (for example see *Moldova Creștină*, 2008a).

Other respondents discussed religion negatively in terms of 'tradition' and 'mentality', and linked it to the negative effects of pronatalism. However, some neutral views were also expressed, such as factual reports of religion's greater influence in rural areas. In addition it was stated several times that religion had a greater influence on older generations and much less over young people, particularly in the cities. It is clear though from a review of media and religious sources that those young people who do ally themselves with the church, either as theologians (such as Laurențiu Dumitru in Romania) or as part of young people's groups such as ASCOR (*Asociația Studenților Creștin Ortodocși Români* – Association of Romanian Christian Orthodox Students) in Romania and *Nouă Generație* (New Generation) in Moldova, are extremely active in promoting a highly conservative religious agenda.

In addition a few respondents in both countries looked on religion and the church as a potentially positive influence. The possibility of dialogue and partnership was mooted by more than one respondent as a potentially productive way forward to avoid future problems, for example an NGO and international donor manager in Moldova stated:

I believe that honestly it's necessary to start a dialogue with the church, ... between organisations that promote reproductive health. A compromise, and to work, to understand that to protect reproductive health, there are some general human values, like religious ones, which support sexual and reproductive health, and ... it's good for everyone to promote them ... No-one expects that the church will promote condoms, but it's important to ... seize this opportunity. I was even at a course with priests organised by UNICEF, and there were very productive discussions. Because, they, the majority of them are very wise (*deștepți*) people, very thoughtful, but importantly very probably they need dialogue, and more information from specialists so that things can go in a more correct direction. (23MI)

Likewise in Romania it was acknowledged that some priests were open (*deschis*) and not automatically opposed to sexual and reproductive health work:

I had a priest colleague and he was very open to this, he understood the fact that some people are trying to decide how to choose, how to behave, because he understood that some people do this: sexual relations exist and he didn't see anything bad in the fact that some come and ask for guidance. So, he was even open. (16RI)

4.6.2 Religious media, and religion in the media and political life

It is clear from both secular and religious media sources that the relationship between politics and religion is complex and powerful. In both countries, religious opposition to homosexuality has been played out at the national, political level. In Romania this took the form of the already-mentioned opposition to the eventual repeal of Article 200 (which criminalised homosexuality) in 2001, and more recently opposition to the growing visibility of the LGBT population and Gay Pride marches. In Moldova the attempts to stall the proposed Anti-Discrimination Law (*Legea Nediscriminare*) by calling on the Ministry of Justice to remove the term “sexual orientation” from the legislation clearly demonstrate the explicit linking in religious discourse of nation, family, health and morality:

The collaborators in the Ministry of Justice, who are supposed to be vigilant about laws and rights, have registered without too many obstacles an organisation which seriously threatens the safety and health of society through the immorality which it promotes. Now, the representatives of the homosexual and lesbian organisation ‘Gender-Doc-M’ have developed a law for preventing and combating discrimination through which they will have all the protection of the state and all freedom to realise their diabolical plan which they have to destroy the family, the personality and the nation through the immorality which they are spreading all over. (*Moldova Creștină*, 2008b).

What is also clear from the media is that there is a distinct lack of a moderate ‘middle way’ in mainstream religious thought and practice in Romania and Moldova. Both Orthodox and minority Protestant groups tend to be very conservative, speaking with remarkable uniformity on such broad issues as sex education, abortion, homosexuality, and more specific issues such as the (ultimately successful) protests against the performance of the play “The Vagina Monologues” in 2007 in Moldova. In an analysis of the furore around the banning of a Gay Pride march in Chișinău in May 2008, where popular opinion largely seemed to accord with conservative religious opposition, there was only a single one among several hundred public comments where a commenter identified her/himself as a Christian and said s/he fundamentally disagreed with the actions of the Christians who had forcibly stopped the march from taking place. However, despite the largely polarised debates for and against the church’s position on sexuality and reproduction (as highlighted in both media and interview data), the occasional voices of moderation and references to individual clergy who are open to discussing sexual and reproductive health issues with

service providers do demonstrate that the reality is more nuanced than the polemical declarations from religious groups might suggest, and that although one worldview does appear dominant, it is not the only one (Verter, 2003:162).

What these findings suggest however is that the church in both countries is still fighting to claim (or reclaim) its place as the arbiter of morality and control over who or what is considered acceptable. This is an ongoing project - Stan and Turcescu (2000:1467) highlight how the Orthodox Church in Romania has used political engagement in order to impose its views on democracy and become a dominant political force in Romania, seeking to “shape democracy, mentalities and lifestyle” (Turcescu and Stan, 2005:291; see also Stan (forthcoming, a.)). They claim it has emerged as both a “powerful political actor and an uncontested source of moral strength” (Stan and Turcescu, 2000:1471) in the years following 1989. It is consistently rated as the most popular institution in opinion polls with high levels of trust placed in it (ibid, p.1471; Rogobete 2006:37). It is posited that it has achieved this through “skillful [sic.] use of nationalism to restore its prestige and strike a chord with Romanians” (Stan and Turcescu, 2000:1472), and by highlighting that salvation is obtained nationally, not individually (ie “that the nation is a socio-historical, ‘metaphysical and theological reality’” (ibid.)). This works both ways of course, with politicians increasingly calling on the church in order to enhance their own electoral legitimacy (ibid.). It has led to a not entirely comfortable relationship, with the church experiencing the contradiction between claiming it is separate from the state (and therefore it is a private entity which should not be open to state intervention or scrutiny) and benefiting from its position of representing public values (Moise, 2003:160). Likewise, in Moldova the calls to protect the family and nation from immorality are enhanced by politicians such as Iurie Roșca, the Deputy Speaker in the Moldovan Parliament until August 2009 and leader of the Popular Christian Democratic Party (PPCD) claiming they are defending the nation’s Christian as well as national heritage through opposing immorality. Religious groups and denominations themselves also employ language that is designed to ‘other’ unacceptable behaviour and groups. This is perhaps best demonstrated by the regular use of the adjective *imoralii* used in place of a noun when referring to homosexuals and those who support them – ‘the immoral’ (*Moldova Creștină*, 2009a) – which serves to dehumanise, shame and stigmatise, and strengthen the view of the ‘righteous’ as ‘under attack’. It also serves to present ‘the nation’ as heterosexual, moral and family-oriented.

The discussion of religion in chapter 2 of this thesis is extremely pertinent to the specific situations faced by society in contemporary Romania and Moldova. The linking of Christianity (specifically Orthodoxy, but also Christianity more widely in non-Orthodox sources) with the nation is common in religious media, with frequent references to the nation as being Orthodox, with the implication that to be a true Romanian or Moldovan a person is automatically Orthodox. Many religious sources also champion national(ist) heroes such as the nineteenth-century Romanian poet Mihai Eminescu or the contemporary Moldovan poet Grigore Vieru (who died in 2009)⁸. This highlights the supposed religious basis of their writing and thereby claiming a linear heritage not only to the holy family to legitimise their religious authority but also to these nationalist figures to legitimise their identity and heritage as the repositories of what it is to be truly Romanian/Moldovan. In addition the use of familial language and rhetoric, with both church and nation considered in familial terms such as *Patria* (fatherland) and the family championed as the ‘basal cell of society’ further serves to reinforce the perception that to be a true Romanian/Moldovan means both to be Orthodox/Christian and to be committed to a particular expression of what family means. From this point it is then relatively easy to declare which activities, policies and behaviours represent alien values, and which therefore can and should be resisted.

The struggle for control therefore not only of people but also of discourses and meanings is still very much active. Appeals to Christian/Orthodox identity and morality in opposition to issues such as abortion, sex education, homosexuality, and contraception are discursively linked to nationalist concerns such as the low birth rate, in order to add validity to the argument (in other words these issues are not only spiritual concerns but also national concerns). If objections are only presented doctrinally they are less powerful outwith the institution concerned. If however (as in both Romania and Moldova) they are couched as national concerns, they gain a wider constituency. Religion is thereby presented as the guardian of both moral, spiritual, *and national* identity.

Because the religious worldview is cosmic, and linked to notions of salvation, sacredness, a higher law, with the territoriality of the nation moving from ‘sovereign’ to ‘sacred’ (Friedland, 2002), secular projects such as sex education, promotion of gender and minority rights, ideas of liberalism, contraception, etc are seen as challenges to the rightful,

⁸ For example, Laurențiu Dumitru (2009) cites Eminescu’s quote “Whoever opposes Orthodoxy is not a Romanian”, whilst *Moldova Creștină* (2009b) in an obituary of Grigore Vieru refer to him both as “one of the greatest people of our land (*neam*) not only for this time but for all centuries” and refers to how “the wonderful way he lived and how he witnessed to our Lord Jesus Christ, gives us hope that the poet was born again and that we will have the happiness to meet him in Heaven”.

'higher' morality of the religious project. So programmes such as *Deprinderi de Viață* are not just attacked for promoting promiscuity, but are denounced as attacking the fundamental basis of state, life and cosmos. McGuire (1990:288) too highlights the importance of body symbolism in both individual and corporate cosmologies – concerns about the body are often used as “metaphors for social concerns” (ibid. p.289), which is clearly reflected in debates in Moldova and Romania around ‘maiming motherhood’ (Turcescu and Stan, 2005) or contraception as damaging to potential future fertility (Ciobanu, 2006).

Friedland (2002) also discusses the relation of religion to the body and family. The state is framed through the use of nationalist discourse as a sacred space as well as symbolically feminine. It therefore has boundaries which can be penetrated – by both alien values and foreign money - and so need protection. These nationalist discourses were used to great effect in Moldova against western funding for a national curriculum for sex education in 2005-6. They also reflect Orthodox discourses of the purity, boundedness and inviolability of the nation-state. Likewise, the family is identified as a crucial site for disciplining and containing sexuality, and a site within which discourses against so-called anti-family issues (abortion, homosexuality, birth control, sex education) can be framed and given legitimacy. Women’s material and reproductive bodies are figured in parallel with the territoriality of the state, and both are regarded as bounded sites of reproduction. Abortion and contraception can therefore be framed as threats both to the woman, through claims that their future fertility will be adversely affected (Ciobanu, 2006), and to the nation through laments around falling birth rates, state dysfunction and divine judgment (Friedland, 2002, Dillon, 1996:32). Physical reproduction is therefore seen as a central representation of cultural reproduction (Friedland, 2002), and the family is seen as the crucial underpinning of such cultural reproduction. The next chapter goes on to discuss in more detail perspectives on the family, as the site both of the debates and battles around sexuality and reproduction and of their lived experience.

4.7 Local interactions with international actors and discourses

Having discussed the main players and context-formers, this chapter concludes with a consideration of the interaction between two of these institutions, namely civil society service providers and international partners. Earlier this chapter state-civil society interaction was explored and the notion that NGO providers saw themselves as more progressive due to their alignment with western donors and discourses was identified.

However, whilst aligning themselves with the progressive, ‘modern’ discourses and practices of the west, NGOs did not always experience this positionality unproblematically. Although many socialist practices and ideologies with respect to the provision of health services had to some extent lost their legitimacy, imported western ideas and ideologies did not necessarily affect wider consciousness (Zhurzhenko, 2004:24) or have an entirely positive impact on how services were able to develop and become sustainable. Many NGOs discussed the priorities of their donors, and occasions where their activities were restricted due to lack of funding or donors concentrating on other issues. It was not necessarily that they disagreed with the fact that these issues were important (in fact many times respondents were very committed to them), but more that the details of the interactions and ultimate decisions did not always coincide between the local and international partners. Thus a Romanian development consultant talked about donor decisions not necessarily representing the needs on the ground, and whilst clearly reluctant to criticise the donors, suggested that their choices could have been different (and better):

... many times programmes are practically driven by the priorities of donors, for example in the project ... I worked in in Romania ... donor organisations ... chose ... the pilot counties ... [A]ny type of intervention is very good, but ... in Bucureşti, for example, in the capital of the country there weren't any interventions, there was just one in the year 2000 ... a single one of a single day, this is absolutely insufficient for a city with 2 million people in which reproductive health programmes categorically aren't provided even today.
(02MI)

Likewise, a Moldovan NGO manager and consultant discussed the problems of donors only funding ‘hot topics’ (in this case human trafficking)⁹, suggesting that the currently ‘chosen issue’ often guides donors into making less wise choices about local partners, and local organisations orienting their activities to attract funding to treat symptoms rather than tackling underlying causes:

... we need to teach donors as well to work not only through their own ideas of programmes, but to work in the context of the needs of the country. ... [I]n ... the last 5 years, [there are] only projects in trafficking. So for violence it's difficult to gain any ... resources, my donors are simply reluctant. ... I've made a huge effort to demonstrate that in fact one of the causes of trafficking in the Republic of Moldova is family violence. Around 70-80% of ... victims of trafficking ... were victims of violence. So it seems to me that donors as

⁹ See also detailed discussion of donor insistence on funding particular issues to the exclusion of other more locally-identified needs in Ishkanian, 2004, and Hemment, 2004.

well need to be more responsible in selecting their priorities and even in selecting their partners with whom they work here¹⁰. (19MI)

Many respondents, particularly in Romania, also talked about the difficulties of planning ahead when they mainly received grants for specific time-limited projects, both in terms of ongoing running costs, planning ahead for the future and even having to spend large amounts of time applying for funding rather than undertaking activities. This is a common issue (see Kay (2000:190) and Flynn (2006:254) for examples from Russia) outlined here by two NGO managers from Romania:

Most funding is for a specific project ...[C]osts for salaries and office rent ... need to be found. ... [T]hey want to simply finance activities, projects providing materials or legal services ... and this is a problem. (02RI)

... we can't think about 5 years [in the future], because all the time we're writing grant applications, ... we can write projects, and it depends as well on the budget we have allocated, it's more ... difficult to think about that now. (06RI)

Something that all these quotations highlight is the tension around who decides what the needs are in a society and how they are to be met, with local NGOs often having relatively little say in how things are done 'on the ground' as they are often constrained by the terms of their time-limited grants. State providers also experience a similar powerlessness due to a lack of funding and facilities and constraints placed upon them by policy makers. Donors have often been criticised for imposing their own assumptions on recipient communities without being fully conversant with the historical and socio-cultural context (Wedel, 1998; Sampson, 1996), as well as defining priorities and concentrating on efficiency and management at the expense of a more political agenda (Einhorn and Sever, 2005). This leads not only to problems with the organising and financing of projects and programmes, as outlined here, but also potentially with the production of meanings. In the context of the services in this research, meanings of 'health' and 'morality' were particularly pertinent – health as many of the services were being carried out within a public health framework, and morality more implicitly as the concepts of sexuality and reproduction are so contested by different institutional interests. Working in the field of sexual and reproductive health is not a values-free operation, precisely because all activity (even the ostensibly rational, scientific and “neutral” approach of public health) involves making judgments on what is healthy and what is appropriate health behaviour.

¹⁰ My transcriber, who herself worked for a small NGO which had a project in the field of trafficking, told me after transcribing this interview that she had never before considered the importance of working out and tackling the causes of trafficking; nevertheless this NGO had been able to attract donor funding despite this significant omission.

It was clear from speaking to practitioners that it was not just in the area of financing that the west and donors had had an influence. Several who had had extensive contact with western organisations and discourses also talked about issues such as gender and rights, concepts that are familiar in the west but less so (or, more accurately, often used differently¹¹) in the wider society in which the services are being provided. For example, Moraru (2006:113) highlights an explosion of new terms in Moldova, including gender, leading to a need to educate the population on the need for gender equality and to ‘sensitise public opinion and disseminate throughout the population ... to integrate the gender dimension in all areas of life’. This is doubly important as gender in particular is a term contested not only in terms of the respective social, cultural and political positions of women and men, but also because it has been misinterpreted by certain church groups involved in the opposition to the *Deprinderi de Viață* sex education course as being synonymous with homosexuality (Ciobanu, 2006). Also problematic is that these terms are largely only available to and used by educated people and organisations with contact with and commitment to western organisations and discourses, with large sections of society either unwilling to accept them or not convinced of their relevance in the local context (Kalb, 2002:319; Rivkin-Fish, 2005a:62-63).

The following two examples, from urban NGOs in Romania (firstly a volunteer, secondly a manager) show clearly how the organisations see themselves as having a role in educating the majority (specialist and lay) in changing societal attitudes and widening knowledge in order to become more ‘progressive’. Both felt that the concept of rights was at the core of their work (unlike in society as a whole and many state services where rights were considered neglected or unrecognized if not violated):

... I came here because I could help bring the attitudes [about sexual discrimination] of others to another level and also because I want to help people who don't have the knowledge about female reproduction or how to protect themselves in the case of violence in the family. (18RI)

... there are many people and specialists who don't see the true magnitude of what sexual and reproductive health means, or to put it better in English, it's difficult to translate in Romanian but in English is “Reproductive Health and Rights”. Yes, so sexual and reproductive rights as well. Many don't understand why an institute of reproductive health is concerned with violence in the family. They don't understand that this is included here ... For very

¹¹ For example see Turbine's (2007a) discussion on how legal and human rights are interpreted at the local level by women in Russia in somewhat different ways to their use in western discourse, where they are often assumed to have universal meaning.

many people, reproductive health means contraception and abortion, and that's it. (15RI)

Although rarely articulated in these terms, notions of 'civilisation', of modernity and progress, were never far from the surface. Kay (2000:176) identifies a similar process at work in women's organisations in Russia criticising 'backwardness' and 'Soviet mentality' and speaking of the need to 'raise ... consciousness' - all criticisms and 'needs' which were expressed to me by respondents in both countries. Mandel (2002:286) and Sampson (1996:141) discuss the manipulation and co-option of western concepts and priorities in order to procure funding. I do not mean to imply that all NGOs do this; indeed many with whom I met were clearly committed to the principles of rights and equality as espoused by western feminist theory and believed them to be vital in improving the situation in their locality and country, such as this NGO manager in Romania:

... the first thing which is a difference between state services and ours is the training we've done through courses, especially those based on western principles, courses on human rights and we try to inspire the volunteers who come here, from the first sessions we do with them we always encourage this attitude towards people. (02RI)

However the importation and dissemination of discourses around issues such as rights was neither simple nor uncontested. The following quotation from a Moldovan gender consultant illustrates the confusion around rights as a public or private issue:

[P]eople don't understand that in fact violence in family is a human rights issue ... The majority think that it is an individual problem ... In the context of human rights we don't have the right to enter into the family ... (19MI)

This quotation highlights well a problem of communication, of meaning, which appears common in both countries, but especially Moldova, namely that different actors with different priorities and positions on sexual and reproductive health use the same terms but mean something completely different by them (as highlighted by the extreme example of misinterpreting the term 'gender' noted above). In this case some actors consider domestic violence to be a human rights issue, but others also use a contradictory understanding of rights to insist on their right to privacy within the family, free from outside interference¹². As Gheauş makes clear, though, the

¹² Of course this is not an exclusively Moldovan (or even post-socialist) issue; however the legacy of state intrusion into private life and the different legacy of gender and rights under socialism means that the tensions inherent in the different meanings and interpretations are reinforced.

concern is that whilst the private (family) sphere is protected by principles of non-interference, injustice within that sphere will only be perpetuated (Gheauş, 2001:183). The use of concepts such as gender, rights, health and healthy behaviour (as understood by donors and by the western groups and activists to whom local activists and service providers look and aspire, and which featured for example throughout the *Deprinderi de Viaţă* sex education programme) in countries where these discourses may not yet be meaningful (Grunberg, 2000:318) becomes a contest over how ‘morality’ and ‘health’ are interpreted and articulated. Opposition to programmes aimed at enhancing sexual and reproductive health and rights is often framed in terms of an immoral imposition from external actors who do not understand or have any interest in local moral understandings. The power to label behaviours as moral, or as healthy, in this way is indicative of relative levels of power in society (Fischer, 2006). As such, sexual and reproductive health care provision is an area where the contestation of meaning is so vociferous, as it also feeds into debates on national vitality and sustainability and challenges who has the power to control behaviour and ideology.

When discussing gender and reproduction, respondents often also mentioned the role and influence of donors and of international obligations. Similar issues arose here as in previous sections – namely the positive and negative impacts of donor involvement, and the idea of progress related to international standards.

Donors and other international partners were seen to have been a positive influence in providing for programmes, with international campaigns often co-opted at the local level. For example, in describing her organisation’s activities this NGO worker in Romania identified how their activities are often planned around these campaigns:

... [our] Gender Equality Festival which takes place in autumn ... and those International Days for Combating Violence Against Women, those 16 days when we are involved with different institutions. These are our annual activities. (06RI)

International funding and assistance bodies also played a large part in providing training and large-scale policy evaluation and reform in areas related to gender and reproduction, in Moldova collaborating well together:

WHO will design and implement 4 teaching modules around the priorities of the reproductive health strategy. This training will be for doctors in reproductive health

clinics, this is a project in collaboration with UNFPA. WHO is responsible for the areas around domestic violence, men's health, older people's health, and genito-mammary cancers. Now, with WHO support, there is a large programme in the Republic of Moldova, an evaluation, research, a large strategic evaluation of abortion and family planning services. (23MI)

In Romania too, international funding was seen as crucial in advancing political reforms and progressing to a more holistic and progressive position:

... a political programme started, establishing policies about reproductive health with these same [non-governmental] organisations, all financed by USAID, through CEDPA¹³ ... more precisely a series of workshops ... to develop a minimum package of services around reproductive health and funding contraceptives and about state budgets and health insurance; this was absolutely new in Romania, already now we talk of the term reproductive health, a transition from family planning to reproductive health ... (02MI)

This quotation clearly shows the positive impact of donor funding and activity to develop services and legislation and an acknowledgement that alongside technical and structural changes, significant discursive changes can also take place.

International involvement in political reform has not always been unproblematic in the area of reproductive health however, for example the same respondent also acknowledged the impact of political and ideological influence in the donors' home countries impacting and limiting the extent of positive activity:

The American political administration has had a positive influence, certainly, in developing the non-governmental reproductive health sector and even the governmental sector in Romania, but there were restrictions with regard to abortion services and this means they were only involved in a part of reproductive health ... (02MI)

Nevertheless, political currents internationally were seen as crucial in ongoing reforms locally:

... the biggest problem [in] financing was this American administration restriction on abortion services, this restriction was launched at the 2nd International Conference for Population and Development in Mexico City in 1984, in Ronald Reagan's time, this ... so-called "Gag Rule" or "Mexico City Policy" ... [it] worsened in the time of President Bush (father), relaxed in the Clinton era and then once again worsened under Bush (son). And I hope that ... in the future, I don't know perhaps a president like Hillary Clinton, who would again relax the policy of the American

¹³ Centre for Development and Population Activities, a Washington-based NGO.

administration from the point of view of reproductive health, because this is what's needed, *this is the reality*, whatever political forces think, whatever women think, long history throughout the world has demonstrated that they will have the number of children they are able to bring up and choose death rather than having unwanted children ... the negative impact is not only on maternal mortality for example, but also on children, who were shown in Romania to be ill-fated, becoming orphans, institutionalised children, institutionalised in Romania as the result of pronatalist policies. (02MI).

Laws around sexuality and reproduction 'mark the political front line between the personal and the public' (Thomson, 1994:40), whilst contestations and debates around morality and sexuality, and the specific interventions undertaken, 'themselves mediate concerns about nationalism, geopolitical relations, and post- or neocolonial identity politics' (Pigg and Adams, 2005:2). As such, 'discussions about human reproduction have an enormous power to moralize politics because reproduction is already constituted ... as a natural, primal phenomenon involving the most fundamental issues of life and death' (Gal and Kligman, 2000a:29). What is ultimately at stake is the power to define the moral and the healthy, and this has a direct impact on the design and provision of sexual and reproductive health services.

