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REPRODUCTIVE INEQUALITY IN ROMANIA: DISPARITIES IN INFORMATION, MEDICAL ACCESS, AND STRUCTURAL VULNERABILITY

Ariana VLAICU[1], **Ionuț FÖLDES**[2]

Abstract: This study investigates the structural roots of reproductive inequality in Romania, focusing on adolescent motherhood, unequal access to healthcare, and limitations in sexual education. Despite being part of the European Union, Romania ranks among the highest in adolescent birth rates, especially among girls under 15. Using official statistics, the study identifies regional disparities in adolescent fertility, strongly correlated with poverty and marginalization. Employing a structuralist lens informed by Bourdieu and Foucault, the research challenges the notion that early motherhood results from individual choice, arguing instead that it reflects constrained agency shaped by socioeconomic deprivation, inadequate sex education, and a fragmented healthcare system. The study also reveals severe limitations in access to abortion and contraception, particularly for vulnerable groups, despite formal legal provisions. Medical practices such as high caesarean rates and stillbirths further illustrate healthcare inequalities. The findings point to a biopolitical regime where institutional inaction and normative control perpetuate reproductive injustices. The paper calls for comprehensive public policy interventions that address both structural barriers and institutional responsibilities to ensure reproductive rights and equity for all Romanian women.

Keywords: reproductive inequalities, adolescent motherhood, sex education, inequality, Romania.

Résumé : Cette étude explore les racines structurelles des inégalités reproductives en Roumanie, en se concentrant sur la maternité chez les adolescentes, l'accès inégal aux soins médicaux et les limites de l'éducation sexuelle. Bien que membre de l'Union européenne, la Roumanie affiche l'un des taux les plus élevés de naissances chez les adolescentes, en particulier chez les filles de moins de 15 ans. À partir de données statistiques officielles, l'étude met en évidence des disparités régionales étroitement liées à la pauvreté et à la marginalisation. En mobilisant un cadre théorique inspiré de Bourdieu et Foucault, la recherche remet en question l'idée que la maternité précoce relève du seul choix individuel, et montre qu'elle est conditionnée par des contraintes socioéconomiques, un accès limité à

[1] MA student in Complex Data Analysis, Faculty of Sociology and Social Work, Babes Bolyai University, 128, 21st December 1989 Boulevard, Cluj-Napoca 400604, Romania, +40-264-42.46.74, email: ariana.vlaicu@stud.ubbcluj.ro

[2] PhD, Lecturer, Department of Sociology, Faculty of Sociology and Social Work, Babes Bolyai University, 128, 21st December 1989 Boulevard, Cluj-Napoca 400604, Romania, + 40-264-42.46.74, email: ionut.foldes@ubbcluj.ro

l'éducation sexuelle et un système de santé inégalitaire. Le travail révèle également de fortes restrictions en matière d'accès à l'avortement et à la contraception, malgré un cadre légal favorable. Des pratiques médicales telles que la fréquence élevée des césariennes et le taux de mortinatalité illustrent les inégalités de soins. L'analyse conclut à un régime biopolitique où l'inaction institutionnelle et le contrôle normatif entretiennent les injustices reproductives. L'étude appelle à des politiques publiques cohérentes, garantissant les droits reproductifs de toutes les femmes en Roumanie.

Mots-clés : inégalités reproductives, maternité adolescente, éducation sexuelle, inégalité, Roumanie.

Rezumat: Acest studiu investighează rădăcinile structurale ale inegalității reproductive în România, concentrându-se asupra maternității în rândul adolescentelor, accesului inegal la servicii medicale și limitărilor educației sexuale. Deși face parte din Uniunea Europeană, România se află printre țările cu cele mai ridicate rate de nașteri în rândul adolescentelor, în special în cazul fetelor sub 15 ani. Folosind statistici oficiale, studiul identifică disparități regionale în fertilitatea adolescentelor, corelate strâns cu sărăcia și marginalizarea. Printr-o perspectivă structuralistă inspirată de Bourdieu și Foucault, cercetarea contestă ideea că maternitatea timpurie este rezultatul alegerii individuale, argumentând că aceasta reflectă o autonomie constrânsă, modelată de inegalități socio-economice, educație sexuală deficitară și un sistem de sănătate fragmentat. Studiul evidențiază și limitările severe în accesul la avort și contracepție. Practicile medicale, precum frecvența ridicată a cezarianelor și rata nașterilor de copii morți, indică, de asemenea, inegalități în îngrijirea medicală. Analiza sugerează existența unui regim biopolitic în care lipsa de acțiune instituțională și controlul normativ perpetuează injustițiile reproductive. Lucrarea susține necesitatea unor politici publice integrate, care să abordeze atât barierele structurale, cât și responsabilitățile instituționale în garantarea drepturilor reproductive pentru toate femeile din România.

Cuvinte-cheie: inegalități reproductive, maternitate adolescentină, educație sexuală, inegalitate, România.

1. Introduction

Reproductive health is among the key priorities on the international development agenda, being included in the Millennium Development Goals (United Nations General Assembly, 2015). This issue is directly connected to state development, as well as to women's rights and emancipation This research examines reproductive and gender inequalities in Romania, focusing on two analytical elements. We initially analyse the variations in adolescent fertility concerning geography and temporal factors. Considering Romania's consistent top ranking among EU nations in the incidence of live births to extremely young mothers, the issue is highly relevant. Romania notably exhibits the greatest number of births among women aged 10 to 14 and 15 to 19. A concerning data that underscores the severity of the issue for Romanian society reveals that in 2023, 42 percent of all children born to adolescent mothers (ages 10-14) in the European Union were born in Romania (Eurostat, n.d.).

The second analytical dimension is dedicated to the discussion on sexual and reproductive education, as well as medical practices and indicators associated

with the direct or indirect effects that medicalisation has on female patients. We began with the current legislation on sexual education in schools and proceeded with an analysis of official data on the number of abortions, caesarean births, and stillbirth rates. By using these indicators, we believe we have managed to provide a comprehensive overview of reproductive and gender inequalities in Romania. The analytical lens we employed was a structuralist one, through which we sought to demonstrate that individual actions are not entirely the result of rational decision-making. Rather, they are the outcome of independent social structures that control and shape individual action (Bourdieu, 1980).

Our study was guided by two research questions. Aware of the high incidence of adolescent fertility in Romania, as reflected in official statistics, our first aim was to highlight the regional and temporal disparities in the incidence of births among girls under the age of 15 and those aged between 15 and 19. Drawing on several studies that document regional disparities in living conditions, economic development, and marginalisation, we sought to overlap these two realities: on the one hand, that of adolescent motherhood, and on the other, that of Romania's unequal economic development. We demonstrated a strong correlation between the two.

Our second research question focused on capturing another structurally determined facet of reproductive inequalities. We aimed to show how education and medicalisation, through systemic dysfunctions, generate inequalities in women's reproductive rights, specifically in their ability to make informed choices and in access to healthcare services intended to ensure physical and emotional wellbeing.

What follows is the conceptual framework of this study and a review of the relevant literature. This section is followed by a chapter outlining the methodology employed. The next part of the paper presents the results of the analysis of official data regarding the territorial distribution of births among adolescent mothers in Romania. In the same section, we examine the evolution in Romania of key indicators such as the frequency of abortions, the intensity of stillbirths, and the rate of caesarean deliveries. Finally, we outline the limitations and main conclusions of our study.

2. Theoretical framework

Adolescent motherhood in Romania remains one of the most acute forms of reproductive inequality in contemporary Europe (Dinu, 2022; Eurostat, n.d.; LeMasters, et al., 2019). Some discourses approach adolescent motherhood either as a straightforward public health issue or as the result of poor individual choices, while others downplay it entirely, regarding it as quantitatively irrelevant on the grounds that, in absolute terms, it does not affect a sufficiently large segment of the population (Iorga et al., 2021). A sociological reading, however, reveals much deeper roots, embedded in unequal social structures and normative regimes of control over young women's bodies. In this paper, we place the phenomenon in theoretical dialogue between Pierre Bourdieu's structuralist constructivism and

Michel Foucault's biopolitical analysis, complemented by critical literature on social policy, sexual education, access to contraception, and poverty.

Pierre Bourdieu's theory of practice provides a fundamental analytical framework for understanding how adolescent motherhood is shaped not only by macrostructural forces but also by the internalised dispositions and everyday experiences of young women. Habitus, as a set of socially acquired schemes of perception and action, is particularly relevant for capturing how life trajectories become structured by social origin, access to education, and cultural capital (Bourdieu, 1990). In many of Romania's marginalised regions, early motherhood is not necessarily the result of misinformation or of 'poor' individual choices. Rather, it emerges as part of a socially constructed life path, where limited access to reproductive healthcare, low-quality education and persistent gender norms converge to shape both the material and symbolic conditions of reproductive life (LeMasters, et al., 2019; Magyari-Vincze, 2006; Neculau et al., 2022, Nanu et al., 2021). In such contexts, reproductive autonomy is severely constrained: choices are made within a narrow horizon of possibilities, and early motherhood may become a socially accepted or even expected solution (Neculau et al., 2022).

Simultaneously, Bourdieu's concept of field invites us to investigate the institutional spaces within which decisions regarding reproductive lives are negotiated. The Romanian healthcare system, with its unequal distribution of services and often arbitrary practices, functions as a reproductive field in which symbolic and material resources are distributed unequally (Magyari-Vincze, 2006; Palaga, 2021). Young women with high social and cultural capital are more likely to receive support and enjoy greater autonomy in making reproductive decisions, while adolescents from disadvantaged backgrounds face numerous barriers stigmatising doctors to the absence of sexual education or accessible contraception (Plan International, 2024).

This structural reading finds a valuable complement in Foucault's theory of biopolitics. Biopower refers to the way in which the modern state exercises power not through prohibition or repression, but through the regulation and administration of life (Foucault, 1978). In Romania, reproductive policies and the state's failure to ensure universal access to comprehensive sexual education and family planning reveal a selective logic of biopolitical investment. Rather than guaranteeing equitable reproductive conditions for all citizens, the state shifts responsibility to families or non-governmental organisations, withdrawing from its role as guarantor of rights (Plan International, 2024). In Foucauldian terms, this absence is not neutral, but constitutes an active form of exclusion, a mechanism through which decisions are made about who is deemed worthy of support and who is left outside the scope of state concern (Gordon, 1997).

Equally important is the dimension of poverty, both as a determinant and because of adolescent motherhood (Oke, 2010). Studies show that teenage pregnancies are significantly more common in regions with high rates of relative poverty, low levels of schooling, and chronic social exclusion (Neculau et al., 2022). Poverty can be understood not merely as a lack of material resources, but as an

absence of the freedom to lead a life one has reason to value (Sen et al, 1993). The theoretical dialogue between Bourdieu and Foucault becomes particularly illuminating when we analyse access to abortion in Romania. Although legal, abortion is increasingly difficult to access. This reflects a symbolic economy of reproductive respectability, in which certain categories of women are morally discredited and excluded from the legitimacy of decision-making (IPPF Europe, 2023). From a Foucauldian viewpoint, we are witnessing a sophisticated form of control: not through explicit prohibition, but through institutional inaction and the delegation of power to moral and religious norms (Gordon, 1997).

In conclusion, placing Bourdieu and Foucault in theoretical dialogue allows us to move beyond the classical dichotomy between structure and agency, and to reveal that adolescent motherhood in Romania is not merely a demographic indicator, but a concentrated expression of social inequality. While Bourdieu shows us how social hierarchies are reproduced through bodily and symbolic practices, Foucault exposes the institutional logic of differentiated governance. Together, these perspectives enable us to reframe adolescent motherhood as a site where social injustice is naturalised, medicalised, and depoliticised, except in those cases where it is critically interrogated and challenged through transformative public policies. This view is in line with scholarly contributions that reconceptualise adolescent motherhood not as a pathological deviation but as a site of embodied social injustice maintained through medicalisation and bureaucratic depoliticization (SmithBattle, 2013; Arai, 2009; Pillow, 2004).

2.1. Poverty and Spatial Inequality in Romania

Hagenaars and de Vos (1988) propose three types of poverty. Absolute poverty refers to an individual's capacity to meet the fundamental necessities of life, such as having adequate shelter, access to nutrition that meets at least the minimum required caloric intake, and proper healthcare services. Relative poverty compares an individual's situation with that of others in order to capture the actual level of material satisfaction (Weziak-Bialowolska and Dijkstra, 2014). The third form of poverty is self-perceived poverty, which is based on individuals' subjective assessment of their material condition and whether they consider themselves to be living in hardship (Betti et al., 2001).

According to official data published by the National Institute of Statistics, the age group 0–17 consistently records the highest relative poverty rates over time. This observation indicates that younger individuals are most frequently affected by poverty, often living in vulnerable contexts such as precarious socio-economic conditions, which have serious implications for their standard of living, educational attainment, labour market opportunities, and overall life trajectory (UNICEF, 2012). The relative poverty rate among young people reached 33.3 percent in 2008, experienced a significant increase to 39.3 percent in 2014, and subsequently began to decline. In 2022, 27 percent of young people in Romania were below the relative poverty threshold. The other age categories, adults (18–64

years) and the elderly (65 and over), registered values ranging between 14.4 percent and 26.5 percent over the period 2008–2022 (INS, n.d.).

Considering the variation in relative poverty rates by sex, official data show that women are consistently the group most affected. One in five Romanians faces relative poverty, 30 percent of the total population cannot afford the necessities for an adequate standard of living, and over 42 percent of the population is at risk of falling into poverty or social exclusion (World Bank, 2016). The "Atlas of Marginalised Rural Areas" (Teşliuc et al., 2016) and the "Atlas of Marginalised Urban Areas in Romania" (Swinkels et al., 2013) are tools used to identify and target poor areas. One third (34%) of the population in marginalised rural areas are children (aged 0 to 17), compared to 22 percent in non-marginalised communities (Teşliuc et al., 2016).

Urban regions classified as marginalised are those that have accumulated disadvantages in housing, employment, and human capital. These are typically poor, socially isolated intra-urban communities that are not captured in official poverty statistics, which are calculated at municipal or county levels. As true pockets of social exclusion, marginalised neighbourhoods concentrate people with low levels of human capital, poor housing conditions, and low employment rates. Families living in these areas have limited or virtually no access to quality services (healthcare, infrastructure, education), reside in poorly constructed buildings or slum-like conditions and are vulnerable to area-specific forms of crime (Swinkels et al, 2013).

2.2. Sexual Education and Contraception in Romania

Sexual education can be defined as a learning experience aimed at promoting healthy sexual behaviour. Its content may vary – for instance, it can focus on abstinence from sexual activity or take the form of a comprehensive curriculum covering all aspects of sexual and reproductive health (Garcia & Fields, 2017). Pupils who receive comprehensive sexual education are more likely to delay the onset of sexual activity and to use contraceptive methods (Bourke et al., 2014). By contrast, abstinence-only programmes have shown no significant impact on delaying sexual debut or reducing associated risks (Santelli et al., 2017). Countries such as Finland and Sweden have implemented mandatory sexual education programmes (Parker et al., 2009) and report among the lowest adolescent fertility rates (World Bank, n.d.). At the opposite end of the spectrum are Bulgaria and Romania, countries that do not prioritise the necessity or mandatory nature of sexual education (Parker et al., 2009). This neglect has serious consequences, as both countries rank at the top in terms of high adolescent fertility rates.