A number of respondents pointed to the need for international obligations around reproductive health and gender to be respected and for governments to be held to account. In this sense international norms can be seen to be a positive influence and a site for action and advocacy:

Here we need to [act] ... from the perspective of the Republic of Moldova's international obligations ... the Convention on Elimination of all forms of Discrimination Against Women ... the UN Committee has a particular point where the government's responsibility to ensure sexual and reproductive rights of men and women including recommending the introduction of sex education into the education system is stipulated. (19MI)

To start with [we need] new laws like the situation in developed countries, with the action plans from international conferences for population and development needing to be implemented ... to monitor action and then to hold them responsible for what they do or don't do. (02MI)

In the area of gender as with others already discussed, a sense of aspiration towards 'the west' was commonly articulated by respondents. As well as notions of 'developed' or 'civilised' in relation to sexual and reproductive health policies, the attraction of *peste hotare* for individuals was also discussed in relation to gender roles, with 'the west' seen as

progressive and desirable not just in material terms but also in terms of gender attitudes, as articulated by this respondent who was involved in social theatre/education in Moldova:

[Women] are not treated well by men ... Women leave, they go abroad (*peste hotare*), and ... see lots there ... men there are more considerate ... so they leave and get married there. (15MI)

This idealised (and somewhat essentialised) view of romantic life and greater respect for women in the west nevertheless exerts a strong pull. Similarly, tradition was viewed by a number of respondents as a step back from progress, complementing the sense of western life as representing progress and modernity. As an example this Moldovan NGO manager and gender consultant laments traditional views of women, relating back to Soviet times and by implication aspiring to more progressive values:

You can ask how this traditional attitude still exists around women's 'capacity'. Basically there are two aspects, one is the role in family and society, the woman should take care of the family; the other ... is women's capacity ... they are inculcated with another logic, ... emotional, sensitive, and politics is too dirty a business [for them] ... Women have this double burden. Family, work, and social activities. (19MI)

The acknowledgement of and attraction to international standards and legislation around sexual and reproductive health and gender was manifest, both implicitly and explicitly, among most of my respondents. However this was tempered by acknowledgements that donors sometimes could be counterproductive in their influence, as with this respondent who was discussing the need for more services aimed at men:

Above all we need [programmes/laws] to encourage men's responsibility and with projects on ... sexual violence and domestic violence, and with social policies, these should be integrated. They've started a bit to be integrated, but I think they haven't succeeded well because a problem is that donor organisations don't work well in partnership and so they each want to have their own domain which they lead and are the head. (02MI)

In addition respondents in Moldova acknowledged that an over-reliance on donors was not a sustainable position in sexual and reproductive health provision, particularly with regard to contraceptive supply, and there were implicit concerns that the government was relying on donated contraceptives rather than working to find a way to provide them from state budgets:

But the problem with reproductive health ... these same contraceptives are [in the insurance system] because of donations, when the donations stop we'll no longer have any [contraceptive] pills. (16MI)

Today contraceptives aren't paid for from the budget, there is no budget for procuring contraceptives. All contraceptives in the Republic of Moldova come from UNFPA and [from other] international donors, but the principal donor for the Republic of Moldova is UNFPA for contraceptives. They're distributed in reproductive health clinics and distributed free for vulnerable people. This has always been the case. But, it needs to be clear for the Ministry of Health, for the government, that international organisations including UNFPA can't always provide this support. There needs to be money in the budget to procure contraceptives and to ensure the continuation of services. (11MI)

The balance between accepting and relying on international donors to provide support and modernise services on the one hand, and developing the capacity to become self-reliant in the face of competing priorities and discourses on the other hand, is an ongoing dilemma for policy-makers and service providers on the ground.

4.8 Societal views of international discourses

As well as service provider views of international discourses, during the course of the media study undertaken as part of this research a number of debates around western values and involvement in sexual and reproductive health (and demography more widely) were frequently found in media accounts. Often the concern about the danger to national integrity can be seen in coverage of the involvement of western donors and discourses in sexual and reproductive health programmes. Coverage of homosexuality and abortion for example often cites European norms and anti-discrimination legislation and implies that moving closer to Europe will require the relinquishing of national values (of moral decency) and the accepting of European decadence and depravity. Europe is also blamed for demographic problems, as evinced in the *Moldova Noastră* (2008) headline "Romania after EU accession: fewer births, divorces ... many", and both EU countries' and national government support for homosexual rights organisations such as ACCEPT (Romania) and Gender-Doc-M (Moldova) are exposed and criticised (*Moldova Creștină*, 2008c; *Curentul*, 2009a). The United Nations too is targeted as the enemy of the family and of traditional morality, for example in this article from *Moldova Noastră* (2009a) entitled "The War Against Population":

"The latest declarations of some UN representatives make transparent the intentions of these world organisations through their policies of the control and reduction of population but also through the undermining of traditional values. At a colloquium

held in Mexico City, Mexico, one of the leaders of the United Nations Population Fund, Arie Hoekman, declared that far from constituting a crisis, the destruction of the traditional family and the conceiving of children outside of this stable framework represented an opportunity to destroy the old, patriarchal, world, in which the family is a basic pillar. For the UN representative, the crisis in the family represents a triumph of “human rights” against “patriarchal society”: “More than a crisis, we are experiencing at present a weakening of patriarchal structures resulting in the disappearance of its economic basis of support and thanks to the appearance of some *new values centred on recognising fundamental human rights.*”

At the same time though, coverage of the influence of the west is somewhat ambivalent, with “Europe” and “Europeanness” seen as a goal to which to aspire as well as something to fear. Popular discourses of “return to Europe” and a “general trust in Europe as a historical warrant of successful market transformation and democratization” (Roman, 2003/2007:63) are widespread in the local media and hence in local discourse. Drazin (2002) highlights how even seemingly simple choices such as cleaning products can represent a sense of progress and modernity, away from the past but also away from the perceived backwardness of the local and familiar and towards the perceived cleanliness (and thus modernity) of the west. Shove (2003:82) argues that cultural and consumer practices “indicate a reconfiguration of social ideals and orders within, but perhaps also between and across societies”. This is arguably also true of “reproductive consumption” (Fletcher, 2006) and, arguably, sexual consumption also, which is evolving and drawing on ever wider sources of legitimisation. No longer is the local tradition the sole arbiter of what is right or moral. This reconfiguration is by no means uncontested, however. My respondents variously compared their situations unfavourably to how they perceived western life to be, referred to the importance of meeting international standards, referred to the west as “civilised countries” or in the case of one Moldovan respondent worried about being “left behind” should Moldova not eventually join the European Union. However, in popular discourse ‘Europe’ and ‘the west’ are often criticised for their lax morality in issues of sexuality and reproduction and also for a sense of imposing external values. Similarly a commentator in Romania on an article about the unsuccessful campaign to vaccinate girls against Human Papilloma Virus commented thus:

“This so-called vaccine has side-effects including death, infertility, terrible migraines and is banned in the US and Canada. It was imposed on the Romanian population (110,000 – this is a simply catastrophic number: Romania won’t exist longer than 50 years if this injection is given to girls or women) to decimate us. There are plans let’s say, the demonic European Union, they are after our land, fertile but without a native population” (Curentul, 2009b).

Another, talking about the authorities behind the HPV vaccine, stated “They thought like “Europeans” who reading ro, -rom on identity cards or passports “understood” gypsy. Perhaps “give” them the vaccine! But 98% of girls – no!” (*Gândul*, 2009a)

These are of course extreme responses, but nevertheless appear regularly in online fora and debates. However, this paranoia is not universally accepted. In this same debate on the HPV vaccine issue, one commentator suggested:

“One of the reasons the campaign was not successful is the ignorance and foolishness that some of the Romanian population struggle with, with brains surrounded by drink and *manele*¹⁴, without being able to discern what is good and what is bad. The publicity was fine” (*Gândul*, 2009a).

The notion of local/eastern mentality and even backwardness that this quotation seems to imply was one that was raised by a number of my respondents. The tension between hostility towards a perceived imposition of values and aspiration to a sense of moving towards a more civilised life and polity as part of Europe is common, and is important as it is played out not only in the discussions following media articles, but also at the policy and legislative level (the development of the *Deprinderi de Viață* course in Moldova and the failure of the HPV vaccination campaign in Romania being good examples of this).

Positive portrayals of the west and of international donors more generally in relation to sexual and reproductive health issues were more common in Moldovan than Romanian media (of 61 broadly positive articles, 51 were from Moldovan sources). The vast majority of the Moldovan articles were factual accounts of donor activity (particularly that of the UN Population Fund, UNFPA), primarily of grants to improve areas of the health system, such as modernising maternity hospitals or donating equipment. There were however also reports of agencies challenging the government on promised reforms, and also discussion of the role played by agencies in issues such as gender and domestic violence, and of a UNFPA-sponsored pro-family festival¹⁵.

¹⁴ *Manele* is a popular and pervasive form of pop music in Romania influenced by Balkan and Roma culture (Roman, 2003/2007).

¹⁵ This Festival of the Family attracted both positive and negative coverage, with some religious groups denouncing the organisers as “enemies of the family” (*Moldova Noastră*, 2009b). This suggests that efforts by agencies working in this field to engage with conservative criticism in more ‘traditional’ areas will not be an easy task. Some of the rhetoric contained within the articles promoting the event also suggest that some areas of contention (around issues such as sex within or out of marriage, and the role of family planning methods and abortion), were placed to one side rather than tackled directly, which could lead to complications should further collaborative work take place.

In addition the majority of pro-western articles were in the largely pro-western independent newspaper *Timpul*. However even conservative publications such as *Flux* (funded by Iurie Roşca, leader of the Popular Christian Democratic Party) carried some positive and largely uncritical coverage of western agencies' involvement as well as some more critical and polemical pieces.

In Romania as in Moldova the bulk of positive articles were about donations from agencies to improve services. There was also coverage of the issue of bringing local services up to 'international standards', again reflecting the aspirations voiced by many of my respondents in Romania, particularly those in the state sector.

4.9 Conclusion

The institutional landscape within which services are provided, encompassing state and civil society, local, national and international actors, as well as external forces such as religion and mass media, mean that contestation around sexuality and reproduction are probably inevitable. As well as specific issues relating to sexuality and reproduction, power and status are continually sought and challenged, with the power over who decides on meanings – or the power to define that which is deemed normative – particularly contested. Sexuality and reproduction, with their links to national vitality and identity, are two important areas where this power and status is challenged. When combined with health, which features powerful voices and interest groups both within (medical professional dominance) and without (governmental and international policy makers), alongside powerful external forces such as religion and the mass media, it is clear that the potential for contestation is great. Within this contested arena, services in all sectors attempt to set out the justification for providing their particular services.

In many cases, the interaction between the various sectors can be characterised as “reluctant interdependence”. Civil society groups, even if set up originally to fill an identified gap or challenge state services, often require local authority support to undertake at least some of their work, whilst the responsibility for dealing with complex cases mainly remains largely the preserve of the state sector. State services such as family doctors and hospital health services also recognise that in certain areas NGOs have a specialism which can benefit their clients and make referrals if appropriate. Both state and civil society sectors have relied on international influence – in the state sector health care reform has largely been driven with the support of multinational agencies such as the UN and WHO,

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whilst civil society organisations remain almost entirely dependent on international donor funding to continue not only individual projects but also their continued existence. Whilst appearing particularly powerful in this equation, however, the opposition from conservative groups to programmes such as sex education and the provision of birth control means that multinational organisations too rely on the goodwill of national partners.

In this chapter, service providers have been shown to be trying to make sense of their place in overall sexual and reproductive health provision and also to identify their own particular role within that provision. However the wider context, influenced by international donors and transnational organisations, as well as other institutional forces in society particularly religion, is shown to provide both enabling and constraining factors in their efforts to provide a service.

Chapter 5

Contested landscapes: demography, family and sexuality

This chapter continues the discussion of the context within which services are designed and provided by considering two issues, namely family and sexuality, which are particularly contested by the various institutions and providers discussed in the previous chapter. These two issues provide a richer contextual backdrop to the services which are provided (these services will be discussed in more detail in chapter 6). Within these issues, aspects of gender and reproduction are threaded throughout the discussion. The chapter begins however with a consideration of the concept of *ruşine* ('shame') as a concept which framed many of the discussions with respondents and also the media sources accessed for the research.

5.1 *Ruşine*

Within the academic literature, 'shame' is a concept largely tackled by the discipline of psychology. Shame was discussed in the early works of Sigmund Freud (such as "Studies on Hysteria" from 1895), but by 1905 he had denounced it as the "master emotion" in favour of his sexual drives theory (Scheff, 2000). Since then it was largely ignored or glossed over in the psychology/psychoanalytic literature until relatively recently, and with a few notable exceptions poorly defined if at all – it was often assumed as synonymous with 'guilt'.

It is clear that 'shame' as a term is used in different ways, with lay interpretations not necessarily the same as clinical ones. Also, the concept of 'shame' is more subtle and nuanced in most European languages (including Romanian) than it is in English – it can denote shame, shyness, embarrassment, guilt, inappropriateness – and certainly my impressions from my interviewees was that embarrassment was important, but also 'fear of social stigma'. Respondents I specifically asked about the use of '*ruşine*' outside of the interview situation gave mixed messages about what they thought was meant. Some said that they thought people meant embarrassed or shy, others were equally sure that people were referring to something terrible or disgusting. These responses had initially broken down along conservative/liberal lines, with conservative/Christian respondents saying that people were referring to something terrible and more liberal/secular respondents saying that it referred to a mild embarrassment. However the more people I asked the less this

distinction occurred, leading me to conclude that elements of all these aspects are present in the overall concept of *ruşine*.

Fortenberry et al (2002) identified both shame and stigma as important barriers to accessing STI services. They identified stigma – “fear of negative social consequences” (ibid., p.378) as a key element in the “hidden epidemic” of these infections in the US, by keeping them hidden and taboo and therefore untreated. The authors identify stigma “as an attribute or label that sets a person apart from others and links the labelled person to undesirable characteristics” (ibid., p.378), whilst shame is defined as a negative emotion after a “failure in relation to personal or social standards”, where the person “believes that the failure reflects self-inadequacy rather than inappropriate behavior [sic.]” (ibid., p.378). The two are clearly linked as “separate but related constructs” (ibid., p.379), i.e. shame can be an internalised reaction to stigma. This has obvious application in my research – as particular behaviours, discussions, subjects (e.g. sex education, discussing sex in the family, buying contraceptives) are referred to and labelled as shameful, the effect is that stigma becomes attached (and internalised) to people who wish to pursue them (even if they are only pursuing knowledge and not actual behaviour). The stigma results in negative social consequences, conferring shame upon the people, and thus resulting in a cycle of silence which is transmitted across generations.

Fortenberry et al suggest that it is stigma rather than shame that is more important as a barrier to seeking STI-related care and services, and it may well be in Romania and Moldova that some of what was meant by ‘*ruşine*’ was fear of being labelled (for example as promiscuous). An important conclusion from this research, given the current civil society/donor/ government strategies around information-giving, is that “[i]ncreasing knowledge or health care access may not address the barriers posed by STD-related stigma” (pp.379-380). Of course better information and access will help matters, but in societies where there is a widely-held perception that “acknowledgement and discussion of issues ... connote approval of proscribed sexual behaviors [sic.] makes such approaches difficult to implement” (ibid., p.380).

Finally, Fortenberry et al identify previous research where lay health advisors (such as the peer educators used widely in sex education, drug education etc programmes throughout central and eastern Europe and the former Soviet Union) are “suggested as an excellent means for promotion of community norms of health sexuality and STD-related care” (ibid., p.380). However, they also highlight “a substantial body of social psychological research

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demonstrat[ing] the resistance to change of social stereotypes, especially in regard to conditions judged to be associated with irresponsible behavior [sic.]” (ibid., p.380). Use of peer educators is potentially useful in a country without an alternative infrastructure for large-scale education, but can only be a partial solution when societal resistance to their message is so strong. This issue is considered in more detail in chapter 6.

Abell and Gecas (1997:99) write about the importance of guilt and shame in the process of socialization, arguing that effective socialisation results in the individual behaving “in accordance with society’s values and norms because these have become important parts of the individual’s self-concept”. Hence the importance of being the group(s) controlling dominant discourses and definitions of what societal norms and values actually are – by controlling discourse, it is easier to dictate (and hopefully control) behaviour. Guilt and shame, according to Abell and Gecas, are used to “keep the individual developing in conformity with his or her group’s standards of morality, propriety, and competence” (1997:100), acting as “internal controls ... encourag[ing] and constrain[ing] individuals to conform to norms of moral and social conduct” (1997:100). The conservative and religious discourses outlined in this chapter and the previous one relating to norms and values around sexuality seem to assent to this in their didactic, even doom-laden tone.

Abell and Gecas (1997) also discuss the fact that guilt and shame are often used interchangeably, so that the distinction between the two is less clear. Much like the discussion above around shame and stigma, it appears from my respondents that both play a part as emotional reactions relevant to the social bond (with shame-proneness linked to personal distress, a lack of empathy and emphasis on self, whilst guilt is more associated with consideration of the social consequences of an action (ibid., p.100).

Importantly, Abell and Gecas highlight the family as the “context in which children are exposed to the standards for moral and social behavior [sic.], which become the basis for feeling guilt and shame. Family interactions and parental responses related to these standards influence how children come to understand themselves as individuals and to define themselves in relation to others and to the rules that guide interpersonal interaction” (ibid., p.101) – in other words, shame and embarrassment as demonstrated by parents become a learnt behaviour that is passed on to the next generation. Parental shame around talking about sex transmits that shame to the next generation and reinforces it as a taboo subject, identifying it as a subject about which “we” do not talk, resulting in a cycle of silence (in the same way as discussed above re stigma). The authors suggest that “the self-

concept is the basis for moral and normative action” (ibid., p.102), and argue that different types of parenting styles will affect how the self-concept develops. So a parenting style that is characterised by embarrassment and silence about a subject such as sex will transmit that embarrassment to the child without necessarily also transmitting the reasons why it is embarrassing, and the child learns to avoid the social shame of an action or discussion because of the threat to their relationship, rather than because of the inherent shamefulness of the action (ibid., p.119). It strikes me that this may also be the case with congregations and populations as well as individuals – because of a fear of disclosure and subsequent censure by the community, people will conform and perpetuate dominant discourses without necessarily thinking beyond the didactic pronouncements of church or government or NGO leaders.

The conclusions of Abell and Gecas’ study can also be applied in policy and programme development (especially given that arguably donors, policy-makers, church leaders and others in positions of power and responsibility take on a sort of parental role with regard to the target population, and also given that parental non-transmission of information about sex was a consistent finding of my research). “[R]esearch that does not take shame into account when discussing parental behavior [sic.] and its effectiveness in transmitting social and moral norms overlooks an important element in the process of socialization. Children may do what is considered moral or acceptable not because they understand their connections and responsibilities to norms or to others, but because of a fear of being found unacceptable or incompetent or being rejected” (ibid., p.119).

Scheff (1995:1053) highlights the linguistic ambiguity of the term ‘shame’ – in English it tends to be regarded as a crisis emotion, whereas in other European languages it is broader and less negative. French has two words denoting the concept, ‘*honte*’ (as English – negative connotations) and ‘*pudeur*’ (an everyday shame more akin to modesty/shyness/a sense of shame) (ibid., p.1054). There is an even wider lexicon of shame in non-European languages, with shame incorporating more consequences relating to social life (ibid., p.1054). Scheff does not attribute this to there being more shame in non-European countries and less in Europe, but rather that it is more likely that in Europe there is an “increase in undercover shame” (ibid.,p.1054). He discusses Elias’ (1978) thesis of shame in European history, which posits that until the end of the 18th century the principal sources of shame in modern society (bodily functions, appearance and emotions) caused little shame and were openly discussed. Teachers of manners discussed in great detail issues of sexuality, decorum and bodily functions, issues which were however from the 19th century

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no longer discussed as knowledge about them became taken for granted (ibid., p.1055). Importantly, this is also linked to decorum: “Silence implies that a well-bred person should know without being told, which is a shaming implication” (ibid., p.1055). Certainly this seems to be the case in issues of sexuality discussed by my respondents – sex is not discussed in families because to do so is ‘harmful’, therefore it becomes shameful to even wonder, and information is found from other sources (Scheff describes this as shame “denied to the point that it has gone underground” (ibid., p.1055)). Silence and shame are therefore socialised – as confirmed by one of my respondents who talked about not talking about sex in families as being “our tradition”. Historically, by the 19th century shame was “used to socialize feelings about sexuality, etiquette, and emotion” (ibid., p.1055), with an example given of a 19th century etiquette guide advising mothers to shame their daughters who ask about sex into silence, although the guide does not explicitly use the word “sex” at all. The use of euphemisms and roundabout ways of discussing the issue (for example “things of this kind”, “such matters” – reflected in Moldovan religious sources) merely reinforce and further socialise the sense of shame and perpetuate the silence (what Scheff refers to as “loops of shame”, with the shame of those pronouncing passed on to parents who pass it on to their children).

The effect of this inherited historical “social system in which politeness and delicacy result in an endless chain reaction of unacknowledged shame” (Scheff 1995:1057) is that a “veil of silence [still] interferes with the kind of sex education that would better prepare ... children for their real lives” (ibid., p.1057). This continuous shame cycle results in a “failure to obtain and use protective devices in sexual activity” and “[t]o the extent that children are socialized to be continuously embarrassed about sexual feelings and behavior [sic.]; to that extent their ability to think and act rationally in this area will be impaired” (ibid., p.1057).

Turner (1995:1061) illustrates how “the essential knot of our human predicament ... include[s] the problematic coexistence of a reflective mind with a smelly, sexed, and partly autonomous body”. This problematic coexistence seems to be something that is exercising both conservative and liberal camps in central and eastern Europe and the former Soviet Union. On the one hand, rational argument is championed by liberal/secular actors, but they do not appear to have touched upon the visceral, emotional sway of the conservative arguments of shame and morality and national values and identity. On the other hand, the conservatives use visceral, emotional arguments but want to control the smelly, sexed body in ways that are entirely rational (for example, sex being only heterosexual, only within the

institution of marriage, only or primarily for procreative purposes, etc) but which do not accord with the views of many members of society.

Tangney (1995:1132) suggests that previously unnoticed distinctions (in this case, between shame and guilt) result “in a clearer understanding of the processes involved and their implications”. This is meant in the context of clinical science, but is arguably also true in social science. There seems to have been minimal previous research in central and eastern Europe and the former Soviet Union in the context of sexual and reproductive health looking at the tensions related to the promotion of individual rights-based approaches in a traditionally collective society where both individual and collective shame are still apparent. Studies considering the subtleties and nuances of these different approaches and societies therefore have the potential to provide clearer understanding of both processes and implications.

Tangney (1995:1132) explains how shame is generally linked with guilt as “moral emotions”, and certainly in both Romania and Moldova it certainly seemed the case that they were used in the context of sexuality as a ‘moral battleground’. Both shame and guilt are considered emotions “that inhibit socially undesirable behavior [sic.] and foster moral conduct” (1995:1132). In the case of *Deprinderi de Viață*, the detractors tried to use shaming language to foster guilt – for example, “when you give your child a condom, you make a whore of your daughter and son” (Ciobanu, 2006) – by prolonging and reinforcing the sense of shame, they were trying to encourage and control so-called moral decency and behaviour. Also, by this process of discourse control, they were able to prolong control over people’s actions and behaviour relating to sexuality, perhaps a key battleground particularly as young people tend to be less likely to accept conservative/church influences and aspire to a more westernised/individualistic lifestyle.

Tangney (1995:1137) also suggests that it is a consistent research finding that “shame often motivates an avoidance response”. In the cases of Romania and Moldova, the elevation of sex to a completely taboo subject means that the avoidance response of silence is socially appropriate to employ.

From the perspective of literary criticism, Bologna (1986:18) suggests that “[t]o want to enclose shame in static rules renders legislation on public morality as absurd as it is arbitrary” (translation mine) – in other words, trying to legislate for what is moral and what is shameful is an arbitrary exercise which fails to capture the complexities of the shame-

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morality continuum. However potentially problematic is the position of the liberal/secular groups who are trying to promote openness around sexuality and reproduction, who also seem to be missing the complexities of the shame-morality continuum – non-judgmental and impartial material is presented in order that people are enabled to make up their own minds, but this has been rejected by large parts of the population.

Shame is posited to be “in perpetual combat between instinct and reason, between conscious and subconscious, between individual and society” (Bologne, 1986:20), and as such can be hypothesised as “the feeling which checks[or holds back] the accomplishment or consideration of all actions (bodily shame) or their representation (artistic shame) condemned by a personal moral code (prudishness) [*prudibonderie*] or *characteristic* of an era and of a given place (*pudeur*/shame), through respect for oneself (individual shame) or for others (social decency)” (ibid, p.20, translation mine). This captures the dynamism of the emotion and the experience of shame in a very rich way, and all of these aspects – checking one’s behaviour due to individual and wider social norms and values which are mediated through historical and geographical context – have been important in the analysis which follows.

5.2 Demography, emigration and national identity

As a precursor to the discussion on the family and sexuality, the second section of this chapter will consider views by media and respondents on demographic issues more widely. Respondents in both countries were well aware of the socialist ‘legacy’ of pronatalism and concerned that the negative aspects of this could return; however many media sources and public comments on media articles expressed concern about the so-called ‘demographic crisis’ and called upon politicians and people to resist outside forces and once again reunite the act of reproduction with the greater needs of the nation. A consideration of the socialist legacy and pronatalism is also therefore included in this section.

A number of the issues raised in the media (particularly homosexuality and pregnancy/abortion) often contain references, either within the article itself or in the public comments which follow, to demographic concerns. Falling birth rates, a decrease in the popularity of marriage and rising rates of STIs are often discursively linked to sexual and reproductive ‘deviancy’ and framed as a threat to national integrity. In addition, the migration of many people of reproductive age, as well as health professionals, is a cause for considerable alarm. Although religious commentators often link the ‘demographic

crisis’ to both spiritual malaise and the relative liberation of sexual mores, they are by no means the only ones.

In general, the term ‘decline’ (*scadere*) is used in headlines rather than ‘crisis’, but this is not always the case. For example, a report from *ProTV* Moldova (2008a) was titled “On the brink of a demographic catastrophe”, and continued:

“The Republic of Moldova is on a razor’s edge with respect to the demographic situation. Every fourth young couple cannot have a child, and the number of abortions is maintaining at the alarming number of 14 thousand per year, in consequence the Moldovan population is getting older with every year. Experts assert that the main cause of this crisis is lack of information and propose that an obligatory health education course should be introduced in schools”.