Contraception is the act of preventing pregnancy, whether through a device, medical procedure, form of medication or internalised behaviour. Among the most used modern contraceptive methods are condoms, oral contraceptives, intrauterine devices (IUDs), vaginal rings, implants, and both male and female sterilisation. Traditional methods such as the calendar method and withdrawal are also still in use. Modern contraceptive methods enable women to have control over

their own bodies and to actively participate in family planning (United Nations, 2015). Access to contraception is vital for preventing adolescent pregnancies (Robbins and Ott, 2017). The use of long-term contraceptive methods is the most effective means of preventing pregnancy among minors (Robbins and Ott, 2017).

An important indicator for measuring contraceptive use is the contraceptive prevalence rate. It also serves as an indicator of a country's level of development, population dynamics, health, and the emancipation of women (UNFPA, 2018). Access to contraception is correlated with higher levels of education (World Bank, 2010). It is also a clear reflection of the availability – or lack thereof – of reproductive health services, which are essential for achieving several development goals related to maternal health, HIV/AIDS, and infant mortality. The prevalence of contraception is directly influenced by access to contraceptive methods and to information on sexual and reproductive health, both of which are governed by social structures (United Nations General Assembly, 2015). The state regulates access to contraception directly through legislation, and this access may also be restricted indirectly by socio-economic and cultural factors (Neculau et al., 2022).

2.3. Politics of Abortion Access

The political regime changes of December 1989 led to the repeal of Decrees 770 and 441 and the legalisation of abortion on request during the first three months of pregnancy, as stipulated in Article 8 of Law 1/27.12.1989 (Parliament of Romania, 1989). Article 185 was reintroduced into the Penal Code to criminalise the termination of pregnancy after the legal limit and to regulate the conditions under which abortion may be performed – in medical institutions and by specialised personnel (Apostol, 2012). Decree 770 of 1966 marked a turning point in women's rights. It imposed strict and highly limiting conditions on the performance of abortions (Apostol, 2012). Decree 441, issued in 1985, further restricted abortion access, leaving women with empirically induced abortion as the only available method of fertility control – an approach that led to an increase in maternal mortality (Klingman, 2000).

Globally, adolescents account for 11 percent of all pregnancies, but 23 percent of these are associated with medical complications during gestation or delivery (Kennedy et al., 2011). Among adolescents aged 10–14, the risk of death due to pregnancy or childbirth complications is five times higher than among adult women, and maternal conditions are the leading cause of death among girls aged 15–19 (World Health Organization, 2006; 2008; Patton et al., 2009). Preventing adolescent pregnancies is crucial for any agenda aimed at improving adolescent sexual and reproductive health, reducing their vulnerability to sexually transmitted infections, including HIV, and protecting them from gender-based violence (Kennedy et al., 2011).

The context of limited access to healthcare, education, and social protection significantly contributes to the occurrence of adolescent pregnancies (Save the Children Organization, 2022). Pregnancy and parenting bring serious social and economic costs to young mothers, directly affecting their educational

and professional paths and, later, their position in the labour market (Nanu et al., 2021). Poverty and material deprivation are both a determining factor and a consequence of fertility among underage females (Oke, 2010). With significant repercussions on education, professional life, and economic opportunities, adolescent pregnancy can have long-term socio-economic consequences. These include poor health conditions, the deepening of gender inequality and material hardship caused by poverty – impacts that extend to the mother, the child, the family and the communities to which they belong (Greene & Merrick, 2005; UNFPA, 2007; World Bank, 2007).

3. Methodology

This study employed a descriptive methodological design based on official data concerning adolescent motherhood in Romania, along with several indicators reflecting the obstetric medical dimension. The units of analysis were mothers under the age of 15 and those aged between 15 and 19, at the national level. Data aggregation was carried out by territorial development regions and counties. We analysed the evolution over time of the number of live births and age-specific fertility rates over the past 30 years. The primary data sources were the National Institute of Statistics, through the Tempo Online platform, and the European Health for All database provided by the World Health Organization. For the first part of the results, we used data on the number of live births to mothers under 15 and those aged 15–19, broken down by territorial development region, and followed their evolution from 1993 to 2023. In the second section of the results, we examined trends in the number of abortions in Romania compared to the European average, age-specific stillbirth rates, and the incidence of caesarean sections in Romania.

To illustrate regional disparities related to the social and economic context, we referred to data on relative poverty by sex and age group, as well as the territorial distribution of marginalised urban and rural areas (Teșliuc et al., 2016; Swinkels et al., 2013). We also consulted national legislation to better understand how the state regulates sexual education. Studies and reports published by the Filia Centre and the Association of Independent Midwives were central in helping us understand the social discrepancies in access to quality medical services and how obstetric violence is experienced by women in Romania.

4. Results

Adolescent Motherhood in Romania

Official data indicates that the fertility rate among adolescent girls aged 15 to 19 years ranges from 27.2 per 1.000 (INS, n.d.) to 34 per 1.000 (World Bank, n.d.). These figures are considerably higher compared to other developed countries. The adolescent fertility rate in the European Union has been reported to be 7 births per 1.000 women aged 15 to 19 years. (World Bank, n.d.). In 2023 the total number of live births to mothers aged 19 or younger was 15.062. Of these, 643 children were

born to very young mothers under the age of 15 (Eurostat, n.d.). This statistic places Romania at the top of European countries with the highest number of children born to very young mothers. According to Eurostat, in 2023, 42 percent of all children born to mothers aged between 10 and 14 across the EU were born in Romania. Moreover, some women in these age groups have experienced multiple births during their youth (see Figure 1). In 2023, of the 648 children born to mothers under the age of 15, 17 already had an older sibling. Ten years earlier, this number was 42. Among mothers aged 15–19, there are already cases of third or even fourth children being born.

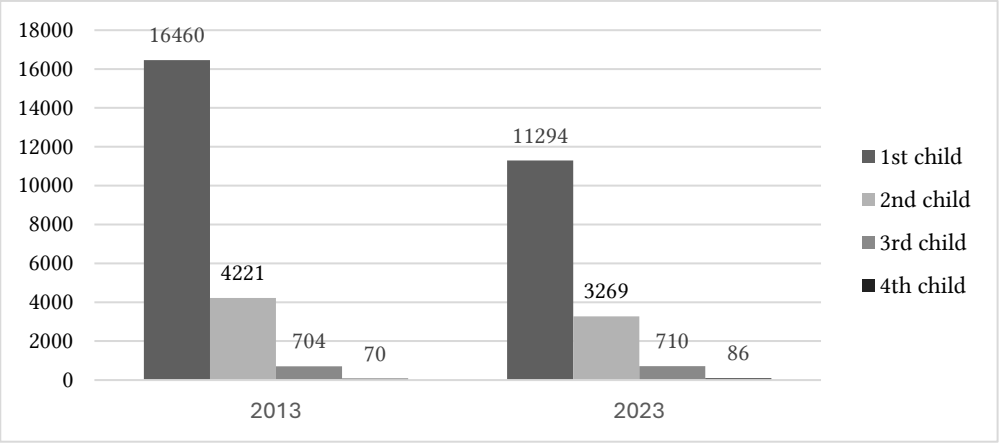

Figure 1. Number of Children Born to Mothers Aged 19 or Younger, by Birth Order
Source: National Institute of Statistics, Romania, authors' calculations

Figure 2 highlights a clear downward trend in the number of children born to mothers aged between 15 and 19 across all regions of the country. The South-Muntenia region records some of the highest values, both in 1993 (8.707 births) and in 2023 (2.488 births), followed closely by the North-East region, which has slightly lower figures. These regions are also those that concentrate the highest proportions of the population living in poverty. On the other hand, the Bucharest-Ilfov region, characterized by increased economic development, has consistently recorded the lowest number of births compared to other regions. Regional disparities were much more pronounced in the early 1990s – for instance, there were nearly 9.000 births in South-Muntenia and just over 2.000 in Bucharest-Ilfov.