This report is interesting in that it links the ‘demographic crisis’ firmly with issues of reproduction (as opposed to the large-scale emigration of the population), and the ‘health education course’ is a reference to the proposed replacement of the *Deprinderi de Viață* sex education course. In response, the Baptist site *Moldova Creștină* (2008d) countered in an article entitled “Why has Moldova come to the brink of demographic catastrophe?” that the reasons stated in the *ProTV* piece were false – that a large number of sexually transmitted infections and lack of information for young people happen despite “seminars one after the other about how to protect yourself with a condom” – and in fact claims that sexually transmitted infections are due to sex education itself rather than the lack of it. This article ostensibly about demography was used to propagate opposition to sex education and the immorality it supposedly promotes. A few months later another article (“What is the true reason for demographic decline?”) in *Moldova Creștină* (2009) added homosexuality to the list of causes of demographic decline:

“Today, the Moldovan Democratic Party (PDM) published a press release in which they state that demographic decline is endangering the future of the Republic of Moldova. It is good that at last even they have seen this, at least now, during the electoral campaign. But perhaps it was the case that they could see the contribution that they have made to this decline through the fact that they are encouraging immorality and the immoral (*imoralii*). Indeed wasn’t Dumitry Diacov the one who declared previously in an interview with *Ziarul Liber*, “You know there are a series of liberties which do not arouse suspicions, but why does sexual liberty need to arouse so much suspicion? Why? I repeat, we are and we will be more tolerant than the others!” How can those in the PDM try to have us believe that they care about the future of the country and the state of the family, when they are the only party which openly supports and promotes all sorts of homosexual organisations and their so-called “rights”? Who are they trying to fool? I’d not be surprised if one day Diacov who is pleading for “sexual freedom” and the party he is leading come up with the initiative of a law through which incest would be legalised, as some

politicians in Romania are trying to do now. God protect us from the lies and wickedness of these people”.

Even in the non-religious press, judgments on non-traditional forms of family and morality are present in accounts which are ostensibly about demographic issues, such as this quote from *Flux* (2009a): “An alarming sign in 2008 was the high level of out-of-wedlock births, the balance of children born outside of marriage being 22.3% (around every fifth child was born outside of marriage)”.

Identity, particularly national identity, was not an issue which arose much in my interviews, with the exception of one respondent who appeared quite angry at the idea of a specifically Moldovan identity and furthermore seemed to specifically equate the project of creating a Moldovan national identity as purely artificial, a political and unsustainable project in the face of the economic problems of the country. When demographic issues were mentioned by respondents, this was usually either in practical terms (discussions of the falling birth rate being problematic in economic and social terms) or in terms of children being left behind by their parents and their education (including about sexual and reproductive health) left to grandparents, friends, or ‘the street’. One Romanian respondent did highlight the difference between popular discourses about the falling birth rate and the role of sexual and reproductive health initiatives and other factors, suggesting that demographic issues could be used by forces in society to promote pronatalist policies whilst not tackling other more pertinent issues:

... demography is another area for those involved in policy-making for reproductive health, and those who are older, they have this idea that the falling birth rate is caused by, this myth in fact, it's a preconceived idea, that it's caused by family planning programmes, reproductive health, and the free right to abortion, this is false. The birth rate was, above all it has been shown that the economic factor is the most important issue in this problem, not programmes for reproductive health, but some still use this as an argument. I hope that it doesn't return to the pronatalist policy because of this argument, because there are very few voices, but now it depends how these very small civil society voices counteract [them], and if they are not counteracted, you never know. (02MI)

Likewise this international donor manager in Moldova highlights how an active pronatalist policy without concurrent economic support and growth will not be successful:

Today, the Republic of Moldova also seems to have a pronatalist policy, but it's not successful, this pronatalist policy. We are seeing continual negative natural growth of the population, already on the road of this last 15-16 years. More people die than are born. And, with all that the government is saying about sustaining the birth rate in the Republic of Moldova, this is once again much more declarative, because a pronatalist policy needs to have consistent financial support, something that does not

exist in the Republic of Moldova. In the Republic of Moldova, women giving birth to a child receive material help to the tune of 100 lei, which is around \$8-10. And that's it. ... Young families today are limiting themselves to a maximum of a single child in the family. Already it's become a tradition to only have a single child in the family. If you have two children in the family already it's a luxury. And young families, young couples are postponing their first child for different reasons, to get a job, to get a house, to buy a car, to do some studying ... (11MI)

The threat of pronatalism was taken very seriously however, with one Romanian NGO manager expressing concern about recent political pronouncements:

On the other hand, the current president right now ... said that he wants through any means possible to increase the birth rate in Romania. Now I hope that it won't end up with the same ideas as those in the communist period. (13RI)

Mostly though, respondents talked about the problems of emigration leading to children growing up *fără grija părinților* (without the care of parents) and the rise in STIs both for adults sexually exploited whilst living and working abroad and for children growing up in-country without a stable family influence. Social problems such as a rise in the number of street children, young people with poor social skills, a rise in delinquency and drug addiction were also noted.

In Moldova I introduced a question specifically about emigration in the interview schedule as I was aware that it was such a big problem there¹⁶; however many respondents there brought up the issue of emigration before I asked about it specifically. In Romania fewer respondents mentioned this issue, although a subsequent analysis of media reports suggest that following Romania's admission to the European Union in 2007 the migration of working-age people is also having a serious effect there too (see for example *România Liberă*, 2008). A number of respondents in Romania however did specifically mention other demographic issues such as the decreasing birth rate.

One respondent also reported the problem of people working abroad returning home for treatment as they are not entitled to treatment in their country of work (particularly if they are living there illegally). For the most part though the issue of migration was presented as a series of practical problems – the secular and religious discourses against such 'dangers' as homosexuality and abortions, which are often linked to discussions of 'the demographic crisis', did not feature in respondents' answers as dangers to family and national social life.

¹⁶ Around 25% of the working age population are now working abroad and more than 35% of Gross Domestic Product is the result of remittances from abroad, which makes Moldova one of the countries in the world most dependent on remittances (Basa Press 2007).

By contrast, two articles on the website *Moldova Creștină* give examples of discourses making a very direct link between family and nation, and how ‘non-traditional’ forms of sexuality can destroy both. In an article entitled “Where does the nation (*patria*) begin?”, the root of the word *patria* (more accurately translated as ‘fatherland’) coming from the Latin word for father is explained:

“[s]o, already through this notion, fatherland begins with parents, with the father and mother ... The first people whom each of us get to know in this world are parents: mother and father. With them the nation begins. The nation then becomes all we inherit from them, our brothers, relatives, villagers, home, village, country, and all that we do to feel well and ‘at home’” (*Moldova Creștină*, 2008e).

In a subsequent article a few days later entitled “National Values Protected by the Supreme Law of the State” the threat to the family and nation by the promotion of ‘non-traditional’ sexuality (in this case homosexuality) is decried:

“With much sadness and tightness of heart (*strângere de inimă*) we establish that a number of collaborators from the Ministry of Justice, under pressure from the “Gender-Doc-M” organisation of homosexuals and lesbians have drawn up a proposed Law for preventing and combating discrimination, which is simply a pretext and a weapon through which the homosexuals seek to use the protection of the state in order that they can promote immorality and to destroy *the institution of the family, personality and ultimately the entire nation*” (*Moldova Creștină*, 2008a, italics mine).

In the secular media the link between family, religion and nation is less strongly made, but a recent survey in Romania did suggest that Romanians still hold the family to be most important to them (followed by work and religion) (*Jurnalul Național*, 2009). The same (secular, broadsheet) newspaper also describes breastfeeding, in an otherwise largely factual article, as “Holy milk from the mother’s breast” (*Jurnalul Național*, 2008a), referring to it as ‘a holy masterpiece’ and thereby discursively identifying the bringing up of healthy children as a sacred task.

How respondents viewed the socialist past (and in particular the pronatalist emphasis of Romanian and Soviet governments) varied, with respondents in neither country exhibiting a unanimous view. However, this said, of those that did feel that the past still influenced attitudes it was notable that in Romania many linked this to the notion of ‘mentality’ and of a conservative family environment where older values were transmitted to the younger generation. For example, this Romanian NGO practitioner stated:

When we talk of that mentality, there are many, those older people don’t agree with abortion, especially you come up against very religious people here ... the anti-abortion mentality is still very big here. (06RI)

whilst this NGO manager agreed:

... there are many worries and regrets ... especially in the way young people are educated in the family by their parents and, also the attitudes of the school are also influenced by the policy of the former regime, because at school they're still not open in talking about 'choice'. (02RI)

In Moldova whilst many respondents remarked that things had changed a lot (*s-a schimbat mult*), they felt that the main ongoing legacy was one of the role and status of the medical profession and of the family. A number of (medical practitioner and/or manager) respondents talked about how the main legacy of the socialist past was in fact an ongoing excessive deference towards the medical profession, but the issue of an unsophisticated and not at all advanced 'sexual culture' was also mentioned by some. For example, this international donor and local NGO manager stated:

... sexual culture, in my opinion, as a specialist gynaecologist, unfortunately in our society is very low, because approaching sexuality in a natural way, in a correct way, is very low, because we don't unfortunately have sex education in society right now ... sexual culture, that is the lack of capacity to communicate efficiently in a couple ... to delegate and assume responsibilities, to ask for information and adequate services. (23MI)

This view was supported by this Moldovan media worker:

... society is suffering a lot because of that, because we don't have a culture around sex education ... Perhaps when they hear about sex education they think about less pleasant things. They think about sex ... they don't think about a protected relationship, an intimate relationship, they think about sex with many partners, ... horrible things ... These people grew up in the Soviet period, when in fact there was another mentality, they have other opinions about youth, how to deal with these [issues]. And, they believe that sex shouldn't be talked about, ... [nor] sex life, reproduction, more intimate subjects. (24MI)

It is in this context of the ongoing legacy of the past, in particular the apparently institutionalised culture of silence and shame and the elevation of the family that service providers and policy makers are attempting to design and provide relevant services. Certainly recent media reports in both Moldova and Romania about women who have had many children attracted public comments of "Bravo!" and praise that they had performed this selfless act (*ProTV* Moldova, 2008b; *Cotidianul* 2008b), which suggests that dominant discourses around the value and importance of the family permeates society as well as politics today as well as in the more overtly pronatalist past. However, the specific invocation of the idea of 'culture' also draws upon notions from the past. Rivkin-Fish (2005a) highlights how in the early Soviet era *kul'turnost'* (translated as 'culturedness') was a value or characteristic to which to aspire, through individual behaviour and etiquette.

The modern-day use of this term in a health context also suggests that it is through individual behaviour change (seeking out correct information, taking responsibility for protection against infection or unwanted pregnancy) that an improvement in overall societal culture will take place, in a reflection of public health approaches targeting individual behaviours.

The specific areas of sexuality and ‘appropriate’ behaviour are issues that were important both for respondents and in the wider society (as represented by secular and religious media sources). This chapter therefore will discuss this issue in more detail, looking at discourses around sexuality and behaviour (historical and contemporary) before exploring the link between morality and health through a more detailed consideration of two of the most contested and commented upon areas of sexuality, namely adolescent sexuality and homosexuality. Before this however, I will consider an important site for the expression and contextualising of sexual and reproductive health behaviour, namely the family.

5.3 Perspectives on the family

Given both the explicit linkage by many commentators between the family and the nation, and the placing by many of my interview respondents of the family as a site for the upholding of unhelpful traditional views, shame, and either silence about sexuality and reproduction or the propagation of incorrect information about it, it is clearly a key area for further consideration and interrogation. The discussion later in this chapter on sexuality, and in particular ‘non-traditional’ forms of sexuality highlights how both sexuality and reproduction are key sites in establishing identity, as well as establishing control over behaviour and discourses and control over the contexts in which services can be developed and provided. This is exemplified by the equation of ‘non-traditional’ with ‘immoral’, the stigmatising of ‘non-traditional’ lifestyles and the ever more urgent rhetoric about ‘the demographic crisis’ in both Moldova and Romania. In many debates, ‘family’ is used as a proxy for the place where optimal reproduction of the national family takes place. Within this, the role of women specifically within the family is crucial.

Secular and religious debates about demography, the role of the family as the ‘building block’ or ‘basal cell’ of the nation (Verdery, 1994), an assumed heteronormativity infused throughout society, and the morality (or otherwise) of particular expressions of sexuality and reproduction differ from but also illuminate and expand upon points made about the family by my respondents. They highlighted issues such as shame and silence and their negative impacts (such as poor information), the paradoxical resistance to sex education in

schools as a usurping of parental responsibility, and also the impact on family members of the phenomenon of the economic migration of working-age people (who are often parents, and who often leave their children behind while they seek work abroad). The issue of expectations attached to women within the family was also frequently raised by respondents. This section of the chapter will provide a brief overview of historical perspectives on the family in Romania and Moldova (considering pre-communist and communist views, the importance of pronatalist assumptions and policies and the complicated relationship of the nation-state to discourses of fertility and reproduction), before then discussing where respondent and media/religious views on the contemporary family intersect and diverge.

5.3.1 Historical perspectives on the family

Throughout the state socialist period – and before - the family was accorded a high status throughout central and eastern Europe and the former Soviet Union. Böröcz and Verdery (1994:223) highlight how throughout the world “the imagined community of the nation is constructed through metaphors of human reproduction and its basic organizational form, the family”. Whilst this is not exclusive to the former state socialist countries it is a very potent discourse which still has profound resonance today. This section will trace some links between discourses of family and nation, primarily from the socialist period, in order to contextualise some of the responses of my respondents about the family and about the challenges they face in trying to provide services and meet the sexual and reproductive health needs of their clients.

In Romania the history of state intrusion into private, family life is well documented (see Kligman, 1998), most notably with Decree #770 of 1966 which made abortion illegal in all but exceptional circumstances. “[T]he family’ was accorded institutional legitimacy” through the reification of “the family ... in ideological campaigns as the archetypical metaphor of the social order itself” (Kligman, 1998:28), and indeed socialism in Romania became known as “socialism in one family” (Kligman, 1998:30). The peasant Romanian patriarchal family structure predicated on the sanctity of marriage and having many children was simultaneously attacked and co-opted by the Communist Party – attacked due to the strong ties of religion and tradition being seen as incompatible with a modern socialist state, co-opted partly for nationalist regions (for example to strengthen Romanian claims to Transylvania; see Kligman 1988) and partly in the construction of “the nation” in familialist terms such as *Patrie* (‘fatherland’) (Kligman, 1988:258; see also Verdery (1994)) and *Neam* (which can have the meaning of ‘people’, ‘nation’ and ‘family’)

(Capcellia, 2002). The linking of 'family' and 'state' was made from the earliest age, with pre-school children "taught "patriotic" songs and poems featuring Elena and Nicolae Ceaușescu as their spiritual parents" (Harsanyi, 1993:43). In the contemporary period, in order to break with the past, pre-communist institutions such as Church and family have been embraced with many turning to "pre-communist assumptions about [women's] status in society, most notably the value of their role in the family and the deep differences between men and women" (Robila, 2004:147).

Similarly in the former Soviet Union, following the early Communist Party attempts to 'replace' the family with Party loyalty, from the 1930s the idea of the family as the building block of society was introduced and thereafter rarely questioned, despite the various iterations of the 'woman question' throughout the Soviet period. The linkage of discourses of fertility and reproduction on the one hand and nation-building on the other were common, and as in Romania, from the 1970s discourses about 'the demographic crisis' were frequent (Kuehnast and Nechemias, 2004; Kay, 2000; Rivkin-Fish, 1999). Thus, policies designed to increase the birth rate were suggested and designed, such as changes in sex education programmes to promote stable families through the reinforcing of strict gender roles and identities (Rivkin-Fish, 1999; Attwood, 1990) as well as the consideration of an improvement in economic circumstances in order that men could work while women were able to devote more time to the family (Kay, 2000:67). The economic realities of life in the late period of the Soviet Union and the early years of the successor states however meant that the nationalistic and pronatalist rhetoric employed infused society in the absence of many tangible economic improvements or incentives. Kay (2000:69) highlights how in the early post-Soviet years in Russia "women's role as mothers [was] framed by both nationalist rhetoric and essentialist discourse", and contemporary discourses in Moldova suggest that these ideas still hold considerable sway 18 years after independence from the Soviet Union. Bodrug-Lungu (2004:178) highlights how motherhood in particular was transformed into a something of a cult, and shows how traditional views of gender roles within the family in Moldova are still prominent today two decades after independence from the Soviet Union (although this is more prevalent in rural than urban areas).

Verdery (1994:250) highlights that alongside a visible ethno-nationalism throughout the region, "anti-feminist and pro-natalist politicking", particularly centered on abortion, is common. Krause (2001:305) agrees that nationalist attempts to control fertility (or at least debates around it) is predicated on the fact that for nationalists "it is unbearable that

women should kill the nation by killing their fruit”. This focus on family, fertility and women’s role in reproduction and the link to the nation-state is something that is common throughout the region. Even in Romania, where the history of abortion under Ceaușescu meant that an anti-abortion lobby took much longer to emerge than elsewhere, Kligman (1992:400) identifies that the transition away from communism “bolstered a movement towards what may be called “re-traditionalization,” a return to traditional values, family life, and religion” (see also Robila, 2004). An emerging anti-abortion movement is now also taking form there. Subsequently homosexuality has joined abortion as a target for nationalists concerned with falling birthrates, rising divorce rates and increased secularisation. As Gal and Kligman (2000a:17) note, human reproduction, which ensures the continuity of both individual and collective, “is a ground for political battles in part because states, families, and other social actors all understand themselves as having much at stake in the control of childbearing and childrearing.”

As well as the link between fertility and the nation-state (referred to by Kligman (1998:8) as “political demography”), research undertaken both during and after the state socialist period suggests that despite the pervasive influence of discourses of reproduction, public discussion of matters of sexuality more widely were notable by their near absence (Rotkirch, 2004:93), at least until the 1980s with the advent of *glasnost* in the Soviet Union and the opening up of many previously taboo topics for debate. Declarations such as “there is no sex in the Soviet Union” referred as much to what was not talked about as what was (or was not) done (Engelstein, 1992). Nearly 20 years following the collapse of state socialism, it was clear from my respondents that the taboo of talking about matters of sex and sexuality within the family is alive and well and still problematic in both countries.

5.3.2 Respondent and media perspectives on the family

There is something of a divergence between interviewee responses about the family and media coverage. Much is made in the media, both secular and religious, of the ‘demographic crisis’ and problems with emigration of working- and reproductive-age people. Respondents however discussed the family much more in terms of a ‘tradition of silence’, of being the place where sexuality is taboo and therefore not discussed. For both countries it was notable that the main issue brought up by respondents was that of either not talking about issues of sexuality in the family or getting wrong information from the family if it was discussed. Related to this, many respondents in both Romania and Moldova suggested that one of the reasons why sex education in schools was important

and needed to be provided and/or improved was precisely because education is not happening in the home due to this traditional taboo.

A good example of this is provided by this NGO worker from Romania, who worked as a psychologist:

... we try in schools to talk about sex education but some parents don't agree with this, and need to be more open, if they can't discuss with their children then at least let the school point the children towards particular centres which can open their eyes ... There are these stereotypes [about contraceptives], and it's bad that young people don't have the courage to talk in their family with their parents or with anyone, or very many ... young people talk with old people or with parents who have these preconceived ideas about sexual life, about contraceptives, how they make you fat, that you become sterile and can't have children if you have the pill. And then they get frightened, why use that method if they can't have children. (06RI)

Likewise in Moldova many respondents agreed that discussions relating to sexuality and sex education do not take place in the family, more than one even referring to this as a 'tradition', such as this respondent, who was head of a state centre for young people's health and trustee of an NGO:

Many times this subject is not discussed in the family. This is a tradition here, that parents have decided not to talk about this. They think that it should be talked about by teachers at school, and the teacher doesn't talk about it either. (06MI)

It is interesting that this respondent highlights parental desire for sex education to be taught by teachers, when much of the opposition to sex education took the form of protesting that moving sex education into schools took the responsibility away from parents and onto teachers. The reality of course was that neither parents nor teachers were proactive in ensuring children's sex education or willing to take on this role.

This situation was stated not only by health care providers but also 'lay' respondents such as this media worker from Moldova:

... in my family where I grew up, where I live, ... unfortunately I didn't speak with my mother about sex education, I didn't dare talk about my relationship with my boyfriend ... In the countryside, perhaps in the city it's different, but in the countryside [pause] Children talk with their parents about studies, about problems, about money, but much less about ... 'I'm in love' ... I don't know, this is how we were educated, this is how we are, this is how we were taught. We don't talk about this in our family. We talk about money, about all sorts of problems, but about sexual relations, I don't know. (24MI)

One concept that was mentioned many times by respondents in both countries in relation to sexuality and reproduction within the family was that of 'shame', as detailed in section 5.1,

this chapter. The commonly brought-up issue of families not talking about sexuality and reproduction was very often couched in language of shame, and used to justify particular activities such as peer-to-peer information exchange, for example:

There are some cases, more rarely there are cases where young people talk to their parents, I don't know why, young people still are afraid to talk to their parents, they are ashamed, I'm really glad that my colleagues at school, knowing that I'm a volunteer with [name of NGO] ask me and ... come with questions and ask me to bring them a condom. (03MI)

They see everything on the television ... but anyway even these parents are really ashamed to talk about this subject with their own children. (13MI)

This accords with accounts from the socialist era in both Romania and the Soviet Union, where the lack of discussion within the family of issues such as sexuality, menstruation or reproduction was because such topics were widely considered shameful or embarrassing (Joy, 1995; Băban and David, 1996, Rotkirch, 2004).

The implications of this culture of silence within the family were generally agreed to be a tendency for young people to get their information from unreliable sources (such as other relatives, friends or mass-media sources, particularly the internet), often referred to collectively as 'the street' (*strada*). The problem of the taboo of talking about sex either at home or at school is something that has also been discussed in the media, for example on Romania's *ProTV* website a news item asks "Who is responsible for children's sex education?" and elaborates on the question: "Parents, who most often avoid discussing this subject, from shame or fear? School, which doesn't offer enough information about the risks with which children are faced?" (*ProTV* Romania, 2008a). The subsequent public discussion of this article highlights some interesting views, shared by several of my respondents, with some suggesting that parents should be the ones to educate their children, others asking how this is possible when parents themselves are not appropriately educated, and perhaps most interestingly a 15 year old pupil pointing out that teachers too are embarrassed to teach about this subject, "especially those who were adolescents during the communist times, when sex was a forbidden subject. In society even now we can still feel the communist influence" (*ProTV* Romania 2008a). The influence of the past was a subject that arose in interviews in both Romania and Moldova, usually framed in terms of 'mentality' in Romania and 'change' in Moldova, as discussed earlier in this chapter.

Interestingly, in Moldova more than Romania one issue which was mentioned a few times which merits further comment was that it was felt that parents were unwilling to accept that their children were growing up. Kay (2000:79) highlights a Russian mother's

mollycoddling of her son (in the context of a discussion about gendered upbringing); in Moldova a perceived over-protectiveness on the part of parents leads to parents delaying discussions of sexuality and reproduction because they have not accepted that their children are no longer innocent. This can be seen in the first quote by a rural family doctor, and in the second by a media worker:

I, as a doctor, I know what needs to be said to a child ... about personal hygiene, about the sexual organs, about let's say relations. But lots of them, when I've spoken with a mother, for example, "Look how my child has grown, and already her pants are small and I need to buy others, and all the rest of it, and make up, and honestly, ... I don't know" ... [and] the child is already 13-14 ... already asking about condoms "Aaaaah, who am I? What can I say?" (16MI)

And look, parents right from the start come with this attitude towards their children, they don't discuss [anything] ... usually they say "Grow bigger and you'll see". They can't see that their child already is big, and their child is perhaps already in love ... (23MI)

It should be emphasised that respondents were not advocating untrammelled sexual activity, or age-inappropriate education. Indeed a number of respondents in both Romania and Moldova expressed concern that due to a lack of appropriate sex education (either in the family or in school) many young people are obtaining their information from sources such as explicit films and websites, where it is much harder to control the material they access, and were starting their sex lives at such a young age before being fully aware of the potential consequences. In addition two of my Moldovan respondents specifically talked about the people with whom they worked (mainly young people, and also both young and older army officers) being eager to learn more about how to become a happy – and indeed healthy – family, how to promote a harmonious family life, whilst also being realistic about the difficulties facing the realisation of this goal, such as lack of financial support and resources and lack of adequate living space outwith the family. For all the criticism levelled against organisations working in the sphere of sexual and reproductive health that they are aiming to pollute and corrupt the nation's young, many were clearly concerned with moral issues such as the effect on a young person of starting their sex life at a very young age, their ability to negotiate and resist peer pressure to have sex before they felt ready, and the issue of promiscuity amongst young people.

5.4 Sexuality

The statement "there is no sex in the USSR" (Engelstein, 1992:786; Healey 2001:2) became an instant anecdote following its utterance on prime-time TV in the 1980s, and twenty years later was still being repeated by my respondents in Moldova. Likewise, in

Romania ‘the Ceaușescu era’ (*timpul lui Ceaușescu*) was remembered and discussed, although interestingly a few respondents clearly did not feel comfortable talking about this issue. One family doctor in particular replied “Categorically, no!” (*Categoric, nu!*) when asked whether the legacy of the communist pronatalist period still affected attitudes today and made it clear that that was the end of any discussion of this particular topic. The discomfort about talking openly about both the past, and about sexuality in general (notwithstanding the proliferation of pornographic and explicit materials such as magazines and films since the end of the state socialist period) was clear from respondents in both countries, and one of the factors that service providers and policy makers felt was most important as a challenge to services today.

In both the Socialist Republic of Romania and the Soviet Union the interplay between citizens’ productive and reproductive lives was complex, with the state attempting to strictly regulate both for the benefit of simultaneous economic and population growth. On the one hand women were actively encouraged to join the workforce and play a full role as workers as well as mothers (Gal and Kligman, 2000a:5; Harsanyi, 1993:44), with the resulting ‘double burden’ of productive and domestic work that has been well-documented (see for example Buckley, 1989). On the other hand from the 1970s in the Soviet Union and from the 1960s in Romania increased rhetoric, policy and discourse around the significance of motherhood (and by extension the nuclear family) to the healthy functioning of the state (Buckley, 1989:270) and the “nation’s future vitality” (Băban, 2000:228) were common.