Over time, these discrepancies between development regions have decreased, yet the gap between the region with the highest number of births and the one with the lowest remains visible. In 2023, the Centre region (leading in the number of adolescent births) registered 2.533 births (an increase compared to 2022), followed by the North-East and South-Muntenia regions with 2.500 and 2.488 births respectively. At the opposite end are the Bucharest-Ilfov and West regions, with fewer than 1.000 and slightly over 1.000 births, respectively.

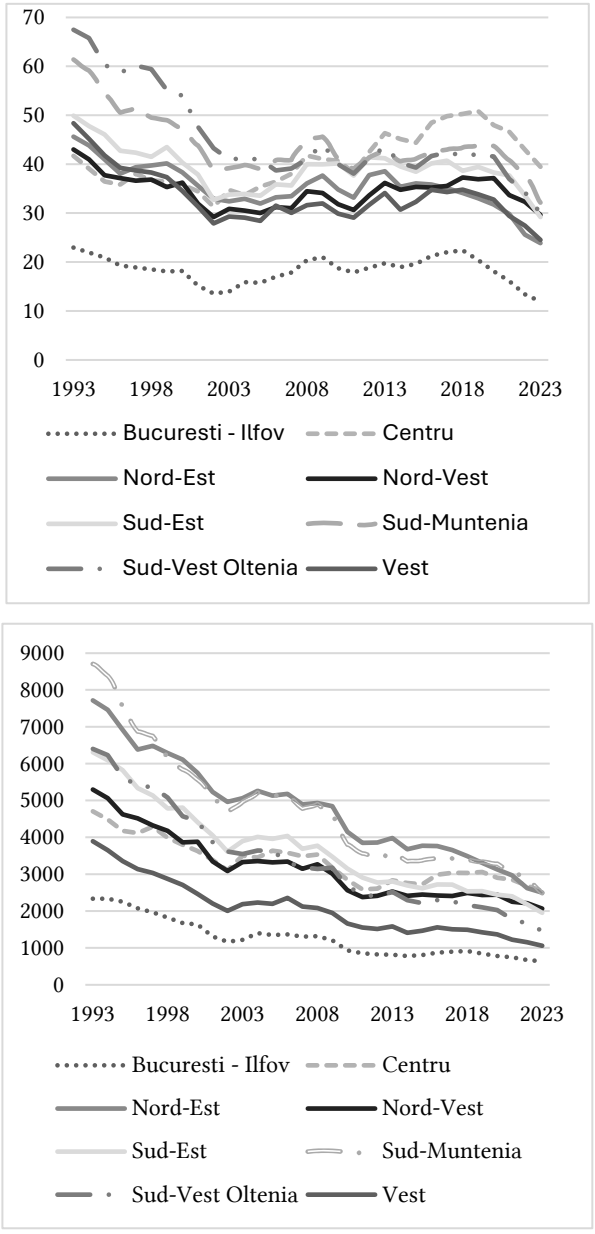

Figure 2. Age-Specific Fertility Rate and Number of Children Born to Mothers Aged 15 to 19
Source: National Institute of Statistics, Romania, authors' calculations

Methodological Note: Fertility rates per 1,000 (left) and absolute number of children born (right). For the period 1993–2011, the population refers to the official population, while for the period 2012–2023, it refers to the resident population.

Discrepancies are not only evident when comparing regions, but they also persist within regions themselves. The county-level distribution of the age-specific fertility rate for women aged 15 to 19 shows that certain counties contribute disproportionately to the high levels of adolescent fertility (see Figure 3). Examples include Sălaj in the North-West region, Mureș and Brașov in the Centre region, and Ialomița, Călărași, and Giurgiu in the South-Muntenia region.

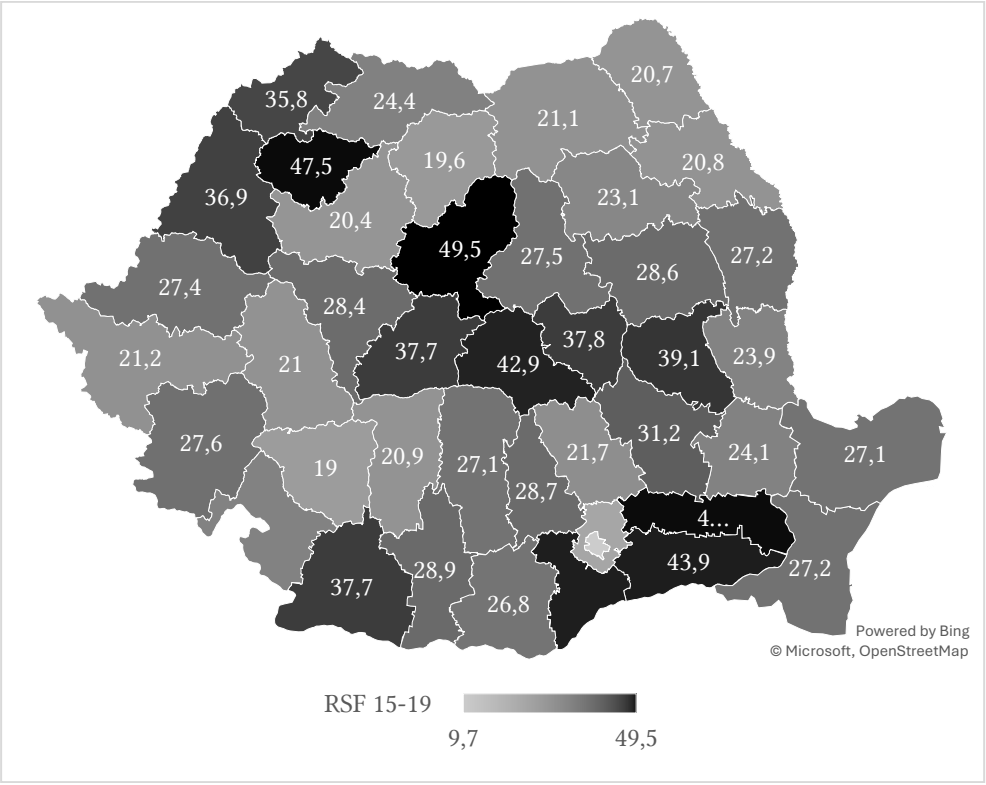

Figure 3. Spatial distribution of the Age-Specific Fertility Rate for Women Aged 15–19 in 2023
Source: National Institute of Statistics, Romania, authors' calculations

The general trend in the number of births to mothers under the age of 15 from 1993 to 2022 is one of increase, with most regions showing significant growth in the number of births among very young mothers (see Figure 4). The region covering the central part of the country recorded the highest number of births – 171 newborns in 2022 – doubling the figure from the first year analysed, which saw only 87 births in the region in 1993. These high values can be explained by the fact that Mureș County registers the highest number of births to mothers under 19 nationally. Similarly, the North-West region also doubled its number of births during the analysed period, from 45 to 101. The South-Muntenia region is also

among the top, with 119 births recorded in 1993. Its trajectory has shown notable fluctuations, reaching 127 pregnancies in the most recent year analysed. The region with the lowest values remains Bucharest-Ilfov, with 22 and 28 births, respectively, and its trend has remained relatively constant over time.

The highest numbers of children born to adolescent mothers are found in the regions of the country with the highest relative poverty rates and those that concentrate the largest numbers of marginalised rural and urban communities. This overlap reflects the link between adolescent fertility and material deprivation. Previous studies have shown that poverty is one of the key determinants of high fertility among young women (Oke, 2010). Most villages with marginalised communities are in the North-East, Centre, South-West Oltenia, and North-West regions (Teșliuc et al., 2016).

Furthermore, the regions with the highest shares of the population living in marginalised urban areas are the North-East and Centre, each with 4.3 percent of the total population, and the South-East, with 4.2 percent (Swinkels et al., 2013). The regions with the highest percentages of the population residing in areas disadvantaged in terms of human capital (education, health, family size, number of children per household) are the North-East with 14.8 percent of the population, the North-West with 13.3 percent, and South-Muntenia with 13.2 percent (Swinkels et al., 2013).

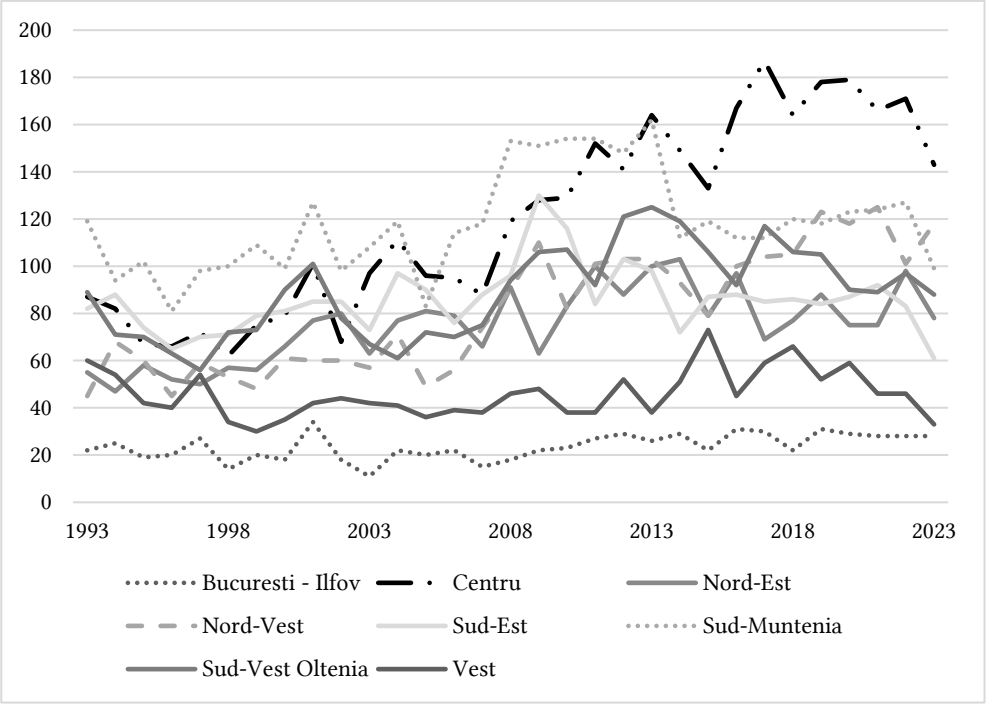

Figure 4. Number of Children Born to Mothers Under the Age of 15
Source: National Institute of Statistics, Romania, authors' calculations

Reproductive Education and Medical Practices

Sexual education is one of the key measures for preventing adolescent pregnancies and is also essential in ensuring the internalisation of knowledge necessary for sexual and reproductive health (Pradhan et al., 2015). Romanian legislation states that sexual education is not mandatory in the school curriculum and can only be delivered with parental consent. Law no. 191 of 2020 (Parliament of Romania, 2020), amending and supplementing Law no. 272/2004 (Parliament of Romania, 2004) on the protection and promotion of children's rights, stipulates in Article 46: "(3) i) the systematic implementation in educational institutions, starting with the 8th grade, with the written consent of parents or legal guardians, of health education programmes aimed at preventing sexually transmitted infections and adolescent pregnancies."

Several weaknesses of this law can be identified. First, it frames sexual education as part of the broader "Health Education" subject, rather than establishing it as an independent discipline. Second, it stipulates that sexual education may only begin in the 8th grade, meaning that it is delivered only to pupils aged 14–15 and above. Yet, statistics show that pregnancies among girls under 15 are on the rise, while the number of births to those aged 15–19 is decreasing. This underscores the importance of providing age-appropriate sexual education to pupils younger than 15 (Neculau et al., 2022). Finally, the requirement for parental or legal guardian consent for participation in sexual education classes (Law 191/2020) may restrict young people's right to informed choice, which undermines the goal of preventing adolescent pregnancies (Neculau et al., 2022).

The high number of pregnancies among very young females can also be explained by limited access to abortion services nationwide. The cost of an abortion can be a barrier for underage mothers, as can the refusal of some doctors to perform the procedure. Although abortion is legal in Romania through Law 286/2009, paragraphs 6–7 (Parliament of Romania, 2009), access to the procedure appears increasingly limited (Association of Independent Midwives, 2024; Filia Centre, 2021). While the number of abortions in Romania has sharply declined (see Figure 5), in contrast to the slightly increasing trend across the EU, this apparent "success" may reflect restricted access to abortion in public hospitals rather than improved access to sexual education and family planning. It is therefore likely that this trend masks significant inequalities among different categories of young women.

Recent research raises important questions about the equity of this apparent progress, as women from disadvantaged backgrounds may face greater obstacles in accessing safe and affordable services. A study conducted by the Filia Centre (2021) revealed that, out of 171 hospitals with obstetrics and gynaecology departments included in the research, only 59 perform abortions on request. The most common explanations given by doctors for refusing such procedures are religious and moral reasons (Filia Centre, 2021).

In a 2024 report on access to safe abortion, the Association of Independent Midwives published a map of abortion accessibility. Of the 176 public medical units included in the study, 111 (63.6%) do not offer abortion as a medical service, and

only 7 public units (4%) provide medication or surgical abortions in accordance with national legislation. Among the private medical facilities included in the study, 59 provide either medical or surgical abortions. The counties with the lowest levels of access to abortion are Botoșani, Arad, Sălaj, Bacău, Vaslui, Covasna, Caraș-Severin, Brăila, Ialomița, Călărași, Giurgiu, Constanța, and Dâmbovița. Consequently, the regions with the most limited access to abortion services are South-Muntenia, North-East, and West. Mureș County registers the highest level of abortion accessibility: 20–30 percent (Association of Independent Midwives, 2024).

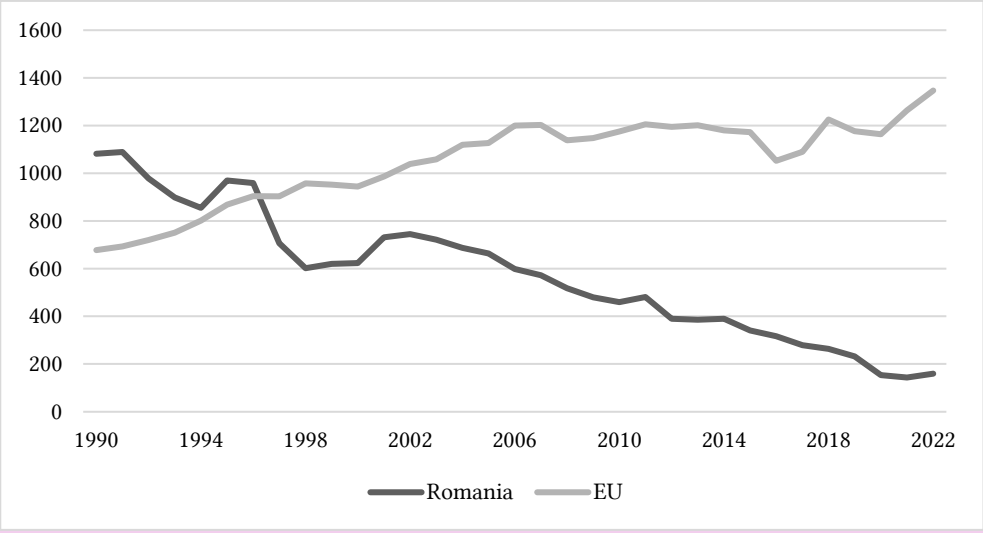

Figure 5. Evolution of the Number of Abortions per 1.000 Births in Romania and the European Union
Source: World Health Organization, European Health for All Database (HFA-DB), authors' calculations