Following the collapse of the state socialist systems, Romania and the Soviet Union’s successor states have had to negotiate and make sense of unfamiliar “discourses, subjectivities, political identities, experiences, and practices” (Roman, 2003/2007:18) as well as deal with the ongoing legacies of a communist (and indeed pre-communist) patriarchal society and entrenched attitudes and beliefs. Discourses and expectations of established gender roles and moral expectations continue to exist alongside a more liberalised media and society, where (despite Romania’s accession to the European Union and Moldova’s aspirations to follow the same path) issues such as “human, ethno-religious, gender, and sexual rights ... are largely perceived as external importations” with “these new ideas of democratic acceptance of otherness ... not ... absorbed into current political and public culture and discourses” (ibid.). The sense of traditions forming part of national identity is important. Capcelea (2002:177) discusses national traditions and social memory, stating that

“[t]raditions express the legacy of customs, traditions, beliefs which are transmitted from generation to generation, constituting the specific features of a population. [They are] a system of particular ideas, unwritten laws, norms of behaviour, a totality of historically crystallised conceptions, traditions which embody specific features of ethno-national memory and psychology”. (translation mine).

These are clearly as important for service providers and policy-makers to take into consideration as public health indicators when designing services and interventions, and something with a powerful resonance for large swathes of the population who continue to be uneasy at the pace of change.

It is to the theme of otherness and the acceptance (or not) of seemingly externally imported values and ideas that the remainder of this chapter turns, first through a consideration of contemporary attitudes towards adolescent sexuality and then of homosexuality, in order to demonstrate “the effects of social norms governing sexuality, and the dissonance between lived experience and society’s expectations” (Cornwall and Jolly, 2006:2).

5.4.1 Adolescent sexuality

Concern with adolescent sexuality is nothing new, and certainly not exclusively a post-socialist concern. For many years in the west, the problematisation of teenage pregnancy and of adolescent sexuality more generally has been a regular feature of popular and political debate, as well as a subject of academic research (for example Duncan, 2007; Breheny and Stephens, 2007; Arai, 2003; Bonell, 2004). In the state socialist countries of central and eastern Europe and the former Soviet Union, the need to control and regulate the sexual desires and energies of young people in order that they could be more productive, civilised and ‘cultured’ members of society was common (see Rivkin-Fish, 1999; Rotkirch, 2004; Attwood, 1990). As has already been demonstrated, with the collapse of state socialism sexuality proved (and continues to prove) a key battleground in the project of nation-building, with young people seen as crucial in the development of national identity, national health and national vitality.

The emphasis placed by providers on public health approaches manifested itself in particular through the targeting of specific populations, especially young people. This approach is encouraged by large institutional donors and in Romania and Moldova, as elsewhere in the world, took the form of an emphasis on peer education and on the transmission of information in order to benefit future outcomes (in terms of greater reproductive and sexual health choice, reduced morbidity, reduced abortion and STI rates, and increased take-up of modern contraception amongst other things). An important focus

was on health behaviour, in particular the promotion of safer sex and responsible relationships. The concept of behaviour change, as promoted in new public health discourse (Peterson and Lupton, 1996) and by organisations such as WHO and UNFPA was key, with many respondents referring to the promotion of a ‘healthy way of life’ (*mod sanatos de viață*), and also regularly using such terms as ‘good’ and ‘responsible’ when referring to promoting sexual and reproductive health behaviours. Other health behaviours, such as excessive alcohol use and drug intake, were included by young peer educators in their programmes, and the early start to young people’s sex lives (in both countries significant numbers start before the age of 15)¹⁷ also often featured in the respondents’ accounts of their priorities and challenges. In both the media and in my interviews, concern was often expressed about adolescent sexuality, about the early age of first sexual activity, and related problems such as the high rates of STIs and abortions and large numbers of sexual partners. For example this Romanian family planning consultant started her answer to the question of the most important and pressing issues she faced in her clinic with the following:

The most important problems, the aspect of the start of the sex life at a very young age, a large number of sexual partners they have before they tackle the problem of contraception, some situations even of aborting a pregnancy (*intrerupe de sarcină*) at 15-16 years old and sexually transmitted infections, these are acute problems. (11RI)

Peer pressure was highlighted by this NGO manager in Moldova as an issue in adolescent sexual activity:

It’s very young let’s say, the start of the sex life, it’s very young, in general of course it reflects the very very many social problems, in other words if you don’t have parents at home you dare go into a sexual relationship. Curiosity, heavy group expectations, peer pressure, is another issue. (05MI)

Two young people told me in Moldova that peer pressure and the approval of friends was more important for young people than that of their parents when it came to making decisions about sexuality and reproduction:

At that age, I think that young people [are more influenced] not by parents. Friends. ... A friend [didn’t want] this ... he suggested having sex, she said “but I don’t want to, I’m not sure I want to do this”, to not be ashamed. ... [it was] what the boyfriend wanted. ... “Forbidden fruit is very tasty.” (20MI)

News reports also often discuss adolescent sexuality – in particular teenage pregnancy and the rise in STIs – and much like in the British media this is problematised and the mainly

¹⁷ A 2007 survey in Romania suggested nearly 20% of the sample had had their first sexual experience under the age of 15 (Neogen, 2007).

young girls who are featured in the report castigated for being naïve, inexperienced and foolish (for example *ProTV* Romania, 2008b). However, despite the condemnatory discourses of fickle and promiscuous young people, and the widely-expressed belief that providing sex education to young people will make them curious to try sex before they should, a number of my respondents reported that young people wanted to take responsibility for their actions and that many of the problems of adolescent sexuality are reflections of wider social and economic problems. This Moldovan NGO manager, for example, pointed out:

Young people have realised that it is very difficult to create (*întemeieze*) a new family, a couple, to register, to go from the idea to the actual form of a family, it's very difficult, the economic situation, the political situation, the social situation is very difficult, young people here understand that when they aren't supported by state institutions, they don't have anywhere to live, in other words if their studies are paid for (*sustinute*) by their parents then to create a family and to decide to have a future child, then it's very difficult for them, this is a very big challenge and is a conflict between the young generation and the state, because the state says with a loud voice that they can help us and at every election they promise this, young people believe them and in the end they realise that it's [for] nothing. (05MI)

Discourses of feckless and promiscuous teenagers sit alongside ones of the dangers to young people of learning about sexual matters 'too early'. For example, a newspaper article on a summer camp educating young people between the ages of 12-18 about HIV-AIDS attracted a public comment suggesting that if minors were at the camp then those who organised it should be questioned under the penal code (*Flux*, 2008a), whilst *Moldova Creştină* (2008d) blames sex education and the many seminars on correct use of condoms for the rise in STIs among young people. This accords with research which suggests that childhood and adolescence are regarded as protected spaces, with "a powerful modern idea of the child as innocent (especially sexually innocent) but always potentially corruptible" (Moran, 2001:75; see also Hillier and Mitchell, 2008).

My interview data however suggests that these discourses do not tell the full story: in many cases young people are active in making decisions about their lives, are aware of the social and economic realities of life which mean that marrying and having a large family is a difficult and impractical option, and they are keen to pursue responsible, monogamous and mutually supportive relationships. The problematisation of adolescent sexuality as either primarily a health problem, needing to be resolved through improved services including sex education, or as a moral problem, needing to be resolved through the shutting down of public dialogue, debate and sex education, does not in either case fully resolve the issues facing either young people or the providers of sexual and reproductive health services.

The majority of programmes in sexual and reproductive health seemed designed primarily to tackle the ‘lifestyle’ perspective, with the majority of provider respondents talking about ‘protection’ (from STIs and unwanted pregnancies) and the importance of education and increasing knowledge in order that informed decisions can be made. This certainly accords with a general public health approach as well as the medical model of health; however wider factors impinging on health such as economic and structural factors are much more difficult to quantify and act upon. It also demonstrates how, far from being values-free or morally neutral, health promotion messages too promote a view of morality and appropriate health behaviours.

In Romania it is apparent, from the sheer number of media articles on the subject during the period of this analysis, that the primary issue of contemporary concern in the media related to adolescent sexuality is that of teenage pregnancy and parenthood. As in the UK, this is usually presented as problematic, an ‘epidemic’, something undesirable and shameful for Romania. It is also seen as a relatively new, ‘postsocialist’ problem – in the communist times the “cultural respect accorded motherhood was contingent upon a woman’s marital status. The stigma attached to illegitimate children stemmed from the social contempt in which nonmarital relations were held” (Kligman, 1998:68). Two decades later, statistics showed that Romania’s teenage pregnancy rate was second only to the UK in the EU in 2008, prompting sarcastic headlines and debates on national shame.

The vast majority of these articles are highly gendered, focusing on young mothers. Individual cases are discussed, using poorly-disguised photographs, real names, and details of home towns or villages, compromising the young person’s confidentiality. The young mother’s decision to keep the child is often presented to show how unprepared and unrealistic they are about looking after a child (*ProTV Romania*, 2008b)¹⁸, conveniently omitting that this is also the case for many older and ostensibly more ‘appropriate’ mothers. Terms such as “*Copiii nasc copii*” (‘children give birth to children’), ‘*mame-copii*’, ‘*copil-mama*’ (‘child-mothers’ plural and singular) and ‘*fetiță-mamă*’¹⁹ (‘little girl-mother’) appear regularly, again highlighting the gendered nature of the coverage of the phenomenon of teenage pregnancy. In the case of under-16s, it is often reported that the baby’s father has been charged with having sex with a minor or is being hunted by the

¹⁸ This article starts “The girl, in her naivety, is really delighted with the fact that she has brought a baby into the world. She says she doesn’t want to stop here, especially as now she has a new boyfriend, with whom she wants to create a family”.

¹⁹ The term ‘*fetele-mame*’ (‘girl-mothers’) refers to unmarried mothers (Ștefan, 1999); the diminutive ‘*fetiță-mamă*’ is used to highlight the particular age-profile of the mothers under discussion.

police in order to be charged, introducing a discourse of risk and victimhood which will be discussed further below. Interestingly, the only significant coverage of teenage parenthood that did not focus on the young mother but instead on the young father was coverage of Alfie Patton, the 12-year old British boy who, it was claimed, fathered a child in the UK in 2009 and which prompted a number of reader comments demanding the international authorities who criticise Romania subject the UK to similar scrutiny.

Other than teenage pregnancy and parenthood, other issues that feature regularly in the Romanian media are the early start of young people's sex lives, incest²⁰, and medical issues such as the failure of the 2008-09 campaign to vaccinate young girls against Human Papilloma Virus (HPV), where comments included people suggesting that Romania's girls were being "experimented on" by Europe and the USA. These articles, like the teenage pregnancy ones, often highlight discourses of risk and victimhood – the girls are at risk from and victims of predatory men (often from their own family) or the predatory 'west', and they are victims at risk from being exposed to sex education too soon (although the often explicit photographs and adverts accompanying these articles are very rarely afforded the same amount of outrage as sex education).

Importantly, there seems to be an almost universal denial of young people's agency as a result of the risk and victimhood discourses – they are considered too young and irresponsible to make appropriate decisions about their own sexuality, hence giving them the tools and information necessary to make such decisions is considered problematic and is often opposed. Likewise even when they do make decisions they are criticised – for abandoning their children, for deciding to keep them, and for trying to access contraceptives and family planning information which could prevent these so-called 'problematic pregnancies' in the first place.

When I did my fieldwork and interviewed service providers in both countries I was struck by the similarity between the two countries in terms of the issues that were raised by them in respect of adolescent sexuality. However in looking at media sources in Moldova it is striking how different the emphases were from media coverage in Romania. There is very little mention of teenage pregnancy at all, despite 2006 statistics showing that 14% of all pregnancies (whether carried to term or not) are amongst young people (*Timpul*, 2006).

²⁰ Again, cases are often reported in such a way that confidentiality is compromised, most notably with the case of an 11 year old girl who had to come to the UK in 2008 to have a late abortion after being raped by her uncle. This case prompted an alteration in the abortion laws for minors but again exhibited much racist anti-Roma and anti-Moldovan discourse. Coverage included photos of her parents (with their full names), the name of her village, and the name of the alleged rapist. The "protective measures" of using her first name and initial only, and the black strip over her eyes in photographs, were rendered useless.

Instead the most common issues when considering adolescent sexuality in the secular media are HIV-AIDS (often considered on its own, though sometimes there is also discussion of other sexually transmitted infections as well), sex education, and risks facing young people (such as drugs and alcohol). Often these issues are linked together, so that HIV-AIDS infection is linked to the lack of adequate sex education in the country. For example an article in *Timpul* (2008) interviews the UNFPA Young People's Co-ordinator. She discusses the fact that it is young people who are the largest group affected with HIV-AIDS, the problems with the withdrawal of sex education from the national curriculum, peer-to-peer education initiatives to try to educate young people about the risk factors for HIV-AIDS, myths and incorrect information associated with discussions around sex, and the role of the press and others in disseminating correct information. Other articles highlight the educational summer camps, designed to provide education about HIV-AIDS, held for young people (*Flux*, 2008a) – these camps were a common feature across the former state socialist region which were subsequently appropriated by both religious and secular civil society groups.

However, there can be seen to be similar discourses of risk and victimhood to those displayed in the Romanian media. Whilst in Moldova many of these discourses come from the religious media, for example diatribes against sex education as this allegedly promotes promiscuity, suffering and the breakdown of the family and nation, they do also appear in the secular media. Here, however, STIs are framed as a 'social disease' and young people are deemed at risk from 'vices' such as alcohol and drugs, and also from the dangers of a lack of sex education.

At first glance it would seem that the Moldovan secular media is more progressive in its reporting of adolescent sexuality, and also in its apparent greater acknowledgement of young people's agency. Often though it was the case that the reports took the form of interviews with professionals in the field (many of them my respondents), rather than in Romania where even when professionals were interviewed this was in the context of a wider commentary by the journalist. This may reflect as much the current state of journalism, journalistic confidence and the development of the mass-media in the two countries as it does the relative discourses around adolescent sexuality. However, it is arguably also the case that media reports are also forming and producing different discourses as well as merely reporting them.

In the religious media and in some of the public comments on secular media articles on issues to do with adolescent sexuality in Moldova, a much greater discourse of external

dangers seems present than in the media in Romania. Although politically Moldova is hoping to join the EU at some point in the future and there is wide public support for this, nevertheless a minority of the public and many religious commentators blame Europe for the encroachment of foreign, dangerous values, such as an increased openness to the toleration of promiscuity, or expressions of ‘non-traditional’ sexuality.

In one extreme case the Orthodox source *Moldova Noastra* (2009c) in its reporting of the introduction of the HPV vaccination in Romania framed this programme as experimentation on children, in an article entitled “Bring your daughter to the sacrifice”. This is a good example of how, despite being separate countries, events in one country often attract comment in the other and are used to formulate and articulate positions in the local context. This is particularly true of events in Romania influencing opinion and practice in Moldova – perhaps due to the relative sophistication of Romanian media, as well as their perceived increased status following EU accession in 2007.

The secular press and much public opinion are generally much more pro-Europe, seeing it as the means of escaping the economic and political problems besetting Moldova. As well as the pro-Europe discourses, there appears particularly in the articles interviewing professionals (often well-travelled and well-versed in western discourses) a sense that if only the issue of sex education in schools was satisfactorily resolved then all the other problems (abortions, HIV-AIDS and other STIs, teenage pregnancies, etc) would be resolved. It is interesting that in this way both secular and religious sources draw on salvific notions – whether through abstinence or increased education.

Another interesting observation is that coverage of sexual and reproductive health issues in the Moldovan media is generally much less obviously gendered than that in Romania. This is perhaps due to the larger focus on teenage pregnancy in Romania. The main exception to this is coverage of issues relating to homosexuality, where the photos used are generally of men rather than of women and (particularly in the religious press) terms such as ‘sodomy’ are freely used. The discourse here seems very much about predatory men and the danger they pose to young people.

Although adolescent sexuality as an issue was discussed extensively by both respondents and in the media, the emphasis of these two sources was somewhat different. In both Romania and Moldova the majority of respondents highlighted the lack of sex education in schools as a significant factor contributing to the problematisation of adolescent sexuality. However in the mass media surveyed only 38 articles were specifically and primarily about

this subject. Whilst some, particularly in Moldova, offered a pro-sex education perspective, these were usually written by or were interviewing people involved in developing sex education services, and there were many more articles where the public was invited to discuss who should be responsible for sex education, or articles about how to approach the subject in the family. Somewhat ironically, given the prevalence in the Romanian media of articles about sexuality and reproduction, it was the print media which largely condemned the presenter of popular TV programme “Sunday in the family”, Mihaela Rădulescu, for presenting a programme which mentioned sex (*Libertatea*, 2009a, *Gândul*, 2009b). Responses to an article on discussing sex with children included more than one observation implying that discussing sex with children meant having sex in front of them and accusing the UN of promoting “perversions” and “obscenities” and referring to population decline.

It could be speculated that this indicates an extreme reinforcement of the view of my respondents that parents and families are unwilling to discuss sex in the family – the reason given by service provider respondents was mainly shame, taboo and tradition, but these responses from the public seem to indicate that many parents feel that discussing sex means promoting it whilst simultaneously damaging national tradition and identity.

It can be seen that a powerful image of young people (specifically, young women) as ‘innocents corrupted’ and victims, yet at the same time out of control and responsible for an epidemic of unwanted and undesirable pregnancies, has been constructed. At the same time, discussion of sex within families is considered shameful yet discussion of sex outwith the family is disapproved. However, the media aimed at young people themselves has a quite different construction of young people. Looking at issues of two of the most popular magazines aimed at this market, *Bravo Girl* and *Cool Girl* from summer 2007, it can be seen that they follow the format of similar magazines in the west, featuring articles on fashion, make-up, pop and film stars, horoscopes, etc. They also feature relationship quizzes, with titles such as “What sort of ex are you?”, “Who will be your great love?” (which aimed to identify your soulmate as sporty, your protector, a star, or your best friend, thus demonstrating several gender stereotypes in one article), and “Does he truly love you?” In both magazines, the underlying subtext seems to be that a heterosexual relationship is the ultimate goal. The focus of the magazines is primarily aspirational, with the “positive identities available to young heterosexual women ... linked to their social relationships with men as girlfriends, wives, or objects of love” (Holland et al, 1990:340). Such a focus is remarkably similar to that identified in similar magazines for young women

in the UK and USA from the 1970s to 1990s (Carpenter, 1998; McRobbie, 1991). The letters pages, titled “Body & Soul”, “Love & Sex”, “S.O.S. Boys”, are dominated by sex and relationship-specific letters – with topics such as “How do I keep him?”, “What can I do to win him?”, “My parents don’t approve of him”, “I’m not ready for sex yet”, “I’m ready for sex, how do I let him know?”, “He already has a girlfriend”.

In both magazines, heterosexual romantic love is both idealised and idolised. *Bravo Girl* does seem to be slightly contradictory, in that as well as all of these features it also seems to play to the younger child audience, with pictures of cute animals and cartoons alongside the heartthrob of the day. Both magazines feature some messages about safe sex, but these are not prominent. Neither magazine covered social or structural issues (such as the inaffordability of housing for young couples, or gender inequalities) affecting young people, issues that are important when making sexual and reproductive choices (Carpenter, 1998). Nor were gender stereotypes actively challenged; on the contrary they were promoted as an ideal to which to aspire (Cotrău, 2003).

An obvious omission from this analysis is the fact that there are no equivalent magazines aimed at young men, and gendered constructions of adolescents in relation to sexuality in the media more widely also focused primarily on girls and young women. Thus, the overwhelming media focus on adolescent sexuality and young women serves to render half of young people invisible. In the portrayals of young women as either victims or aspiring to the security and ideal of heterosexual romantic love no space is given for discussions and portrayals of young people’s agency. In addition, the omission of any mention of same-sex attraction and the lack of positive articles about minority groups such as Roma young people constructs a notion of acceptability and unacceptability that serves to both highlight differences whilst simultaneously rendering them invisible.

One of the issues which was very often linked to concerns about demography and national vitality in the media, with very many articles on the subject, was homosexuality, to which this chapter now turns.

5.4.2 Homosexuality

Discussion of homosexuality among my respondents was limited to two brief comments by two Romanian respondents (these are discussed in more detail later in this section). However as an issue it seems to be rarely out of the news media in either country, with

regular articles discussing events such as gay pride marches or gay festivals at home and abroad, survey findings on attitudes towards homosexuality, the lives of gay celebrities, and the passage of anti-discrimination legislation. Many of the articles, particularly though not exclusively in Romania, are accompanied by photographs of male transvestites on pride marches, regardless of the actual subject of the article. This is important as “[p]ictures *signify* the world in graphically perceptible forms. They are always structured according to specific cultural patterns of meaning and perception, and thus they transmit normative attitudes toward the world ... They orient perception, the individual assignment of meaning to reality, as well as the practical actions of the viewer” (Dölling, 1993:168). If any conclusions could be drawn about homosexuality in Romania and Moldova exclusively from the pictures that accompany media articles on the subject, it would be assumed that ‘the homosexual norm’ is of male transexuality, with heavy make-up and provocative and sexualised behaviour in public. Images of homosexual men and women as workers, sons and daughters, parents, are virtually absent. There were very few articles on homosexuality which promoted or discussed sexual health, although in the public comments following the articles a link between homosexuality and HIV/AIDS was often made, again regardless of the subject of the article.

Perhaps even more so than is the case with adolescent sexuality, homosexuality is often framed directly as a threat to the integrity of the nation and of the family, not only by religious leaders and media, but also by elected politicians. For example the Deputy Speaker of the Moldovan Parliament, and leader of the Popular Christian Democratic Party at the time of this research, Iurie Roșca, has been very outspoken both in the press and in parliament against homosexuality in general and the proposed anti-discrimination law in particular (see *Flux*, 2008b). Articles in online newspapers (not only tabloid but also serious broadsheets) are followed by lengthy public discussions, overwhelmingly against homosexuality and often both pro-religious and nationalistic in tenor, indicating that “the discourse of popular homophobia” (Lambevski, 1999:406) is strong and very influential. Articles in online fora such as newspapers, blogs and discussion boards frequently equate homosexuality with paedophilia, and the danger to the young people of the nation is often invoked in discussions about the greater visibility of homosexuality and calls for rights for same-sex-attracted people. This is true not only in central and eastern Europe and the former Soviet Union, but also western countries such as the UK (Moran, 2001) and Australia (Hillier and Mitchell, 2008); however, the discussions in eastern Europe seem to be particularly vociferous. In addition, links are very commonly made in public discourse

between homosexuality and HIV/AIDS, despite for example in Romania HIV/AIDS infection being historically the result of paediatric blood transfusions (Human Rights Watch/IGLHRC, 1998)²¹.

In Moldova, much has been made of the ongoing process to draft an anti-discrimination law, in particular the proposal to include the term “sexual orientation” in the law as signifying a group of people against whom it will be illegal to discriminate. Even in the secular press, a seemingly innocuous article about the participation of representatives of Gender-Doc-M (the most prominent LGBT organisation in Moldova) at the Democratic Party congress in April 2009, bringing the message that “the democratic youth, oriented towards European democratic values, should not have prejudices and stereotypes” and the choosing of a Gender-Doc-M member as an election candidate (*Flux*, 2009b) demonstrates its disapproval not in its words but in the picture it uses to accompany the article, which is of the head of a senior Democratic Party politician superimposed onto the body of a man wearing a ballerina’s tutu. The clear message is that homosexuality and masculinity are incompatible, and that ‘European democratic values are linked with those who are ‘not normal’. This is an example where the main content of the article was not overtly discriminatory - the main bulk of discriminatory content features in the public comments or in the religious media’s use of terms such as ‘*imoralii*’ (‘the immoral’) ²². However the overall message of the article is reduced by the picture to being clearly critical and reinforcing the view that homosexuality is ‘not normal’.

Similarly in Romania, articles covering a European survey in March 2009 which demonstrated Romanians’ continued intolerance towards homosexuality (the study showed only 11% of Romanians in favour of homosexual marriage and only 36% of Romanians not objecting to having a homosexual neighbour) (*Libertatea*, 2009b) resulted in an outpouring of public comments which linked homosexuality to both religious and health discourses, for example:

“If they have chosen this hell, at least do it in their bed, not on the street!!! But these gay parades, they’re macabre!! They are a violation of the last dram of morality that still exists!! They are grotesque!!! Mentally ill exhibitionists!!!” (*Libertatea*, 2009b)

²¹ Heterosexual transmission and injecting drug use are now the most prominent means of transmission in both Romania and Moldova (Ciobanu, 2005; Johnson and Buzducea, 2007).

²² See for example *Moldova Crestina* (2008f) who write: “The immoral have called their organisation “Gender-Doc-M Information Centre”. But what type of information are they providing, and what is the effect of this sort of information ...”.