The Code of Medical Ethics of the Romanian College of Physicians (04.11.2016) states in Article 34 – Refusal to Provide Medical Services, paragraph (1): "Refusal to provide medical care is permitted strictly under the law or if, through the request made, the person in question asks the physician to carry out acts that would undermine their professional independence, affect their image or moral values, or the request is not in line with the fundamental principles of the medical profession, its purpose, or its social role" (Romanian College of Physicians, 2016). This legal framework significantly restricts access to safe abortion, even though abortion is legal in Romania. Additionally, such procedures come with material costs that people in need may not be able to afford. The cost of an abortion varies between 70 RON and 1,200 RON, depending on the hospital (Filia Centre, 2021). A large part of Romania's population experiences material hardship, which may act as a barrier to accessing this medical service. Many pregnant minors come from families living in extreme poverty, with less than 3–4 USD per day per family

member (Save the Children Organization, 2024). Furthermore, the Coronavirus crisis has significantly contributed to the inaccessibility of abortion services: fewer and fewer medical facilities performed abortions on request during the pandemic (Filia Centre, 2021).

Romania's network of family planning clinics was created in 1992 following the model of the Society for Education in Contraception and Sexuality (SECS). In 1994, there were 242 public clinics; by 2020, only 117 remained operational. Additionally, health insurance covers only two consultations per year for family planning (Draghici, 2022). This withdrawal of the state from providing reproductive health services has multiple negative implications for women's sexual and reproductive health. The global family planning policy effort index shows that Romania scores the lowest among all countries analysed (Rosenberg et al., 2023). Moreover, contraceptive prevalence in Romania was only 53.5 percent in 2019 (United Nations, 2019). The most used contraceptive method is the condom (20.3%), followed by oral contraceptives (14%) and the calendar method (6%) (United Nations, 2019). An important point to note is that in Romania, the cost of contraceptives is not covered by the health system –neither for young people (up to the age of 19 or 25), nor for people in vulnerable situations. Countries such as France and Belgium rank at the top of the index, with scores above 90 percent. According to Save the Children Organization Organisation, the lack of contraceptive use and insufficient information account for two-thirds of pregnancies among underage girls (Save the Children Organization, 2024).

The stillbirth rate is an indicator that measures the frequency of births resulting in stillborn infants. This indicator reflects both access to and the effectiveness of medical care during pregnancy and childbirth. High values may indicate the absence of regular medical check-ups, undiagnosed complications, insufficient or delayed medical interventions, among other factors. At the same time, the stillbirth rate is also a social indicator that allows for comparisons across time and between different groups of women. According to Figure 6, in Romania, the incidence of stillbirths has been declining. For the population of young women aged 15 to 34, the stillbirth rate in 1990 ranged from 5.5 to 9 per 1,000. In 2023, it does not exceed 4 per 1,000 among this age group.

Based on age group, Figure 6 shows that, in recent years, the stillbirth rate has been highest among mothers under 15 and those aged 15 to 19. This is not an unexpected result for several reasons. Women who become pregnant at very young ages, as well as those who do so later in life (over the age of 35), are at higher risk for obstetric complications (National Institute of Public Health, 2022). For very young pregnant women, limited access to medical services and restricted reproductive education also play a role. The extreme values of the stillbirth rate in 2006 and 2015 for the under-15 category coincide with sharp increases in adolescent births during those years. Rapid short-term increases in the number of births, age-specific fertility rates, and stillbirth rates indicate a structural issue within the Romanian healthcare system, one that routinely neglects certain social groups, especially women from disadvantaged backgrounds.

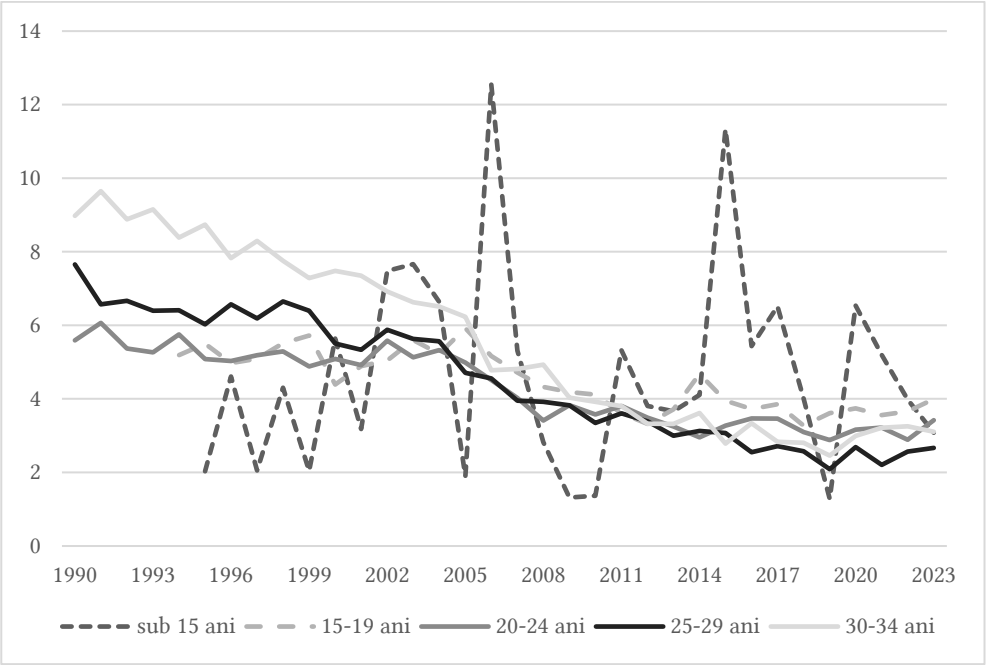

Figure 6. Stillbirth Rate by Mother's Age Group
Source: National Institute of Statistics, Romania, authors' calculations

While stillbirth rates raise critical questions about the quality of perinatal care and the healthcare system's ability to prevent avoidable deaths, another important indicator of how medicine shapes the childbirth experience is the frequency of surgical interventions. Caesarean section, a predominant surgical technique in obstetrics, can serve as an indicator of reproductive disparities. The frequency and circumstances under which this intervention occurs point to significant inequalities in access to quality medical care, women's autonomy in making informed decisions about their bodies, and the effectiveness of health policies and medical practices in addressing the needs of diverse social groups (Betran et al., 2021).

In Romania, caesarean birth is an increasingly common practice. More than 45 percent of all live births occur via caesarean section (see Figure 7). This rate places Romania among the top European countries in terms of caesarean incidence, significantly exceeding the 10–15 percent threshold recommended by the World Health Organization.

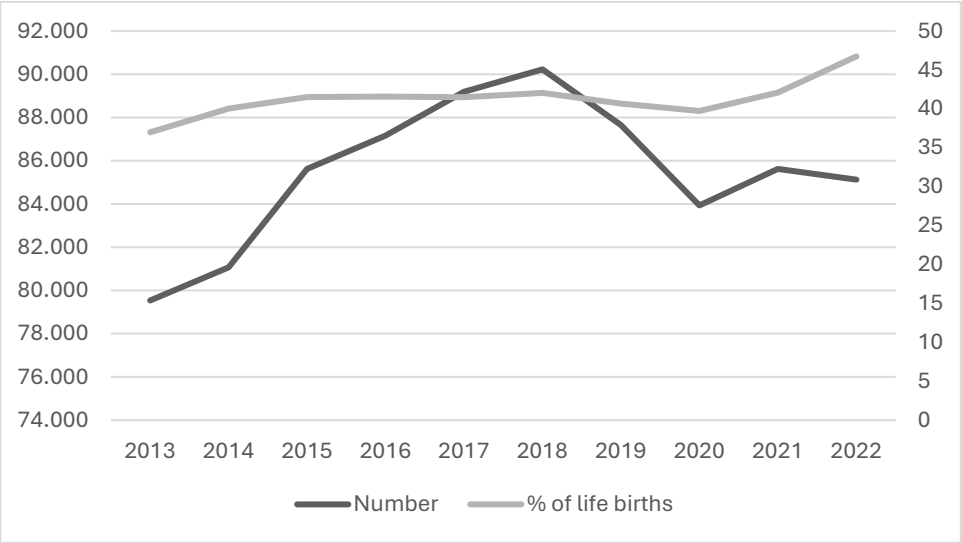

Figure 7. Caesarean sections in Romania
Source: National Institute of Statistics, Romania and Eurostat, authors' calculations

Other recent studies show that more than half of all births in Romania are performed by caesarean section (Slovenski et al., 2024). Most of these caesarean births are scheduled in advance and are not the result of medical emergencies (Neaga et al., 2024). The limited research available on this issue also highlights the inequalities between public and private healthcare services. For financial and profitability reasons, rather than due to informed personal choice or considerations of maternal and infant health, almost 80 percent of births in private maternity clinics are caesarean deliveries (Slovenski et al., 2024). A similar pattern is observed in public hospitals, which receive higher public funding if procedures are classified as more complex, such as caesarean sections. In over 70 percent of cases, the decision to undergo a caesarean section was made following the doctor's recommendation, and among the women who made the decision themselves, the most common reason cited was fear of pain (Neaga et al., 2024).

4. Conclusions

By overlapping the image of uneven economic development with that of adolescent fertility, we have shown that poverty intersects with gender in a profound way. Although our analyses are not complex enough to demonstrate the statistical intensity of the relationship between these two phenomena, the descriptive results we presented offer clear evidence of the link between structural factors, primarily poverty, and adolescent motherhood. We argue that adolescent girls living in the most marginalised areas of the country are disproportionately affected. They grow up in environments where patriarchal norms are deeply entrenched, reproductive autonomy is restricted, and institutions are perceived as absent or hostile. In this context, adolescent motherhood can be understood not

only as a consequence of economic precariousness but also as part of a broader dynamic of structural gender violence. The lack of access to safe reproductive services, quality education, and institutional support constitutes a profound capability deficit. These conditions are perpetuated, reinforcing the social marginalisation of young mothers and their children. In Bourdieu's terms, the lack of educational and economic capital among these young women limits their ability to navigate the reproductive field as conscious and autonomous actors. The overlap between poverty, unequal access to prenatal care, and high rates of invasive medical interventions signals a healthcare system that, rather than correcting structural inequalities, reproduces and even intensifies them.

These structural dynamics cannot be understood separately from the legal and institutional framework that shapes access to sexual education, safe abortion, and obstetric care. We have also examined how the legal context contributes (directly or indirectly) to the perpetuation of adolescents' reproductive vulnerability. Although abortion is legal and sexual education is formally regulated, real access to these services remains severely limited. The Health Education Law, conditioned by parental consent and implemented only from the eighth grade, excludes precisely the most vulnerable category, girls under the age of 15, where the number of births is rising, alongside a persistently high stillbirth rate. Access to abortion is systematically constrained by costs, institutional refusals, and inadequate medical infrastructure. In Foucauldian terms, this situation may be interpreted as a form of biopower that disciplines young bodies through deliberate inaction, delegating moral responsibility to the familial and religious spheres.

One important limitation of this study is its inability to quantify, in probabilistic terms, the strength of structural factors' effects on women's reproductive health. In arguing that reproductive inequalities and gender violence have structural determinants, one might expect a statistical testing of relationships between the various proxies that describe the phenomenon under study. However, this study does not claim to offer a statistically advanced model that thoroughly captures the complexity of this social and demographic reality. Rather, our aim was to explore an empirical universe that is largely overlooked in current research and scarcely addressed by the state as a matter requiring intervention.

The primary contribution of this study is its capacity to consolidate many aspects of reproductive inequality and gender-based violence in Romania into a singular narrative. Although numerous publications we reviewed examine reproductive inequalities with scientific rigour, we identified no study that synthesises the diverse factors discussed here into an integrated framework. This work establishes an important basis for a scientific and institutional agenda that perceives adolescent motherhood not as an individual deviation, but as a significant indicator of systemic inequality that necessitates acknowledgement, examination, and intervention.

References

Apostol, N. (2012). *Dreptul la avort și la drepturi reproductive în Europa și România* [*The right to abortion and reproductive rights in Europe and Romania*]. Center for Curricular Development and Gender Studies FILIA.

Arai, L. (2009). *Teenage pregnancy: The making and unmaking of a problem*. Policy Press. https://policy.bristoluniversitypress.co.uk/teenage-pregnancy

Asociația Moașelor Independente [Association of Independent Midwives]. (2024). *Raport privind accesul la avort în siguranță* [*Report on access to safe abortion in Romania*].

Betran, A. P., Ye, J., Moller, A. B., Zhang, J., Gülmezoglu, A. M., & Torloni, M. R. 2021. Trends and projections of caesarean section rates: Global and regional estimates. BMJ Global Health, 6(6), e005671.

Betti, G., Dourmashkin, N., Rossi, M. C., & Yin, Y. (2001). *Study of the problem of consumer indebtedness: Statistical aspects final report*. ORC Macro.

Bourdieu, P. (1990). *The logic of practice* (R. Nice, Trans.). Stanford University Press. (Original work published 1980)

Bourke, A., Boduszek, D., Kelleher, C., McBride, O., & Morgan, K. (2014). Sex education, first sex, and sexual health outcomes in adulthood: Findings from a nationally representative sexual health survey. *Sex Education, 14*, 299–309.

Filia Center. (2021). *Research report: Refusal to perform abortion on request in Romania*. Bucharest.

Dinu, M. S. (2022). *Sexual and reproductive health education: A study in the context of Romania (Doctoral dissertation)*. Global Campus Europe.

Draghici, D. 2022. Romanian NGOs' uphill battle for CSE in schools, FP clinics, unrestricted access to abortion, and trafficking prevention. Sexul vs. Barza Association.

Eurostat. (n.d.). *Population by age and sex (demo_fasec)* [Data set]. Eurostat. Retrieved June 17, 2025, from https://ec.europa.eu/eurostat/databrowser/view/demo_fasec/default/table?lang=en. DOI: https://doi.org/10.2908/DEMO_FASEC

Foucault, M. (1978). *The history of sexuality*. Gallimard.

Garcia, L., & Fields, J. (2017). Renewed commitments in a time of vigilance: Sexuality education in the USA. *Sex Education, 17*, 471–481.

Gordon, L. (1997). Feminism and Reproductive Rights: The Limits of Liberalism. *Journal of Women's History, 8*(4), 44–59.

Greene, M. E., & Merrick, T. (2005). *Poverty reduction: Does reproductive health matter?* (Vol. 33399). World Bank.

Hagenaars, A., & de Vos, K. (1988). The definition and measurement of poverty. *The Journal of Human Resources, 23*(2), 211–221.

INS. (n.d.). POP203B - *Fertility rate for live-born with usual residence in Romania by urban/rural area of usual residence, mother's age group, macroregions, development regions and counties* [Data set]. INS Tempo Online. Retrieved June 17, 2025, http://statistici.insse.ro:8077/tempo-online/#/pages/tables/insse-table

INS, (n.d.). *SAR102B-Relative poverty rate by age group* [Data set]. INS Tempo Online. Retrieved June 17, 2025, http://statistici.insse.ro:8077/tempo-online/#/pages/tables/insse-table

Institutul Național de Sănătate Publică [National Institute of Public Health]. (2022). *Mortalitatea infantilă în România 20222* [*Infant mortality in Romania in 2022*].