As well as articles on homosexuality in the law and in public, occasionally it is used as an issue for discussion of personal sexuality. However here the tendency is more towards the use of discriminatory language, for example in an article entitled “Am I a lesbian if I have fantasies about my (female) friend?”, the reply by *Libertatea*’s “specialist” (NB her “speciality” is not elaborated) is very forceful:

“It is not normal to feel a sexual attraction for your friend. It is natural that erotic relations where sexual attractions exist are for a person of the opposite sex. Orientation towards intimacy with a person of the same sex is called homosexuality.”
(*Libertatea*, 2009c)

Such coverage not only demonstrates that legislation and a general trend in politics towards attempting objectivity have gone before any widespread alteration in general societal views and perceptions (Turcescu & Stan, 2005), but also highlight the discourses of normality, morality and health within which homosexuality is discussed. The fact that as an issue it is discussed so widely as something to be feared, avoided and condemned, whilst in the main sexual and reproductive health services do not adequately address or articulate the health needs of gay people, means that in society a significant minority of people face discursive (and often physical) discrimination in society as a whole whilst simultaneously being ignored by health services. The framing of homosexuality as a threat to family and nation alike is alive and well, and shows little sign of diminishing.

In much of the coverage of ‘the demographic crisis’, homosexuality is often cited as a danger to personal and national reproduction, clearly showing a tendency towards heteronormativity in the media, where sexuality is linked to reproduction and gender essentialism. As an example, Dumitru (2009b) links homosexuality (amongst other things) to national disaster and immorality as he advertises the showing of a film called “Demographic Winter”:

““Demographic Winter – the Decline of the Family” shows the dramatic consequences of the “modern” way of life, marked by family and moral decline, the trivialisation of abortion and “normalisation” of homosexuality, of the noxious influence of the majority of the mass media and of “Hollywood culture” which promotes egotism, frivolity and abdication of responsibility” (*fuga de responsabilitate*, lit. “running from responsibility”).

Here homosexuality and abortion, as well as ‘modern’ ‘western’ values as exemplified by the media and popular culture, are framed as the enemies of ‘right’ living – promoting the heterosexual family and reproduction as ‘the norm’.

Despite this extensive media discussion, however, homosexuality as an issue was barely raised at all during my interviews in either country. This is, of course, not to imply that agencies and providers working in the field of sexual and reproductive health are against homosexuality; indeed I am aware of several where issues around sexual identity and orientation are actively considered through (for example) articles and Frequently Asked Questions on one organisation's website, or where one of my respondents had been honoured by a national homosexual rights and advocacy NGO for her own work in countering prejudice. However, in more than forty interviews the issue of homosexuality, in terms of access and rights to sexual and reproductive health services, was only mentioned by two respondents. Hillier and Mitchell (2008) highlight in their study in Australia how even progressive sex education is largely addressed from a heteronormative perspective which does not necessarily meet the needs of younger same-sex-attracted people, and it is certainly possible that many of the services in Moldova and Romania are oriented more towards an assumed heterosexuality. With the increasing visibility of LGBT rights organisations such as Accept in Romania and Gender-Doc-M in Moldova, it is perhaps felt that these organisations are the ones catering specifically for same-sex-attracted people who wish to access sexual and reproductive health services. This rather essentialist assumption however takes no account of those people who do not feel represented by such campaigning organisations, those who have not yet clearly defined their sexual identity or those who are actively resisting identifying as a particular sexual identity.

Both of my respondents who did explicitly refer to homosexuality were from Romania (although the two examples of positive work cited in the previous paragraph are both from Moldova), and both brought up the issue in the context of a question about preconceptions and stereotypes. One was a development consultant who had been very involved since the early 1990s in developing and increasing access to services and working with a wide range of actors, not only health professionals but also NGOs and the media, and in international as well as local settings:

... about sexual minorities especially, there are wrong ideas and preconceptions, prejudices, which exist even today, of course, although in Romania we have an organisation called Accept with whom I've collaborated very well. And another thing, the first time at the health exhibition in 2000, that was the first time when I invited them to participate alongside all the other organisations, not excluded because they are involved with the rights of sexual minorities. And from there bigger steps have been made, even organising the gay parade in Bucharest. It's true that they're always marked by violent incidents, in Bucharest, in Moscow, and in Warsaw, I've seen the same model, exactly the same as throughout the world. I

think, these exact same prejudices don't only exist in Europe, exactly the same prejudices, still I think that the world will open up and the prejudices will start to decrease, but, they exist and they'll always exist. (02MI)

The other mention of homosexuality came from the manager of a Romanian NGO. It is notable that whilst it was also in the context of a question on preconceptions and stereotypes, and indeed the respondent's substantive point was how these preconceptions and stereotypes prevent same-sex-attracted people from accessing health services and mean that they are vulnerable as a neglected, misunderstood and rejected minority, nevertheless the answer used terms such as 'deviant' to describe them, indicating that even service-providers are not immune from the influence of popular homophobic discourse:

... as well as that, with regards to deviant sexual behaviour, let's say, homosexuality and lesbianism, there are many prejudices about this, where again it is detrimental to reproductive health. On one hand because the general population tends to marginalise them, to reject deviant sexual behaviour, and on the other hand, those who display these behaviours are marginalised, and in fact marginalise themselves (*se automarginalizează*), in other words they don't go to have an HIV test, for example, because they feel, they are ashamed to go to a doctor's clinic and say 'I'm gay and I want to have a test'. And then they don't have much access to information. ... [M]any times in Romania before '89 ... among the general population they say that 'illiterate' (*analfabete*)²³ people didn't exist. And, in fact nothing else is being done, denying even now that it exists anyhow ... Something of this type has started, such an attitude like this doesn't exist, and sexual minorities still don't exist, or, when they exist we reject them. (05RI)

Discourses of predatory and immoral homosexuals abound, and despite laws in both countries becoming more progressive (for example with the repeal of Article 200 of the Romanian Penal Code, and with the proposed Law for Combating and Preventing Discrimination in Moldova), it is clear that popular opinion is still largely suspicious of, if not openly hostile towards, homosexuality, and there are many politicians and religious leaders who are willing to use this public fear and prejudice to promote their own positions. Sexual and reproductive health services, on the other hand, whilst neither actively promoting heterosexuality as normative nor actively condemning homosexuality, do appear to be working in a largely heteronormative discursive and socio-cultural environment which may well mean that the needs and rights of same-sex-attracted people are not met. They clearly walk a difficult line, between trying to widen access to their services (thereby hopefully improving health and wellbeing outcomes) whilst trying to not antagonize those powerful voices (secular and religious) who wish to promote a more conservative agenda.

²³ *Analfabet* literally means 'illiterate', but is a common derogatory term used in public discussions and debates against homosexuality, often alongside *pedofil* (paedophile), *zoofil* (zoophile) and *bolnav mintal* (mentally ill).

The framing of the default state of ‘normality’ as heterosexual, understanding heterosexuality as a “coherent, natural, fixed and stable category ... universal and monolithic” (Richardson, 2000:20) is reinforced through these media accounts of homosexuality, constructing homosexuality as ‘other’, as ‘abnormal’ and thereby reinforcing the dominant construction of heterosexuality as commonsensical (Brickell, 2001). Katz (1997:313) suggests that one effect of the mass media “is to encourage privately held attitudes and beliefs to become sufficiently public as to provide consensus for moral action”. Furthermore homosexuality is framed as excessive (Brickell, 2001:222) (as seen through photographs of extravagant transvestite men challenging the public/private delineation of space) and as threatening to the overall body politic. As Carabine (1996) suggests, when considering public/private spaces sexuality is usually framed as belonging to the private domain, hence public manifestations such as Gay Pride marches threaten this taken-for-granted norm. In addition the regular discussion of homosexuality, focusing on what is considered ‘abnormal’, thereby indirectly but no less powerfully constitutes and reinforces that which is considered ‘normal’ (ibid, p.60) – i.e. a heterosexual, reproductive, non-threatening sexuality.

5.5 Conclusion

It can be seen that there are strong local discourses around family, sexuality and nationality, mediated through both secular and religious sources, which have profound implications for the context in which my respondents provide services. These discourses are, to some extent, contested and challenged by many of my respondents, and this contestation is often framed as a battle (*luptă*) for the soul of the nation and the good of the people. New programmes being introduced, usually with the support of international bodies such as the United Nations and World Health Organisation, are welcomed by many, but also rejected by many.

The discursive frameworks within which actors interpret the context around them are powerful precisely because they consist “of a set of common assumptions that sometimes, indeed often, may be so taken for granted as to be invisible or assumed” (Cheek, 2004:1142). Reinforced by media accounts privileging the married heterosexual family, defining deviance as non-heteronormative sexuality and linking both to the vitality and sustainability of the nation-state, these common assumptions about the family and sexuality underpin a discursive context which service providers cannot afford to ignore.

Chapter 6

Sexual and Reproductive Health services and providers in Romania and Moldova: Activities and Influences

Having provided a detailed overview of the complex and contested issues which form the contextual backdrop for the provision of services, this chapter will explore the main services provided by my respondents and link them to the thesis themes. Chapter 5 considered important themes that emerged as shaping the national context, in particular family, sexuality and reproduction, their relation to demographic concerns, and how these are both influenced by and impact discourses on nationalism and national identity. This final chapter explores these themes in more detail through consideration of both media and respondent activities. Specifically, through a detailed analysis of activity in the fields of adolescent sexuality and sex education, maternity services (including fertility and abortion as well as pregnancy), and gender and domestic/sexual violence services, the themes of health and morality and contributions and limitations of a public health approach to such services are interrogated. This analysis will demonstrate how state and civil society actors, donors and politicians, and national and traditional perspectives on sexuality and reproduction all interact to affect the type of services provided and the challenges faced by practitioners and within society more widely.

The three areas of activity were chosen because they cover the bulk of services provided by the organisations represented by the respondents in this study, thereby providing a rich overview of contemporary sexual and reproductive health service provision in Romania and Moldova. They also featured extensively in my media review and so both popular and professional perspectives on these issues can be identified and interrogated.

6.1 Adolescent sexuality/sex education

Having considered media coverage of adolescent sexuality in the previous chapter, I now consider the services provided for this group by my respondents. As I became more aware of the multiplicity of issues and services, and the multiplicity of providers, I began to wonder to whom these services were being offered, who was accessing them (or not), and the extent to which targeting of services was (or was not) taking place. All providers ostensibly provide services to all regardless of age, ethnicity, or location. However it became clear that a large number of the NGOs in both countries were targeting resources on young people in particular – for well-thought out, pragmatic and logical reasons –with

the sexual and reproductive health needs of older people being comparatively neglected. A number of NGO respondents highlighted the fact that young people are often reluctant to talk about sexual and reproductive health with their family doctor (due to shame, fear about lack of confidentiality, and preferring to discuss such issues with their peers), meaning that a number of NGOs provide programmes aimed specifically at adolescents and young people as a conscious and strategic decision. Examples are provided by a Romanian development consultant and a Moldovan gynaecologist/NGO manager, this second quotation also highlighting both the use of a largely western term ('third age') to refer to older people, but also the existence of social taboos and lack of state priorities around the sexuality of older people:

... studies about reproductive health which were done in Romania ... showed that behaviour change is brought about most effectively among young people. ... it was shown in various studies of reproductive health and other types of studies that the best chance of continuing this programme [i.e. the take-up of modern contraceptives and condoms] is to work with young people, because that's the best chance of changing behaviour among young people, among adults you can't do that so much ... in fact ... it is very difficult or almost impossible to change adults' behaviour but with young people really there are more chances, also donors are involved, also non-governmental organisations, the most active are those of young people, those with older people aren't so active, that's the reality, they have other obligations, other interests. (02MI)

If we talk about adolescents, at least at the formal level they are declared as a priority ... There are some small pieces of research in the republic which show the needs of these people [i.e. older people], but ... the third age doesn't just mean for example a woman needing hormone replacement ... this isn't accepted by society in general ... That is to say, if we talk about their sexual well-being, (laughs), absolutely nothing is being considered at the moment, unfortunately. (23MI)

Many NGO providers identified as a problem young people being unwilling and reluctant to talk to state providers such as doctors about their sexual and reproductive health. Although fewer state providers expressed the opinion that young people were reluctant to talk to them, many did express that they felt that more should be done to educate children and young people at school about sexual and reproductive health, as they felt that they were expected to do too much in a short consultation and were not able to give the time required for extensive counselling or preventive work.

A number of NGO respondents in both countries provided sex education services either through direct work in schools, activities such as summer camps, or through publicity and awareness-raising campaigns. State respondents such as family doctors did not provide

such services themselves, but most were direct about the need for more work in sex education in schools as an item of key importance in improving sexual and reproductive health, such as this family doctor from Moldova:

Education, for a start. Don't leave it to the family doctor! ... [discussion about the withdrawal of *Deprinderi de Viață* the previous year] ... So I reckon that it would be good to have this education, special courses ... It would be good to have school classes ... But they don't even know how to correctly say the names of male and female sexual organs, ... So it's all a problem. Usually when you make a programme, a project, you don't expect results after 6 months or a year. Results could be after 10-20 years, but here no. Here a programme, like it was before with the communists, 5 years, 5 year plans for them. In other words we still haven't restructured, we're neither in communism or capitalism. In fact we're in a suspended state. (16MI)

Likewise this family doctor in Romania felt that sex education in schools would reduce a lot of the problems she saw as a doctor in her surgery:

What would improve things? Things they do in schools, education is very important so that young people can understand correctly and not have misunderstandings. ... It's very important to also understand the marketplace, to start (the sex life) when they are sufficiently mature and can support the consequences ... some say that they need to experiment earlier, but then if you haven't got enough information, along comes a surprise. I've had pregnant girls of 14-15. It's very serious, children who have children ... in general I've seen that ... they don't have a basis of this information, or don't do it at school ... often the family doesn't know how to instruct the child. So the only solution would be school, organised, someone specialised and efficient. We'll see. (09RI)

Although some similarities between Romania and Moldova could be seen, there are also some important differences in how sex education is organised and provided. Obvious similarities are that neither country has sex education systematically provided in schools, and that periodically discussions in local and national media debate the pros and cons of sex education, often in response to a "critical discourse moment" (Brown & Ferree, 2005) such as the case of the 11 year old girl in Romania who became pregnant after being raped by her 19 year old uncle (see footnote 20, chapter 5), or the debates around the contested *Deprinderi de Viață* programme in Moldova.

Another important similarity is that state and NGO providers all agree about the importance of good sex education in schools. This NGO manager and gynaecologist from Moldova, echoing the family doctor respondents above, stated:

In the first place very efficient programmes need to be produced for the school curriculum in sex education ... to create adequate needs and adequate knowledge and adequate behaviour. ... But in the first place I believe that in order to improve sexual health in this country we need many efforts in sexual education for all groups of the population. (23MI)

Important differences between the two countries involve the attitude of government towards sex education. In Romania political will, not just around sex education but around sexual and reproductive health more widely, has been somewhat ambivalent, as explained by this development consultant:

... at the legislative level, they're not clear, perhaps it's still a problem, I don't know if it's considered a problem, because the system still functions, there is a strategy for reproductive health, but see how Romania in the year 2007 doesn't have a law for reproductive health, although Romania has the most sad history in reproductive health ... A reproductive health law was promoted in parliament in Romania in 2003 ... Fortunately, together with the deputies who proposed the law they helped the development of a quality reproductive health law. Unfortunately, the law wasn't passed, because there were presidential elections between two presidents, so the health law fell, it wasn't promoted by anyone because it wasn't a priority, the problem is that reproductive health no longer represents a priority, to be discussed, then the new president didn't give it any attention, it was brought for presidential signature, but there were some counsellors in the president's circle who could see that the law isn't perfect because it is called the Law of Reproductive Health and Medically-Assisted Human Reproduction, it's this portion about medically-assisted human reproduction which is controversial and the constitutional court withdrew the law ... Since that moment, not a single person has discussed the law and there is no longer a base in civil society who are working on the law, there is no interest, not on the part of the government, nor civil society, so this process has remained unfinished, unfortunately. (02MI)

In Romania it appears that political debate follows popular discussions rather than initiating them – for example debate on abortion services for minors followed the media uproar around the 11 year old girl travelling to the UK for an abortion following rape. In part this can perhaps be seen as a political reluctance to getting involved in sexuality and reproduction following the gross intrusions of the Ceauşescu years (see chapter 2). In addition, during the 1990s and early 2000s western funding attempting to build national capacity in sexual and reproductive health services including sex education was forthcoming from agencies such as USAID and UNFPA, with less direct input from national policy-makers. However both these organisations subsequently withdrew from Romania in 2008 and with Romania's accession to the European Union in 2007 much international funding has been withdrawn and diverted to ostensibly more needy countries. This issue was highlighted in particular by two Romanian respondents, the first also

suggesting a lack of political will to ‘pick up the slack’ in sexual and reproductive health when international funding has reduced:

... in Romania there was a short-term project where pharmacists were trained to provide minimal advice about contraceptives which they could give with or without prescription This type of intervention would be good to be done systematically Now it can be said that an ongoing problem is that up until now financial assistance has been given by international organisations, it was USAID, UNFPA, World Bank, all these ... USAID is withdrawing from Romania, already they’ve said their assistance in Moldova will be reduced, one reason is because Romania has become a European Union member The World Bank has also finished financing, the intention is that perhaps they’ll be able to continue something in cooperation with the European Union, but the European Union doesn’t have as a main priority supporting this area of sexual and reproductive health, therefore governments need to continue to support it at the national level, except that there is never the necessary budget to support these activities ... (02MI)

... we are a bit reserved about our development plans because this year since the admission of Romania to the European Union, Romania is no longer of such interest for people from abroad. They think that now Romanian is a member of the European Union, the European Union has money for Romania, so I, citizen of Great Britain or Germany for example focus on other areas – the tsunami, Iraq, others. (05RI)

On the other hand, in Moldova the political will to provide a national sex education curriculum in the early-mid 2000s, supported by the ongoing input of international organisations such as the UN and WHO as well as the World Bank, was much more proactive. Indeed, media debate (both for and against sex education) largely followed the introduction and subsequent withdrawal of *Deprinderi de Viață*, rather than preceding events as was often the case in Romania. Even following the withdrawal of the programme, tacit government support remained in principle, with the programme still being available on an optional basis and government continuing to support and engage with the organisations involved in developing it, even though to the disappointment of campaigners, health and education professionals the national programme was no longer pursued. Individual projects such as Organisation 5’s and UNFPA’s work in training peer educators were officially contracted through the Ministry of Education, whilst the army and prison education work is contracted through the Ministry of Defence.

In fact everything we do ... needs to be approved by the Ministry of Education or Ministry of Health. All the certificates for the young people who have gone through training are signed by a vice-minister. This is standard. ... (10MI)

I’m talking about a project aimed at young soldiers and officers from the national army. The project is running for its third year, we work in a very close collaboration

with the Ministry of Defence of the Republic of Moldova who are very willing, they help us a lot. (25MI)

However, despite political will for this particular programme (underwritten by considerable funding from international donor organisations), support for an opening up of the debate around sexual and reproductive health more generally was marked by reluctance in Moldova also:

So here I believe that we need political support, we need courageous politicians, we need political will. This doesn't exist for our politicians. We ... tried many times to challenge the President of the Republic of Moldova, to come with an anti-HIV/AIDS message, for the population, for young people. It didn't happen. Because, reproductive health, sexuality is considered a shameful thing, a taboo thing and they don't want to discuss it. There is no political courage in our politicians. (11MI)

Particular activities in sex education varied across organisations as well as across the two countries. In Romania, there were different experiences of providing education.

Organisation 2 provided a formal series of lessons as part of a contract with the county education authorities, and indeed were often invited by head teachers to provide these services:

... our services are complementary to the services already offered in institutions such as schools. ... We go to schools, we discuss with the school directors and where there is a need for our programmes we draw up an intervention plan. On the other hand at the county level we have a partnership project contracted with the county authorities in education, health, and in work and social protection. (05RI)

Conversely, Organisation 1 had a less positive experience of this and by the time of my fieldwork was no longer providing lessons in schools.

Recently we've no longer done these activities in schools but more in our camps. Because, it was controversial, there were some cases where ... some parents were accusing teachers of promoting sex in sex education classes ... To avoid this type of problem we have tried to discuss these sorts of things here in our organisation, bringing the young people here to us to do our school work here. (02RI)

This group did undertake some work on their own premises with teenage pupils, and in the context of a wider programme looking at gender, violence, relationships, diversity and issues identified by the pupils as important to them a sex education lesson (in which I was invited to participate, although I felt that my language skills were not sufficient to do this as well as I would have liked) was included. This took the form of a discussion mostly led by the organisation's psychologist, who clearly had already developed a rapport with the

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girls who were aged 16-17. These notes from my observation, written up immediately afterwards, are interesting in that they highlight some deeply ingrained assumptions about gender roles and fertility control:

“They knew lots of the “right answers” (e.g. the need to use a condom to prevent STI transmission) but one or two cultural norms did emerge. Most notably, they were all quite adamant that it would be really embarrassing the first time if they were the one to produce a condom from their bag. Also, when E. asked about options if someone found they were pregnant, all six chimed in unison “Avort” [‘abortion’] – although discussion on what they all thought of abortion suggested that they ... would not want to have one themselves, they would have the baby and get their mums to look after it, they felt abortion was wrong, although they seemed open and in agreement with E’s suggestion that judging someone who had an abortion was wrong. They all seemed knowledgeable about where to go for pregnancy/STI testing.” [notes p17]

However this type of small group work is somewhat resource-intensive and so unsustainable on a large scale at current funding levels.

6.1.1 Peer education

Something which was used in both countries and which was increasingly being considered as an important means of addressing the information deficit around sex education was the method of peer education, particularly in Moldova. Peer education evolved from a recognition that young people are more inclined to discuss health information (particularly around stigmatised issues such as sexual health) with their peers rather than parents or adult professionals (Richardson and Taraskin, 2006). Certainly, my respondents in both countries frequently identified as a problem young people’s unwillingness to talk with parents – however this was framed as much about parents’ unwillingness to discuss taboo subjects such as sexuality and reproduction as about young people’s unwillingness to discuss them. Ștefaneț and Leșco (2005) identify on the contrary that many young people wish to talk more with their parents about these issues. The concept of peer education can be considered potentially culturally relevant in the Romanian and Moldovan contexts due to the socialist era constructions of the peer educator “as a role model for other young people to look up to – young people should aspire to be ‘good citizens’” (Richardson and Taraskin, 2006:84). They thus represent a continuation of socialist youth policy through their structuring of young people’s leisure time and through “provid[ing] peer educators who lead by example” (ibid., p.85). This following section will discuss the experience of peer educators interviewed during this research, and then discuss some critiques of this particular activity.

Organisation 3 was the only organisation with whom I spoke in Romania which used the method of peer education as part of a much wider set of activities such as first aid as well as sex and relationships education. A group interview with the young volunteer peer educators identified their activities and what they saw as its importance, namely the transmission of ‘correct’ information:

... we go into schools at form time to talk with the pupils on different subjects, such as drugs, contraception, starting sexual relationships, smoking, alcohol, also team work ... about what it’s like to volunteer. (01RG)

They need to be informed about what contraception is and what methods of contraception there are, that it’s very important when they have a sexual contact to protect themselves from very many sexually transmitted diseases and also to know what the advantages and disadvantages are, where they can get them from and in case God forbid they get an illness to know what to do, how to deal with it. (01RG)

In Moldova in organisations that used the method of peer education, it was seen as the primary activity and large numbers of young people (between 14-22 years of age) were trained to work with their peers to promote sexual and reproductive health. Following the withdrawal of *Deprinderi de Viață*, formal schools work such as that provided by organisation 2 in Romania was not possible on a large scale. Instead they concentrated on providing information online, through broadcast media and through the use of ‘social theatre’, as well as through having stalls at events such as music festivals and involvement in campaigns such as Dance4Life where printed information and free condoms would be distributed. Interviews and observations with the peer educators showed they were confident, articulate, committed to the activities they were undertaking, and certain of the positive impact of their work. Again the transmission of ‘correct’ information was seen as paramount:

In fact when we go into schools and camps, we’ve become sort of destroyers of stereotypes and myths which circulate throughout our society, young people ask very many questions and of course have very many problems, one of the most important problems in schools is the fact that to discuss reproductive health, discuss sexual relations and in general about intimate relations, it’s still a taboo in our society and all this is connected to these young people still not knowing and trying to learn ... (03MI)

Organisation managers and funders were also convinced of the efficacy and efficiency of the use of peer education, and so committed considerable time and resources to the training:

The *Pro-Health Campaign* we do twice a year, in spring and autumn, when we go with our volunteer peer educators to different regions of the republic ... Now, yesterday I received a letter from the Ministry of Education and Youth which permits us to go to education establishments in the whole republic ... with an information and education campaign in health and sexual and reproductive rights ... This year we've participated in a national radio programme, every Thursday with specialists, with young volunteers, with peer educators ... (25MI)

The Y-Peer network is ... promulgated by the Ministry of Education [which] has already recognised that for example peer education is a very efficient method of transmitting information about reproduction and sexual health ... (10MI)

The peer educators also worked in the arts and mass media, taking part in social theatre training and in a weekly national radio programme. They were clearly developing skills in communication and were in effect authoritative voices amongst their peers. Richardson and Taraskin (2006) highlight how peer education programmes do not always demonstrate tangible results among the target group populations, but do bestow considerable benefits to the educators in terms of skills gained. This study did not seek to measure the effectiveness of the peer education programme among the target group, but it was certainly the case in Organisation 5 that the educators were skilled and benefiting greatly from the programme.

I stated above how peer education efforts can be seen to represent a continuation of socialist era youth policy and practice. However, since the end of the state socialist systems, many peer education programmes developed with the help of western interventions have used peer educators in a different way. Using a more western-favoured approach from a harm-reduction perspective, peer educators were used "in the form of credible oracles possessing a deep knowledge of taboo subjects" (Richardson and Taraskin, 2006:85), focusing on a neutral approach which transmits the 'truth' about the subject of the education intervention. In many western settings such interventions are viewed as radical as power is thus devolved to the young people on the basis of their credibility amongst their peers (rather than necessarily their status in adult terms such as through academic achievement) and young people themselves are involved in the development of the programmes (ibid.).

The respondents interviewed for this research in many ways represent a hybrid of these two positions. On the one hand, the content of the peer education interventions, and the underlying philosophy of the peer educators themselves, was the transmission of 'the truth'

and the invocation and legitimisation of scientific ‘fact’ about sexual and reproductive health, representing a means of reinforcing the presumed scientific and rational approaches of the western institutional funders and medical profession. The young people, particularly in Moldova, were also involved in designing both policy and programmes and had a high level of autonomy in the activities they undertook. However, the profile of the educators was one of highly motivated, academically able and confident communicators, the type of people who would have been chosen even during the socialist era as the type of people who could lead by example and provide an acceptable role model. The radicalism of the programme could therefore be diluted by the ‘positive role model’ approach as it may affect the credibility of individual educators (Richardson and Taraskin, 2006) who could be seen as emulating adult ‘masters’ rather than providing information from a position of credibility with their peers as people who have ‘learnt the hard way’ through personal experience.

Another potential issue with the reliance on and dominance of peer led education programmes is the underlying assumption that “‘older’ educators are less likely to understand youth culture and subsequently relate to young people in a meaningful way” (Allen, 2009:45). The largely uncritical belief in peer education as the best way to reach young people needs to be looked at further. Allen (2009) in research from New Zealand highlights that the identity of the educator (be it peer, doctors, parent, teacher), is less important than the qualities they possess as educators, and the assumption that young people always prefer talking to people their own age needs to be carefully critiqued. For example, whilst “[w]ith a known educator there can be more opportunities to develop rapport and trust as well as offering students a convenient source of support” (Allen, 2009:45), issues around anonymity and continued exposure to the peer educator in other social settings may mean that some young people are more reluctant to discuss such matters with peer educators for fear that the information they share will become more widely known in their peer group. The assumption that a similarity in age will

“engender greater understanding of young people’s lived realities ... facilitate communication and understanding demonstrates an essentialist logic [which] can ignore the complexity of young people’s subjectivities, which are produced at the intersection of structures such as class, ethnicity, ablebodiness and sexuality (to name a few)” (Allen, 2009:44).

There remains a need to critique the assumptions underpinning the dominance of peer education approaches for sexual and reproductive health – not to denounce or undermine them, but precisely to increase their effectiveness through challenging the dominant values

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underpinning them in order that they may more effectively counter opposition to sex education more widely.

6.1.2 Most important issues for providers

Given this background of a complex history regarding sex and reproduction in both countries, and the emergence of many different types of service in response to a mixture of local need, state-mandated priorities and donor/funder priorities, I found it quite difficult to ‘pin down’ where needs, priorities and services intersected. I asked respondents what they felt were the most important sexual and reproductive health issues facing their country today, and whilst some issues emerged repeatedly (in particular around a lack of (or incorrect) information, inadequate sex education in schools, a reluctance to talk about sex in families or with doctors, a particular lack of access to services and information among the rural population, early age of first sexual activity, and myths about modern contraception) in both Moldova and Romania, from providers in all sectors, other issues also emerged where there was less agreement, perhaps reflective of the respondents’ particular interests. These issues include poverty, lack of equipment, supplies and adequate/suitable consultation spaces, poor reporting and data collection, ad hoc provision of sex education, gender and sexual stereotypes, financing of the health system, inadequate screening services, poor wider health behaviours, influence of religion and tradition, birth services, lack of a concept of sexual and reproductive rights, sexual and reproductive health not being a political priority, healthy relationships/divorce, medical/nurse training, lack of social advertising, abortion (quality and numbers), migration, professionalism, and donor priorities.

Looking at the common issues in closer detail, most can be seen to be somewhat interlinked. Inadequate and incorrect information, a lack of sex education in schools, a reluctance to talk about sex in the family (leading to it being widely framed as shameful and taboo), a reluctance to visit doctors, and the corresponding reliance on mass media and lay sources (relatives, friends, or what was often referred to as *strada*, ‘the street’) for information are clearly important and complex issues which need to be taken seriously by policy-makers and service providers. The persistence of myths and stereotypes which are still going largely unchallenged can also be linked to this problem of information and education – certainly discussions in the media on items about contraceptive methods demonstrate ongoing mistrust and myths, suggesting that health education campaigns are

having a limited impact – something that was lamented by a public health authority manager in Romania:

I'd say that results in my opinion were pretty poor ... there's not a single method we've used that has been well adapted to the Romanian mentality, ... so personally I'm not happy with the results, ... there aren't the results which I personally would like ... women become pregnant still, the abortions which they do, some who have never heard even that a method of contraception exists or haven't heard that there's a family planning clinic, this still happens ... (04RI)

The oft-mentioned concept of 'mentality' also was generally invoked in generational and geographical terms, and again the role of the medical and allied professions played an important part. The concept of mentality is problematic, in that it is easy to essentialise a population and assign to them a label which does not differentiate between people or their reasons and reactions. However, many of my respondents used the term in precisely this way, particularly when talking about their geography and history, and so this is something with which any health system reform or service development needs to engage.

The 'mentality' of younger and older people was often contrasted, and used to give a sense of change and progress, as well as of the challenges facing services. It was also often linked to the unwillingness to discuss sex in families previously discussed:

These people were brought up in the Soviet period, when there was in fact another mentality, they have other opinions about young people, how to address this [subject]. And, they believe that you don't talk about sex ... about the sexual life, reproduction, more intimate subjects. (24MI)

Some younger people who have a vision and a new mentality, that's to say not restricted by the communists and the results are very, very good ... the young generation, yes, they are much more open, and discuss, and are non-conformists, and aren't afraid to discuss with doctors about these subjects Even if it is a challenge, they discuss it. If we talk about the older generation, yes there is a taboo there. To discuss about ... reproductive health, for them it's a taboo ... It's a manifestation of the mentality from the Soviet system, the communist system. And this occurs not just with ... the population but also with doctors. It also happens in the family ... it's not considered important to discuss with children about sexuality, about risks, about STI protection ... (11MI)

... we have arrived now at a crossroads, so we are in a [period] of changing the mentalities and values and we need to be very aware of the fact that we can't change the mentality of people in just a year or two ... We are succeeding to influence the mentality, to ... bring new ideas, new models of partnership, of relationships, so the country has a future. (19MI)

These discourses were sometimes presented in a fatalistic way, suggesting that these are the barriers which services and practitioners have to overcome, and that it is no wonder that things are not changing, or only changing slowly. Although it is problematic to tar entire populations with the same brush, nevertheless it seems important for donors to engage creatively with this concept of mentality, as not taking it into account potentially causes problems. Most notably, the protests against the introduction of sex education in Moldova (discussed in detail in chapter 4) included charges it was inappropriate for such subjects to be discussed in public and in school, something which respondents had identified as part of the ‘mentality’. Greater cultural awareness and engagement with local cultures and mores may well prove more helpful in future service design.

None of the problems identified by respondents are new to the post-socialist era, but were also prevalent throughout the period of state socialism. David and Băban (1996:242) highlight how sex was a taboo subject at home, “resulting in misconceptions about sexual facts, overvaluation of virginity, a distorted relationship between boys and girls, and an interpretation of premarital sex as sinful and dirty. Young women were ill prepared to cope with their sexuality.” The same authors quote Romanian women very explicitly talking about not being told about sex, menstruation or relationships in their family but finding out by themselves (Băban and David, 1996). This situation arose often in my interviews, in both countries – firstly a Romanian NGO practitioner discusses resistance to sex education at school and at home, and then a Moldovan gynaecologist repeats a theme which emerged regularly, that of lack of discussion as a tradition:

But it would be better to be more open and to ... educate children, to be more open ... so we tried to talk about sex education in schools but some parents disagreed with this activity, and they need to be more open, if they can't discuss with their children at least let the school or send the children to centres which ... can open their eyes ... (06RI)

Often they don't talk about this [sex, sexuality etc] in the family. This is a tradition here, that parents have decided not to talk about this. (06MI)

Likewise, Johnson et al (1996:528) highlight the lack of sex education in Romanian schools, and the opinion of many professionals that this would be vital in countering myths about contraception. They also highlight the problems of teachers themselves having inadequate knowledge, and of both parents and teachers expressing concern that such discussions in school will promote early sexual behaviour. More than 10 years later I

found that these issues were still very much ‘live’, with one young client talking about the reaction of her parents’ generation to sex education:

... among parents ... if we ask about these things, we want to do them! But, I told my parents that I don’t want to do them, I only want to know. (20MI)

6.2 Pregnancy and maternity services

Another area where a number of my respondents worked was pregnancy and maternity services. This also features extensively in the media in both countries and links closely to wider demographic debates on national health and vitality. This next section considers media coverage of pregnancy and maternity services and then the activities of my respondents in order to highlight the complex interactions between ideas of responsibilities and desired outcomes on the one hand and the limitations of services on the other.

Articles relating to pregnancy, fertility, infertility, abortion and maternity services are fairly frequent in the media. As well as the many articles on teenage pregnancy and parenthood discussed in chapter 5, articles tend to fall into a few main categories. These include: health education articles (on foetal development, appropriate diet, exercise – these are more common in Romania than Moldova), fertility issues (ways of maximising fertility, reproductive technology such as IVF or surrogacy), parenting (child development, nutrition, breastfeeding etc), maternity services (generally concentrating on poor or high standards of hospitals and other facilities plus medical negligence and malpractice), and abortion (ethics, prevalence, services). Within much of this coverage, strong images are produced of what is normal, responsible and healthy behaviour within a strongly heteronormative paradigm. There are also examples where motherhood is both implicitly and explicitly promoted in quasi-religious terms, even in the secular press, including titles such as “Breastfeeding can save your baby’s life” (*Libertatea*, 2009d) and from Moldova, “Breastfeeding – a total offering” (*Flux*, 2008c).

Pronatalist messages are rarely overt, as in Romania in particular the legacy of Ceauşescu’s pronatalism is such that this is still a very sensitive topic (Turcescu and Stan, 2005); however in both countries features on large families can be seen, with the term ‘heroine mother’ so lauded during the socialist era being used by both public commentators and sometimes also in the article itself. The responses to these articles are mixed, with both praise for a selfless sacrifice and commitment to family and nation, and scorn for

ignorance of modern contraception, reliance on welfare benefits and an assumed traditionalist religious belief.

Infertility, and IVF in particular, are treated very differently in the secular and religious press in both countries. All the religious sources accessed for this study without exception categorically denounced IVF as dangerous and immoral, for example this article from *Moldova Creștină* (2008g) which includes in its advice to someone asking what to do if they are unable to become pregnant:

“Don’t accept methods which involve death. In-vitro fertilisation is genocide, and anyone who resorts to this method commits a terrible crime against their own children who will be annihilated en masse. Don’t dare to think that you could ever do such a thing.”

Secular sources on the other hand merely tend to outline the legislation, costs and barriers to IVF and the public responses are overwhelmingly in favour of IVF (see for example *ProTV Romania* (2008c) where many comments requested further help to access funding and treatment and criticising the Romanian health services for not making access to IVF easier). This response contrasts very clearly with the responses to articles on abortion, where there are many more responses (the majority) which categorically denounce abortion as evil and a crime.

It could be regarded that this reaction on the part of conservative and religious commentators against IVF represents another example of the rejection of forms of intervention in sexuality and reproduction. The framing of assisted reproductive technology as an unnatural imposition, going against the ‘natural’ or assumed ‘norm’ reflects the heated debates such as those around *Deprinderi de Viață*, closing down the possibility or desirability of outside intervention, whether this be by outside ‘experts’ or by modern science. In the particular case of IVF this rejection of intervention does not seem to be reflected in public opinion in the way that objections to sex education seemed to garner more popular consensus; however this does represent another example of the type of objections and barriers to sexual and reproductive health services encountered by my respondents.

Articles on maternity services in both countries demonstrate an aspiration to European standards and a criticism of local conditions. Titles proclaiming European standards and UNICEF endowments contrast with bleak headlines about poor conditions in hospitals and

Romanian women seeking to give birth in Hungary. The tensions between rejecting 'Europeanness' and holding firm to traditional national values shown in other topics is not present at all when considering maternity services; instead 'Europeanness' is something to which to be aspired. This accords with a number of my respondents when discussing health services as outlined in chapter 4.

Given the importance placed by society and popular discourse in both countries on sexuality, reproduction and the family (see chapter 5) it is then no surprise that all aspects of pregnancy and maternity are key in the debates around sexual and reproductive health services and their meanings and importance for national health. The fecund, pregnant body is used as a powerful symbol of national vitality, and the enabling and control of the means of reproduction is particularly important in nations facing lowering birthrates and increased economic migration. Discourses of 'demographic crisis', as outlined in chapter 5, often sit alongside debates about sexuality and morality, with 'approved' and 'deviant' sexuality clearly demarcated. Pregnancy, as a symbol of the heterosexual family and the future generation, is therefore a privileged domain where women become more than individuals carrying a child (whether wanted or unwanted); they bear the hope of and responsibility for the nation's future. The meaning and significance of pregnancy, therefore, is not simply biological but social (Lee and Jackson, 2002). All aspects of reproduction – fertility, abortion, pregnancy – become the preserve of experts, and the pregnant body (or the body desiring to become pregnant) becomes subjected to expert scrutiny, most obviously by the medical profession.

In Romania and Moldova, although they experienced different manifestations of medical and state regulation of reproduction during the socialist era, today both see maternity and pregnancy services remaining highly medicalised. Among my own respondents, even in the NGOs offering maternity-related services, the services offered conformed to a largely medical, public health approach. Organisation 2 was unusual in that its services were not provided by a gynaecologist (although their previous director was medically trained), and it did offer non-medical services such as exercise classes; however even here the emphasis was on promoting health through increased education and knowledge rather than on challenging medical hegemony. The vast majority of maternity services in Romania are provided through the state medical system, with a clear professional hierarchy consisting of specialist obstetricians and gynaecologists and family doctors, with midwifery considered a much lowlier job with less responsibility and minimal professional autonomy. Doctors would refer patients to NGO services (such as those of organisation 2) if they

knew they existed, but in general there seemed to be little collaboration between the state medical sector and NGOs. Clients, whomever they attended for consultations, were subject to medicalised scrutiny and expected to take on board professional advice.

In Moldova as in Romania the system with respect to all aspects of reproduction is very medicalised, with the medical profession more important and (at least in the city) midwifery less so²⁴. The main difference in Moldova is the increased hybridity between state and civil society providers, with many practitioners working in both sectors. In these cases collaboration in individual cases between the two sectors is greater, particularly in the large cities where NGOs are concentrated. However even here this is largely dependent on which practitioners are involved with the pregnancy; I interviewed two women (one pregnant, the other 8 months postnatal) and whilst one accessed UNICEF-sponsored parenting preparation classes at the maternity hospital where she was registered similar to the classes provided by Organisation 2 in Romania, the other had accessed no civil society-led services at all and was unaware of any in the city.

A common thread in discussions (formal and informal) with pregnant and postnatal women in both countries was the issue of corruption, particularly in the form of informal payment for services. Despite European Union accession for Romania and the introduction of a sophisticated health insurance scheme in Moldova which is showing signs of considerably improving the financing of the healthcare system (Atun et al, 2008), in both countries the payment of ‘under the table’ payments for services was considered routine, inevitable and simply how things were done (Rebeleanu, 2008; Richardson, 2008; Balabanova et al, 2004). Payments were mentioned in order to secure the right to give birth in a particular hospital in Moldova:

I gave birth here at the [hospital name] even though I didn't have the right to give birth here. For our area of the city I should have given birth at another hospital, but ... I wanted to have the doctor here who delivered my son some time ago. ... I came here again ... knowing now what it is like ... [I]f I'd gone to the official hospital I wouldn't have had to pay anything ... but here, you go if you have an understanding with the doctor, you pay for everything, he tells you the price and you pay him – that's how it is here with us. (21MI)

²⁴ In the villages in Moldova, many of which have no doctor, the midwife is more important though often powerless due to a lack of equipment or health promotion material – one respondent told me of a midwife in a rural village who had cried as she told her that she had received no contraceptives to distribute to anyone who wanted them or any material to talk about contraception and sex with the women and adolescents in the village for some years.

The need to buy gifts for the doctor who delivered the baby and the midwives and nurses who provided peri- and post-natal care was also mentioned in Romania. Women in Moldova also mentioned simply not being told that pregnant women were exempt from paying for particular medication during pregnancy so continuing to pay the doctor for providing a prescription.

In Romania all of the state services but only one NGO provider with whom I spent time provided services relating specifically to pregnancy. Organisation 2 ran a series of weekly antenatal classes for expectant parents (including fathers, although during the sessions I observed fewer than half of the pregnant women were accompanied by their partner) and a twice weekly exercise group for expectant mothers specifically. Topics covered in the classes included Conception and In-Vitro Development of the Foetus, Birth, Health in Pregnancy, Breastfeeding, Bathing the Newborn and Child Safety, and Contraception. There was also a session scheduled on Psychological Aspects of Pregnancy, but due to staff absence this was not run while I was present in the field. All of the sessions were led from the front by the Programme Manager (a qualified nurse) and although she was happy to take questions throughout the session as and when they arose, the impression was very much of information being imparted from the professional to the lay audience. Some of the sessions included western videos which were either subtitled in Romanian (breastfeeding) or the Programme Manager translated over the top of the English narration²⁵. A lack of locally produced information and teaching material was highlighted in both Romania and Moldova; in this case it could even be argued that it was counter-productive as much of the video showed UK-specific practice (birth being attended by a skilled and autonomous midwife and the partner present throughout) which was simply not applicable to the Romanian situation where fathers are not usually allowed to be present and midwives are much less autonomous in their practice, particularly in urban areas.

Family doctors also often highlighted pregnancy and the immediate postnatal period (*lăuzie* – probably best translated as ‘confinement’) as a large part of their role with regards to sexual and reproductive health. However when I asked them what the most important issues facing sexual and reproductive health were in the country they all focused on sex education rather than on pregnancy, suggesting that in general they felt that current pregnancy provision was, if not acceptable, at least not as urgent a need as sex education.

²⁵ The Birth video is one used regularly in UK antenatal classes and no doubt reflects the organisation’s founder’s professional background. It was a video that I myself had used in my own professional practice prior to undertaking this research!

One family doctor linked abortion to lack of contraceptive availability and knowledge, as well as to cultural issues:

I'd say that it is a problem here ... especially about information. I'll give you an example, my husband is an occupational health doctor and has many firms. One of his firms is in the countryside ... near Sibiu. 400 workers of whom 300 are women. The boss bought a factory in another county, in a Hungarian county where there are predominantly families of Hungarian ethnicity. And he was extraordinarily and unhappily surprised at the lack of sexual information here in Sibiu, an enormous number of abortions per woman, compared to the Hungarian women from ... Harghița, where the number of abortions was much smaller, tiny even. They had 2-3 children, 4 even but they didn't have abortions. ... If you don't know and don't have contraception of some sort or other, you're not going to have just 2-3-4 children. So these women needed to get their information from somewhere. I think that they got information because they were Hungarian, they have relatives in Hungary and got information from there, often also contraceptives from there if I remember correctly, when I was a student I also took contraceptives from Hungary. So this gives an idea, an example about lack of information. (12RI)

In Moldova the main pregnancy-related services provided by my NGO respondents were abortion (organisation 6), infertility (an NGO which was based in a state hospital and was a national-level facility) and some gynaecological services (organisation 7). In addition, state providers I spoke to (often in their capacity as volunteers and board members for NGOs) worked as gynaecologists/obstetricians in the state sector, providing all pregnancy- and abortion-related medical services. As in Romania, in Moldova all activities and services related to pregnancy are primarily in the medical sphere.

Organisation 6's activity is based around providing safe abortion services in accordance with WHO standards, educating the population through its website and broadcast media about methods of abortion and about their rights and entitlements. They have also been involved in randomised controlled trials of medical abortion, and have been key players in formulating the national Strategic Report on Abortion Services and the National Strategy for Reproductive Health. As the main implementing agency for the national abortion strategy, charged with improving services and access to them, they work closely with the Ministry of Health, WHO, NGOs (both health and gender) and UN agencies. As with organisation 2 in Romania, clients mainly hear of them and attend the service through word of mouth.

However although organisation 2 did have agreements with the Ministry of Education at the *județean* (county) level in Romania, organisation 6 in Moldova has been successful in gaining access to decision-makers and policy-makers at the national level and so is able to

‘punch above its weight’ through being regarded as an expert in the field. This is also the case with organisation 8 in the field of gender and domestic violence and to an extent also with organisation 5, particularly in the field of sex education. In Romania it is probably only organisation 4 of the organisations with whom I spoke who had this kind of reach.

This issue of national reach and influence was more obviously demonstrated in Moldova than Romania, although one of the main reasons could be that in Moldova (unlike Romania) most of my respondents were based in the capital city so were closer geographically to the centre of power and decision-making. However this was not the only reason, as organisation 4 in Romania which has been extensively involved in policy consultancy at national and international levels is based in a regional centre several hours away from Bucureşti. More striking in Moldova was the issue of hybridity, with those NGOs retaining close links to the state and whose managers often moved between state and NGO roles particularly seeming to retain a seat alongside the decision-makers in government (see Kulmala, 2011). Although a number of respondents suggested that collaborative work in Moldova was rare or poorly-executed, for those organisations that did work alongside state services and policy-makers, the rewards in terms of potential to influence the future direction of reproductive health policy were great.

Pregnancy services, perhaps more than any other area of sexual and reproductive health, illustrate the troubled link between the socialist past and an uncertain future, and show how the conflict between tradition and aspiration is often played out through the battle to control reproduction. I asked my respondents about whether or not they felt that the socialist policies particularly around reproduction still affected attitudes today, and whilst responses were mixed in both countries with some people disagreeing that there was any ongoing influence, of the majority of respondents who felt there was still an influence from the socialist era the majority talked about issues of pregnancy and abortion, often linking them to demography:

... it’s less now. But it’s still there, abortion in particular is still used, unfortunately, as a method of contraception. Still, there are many people who do this. So we in NGOs and hospitals with family planning departments try to speak more powerfully to change this wrong mentality (*mentalitate greşită*). (03RI)

We used to do abortions, but did them in secret (*pe ascuns*), and illegally ... and resorted to unsanitary and unhygienic methods, and lots of people died. Now, after the revolution, it’s more, we were given freedom, in other words abortion, it’s not illegal to have an abortion ... Yes, because when we talk about that mentality, there

are many, older people who don't agree with abortion, or especially very religious people ... But this mentality is still here which is against abortion. (06RI)

I don't think it was a bad policy, in fact, in the sense that it placed a high value on the child, it placed a high value on the family ... Actually in my subjective opinion, the worst problem now is the policy of the genocide of the population of the Republic of Moldova. ... A quarter of the population ... has emigrated abroad and this is the population of reproductive age. ... In 10-15 years we will have very serious consequences from this exodus. People with higher level studies, well-trained people ... perhaps this will be positive. But also, there is a very negative impact against family values in general ... values about sexual behaviour. (23MI)

This link to demography illustrates how and why pregnancy and maternity continue to be a key issue as Romania and Moldova face their future.

6.3 Gender and Domestic Violence

Gender as a concept is claimed explicitly by most of the donor organisations related to this research. The language of 'gender mainstreaming' and 'gender action' is now established (Porter et al, 1999; Ghodsee, 2004), but it is not always clear how critically this is considered in practice (Einhorn, 2006/2010). The gap between many eastern women's groups and the constituency they purport to serve and represent is well documented (Kay, 2000; Grunberg, 2000), as is the potential problem of a focus on gender 'masking' other important areas of inequality such as class (Ghodsee, 2004; Olsen, 1997). This uncritical application has led to something of a disconnect between some eastern and western feminist academics and activists over understandings of the role of the family and terms such as 'emancipation', and over priorities for action (Ghodsee, 2004; Snitow 2006; Drakulić, 1998; Šiklova, 1998; Einhorn, 1993).

It would be wrong to assume that the shortcomings of east-west feminist engagement negates the positive work that is being done in areas such as sexual and reproductive health and rights awareness, the promotion of gender equality and campaigns against gender and sexual violence. Equally, organisations in receipt of funding in this area were clearly committed and passionate in wanting to improve the situation for their constituent groups at a structural as well as at a project level, and have been enabled to undertake important education and awareness work (as well as provide practical assistance) by their involvement with western funders and feminist discourses. However the practicalities of applying for funding in a context of changing donor priorities were highlighted by a

number of respondents (see chapter 4), and the acceptance of these funds and discourses did not necessarily lead to wider cultural acceptance of their programmes and priorities.

A number of my respondents in both countries worked in the area of gender equality/awareness, and included a significant focus on domestic violence in their work. Domestic violence has been recognised internationally as a public health issue (Fimka and Butchart, 2005), and given that, for example, pregnancy doubles a woman's risk of experiencing domestic violence (Richardson et al, 2002), many organisations dealing with both gender and domestic violence often also include sexual and reproductive health issues as part of this work. For this reason media articles focussing on both gender generally and domestic violence specifically were also accessed for this research.