Iorga, M., Pop, L.-M., Gimiga, N., Păduraru, L., & Diaconescu, S. (2021). Assessing the opinion of mothers about school-based sexual education in Romania, the country with the highest rate of teenage pregnancy in Europe. *Medicina, 57*(8), 841.

IPPF Europe. (2023, March 27). *High costs and broken health system freeze many out of abortion care in Romania.* https://europe.ippf.org/stories/high-costs-and-broken-health-system-freeze-many-out-abortion-care-romania

Kennedy, E., Gray, N., Azzopardi, P., & Creati, M. (2011). Adolescent fertility and family planning in East Asia and the Pacific: A review of DHS reports. *Reproductive Health, 8*, 11.

Kligman, G. (2000). *Politica duplicității. Controlul reproducerii în România lui Ceaușescu* [*The politics of duplicity. The Process of Communism Collection*]. Humanitas.

LeMasters, K., Wallis, A. B., & Cherecheș, R. M. (2019). Pregnancy experiences of women in rural Romania: Understanding ethnic and socioeconomic disparities. *Culture, Health & Sexuality, 21*(8), 851–865.

Magyari-Vincze, E. (2006). *Social exclusion at the crossroads of gender, ethnicity and class: A view of Romani women's reproductive health.* Open Society Institute.

Nanu, M. I., Stativa, E., Vălceanu, D., & Oţelea, M. R. (2021). Teenage pregnancy in Romania. Association for Health for Mothers and Infants (SAMAS). Bucharest.

Neaga, D., Grunberg, L., & Radu, C. (2024). Experiența nașterii în spitalele din România: Raport de cercetare privind violența obstetrică. Asociația Moașelor Independente.

Neculau, A., Neguț, D., Văcaru, M., & Vladu, C. (2022). Policy framework for preventing adolescent pregnancies and their consequences. UNICEF.

Oke, F. (2010). Poverty and Teenage Pregnancy: The Dynamics in Developing Countries. OIDA *International Journal of Sustainable Development, 2*(5), 63-66.

Palagă, A. C. (2021). *Avatarurile economiei informale în România postsocialistă.* Presa Universitară Clujeană.

Parker, R., Wellings, K., & Lazarus, J. V. (2009). Sexuality education in Europe: An overview of current policies. Sex Education, *9*(3), 227-242.

Parliament of Romania. (1989). Law no. 1/1989 regarding certain measures concerning the organization of state power in Romania. Monitorul Oficial, no. 1/1989.

Parliament of Romania. (2004). Law no. 272/2004 on the protection and promotion of children's rights. Official Gazette of Romania, no. 557/2004.

Parliament of Romania. (2009). Law no. 286/2009 on the Criminal Code. Official Gazette of Romania, no. 510/2009.

Parliament of Romania. (2020). Law no. 191/2020 for amending and supplementing the National Education Law no. 1/2011. Official Gazette of Romania, Part I, no. 803 of September 1, 2020.

Patton, G., Coffey, C., Sawyer, S. M., Viner, R. M., Haller, D. M., Bose, K., Vos, T., Ferguson, J., & Mathers, C. D. (2009). Global patterns of mortality in young people: A systematic analysis of population health data. *The Lancet, 374*(9693), 881–892.

Pillow, W. (2004). *Unfit subjects: Educational policy and the teen mother.* Routledge.

Plan International. (2024). *Sănătatea sexuală și reproductivă și drepturile aferente în România. Situația actuală și tendințe viitoare [Sexual and reproductive health and rights in Romania].* https://plan-international.org/uploads/sites/104/2024/08/full-report-ES-PI-RO_converted.pdf

Pradhan, R., Wynter, K., & Fisher, J. (2015). Factors associated with pregnancy among adolescents in low-income and lower-middle-income countries: A systematic review. *Journal of Epidemiology & Community Health, 69*, 918–924.

Robbins, C. L., & Ott, M. A. (2017). Contraception options and provision to adolescents. *Minerva Pediatrica, 69*(5), 403–414.

Romanian College of Physicians – CMR. (2016). Code of medical deontology of the Romanian College of Physicians from 04.11.2016.

Rosenberg, R., Hardee, K., & Zosa-Feranil, I. (2023). *The National Composite Index for Family Planning (NCIFP): 2021 Global Report.*

Santelli, J. S., Kantor, L. M., Grilo, S. A., Speizer, I. S., Lindberg, L. D., Heitel, J., & Ott, M. A. (2017). Abstinence-only-until-marriage: An updated review of US policies and programs and their impact. *Journal of Adolescent Health, 61,* 273–280.

Save the Children Organization. (2022). The story of mothers under 15: 45% of births recorded among girls under 15 years old in the European Union come from Romania. Bucharest, Romania.

Salvați Copiii România [Save the Children Organization]. (2024). *Studiu privind mamele minore și gravidele minore: Raport de cercetare* [*Study on minor mothers and minor pregnant girls: Research report].* ISBN: 978-606-8038-60-5

Sen, A. (1993). Capability and well-being. In A. Sen & M. Nussbaum (Eds.), *The Quality of Life* (pp. 30–53). United Nations University.

Slovenski, I., Krech, R., & Evans, D. 2024. Patterns of cesarean birth rates in the public and private hospitals of Romania. *Discover Public Health, 21*(1), 246.

SmithBattle, L. (2013). Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal/Child Nursing, 38*(4), 235–241.

Swinkels, R., Stănculescu, M. S., Anton, S., Koo, B., Man, T., & Moldovan, C. (2013*). Atlasul zonelor urbane marginalizate din România [Atlas of marginalized urban areas in Romania].* Regio.

Teşliuc, E., Grigoraș, V., & Stănculescu, M. S. (2016). *Atlas of marginalized rural areas and local human development in Romania.* World Bank.

UNICEF. (2012). *Child poverty in perspective: An overview of child well-being in rich countries (Innocenti Report Card 7).* UNICEF Innocenti Research Centre.

United Nations, Department of Economic and Social Affairs, Population Division. (2015). *Contraceptive use by method: Data booklet* (ST/ESA/SER.A/372). United Nations.

United Nations Department of Economic and Social Affairs, Population Division. (2019). Contraceptive use by method 2019: Data booklet.

United Nations General Assembly. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development.* Resolution adopted by the General Assembly.

United Nations Population Fund (UNFPA). (2007). Briefing notes for Pacific parliamentarians on population, development, and reproductive health issues. UNFPA Office for the Pacific. Suva.

United Nations Population Fund (UNFPA). (2018). *Contraceptive prevalence and development indicators.*

Weziak-Bialowolska, D., & Dijkstra, L. (2014). *Monitoring multidimensional poverty in the regions of the European Union. European Commission.* Joint Research Centre.

World Bank. (2007). *Development and the next generation. World Development Report.* International Bank for Reconstruction and Development. Washington, DC.

World Bank. (2010). *Meeting the challenge of adolescent fertility through education and family planning.* The World Bank.

World Bank. (2016). *Poverty and shared prosperity 2016: Taking on inequality.* World Bank Group. https://doi.org/10.1596/978-1-4648-0958-3

World Bank. (n.d.). Adolescent fertility rate (births per 1,000 women ages 15–19) [Data set]. World Development Indicators. Retrieved June 17, 2025, from https://data.worldbank.org/indicator/SP.ADO.TFRT

World Health Organization (WHO). (2006). *Adolescent pregnancy: Unmet needs and undone deeds.* Geneva.

World Health Organization (WHO). (2008). *Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?.* Geneva.