Articles on gender tended to focus on the issues of gender stereotyping and on attempts to promote equality, for example in articles on gender awareness in the media, women working in leadership positions, and women's rights. However articles such as the one headlined "Sexually active women risk becoming ill with cancer" (*Adevărul*, 2006) highlight that stereotypes and negative images can also be created and promoted as well as reported by the press. An example in the popular Romanian broadsheet *Jurnalul Național* (2008b) entitled "The extraordinary power of femininity" begins:

"Sometimes, the power of tenderness, goodness and of love can move mountains. This power needs to be learnt again by women, to balance the environment in which they live, from the family right up to the societal level. Our power is in our identity, but, sometimes we forget who we are on the inside, suffering one way or another without understanding why."

It then goes on to explain:

"We are constructed differently, women and men, like the yin and yang energies ... If, for example, in a couple both partners have yang (masculine) traits, communication can be a problem; there could be arguments, aggression, excessive reasoning or competition ... When a woman loses her femininity (yin) she renounces her right to form a balanced couple with her life partner (yang)."

This extreme framing of a gender binary and the ideal for women to be gentle, tender and above all not masculine again reinforces both gender stereotypes and heteronormativity. The construction of the 'ideal type' of woman is thereby reinforced in the national media. The political sphere too is not immune, for example in the Romanian broadsheet *Cotidianul* (2009) an article on women in politics around the time of the European

elections displays stereotyping about women in ways that would not be expressed about men:

“The discussion about the presence of women in Romanian politics is already getting boring. The conflict between Mungiu-Pippidi and Elena Bănescu²⁶ represents a profound clash between two paradigms. The 80s and 90s produced important feminine figures, of great stature. Like Ana Blandiana, who had the power in '90 to choose the future Romanian president, right up to Gabriela Adameşteanu, Renate Weber or Alina Mungiu-Pippidi. From this succession the most recent is Monica Macovei, a ‘strong’ personality like all those before 2000. The last 10 years have brought to the forefront women from another paradigm: Udrea, Elena Bănescu, Birchall, Sandru, Iacob-Ridzi. What do you think has caused this phenomenon? ... I have my own version of events. Paradoxically, after the enthusiasm and effervescence of the '90s, a new reactionary and ultraconservative wave has been let loose in Romanian public space. A renewed machismo has gained ground in politics ... She may seem to have strong support ... but Alina Mungiu-Pippidi's tentative steps into politics won't fail accidentally. ... Today's successful women in politics are cyborgs manufactured in the heads of macho politicians. Ridzi is pretty, like Elena Bănescu and reached the top of the party hierarchy; then she got a ministerial post – that's the algorithm. ... Macovei and Weber (and perhaps Mungiu-Pippidi) are only good for group photos in Brussels.”

Moldovan broadsheets tend to cover the issue of gender less often, although *Timpul* has featured a number of articles on gender equality which were generally more measured. These articles are often produced from reports and seminars on the subject of discrimination led by experts in the field. However gender stereotypes also appear in the Moldovan media, for example in a discussion programme on *ProTV* in March 2008 which asked “Can a woman have a career, and be a mother, and please men?” (*ProTV* Moldova, 2008c)

Domestic violence was generally presented in terms of the services available, incidence and legislation, as well as campaigns by national and international celebrities such as Keira Knightley and Nicole Kidman against violence in families. Most articles were factual in nature, and many highlighted the relationship between national and international actors. A number of articles highlight services such as women's refuges (and the fact that demand is higher than the number of places available). As with articles on maternity services, domestic violence too is an issue that is often presented in terms of international standards or design.

²⁶ Alina Mungiu-Pippidi is the Director of the Romanian Academic Society and a well-known political scientist and commentator. Elena Bănescu, a former model, is the youngest daughter of the current Romanian president and was elected in 2009 to the European parliament.

At the level of individual NGOs it appeared from my sample that organisations with a main focus on gender (all of which included awareness about domestic and sexual violence as a prime focus within a gender approach) incorporated sexual and reproductive health within their activities and recognised the links much more explicitly. Organisations which came from a primarily public health perspective on the other hand (with the exception of organisation 4 in Romania), including state providers, were less likely to discuss or address directly issues of gender and domestic violence, instead concentrating almost exclusively on the health aspect without an explicit focus on the different gendered experiences of reproductive and sexual health.

Some of the major donors involved in funding some of my respondents approach their activity from a particular gender perspective, and this did seem to be reflected by the recipients of their funding – for example one NGO manager in Romania estimated that sexual and reproductive health issues took around 25% of their time and focus, within a wider gender focus that concentrated on equality, rights and combating discrimination and violence. Similarly in Moldova the manager of a gender-focused NGO was also involved in the national strategic evaluations of sexual and reproductive health services, but she participated in this activity from a wider gender perspective. Other donors (such as WHO and UNFPA), whilst having a commitment to gender equality and mainstreaming as a large part of their focus and priorities, are based primarily within a public health paradigm, with many of their senior managers having a medical background. In the programmes they support, sexuality and reproduction are conceptualised first in health terms, with goals of reducing morbidity and mortality and improving the quality of and access to health services. Even contested concepts such as rights are assigned measurable indicators (WHO, 2001). The focus on health is perhaps easier to quantify in reports to donors and governments, but the assumptions behind a public health approach are not straightforward and unproblematic, with a blurring of the boundary between population and individual rights and needs, and some resistance on the part of conservative commentators to the encroaching of organisations ostensibly with a health mandate in areas they consider to be of moral import.

In terms of activities in the field of gender and domestic violence, the three main strands of activities were education and awareness campaigns (around subjects such as gender equality, rights, and action to take in situations of violence), campaigning at the local and national political level, and the provision of direct services to victims of domestic violence, generally counselling services but sometimes also supporting activities such as working

with abusers and providing shelters for women who are suffering violence. This section will focus mainly on the education and campaigning aspects of this work.

For organisation 1 in Romania, as well as their counselling service they did a lot of education and campaigning at a local level. They organise two annual campaigns, one a festival about gender equality designed to raise awareness about and combat gender stereotypes and discrimination, and the other a festival over sixteen days in November and December (coinciding with an international awareness campaign) about domestic violence. This second campaign includes collaboration with the local police to raise awareness of local women who have died as a result of domestic violence. As a small organisation relying largely on volunteers, these campaigns are primarily at the local (county) level.

Organisation 4 also provides counselling services and conducts research and awareness-raising activities. As a national organisation they have a wider reach – at the time of my interview in 2007 they had specific domestic violence projects in ten of Romania's forty counties. This organisation was unusual in that it incorporated domestic violence as part of a wider health framework, and discussed the difficulties that many health workers and authorities had with this:

... we see reproductive health in the true sense of the word and absolutely everything that means, reproductive health for the old and young, and violence in the family, there are many people and specialists who can't see the true magnitude of what reproductive health and sexuality means Many don't understand why an institute of reproductive health works with violence in the family. They don't understand that this is included here. ... for very many people, reproductive health means contraception and abortion, and that's it What could be improved and needs more work is still the area of violence in the family where we still don't give enough importance to this huge phenomenon, it's still not really perceived that this is truly a social problem and one of public health. (15RI)

Domestic violence as a public health issue was indeed not mentioned at all by my state respondents in Romania, and although many suggested that women tend to take the initiative and responsibility for seeking out sexual and reproductive health services, this was the extent of discussion around the gendered experience of sexuality and reproduction with these respondents.

In Moldova, organisation 8, led by an academic who was widely regarded as an expert consultant on gender, was the main respondent organisation which dealt specifically with issues of gender and domestic violence. Like organisation 4 in Romania, this organisation

campaigned at a national level to raise awareness of structural gender inequalities and promote laws relating to gender, to combat domestic violence through education and campaigning, and it also has a programme relating to sexuality and sexual and reproductive health. They identify the fact that domestic violence is seen as a private problem and therefore not a political priority:

In fact the area of domestic violence still remains barely prioritised in the Republic of Moldova ... Not everyone, not even specialists, are aware of the phenomenon since for years in the Republic of Moldova it's been considered that violence in the family ... doesn't need society and the state to be involved ... The state structures and NGOs are more receptive about ... the issues around violence towards children, but violence between partners in the family arouses more discussion and misunderstanding. So at the parliament level, the government level consider that we don't need special services, consider that all is very private. Everything. (19MI)

As a result, much of this organisation's activity involves campaigning and lobbying policy-makers, and its director is often featured in media coverage of issues of domestic violence.

An element which featured quite often in my interviews and informal discussions with gender organisations was the importance of conforming to international/western standards. For example the Director of organisation 8 talked about Moldova's international obligations:

Here we need to look from ... the perspective of the Republic of Moldova's international obligations ... in the first place is the Convention on the Elimination of Discrimination Against Women ... the UN Committee addressed the Republic of Moldova, we have a particular point where the government responsibility to ensure sexual and reproductive rights of women and men are stipulated and recommends the government to introduce sex education into the education system. (19MI)

but also highlighted the problematic nature of western involvement in this area:

... donors also have to work not only through the prism of their own ideas of programmes, but work in the context of the needs of the country. (19MI)

Organisation 1 also discussed western standards as something to which to aspire, contrasting Romanian standards unfavourably:

... standards aren't low, in fact they're taken from the western experience, but, Romanian legislation imposed some standards which ... in western countries are

really not usual ... And suddenly the budget we drew up initially needed nearly doubling in order to get authorisation from Bucureşti. (02RI)

The same respondent and her colleague both talked about the difficulties associated with western funding (see chapter 4), again highlighting the tension between on the one hand the aspiration to western standards and services and on the other hand the restrictions and difficulties in accessing western funding to develop such standards and services.

6.4 Access, empowerment and rights

Many of these issues relate to that of access for clients and potential service users.

Although the term ‘empowerment’ was not used often by respondents, they had plenty to say about access, rights and information, all themes that are addressed by donor organisations as essentially empowering. Access tended to be considered in three main ways, geographical, informational, and economic (though clearly the three areas are in many ways linked).

Respondents across all sectors were broadly in agreement that rural communities were worse off than urban ones in terms of their access to services and information. This was due to a multiplicity of factors, including the number, standard and motivation of medical staff in the countryside, the preference for NGOs to work in the urban centres, and more difficult transport links to urban and regional facilities. As well as this, access to information and media sources, particularly the internet, was more limited in the rural areas due to wider infrastructural and economic factors, and personal poverty was also regarded as a barrier to accessing services (and thus rights) to which people were entitled. The following quotes highlight how geographical and economic disadvantage can negatively affect the extent to which services are accessed:

... in the first place access is limited for the village population ... like it is globally. There where there aren't any family doctors, or family doctors ... with the motivation to [provide] these [types of] services. (23MI)

... young people can be embarrassed to go and buy a packet of condoms, at the same time the cost means they're not very accessible, so there are many factors which ... contribute to a reduction in use.” (06RI)

The concept of rights was also widely invoked by respondents, again in a number of different ways. The general concept of sexual and reproductive rights as a goal for the services to promote and enable their clients to claim was mentioned several times, but as

well as this the issue of people not being aware of their rights, and the inability or unwillingness of the medical profession to respect client rights or relinquish their own perceived position of superiority was also often raised. The assumption appeared to be that knowledge of rights would automatically result in those rights being claimed and that quantifiably better health outcomes would be the result (WHO, 2001:9). There was also an acknowledgement that many local practitioners and policy-makers did not fully appreciate the magnitude of what rights and rights-claiming in relation to health actually meant.

However despite programmes advocating awareness of sexual and reproductive rights, many respondents lamented the fact that people were unaware of their rights (and, by implication, failed to access the services to which they were entitled).

And as well they don't have all the knowledge about what reproduction means or ... health in general or even they don't know their rights in totality, they're a bit more ... reserved, they don't have much contact with what is happening here. (16RI)

... they don't know their rights – not one of them knows that, being poor, she has the right to come and ask for a free abortion. (12MI)

Worryingly, particularly considering the donor efforts to promote concepts such as patient rights, a number of respondents expressed the lack of respect of patient rights by the medical profession.

The doctor here is at the centre and as far as patient rights, client rights are simply not respected more often than not, not to mention the poor quality of services ...: lack of confidentiality, lack of objective information given ... (12MI)

... clinics ... don't have the necessary space that conform to the regulations, there is no confidentiality, respecting the rights of patients above all, the free right to confidentiality and privacy. So, this confidentiality is not always respected. (11MI)

Client rights are also considered limited even by those clients who are aware of them, and more 'traditional' means are employed to circumvent the system, such as the 'under the table' payments already mentioned.

An issue which respondents considered crucial in terms of access and empowerment was that of information (or lack thereof). In particular many respondents, in both state and NGO sectors, both professional and volunteers, very often referred to 'correct' and 'incorrect' information and highlighted how such poor knowledge led to people not having the means to access the services and facilities to which they were entitled, whether these be modern contraceptives or the ability to make decisions about their own sexuality and reproduction. This accords with the approach of international organisations working from

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a public health perspective, where the dissemination of the ‘correct’ way(s) of behaving or treating issues and illnesses, often using language of evidence-based practice, is promoted. This led for many of the participants in this research to a large focus on the concept of peer education when working with young people (discussed in more detail in section 6.1.1, this chapter) and on the view that information and knowledge is empowering as it leads to positive change:

And I believe that through us, volunteering, it will be possible to make some changes through the fact that we inform young people, they can then transmit this information on that we have given them ... to other young people. And I believe that this is one of the most important things about being a volunteer. (04MI)

What would improve things? Of course in fact what we’re doing. Informing, training with young people, developing and strengthening the peer educators network, developing youth-friendly services, informing them ... through mass media. (08MI).

Geographically speaking, a number of respondents (most of whom were based in urban centres) remarked that people in the rural areas were more ashamed to talk about sexuality and reproduction than their urban counterparts. This was often linked to issues of confidentiality and judgmentalism (Ringheim, 2007), as well as to the previously-discussed issues of access and poverty, as seen in the following quotation:

She ... is ashamed to go to the village gynaecologist, because someone else might find out, believing [about lack of] respect of confidentiality ... everyone knows that she has gone to the gynaecologist there and that she has some problems. So she needs to go to the county centre, or another village, some perhaps don’t have the money to go there ... (13MI)

Issues of community/societal expectations around sexuality and fertility in rural areas was also mentioned:

In the rural areas, it’s a bit more, people are more ashamed to talk about this, and there there are problems in the rural areas especially from the perspective of what to do to not have any more children, in the urban areas the problem is put in perspective, what to do to avoid contracting a disease, some sexually transmitted infections, what age is it good to start the sex life? But that problem isn’t so easy to deal with in the rural areas because everyone believes ... that you should start your sex life after you get married. So those would be the main differences ... (06RI)

Confidentiality and judgmental attitudes were also attributed to the medical profession (and associated professions) by a number of respondents, and associated with the tenor of shame associated with the public discussion of sexuality and reproduction:

I'm a young person, and me for example, I work as a volunteer, and ... I know where the information is, but ... I thought about if I was a young girl on the street I'd be ashamed to go to a doctor to say to him look at this problem and tell me what will happen to me in the future. That's how it is, and all young people think like this. (03MI)

They don't buy condoms from the pharmacy, they consider in the first place that it's not a serious issue. That it's a shameful thing to buy from the pharmacy. Buying condoms from the pharmacy or the shop, what will the pharmacist or the shopkeeper think, if they buy condoms? (11MI)

More than that, they're ashamed that their doctor will tell their mum or dad, what will they do to me if he tells them? (01RG)

This perception represents a considerable block to accessing services; however although attempts are made to provide confidential services, opponents to these services often claim they undermine the role of the parents and their rights to know about their children and their activities.

The problem of people not presenting to the doctor until they had a serious problem, rather than in the early stages of a disease, or for preventive advice, was mentioned by a number of respondents, and represents a considerable public health challenge, for example this respondent in Romania stated:

On the other hand we have the fact that the population isn't educated and doesn't know the dangers they expose themselves to if these diseases aren't diagnosed or treated, out of shame many people don't go to the doctor, they self-medicate and because of this some people present [when they are] very ill, in serious cases for example with syphilis they go to the doctor in stage 3 or stage 2 not in the early stages ... (04RI)

Whilst increasing information and screening is one way to approach this, without tackling the underlying and endemic culture of shame as a major cause of disengagement with health services, public health initiatives may well be found wanting and less effective than hoped.

Another area where NGOs in particular tried to work according to the principles outlined by the large donor organisations to empower service users and increase access to services was in the area of advocacy and political influence. A number of respondents referred to the power of making strategic alliances, and interestingly more than one respondent in Moldova also looked to making more unusual alliances with a group not usually associated with promoting sexual and reproductive health, namely the church:

... in our work, we need to take account of which regions are influenced [by religion] and what sort of belief, yes? And to start a collaboration with religious leaders ... and if we have a positive experience, for the future perhaps we could extend this. But I believe that we mustn't negate the [influence of] church leaders, but we need to find areas where they can be sympathetic to us. But for this we need to know the Bible well ourselves, ... to see how we could present our issues to not affect the interests of the church, and they won't affect the work we're doing. In other words I'm talking about a collaboration, about a partnership. (25MI)

The power of strategic alliances, at local, national, international, state and non-state levels was acknowledged by many respondents, with this also considered an efficient and effective way of working:

Perhaps some partnerships with other NGOs, to be a more powerful force to inform more and to be more insistent about particular issues. (18RI)

I want to say that, in my view, the activities aimed at informing the population making the biggest difference with the biggest impact are those done through Non-Governmental Organisations. Especially for the rural population, but not just for them. And it's easy, very easy and efficient to work together with Non-Governmental Organisations. Because, the NGO volunteers are enthusiastic, they want to learn, to teach, they are motivated to see successes in their work, so they provide quality training, quality information. (11MI).

Some respondents (including the Moldovan donor respondent just quoted) did however lament the poor quality of partnerships and alliances in general, suggesting that the good examples are rare and that this is an area where despite the aspirations and good intentions, not to mention the considerable attention paid to partnership working by donors, much still needs to be done.

6.5 Conclusion

This chapter, and the specific topics and organisations represented here, highlight just a small sample of the activities which are undertaken under the rubric of sexual and reproductive health. All three areas – sex education, pregnancy and gender/domestic violence – are intensely political subjects, speaking to contested understandings of gender, sexuality and reproduction. However the political engagement of organisations varies in intensity and scope, with some campaigning for change at local and/or national levels whilst others work to provide a service for a defined client group without necessarily engaging in lobbying local or national authorities to develop policies and laws to improve services and access. It is also largely the gender-based organisations in both countries and

those organisations in Moldova which featured staff and volunteers working across NGO and state sectors which are the most politically active. Organisations working within a public health paradigm, particularly in Romania, tended to focus more on their individual activities and programmes and have less involvement in campaigning for structural and political change²⁷. A common feature of most of the organisations was an awareness of and aspiration to western standards of policy and services, but this aspiration was not always unproblematic. These cases link to previous chapters and highlight how issues of demography, morality and family (as outlined in chapter 5) are played out in services; how the influence of the west both helps and complicates the development of services (chapter 4); how state and civil society interaction (or lack thereof) affects the expression and provision of services (chapter 4); and how the concept of health is not straightforward but instead is contested, enlarged and affected by socio-cultural influences (chapter 1) which can act as either enabling or restricting influences on service provision.

It is interesting to consider the extent to which these various priorities and issues named by respondents as most important in impacting on sexual and reproductive health in Romania and Moldova are reflected (or not) in the actual services provided. Certainly the information deficit seems to be being tackled by many NGO providers, with initiatives in sex and contraceptive education, antenatal classes, health education campaigns and peer education programmes. These campaigns, whilst not exclusively aimed only at young people do seem to prioritise young people, using the logic that future indicators and outcomes will improve, that it is easier to influence behaviour at an earlier age, and that young people are more willing to engage with these issues, making this an efficient and cost-effective way of improving sexual and reproductive health outcomes in the medium and longer terms. Among state providers the information deficit is also acknowledged and lamented, but other constraints such as excessive bureaucracy and other priorities and issues (such as the focus on curative care over primary care in Romania) mean that these providers feel less empowered or enabled to spend the required amount of time providing information, considering instead that this should be provided in schools, and in the meantime relying on ad hoc media, NGO and government health education literature.

However, the societal taboos around sex and sexuality, ‘mentality’, the notion of ‘shame’, religious and traditional views and a widely-acknowledged reluctance to talk about sex in families or access services is much less widely tackled by policy-makers and service

²⁷ For more on the levels of political engagement of activists working within reproductive health, see Rivkin-Fish, 2004.

providers. Of course these issues are much less ‘tangible’ than providing information, education, practical supplies and materials, and so it is more difficult for state and NGO providers alike to practically address entrenched social taboos. Nevertheless, given that these taboos and views are so entrenched and such widely-acknowledged barriers to accessing sexual and reproductive health services do exist, it is crucial that providers, politicians and donors start to take them seriously. Societal taboos and shame permeate throughout consideration of the family and sexuality and provide significant barriers to providing services.

Conclusion

In this thesis the experiences and perceptions of service providers and facilitators, as well as some clients, have been discussed in relation to the discursive, political and international context in which sexual and reproductive health services are designed, provided and accessed. The limitations of a supposedly values-free, morally neutral public health approach to the complexities of providing services in such a contested area of health, and indeed the contestation of what is in fact meant by 'healthy' at all, has been explored through consideration of interactions between providers and donors, civil society and state and of the underlying discursive and political environment in which they operate. Qualitative data from in-depth interviews, observations and extensive analysis of online media sources indicate that services attempt to be responsive to wider global currents and opinion as to best practice, but are less well equipped to deal with local oppositions to their approaches. Aspects of moral debate are insufficiently considered when designing and promoting services and this potentially limits their impact and reach.

Although two countries were the subjects of this research, there were very many similarities in findings with regard to issues of financing for services (both state and NGO) and many of the key issues felt by respondents to be particularly important in their day to day work. Western-prompted and financed health care reforms in the state sector reoriented health services away from the Semashko model (Atun et al, 2008; Vlădescu et al, 2008) towards a system financed by insurance contributions and oriented away from a heavy focus on curative interventions towards prevention. This however has led in both countries to a sense of dislocation and powerlessness for practitioners and a replacement of one set of bureaucracy (providing statistics for central planners) with another (completing returns for both Ministry of Health and insurance houses), whilst not delivering the expected improvements in working conditions, facilities and equipment. In the voluntary sector, NGOs which had been viewed by international donors as the powerhouse of democratisation initially proliferated, but now experience the vagaries of the 'grant cycle', working from one grant application to the next and in many cases struggling to move beyond their immediate locale or area of specialisation as they lack the capacity to expand. The two sectors in both countries do work together in some cases, but were also characterised by a sense of superiority with regard to each other, even whilst they often expressed similar desires in terms of outcomes for clients and for demographic indicators more widely. The influence of western discourses, analyses and funding was experienced

similarly in both countries, with NGO respondents both responding positively to the perceived progressive ideals of discourses around rights, gender and sexuality, whilst also struggling in the 'funding marketplace'. Ideas of progress and modernity, expressed in terms of becoming more 'civilised' and reaching European standards were common; nevertheless frustrations at working to donor priorities which did not necessarily reflect local realities were also expressed by respondents in both countries. This study therefore accords with many others of the postsocialist region (for example Ishkanian, 2004; Hemment, 2004) in that it highlights the tensions between on the one hand aspiring to western standards and conditions of working whilst having to work within the constraints of a funding environment where the power is arguably held by donor organisations who do not necessarily have the local experience and knowledge of local needs. It also reflects at a micro level some of the frustrations found by earlier scholars of civil society in the postsocialist region around the disconnect between the stated aims of foreign-funded development processes and the realities 'on the ground' (see for example Mandel, 2002; Kalb, 2002).

Through consideration of popular, lay perspectives (including religious perspectives) on the family and sexuality and then discussing the primary categories of activities undertaken by respondents (adolescent sexuality and sex education; pregnancy and maternity services; and gender and domestic violence services) this research has generated insights into the enabling and constraining factors facing sexual and reproductive health services in Romania and Moldova which then affect the impact, reach and effectiveness of these services. Whilst respondents interviewed in the research were active and articulate in identifying both challenges to their work and the positive impact they could make, their responses to the challenges they face were in many cases constrained by a number of factors.

This concluding chapter highlights the key findings of this research, discusses their contribution to existing theory and identifies potential areas for future research. The thesis began with a consideration of medicalisation and the medical model of health, public health, sexual and reproductive health and health and morality approaches, both generally and in the particular regional context of central and eastern Europe and the former Soviet Union. The findings of this research confirm that it is difficult to confine sexuality and reproduction within a wholly medicalised paradigm, and they should also be considered within the wider sociocultural context within which they are sited. NGOs are well placed to contribute to this paradigmatic realignment; however their focus on survival beyond the

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next grant round means that relying on them to deliver change without a concomitant shift in societal understandings and practices with regard to sexual and reproductive health is likely to be insufficient. It is ironic that in the early 1990s the push from western donors to fund and develop the NGO sector was intended to produce such a shift in societal understandings; however the great hope for NGOs was not met due to a number of factors. One of the impacts of western funding and grant aid is that NGOs have a tendency to look outwards towards the source of funding – thus working to donor priorities rather than local need – and this “tension between regional specificity and global discourses and processes of change” (Flynn and Oldfield, 2008:10) thus far appears to have mitigated against a greater impact by NGOs. In addition historically low levels of trust in (and indeed awareness of) NGOs at the local level as well as local contestations of NGO legitimacy, such as those expressed by my state sector respondents, add to the limits of NGO effectiveness.

The thesis has shown that formulations of sexuality and reproduction as espoused by agencies such as UNFPA and WHO which are involved at operational and policy-making levels and thus influence national policy in this regard, together with social taboos and expectations and other institutional actors within society such as the mass media and religion result in multiple understandings of what is meant by ‘healthy’ and therefore which activities should be promoted and which ones opposed. An example of this is the debate around sex education, with conservative leaders stating that outcomes such as STIs are caused by immorality itself and therefore those that behave morally by abstaining from sexual activity have nothing to fear. In this worldview, preventive approaches such as condom distribution and sex education act to encourage immoral behaviours (Brandt and Rozin, 1997). On the other hand are arguments that “the only acceptable moral position is to view everyone as being at risk ... Only by recognizing that we are all vulnerable do we create an environment of compassion and communal caring” (ibid., p.4). The intersection of these positions, both profoundly moralistic, is precisely where sexual and reproductive health services in contemporary Romania and Moldova find themselves. Many services at state, civil society and transnational levels argue that by providing information people will be empowered to make informed decisions about their sexual and reproductive health needs; this was certainly true of the majority of my respondents who highlighted the ‘information gap’ as one of the most crucial inhibiting factors affecting their work and sexual and reproductive health outcomes more widely. However this then suggests that services are insufficiently equipped to deal with those that would challenge the legitimacy of the information and services that they are providing, and given the importance of donor

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agencies and transnational organisations in enabling organisations to develop services, the thesis contends that a lack of consideration of the sociocultural context, and in particular dissenting voices, within which services are to be provided represents a considerable deficit. The gap between the two positions somewhat reflects, at a micro level, macro-level processes around competing rhetorics and ideologies and the battle for power over control of discourses discussed throughout the thesis, a battle which then has significant impacts on local level services and policies. Following the collapse of the communist ideology the ability of the state to exert a major moral influence over the population was challenged – this is perhaps most obviously seen in Romania with the lack of trust in any action by the state seen as interfering in the reproductive life of the population, as exemplified by the recent unsuccessful HPV vaccination campaign. However this is not the only challenge; the case of *Deprinderi de Viață* in Moldova shows clearly the challenge by conservative religious and nationalist actors to the authority of the international community to have a say in shaping and defining what is seen as healthy in the field of sexual and reproductive health and in particular a challenge to the international community's authority to be considered a moral actor. The disconnect between state and civil society provider views outlined in this research indicates still another battle for legitimacy.

Significant variations between the two countries in terms of aspirations of service providers and the main issues they perceived as important were not found in this research, notwithstanding the differences in legislative developments and contemporary political landscapes. Indeed the similarities between respondents with regard to their narratives of aspiration to higher/western/European standards, concern about incorrect information circulating in society and concerns around current poor sexual and reproductive health outcomes were striking. Such narratives were found in all sectors participating in the research in both countries, along with narratives of shame, mentality and taboo, suggesting a sociocultural phenomenon which transcends national borders. Indeed, despite the great diversity to be found throughout the former state socialist countries of central and eastern Europe and the former Soviet Union, it could be argued that “the similarities of socialist institutions imposed a layer of uniformity on top of all this diversity” (Hann, 2002a:8; see also Verdery, 1991).

Greater differences were however observed between respondent narratives and those found in the media analysis. Whilst debates around aspiration to European standards were present in media accounts, these were alongside many others which criticised

European/western morality and suggested that coming closer to Europe represented a retrograde step in terms of accepting foreign morality in the form of perceived lax sexual mores, homosexuality and a sexual openness that was markedly not considered Romanian or Moldovan. In this regard debates around sexuality could be argued to represent a continuation of late Soviet/*glasnost*' era debates around 'invasions' of lax western moralities. The acceptance of perceived western approaches to practice, such as a greater openness towards sex education, were addressed much more critically in the media, and public comments on the articles revealed that whilst some commentators supported moving in a more 'progressive' direction, many others were expressing profound doubts. This can be seen as a rough proxy for wider societal views and represents a serious challenge for policy makers and service providers. Although the views of some conservative leaders and religious groups could be considered extreme or marginal, the media analysis in this research suggests that they do enjoy some currency, and the withdrawal of the *Deprinderi de Viață* programme despite government and practitioner support and significant transnational funding demonstrates that such views have powerful practical as well as discursive effects.

Given the considerable emphasis by respondents on shame and the emphasis in both countries on a reluctance to talk about issues of sexuality and reproduction in the family or with professionals, as well as the aforementioned media debates questioning the validity and legitimacy of health interventions as an imposition of foreign immorality, the theoretical debates around health and morality cannot be ignored. Opponents of sex education and other sexual and reproductive health programmes have already shown that they are powerful political actors who have not inconsiderable public support, or at least sympathy. This is illustrated most graphically through their success in getting *Deprinderi de Viață* withdrawn from the Moldovan school curriculum but also through continued visible and vocal opposition to gay pride marches in both countries, the successful stopping of performances of 'The Vagina Monologues' in Moldova in 2007 and the successful blocking of one of my Romanian respondent organisations from carrying out work in schools. The co-opting of arguments around health and sexuality by both secular and religious conservative groups which seek to define the 'healthy', 'moral' and 'normal' within society serves to strengthen their claim to be the arbiters of what is truly Romanian or Moldovan, a symbolic power which will not be ceded lightly. The findings of this research suggest that appealing simply to notions of progress and modernity will not be enough to halt the obstruction of services. Hann (2008b:157) suggests that the "normal basis of sovereignty in the West", that of making "polity and nation coincide" (ibid.) is not

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enough in regions where there are such powerful notions of national identity coexisting within the same society. The findings from this thesis suggest that an acknowledgement of the moral basis underpinning health interventions, particularly in such a morally contested arena as sexual and reproductive health with its links to discourses on gender, power and nationhood (see for example Peterson, 1999; Pryke, 1998), may well be an important step in opening up productive debate on how to develop services responsive to individual, community and population need. Related to this, there is a need to acknowledge the struggle to define what is 'healthy' in respect to sexuality and reproduction and the fact that this is not a values-free exercise but profoundly moral and one which affects not only individual practitioners or services but permeates actors and interest groups at every level. This is key to ensuring that the debate moves beyond simple right/wrong formulations and begins to address the very real and all-pervasive taboos and shame around sexuality and reproduction in society.

The importance of moral issues as a theme threaded throughout the thesis points to the contribution of this research to theory and ethics in public health practice, and health and morality in particular. In particular, debates around the limitations of the underlying assumptions of public health as a morally neutral and values-free enterprise are furthered by this study's findings that many public health interventions are experienced as profoundly moral and intersect with deeply-held values which may not necessarily be compatible with the aims of the health intervention. The research is particularly valuable in that it contributes an area studies perspective on a subject usually considered within a western paradigm where universalising assumptions do not necessarily resonate with more local understandings of morality and health. The study also has practical implications for practitioners within public health, with its warning that services cannot afford to ignore or dismiss opposition when that opposition holds such a powerful emotional sway over the target population. The example of the withdrawal of *Deprinderi de Viață* from the Moldovan education curriculum is but one of many where the profound disappointment of practitioners and policy makers has not yet led to a substantial acknowledgement of the need to change tactics and critically engage with the objections to their programmes.

In considering the particular case of sexual and reproductive health in two eastern European countries, it was suggested in chapter 1 that the tension between debates about individual and population health reflected wider debates around east/west interactions within neoliberal development policies which sought to promote individual liberty and economic opportunity in societies with a strong history of egalitarianism and social justice

(see Einhorn, 2006/2010:22). In the context of this study, the ongoing tensions between the experiences of those trying to secure western donor funding and those who are reliant on state funding illustrate well the limitations of 'transition' processes in contemporary society. It is perhaps ironic that a donor focus on individual NGOs, which benefit from (at least short-term) donor funding whilst in many cases having a much smaller reach within the wider population, has not resulted in the wider societal transformation hoped for from investment in civil society. The focus of donors in the health field on population-based outcomes whilst promoting individual health behaviour and lifestyle changes reflects the wider assumptions of economists who assumed that the benefits of national programmes would 'trickle down' to individuals who would thus benefit; this study suggests that sexual and reproductive health is therefore an instructive area when considering the effects more widely of east/west interactions and the 'project' of reforming eastern European systems and promoting western ways of governing.

As well as theory on health and morality and the ethics of public health interventions, the thesis also makes a significant contribution to the study of sexual and reproductive health in central and eastern Europe and the former Soviet Union more widely. Both postsocialist health care and sexual and reproductive health have been the subject of considerable scholarship (for example Kligman 1998; Rivkin-Fish, 2005a; Henry, 1999; Gal and Kligman, 2000b amongst many others); however this is one of very few studies which consider the issue in Moldova specifically, and the juxtaposition of Moldova with its near neighbour Romania highlights the similarities and differences between regions more often considered separately. Previous epidemiological studies give a macro-level overview of policies and trends as health services are reoriented; this thesis provides a more nuanced view of the effects of these trends on day to day service provision at the local level and the ability of practitioners in all sectors to respond to the needs of the populations they serve. The study therefore contributes to the growing body of literature on sexual and reproductive health in the region, particularly highlighting the local response to national and international debates around sexuality, reproduction and public health. It also adds to the literature which looks at the role of civil society actors and transnational donor agencies in countries experiencing economic, social and political turmoil as the result of the dislocation of the worldview underpinning the legitimacy of the state, and adds weight to the calls to develop more locally-responsive services and health care systems (see for example Pigg, 2005).

The study also adds a significant contribution to the field of postsocialist studies. In particular, the debates around western involvement in local development and the ongoing opposition to many initiatives within sexual and reproductive health services suggest that a consideration of the specific historical context, and in particular the importance of the state socialist period, remains a pertinent issue if the universal assumptions of western-based theories are to be challenged and rendered locally relevant in non-western contexts. As Flynn and Oldfield (2008:7) identify, “an exploration of locally embedded interpretations of, and engagements with, the changing political and economic context promises to provide an important counter-balance to the normalising and simplifying tendencies of transition discourse”. There is of course the danger of essentialising “the post-socialist condition” (ibid., p.18; see also Kulpa and Mizieleńska, 2011), but the importance of “open[ness] to the specificity of place” (Flynn and Oldfield, 2008:18) and of historical backgrounds remains important, in order to both “document ... the everyday experiences of post-socialism” (Stenning and Hörschelmann, 2008:314) and avoid the dangers of imposing western theoretical understandings on unique circumstances.

Future research

This thesis provides the basis for further fruitful research in the future. The original idea for the research of investigating the role of civil society activity in influencing state policy and provision of health services is an important area of investigation which could usefully be explored, particularly given the different models of civil society in the two countries with Moldova experiencing much greater overlap of civil society and state sectors than Romania. In addition, research with service users in the two countries, whilst beyond the eventual scope of this study, would be important, particularly given this thesis’ finding that that popular/lay views on issues of sexuality and reproduction do not necessarily accord with those of service providers. The areas of similarity and disconnection between service users, providers and policy makers would provide not only new theoretical insights but also a practical basis on which to refine services and make them more responsive and effective. The issue of the effectiveness of peer education in sex education was highlighted in the thesis; there are many other areas where such a critical approach would also be useful.

Another area of potential further research, albeit one that would be difficult to undertake, would be a study of the groups, institutions and individuals who currently oppose any development of sexual and reproductive health services. Whilst some macro-level studies

have looked at certain specific groups (for example Stan and Turcescu (2007) about the Romanian Orthodox Church) through studying policy and national activities of those groups, there is much less work with these groups at a qualitative, micro-level. Understanding the subtleties of why groups object, and indeed the extent to which they do, may well be an important means of highlighting common ground on which progress and a way forward through the current impasse might be found.

Concluding remarks

The thesis has discussed findings from research in two different countries, in two different types of location. Despite the differences, the remarkable homogeneity of responses across respondents whether they be from a Romanian county town, the Moldovan capital or a rural village, or from civil society, state or transnational body, means that whilst the study is grounded in local responses and cannot be fully generalisable, insights can be brought to bear from this thesis to critique existing theory and research on sexual and reproductive health in the region, as well as on public health more generally.

The thesis' findings have critiqued the assumption of public health provision as a values-free and morally neutral activity. In paying close attention to local understandings it has highlighted how it is at "the moral nexus of the debate" (Brandt and Rozin, 1997:4) that services are both enabled and constrained. The fact that 'shame' emerged so often as a concept in interviews, identified as a significant barrier to progress but remaining relatively unaddressed at policy level, suggests that those organisations and institutions making policy and providing health services need to take the moral position of the population much more seriously and address them proactively in their programmes.

The findings of this thesis are broadly in line with other studies on sexual and reproductive health in the region in that they highlight the contextual issues of concern around demographic indicators, contested debates around gender, nationhood and national reproduction, and the impact these have on the ability of policy makers and practitioners to develop responsive services. In addition they highlight the ongoing difficulties of engaging with conservative opposition to sexual and reproductive health services. This is by no means an exclusively Romanian, Moldovan or even regional issue; similar gaps between conservative and non-conservative interest groups around sexuality and reproduction exist throughout the 'developed' west also. However, the fact that responses in this research were similar across different sectors and different countries suggests that

the category of postsocialism and the study of countries within central and eastern Europe and the former Soviet Union remains relevant two decades after the collapse of state socialism. It also demonstrates that this thesis has much to add to global as well as local debates challenging existing assumptions about the role and place of sexual and reproductive health services.

Appendix 1 – Participating Organisations

The following is an outline of the civil society organisations whose staff and volunteers I interviewed for this research.

Romania

Organisation 1 is locally founded and staffed and concentrates on gender awareness and campaigning. One of the main issues on which their work concentrates is domestic and sexual violence; however staff estimated that a significant minority (around 25%) of their work also touches on sexual and reproductive health. Their activities are primarily campaigning on a local level about domestic violence and gender equality, and providing a counselling service. They have also been involved in some sex education work within and outwith schools. Start-up funding came from the Peace Corps, and their continuing funding is in the form of grants from various Western donors for particular projects, and the Global Fund for Women which funds ongoing running costs. There is one full-time salaried member of staff; most other members including the Director are volunteers. The organisation hosts final year psychology students from the local university on placements, who contribute to the counselling and campaigning activities. It also has built up a small library of texts (primarily by Western scholars such as Gal & Kligman, 2000a) about gender issues.

Organisation 2 was fully locally-staffed at the time of the research, but was originally founded by a British couple who lived in Romania for many years from the early 1990s. The organisation has two strands, an ecumenical organisation working on peace and reconciliation, and a social-educational aspect which covers programmes for families with disabled children, psychotherapy, sex education in schools, first aid training and antenatal programmes (both education in the form of antenatal classes for expectant parents, and exercise classes specifically for pregnant women). Almost all of its funding came from a UK-based fundraising organisation founded by the British couple who founded the organisation on their return to the UK, and their contacts. The antenatal and sex educations are very much placed within a public health framework. The schools work is undertaken under a formal agreement with the regional state education services, and many of the antenatal clients were originally referred there by their family doctors – although by the time of my interviews in 2007 most people knew about the service by word of mouth.

Organisation 3 is the local branch (*filială*) of a national and international NGO, and is locally staffed. It also undertakes a lot of work with volunteers. Although it is affiliated to the national organisation it does not receive any funds from there (indeed it is expected to contribute to the coffers of the national organisation); funding comes from subscriptions and participants in its training programmes, and also from grants from western donors for specific projects. The focus in this organisation is on health, for example first aid training, emergency work (for example providing advice and basic medical services during the heatwave in the city), and health promotion campaigns. This organisation also incorporates some sex education work in schools, and with its volunteers uses the method of peer education.

Organisation 4 is a national NGO which undertakes research in all aspects of sexual and reproductive health, consultancy to national and regional governments on sexual and reproductive health policy, free contraceptive supplies, consultations with gynaecologists, and support, counselling and awareness-raising in the area of domestic violence. Its work is in agreement with *judetean* (county) and national authorities, and it is unusual in receiving local and national state funding as well as funding from western donors.

In addition to these organisations, state actors such as family doctors and specialist gynaecologists also had much to do with either providing services (especially around maternity) or expressing the need for a change in how and what services are provided (especially around sex education).

Moldova

Organisation 5 is a national NGO affiliated to the international organisation International Planned Parenthood Federation (IPPF), from where it gets the bulk of its funding. It is also contracted as the operational partner of the UN Population Fund (UNFPA) in Moldova. The organisation provides information and education services in the area of sexual health, through mass-media campaigns, the training of a network of peer educators, and a website which provides advice, articles and discussions which is widely accessed in Moldova and beyond (in Romania and Russia as well as Moldova). It is also involved in national strategic evaluations of sexual and reproductive services and policies. In common with many NGOs in the region it also undertakes summer educational camps. It has a large number of volunteers working in peer education, publicity and media, and also in providing sex and relationship education in army barracks and prisons.

Organisation 6 is an NGO based in a state hospital which is primarily concerned with providing safe abortion, through both service provision and in being the main operational partner of the Ministry of Health in developing services and awareness of services and rights. It employs two gynaecologists (one of whom is its Director) and administrative staff. As well as providing an abortion service it also campaigns on the increased use of medical abortion, and has been involved in consulting nationally and internationally on abortion and sexual and reproductive health policy. It receives funding from both western donors and national authorities.

Organisation 7 is a 'youth-friendly service', funded by UNICEF (although it is an independent NGO) which provides a range of sexual and reproductive health services for young people, including medical services, provision of contraception, opportunities to volunteer and sex education. It also undertakes some small-scale research projects on young peoples' attitudes and behaviour around sexual and reproductive health. Staff are primarily state-employed gynaecologists and other doctors who provide their services voluntarily, and the Director also works for an international organisation (WHO) in policy and strategy nationally.

Organisation 8 is an NGO based in a state university which primarily campaigns and undertakes research in the areas of gender and domestic violence. The Director is a nationally- and internationally-recognised expert in the field who is regularly called upon to comment on gender and violence to government and in the national media. They are also involved in international campaigning networks such as KARAT and ASTRA promoting gender awareness throughout the region.

In addition to these organisations, a 'hybrid' state/NGO organisation works in the area of fertility and assisted conception, and I also spoke with respondents who work in the arts and media who have been involved in education efforts in sexual and reproductive health. As well as these, as in Romania state providers such as family doctors and nurses had much to contribute to the debates.

Finally, in addition to the above organisations in Moldova, I was also able to speak with representatives from UNFPA and WHO, to gain an international perspective on sexual and reproductive health in the region.

Appendix 2 – Table of Interviewees

Interviews were numbered consecutively and according to whether or not they were group or individual interviews. Quotes from interviews are therefore appended with an interview number which gives the unique interview number, country and whether it was a group or individual interview.

Interview number	Country (R/M)	Group / Individual interview	Role	Gender	Organisation	More than one interview? (no.)
01RG	R	Group	Volunteers	Mixed	3	-
02RG	R	Group	Clients	F	2	-
01RI*+	R	Individual	Director	F	3	Y (1) – 13RI
02RI	R	Individual	Director	F	1	Y (1) – 14RI
03RI	R	Individual	Programme Manager	F	2	Y (2) – 10RI and 16RI
04RI	R	Individual	Doctor	F	Public Health Authority	-
05RI	R	Individual	Director	M	2	-
06RI	R	Individual	Psychologist	F	1	-
07RI	R	Individual	Pharmacist	F	(state)	-
08RI*	R	Individual	Family doctor	F	(state)	-
09RI	R	Individual	Family doctor	F	(state)	-
10RI	R	Individual	Programme Manager	F	2	Y (2) – 03RI and 16RI
11RI	R	Individual	Consultant doctor	F	(state - hospital)	-
12RI	R	Individual	Family doctor	F	(state)	-
13RI	R	Individual	Director	F	3	Y (1) – 01R
14RI	R	Individual	Director	F	1	Y (1) – 02R
15RI	R	Individual	Director	F	4	-
16RI	R	Individual	Programme Manager	F	2	Y (2) – 03RI and 10RI
17RI*^	R	Individual	Family doctor	F	(state – rural)	-
18RI	R	Individual	Volunteer	F	1	-
01MI*	M	Individual x 2	Antenatal couple	mixed	-	-
02MI	R	Individual	Consultant –	F	(civil soc –	-

	(conducted in M)		civil soc.		international)	
03MI	M	Individual	Volunteer (peer ed)	F	5	-
04MI	M	Individual	Volunteer (peer ed / coordinator)	F	5	-
05MI	M	Individual	Programme co-ordinator	F	5	-
06MI	M	Individual	Director, youth centre / volunteer board member	M	5 and state	-
07MI	M	Individual	Volunteer (peer ed)	F	5	-
08MI	M	Individual x 2	Volunteers (peer ed)	mixed	5	-
09MI	M	Individual	Volunteer (teacher / psychologist)	F	5	-
10MI	M	Individual	Youth Programme Coordinator	F	International agency	-
11MI	M	Individual	Adjunct Director	M	International agency	-
12MI	M	Individual	Director	F	6	-
13MI	M	Individual	Senior Civil Servant	F	Ministry of Health	-
14MI*	M	Individual	Volunteer Coordinator	M	NGO	-
15MI	M	Individual	Actress / volunteer	F	Works with volunteers from org 5	-
16MI	M	Individual x 2	Family doctors	F	(state – rural)	-
17MI	M	Individual	Gynaecologist – volunteer board member	M	5 and state	-
18MI	M	Individual	Director / gynaecologist	M	State/NGO	-
19MI	M	Individual	Director	F	8 and state	-
20MI	M	Individual x 2	Young potential clients	F	-	-
21MI	M	Individual	Postnatal mother	F	-	-
22MI	M	Individual	Nurse	F	(state)	-
23MI	M	Individual	Director (NGO) / gynaecologist (state) –	F	7 and state and international agency	-

			coordinator (international agency)			
24MI	M	Individual	Radio presenter	F	Works with volunteers from org 5	-
25MI	M	Individual	Director	F	5	-

* Interview not recorded.

^ Interview not conducted by the author.

+ Interview conducted in English.

Appendix 3 – Observations

Country	Organisation	Nature of Observation
Romania	1	Observe and participate in group education session on sex and relationships (2 hours).
Romania	2	5 x antenatal classes and several exercise classes for pregnant women (5 x 2 hour antenatal classes plus seven more hours for exercise classes).
Romania	County Hospital	Observing waiting area outside family planning clinic (1 hour)
Romania	2	Observation as NGO prepared to undertake sex education lessons in school (1 hour).
Moldova	5	Advocacy training with external consultant for staff and volunteers (6 hours).
Moldova	5	Observe and participate in 2 radio phone-in shows with volunteers around issues relating to sexuality and reproductions (2 x 1 hour).
Moldova	5	Observe social theatre workshop with actors and volunteers (4 hours).

Appendix 4 – Media Sources

Romania

Name	Type	Time period	No of months	No. of articles	Average per month
Adevărul	National broadsheet	Sept 06-Apr 07; Oct-07-Aug 09	35	248	7.085
Antena3	National TV news	Feb 08; Aug 09	2	5	2.5
Blogul lui Laurențiu Dumitru	National religious blog	May 08-Aug 09	16	38	2.375
Cotidianul	National broadsheet	Sep 06-Feb 07; Oct 07-Aug 09	35	107	3.057
Curentul	National broadsheet (free distribution)	Oct 07-Aug 09	23	172	7.478
Evenimentul Zilei	National tabloid/ broadsheet	Jun-Jul 08; Nov 08; May 09-Aug 09	7	25	2.571
Gândul	National broadsheet	Feb 08; Jun 08; Jan 09-Aug 09	10	67	6.7
Jurnalul Național	National broadsheet	Oct 07-Aug 09	23	156	6.782
Libertatea	National tabloid	Jan 09-Aug 09	8	126	15.75
Mediafax	National news agency	Feb 08-Aug 09	19	86	4.526
Monitorul de Alba	Local broadsheet	Jul 08- Aug 09	14	16	1.142
Monitorul de Cluj	Local broadsheet	Jul 08 – Aug 09	14	34	2.428
Monitorul de Sibiu	Local broadsheet	Feb 08- Apr 09	19	25	1.315
ProTV	National TV news	Feb 08-Aug 09	19	157	8.263
România Liberă	National broadsheet	Nov 05-Apr 07; Oct 07-Aug 09	40	142	3.55

Total number of articles: 1,404

Moldova

Name	Type	Time Period	No. of months	No. of articles	Average per month
BASA Press	National news agency	Oct 07-Aug 09	23	31	1.347
Flux	National broadsheet	Sept 06-Apr 07; Oct 07-Aug 09	35	126	3.6
Interlic	National news agency	Nov 07-Aug 09	22	36	1.636
Jurnal de Chişinău	Local broadsheet	Aug 06-Apr 07; Oct 07-Aug 09	32	43	1.343
Moldova Azi	National news agency	Feb 06-Apr 07; Oct 07-Aug 09	38	27	0.71
Moldova Creştină	National religious blog/news agency	Oct 07-Aug 09	23	157	6.826
Moldova Noastră	National religious news agency	Oct 07 – Aug 09	23	100	4.347
Moldova Suverană	National broadsheet	May 09-Aug 09	4	7	1.75
Moldpres	National (government) news agency	Sep 06-Apr 07; Oct 07-Aug 09	35	6	0.171
Novopress Chişinău	National religious news agency	May-June 09	2	6	3
ProTV	National TV news	Oct 07-Aug 09	23	70	3.043
Timpul	National broadsheet	Sept 06-Apr 07; Oct 07-Aug 09	35	103	2.942

Total number of articles: 712

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